

Medical Narratives of Military PTSD: Moving Beyond the Biomedical Approach

by

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Abstract

Barriers to care among soldiers within the Canadian Armed Forces is a topic in need of recognition, with the majority of Canadian soldiers failing to seek healthcare for a mental health issue. Most current literature comes from the medical and psychological disciplines, using quantitative research methodologies to identify specific factors such as stigma, which act as barriers to care. In order to move beyond this current positivist paradigm, there must be a collaboration between realist and constructivist frameworks. This study utilized a qualitative constructivist approach to analyse the narratives of Canadian psychiatrists surrounding the PTSD diagnosis within the military. Analysis of these narratives sought to address the power relations, construction, and framework of this diagnosis. Finally, these medical PTSD narratives were compared to military PTSD narratives in order to identify how well they served those suffering from this medical disorder.

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Chapter 1: Introduction

According to Conrad (1992) “medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (p. 224). The psychological stress caused by combat was medicalized into Post Traumatic Stress Disorder (PTSD), in order to allow veterans returning from war to have a verified medical condition that allowed them to receive medical treatment (Summerfield, 2001). At the end of the Second World War, soldiers were given labels such as “psychopath” and “baby killer” in response to the actions they took in combat which were depicted in the media for civilians to see (Summerfield, 2001). These labels represented dominant attitudes towards soldiers at the time; in order to improve upon medical care available, the diagnosis of PTSD was used to remove the negativity and responsibility of combat from the soldier as an individual, and to instead place it on the traumatogenic nature of war (Summerfield, 2001). This allowed soldiers to subvert the negative labels associated with their war efforts, and instead reconstruct their identities as victims. This was done through the process of legitimizing their victim status through the diagnosis of PTSD (Summerfield, 2001).

Summerfield (2001) argues that the diagnosis of PTSD remains a means of seeking a victim status, he explains “the profile of Post-Traumatic Stress Disorder has risen spectacularly, and it has become a means by which people seek victim status-and its associated moral high ground-in pursuit of recognition and compensation” (p. 96). Tavis (1993) problematizes the medicalization of PTSD by explaining, “if a mental disorder reliably and stereotypically fits a narrow category of people, then we should be looking at what it wrong with the conditions of the people in that category, not exclusively at their individual pathologies” (Tavis, 1993, p. 186). She argued for a

social science based approach in order to understand the conditions that cause PTSD rather than attempting to use a psychiatric approach to relieve the symptoms (Tavris, 1993).

The medicalization of PTSD is a useful framework in understanding the power structures involved in creating and maintaining such a diagnosis, so I will be utilizing this framework. However, it is important to note that between 6.6% (Brunet, Monson, Liu & Fikretoglu, 2015) and 11.1% (National Defence and the Canadian Armed Forces, 2016) of Canadian soldiers experience PTSD within their lifetime. Whether or not the diagnosis is universally agreed upon I believe that it is important to view this diagnosis as a tangible phenomenon which causes suffering among soldiers as this taxonomic category allows for researchers to discuss and identify it within their research with greater ease.

Furthermore, Western soldiers experiencing PTSD tend to underutilize health care (Molendijk, Kramer and Verweij, 2016; Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L., 2004; Kim, P. Y., Thomas, J. L., Wilk, J. E., Castro, C. A., & Hoge, C. W., 2010). Under-utilization refers to failure to seek health care among individuals suffering from mental disorders. Along with this phrasing comes the implication that sufferers of mental disorders 'ought' to seek health care; however, I will be using this phrasing for convenience. Dominant literature identifies perceived stigma (Hooyer, 2015; Kim et al., 2010; Schreiber & McEnany, 2015; Vogt, 2011), negative attitudes towards care (Britt, Greene-Shortridge, Brink, Nguyen, Rath, Cox,... & Castro, 2008; Hoge et al., 2004; Kim et al., 2010; Wright, Britt & Moore, 2014) and the desire to handle mental distress on one's own (Naifeh, Colpe, Aliaga, Sampson, Heeringa, Stein, M.... & Zaslavsky, 2016) to be the most important barriers to mental health care among military personnel.

It is important to note that both women and men within the military can experience PTSD, however gender was not explicitly discussed within this research. Much of the literature on barriers to health-care among military members with PTSD does not differentiate by gender (Hoge et al., 2004; Kim et al., 2010; Molendijk, Kramer and Verweij, 2016). In order to build upon previous research in this area, a similar framework was used as to include all military members who experience PTSD, speaking to general narratives and perspectives of PTSD among practitioners that could be applied to all patients, and were not gender-specific.

Most current research on barriers to mental health care among military personnel come from the disciplines of psychology and medicine, utilizing realist frameworks and quantitative methods to identify individual correlates of lack of help-seeking among this cohort (Hoge et al., 2004; Kim et al., 2010). Realist frameworks refers to the perspective that the phenomena are objectively 'real' and can be understood accurately for what they are. This realist perspective fails to address the relationships between identified barriers to care and the processes which put these factors in place. Questions need to be asked such as "does this dominant conception adequately address and explain PTSD among veterans?", "how does this conception fit within military culture and infrastructure?" and "how do dominant narratives compare to military narratives?" A constructivist framework will allow me to address these questions. I will look at the constructivist frameworks of the medicalization of PTSD as informing the development and maintenance of PTSD, while subsequently viewing PTSD as a valid phenomenon of suffering among past and present military personnel.

This research utilizes the social constructivist theoretical orientation alongside Foucault's (1973) theory of medical gaze in order to address the following research questions: What

narratives of PTSD emerge within the medical discipline? Further sub-questions include: How might these narratives compare to military narratives of PTSD? What are the consequences of conflicting narratives of PTSD within the military and medical institutions? How do medical PTSD narratives impact care-seeking behaviour among military personnel?

A narrative analysis was used in order to assess and examine the stories which are being told by psychiatrists about PTSD and about their profession. Biomedicine is the dominant authority on the topic of PTSD (Foucault, 1973; Rose, 2001), causing the biological assumptions of this field to carry over into dominant understandings of PTSD. In other words, biomedicine has the authority to deal with PTSD, and the biomedical PTSD perspective is viewed as the perspective of PTSD with the most authority. It is important to understand the ways in which PTSD is constructed within biomedical discourse to gain a deeper understanding of the ways these narratives of PTSD affect those suffering from this disorder.

This research seeks to utilize a qualitative framework to examine the presently identified barriers to care, and further explore the relationships between them through a focus on medical narratives. Medical narratives impact the patient's experience and understanding of their disorder ; (Kleinman, 1988; Frank, 1996) however, narrative research is not conducive to that of a realist perspective, causing it to be largely absent from current literature. This thesis will address this gap in the literature, allowing for future research on barriers to care to build upon a more constructivist perspective.

Chapter 2: Literature Review

Medicalized Approaches to PTSD

The Variance in Understandings of PTSD

Within the social sciences disciplines, there has been a large focus on studying the shortcomings of the Western PTSD model across many cultures. However, there is a lack of attention to the applicability of this model within individual Western cultures, specifically Western military culture. Sociocultural factors can affect the ways in which individuals experience, understand, and attach meaning to trauma, causing trauma to be understood and experienced differently across cultures (Hinton & Lewis-Fernandez, 2011; Somasundaram, 1996; Jones, Vermaas, McCartney, Beech, Palmer, Hyams & Wessely, 2003). For example, this is evident among Tibetans who found the destruction of religious symbols to be more traumatic than torture, and survivors of the Rwandan genocide who described the inability to perform religious rituals for the dead to be traumatic (Hinton & Lewis-Fernandez, 2011). Many historians and anthropologists agree that “the subjective experience of trauma and subsequent expression of symptoms vary considerably over space and time” (Stein, Seedat, Iversen & Wessely, 2007, p. 139; Jones, et al., 2003). This is evidence of a need for situated attention to the understandings of PTSD within specific geographical areas as well as across time, cultures, etc.

Symptoms commonly associated with PTSD such as flashbacks have not always been associated with this disorder (Jones, et al., 2003). Experiences of flashbacks were rarely reported among Veterans serving in the First and Second World Wars (Jones, et al., 2003). In historical cases of PTSD, somatic symptoms were more frequently expressed as opposed to psychological

symptoms, which are more common today (Jones, et al., 2003). Although this could speak to differing symptom expressions, it could also speak to the changing DSM criteria for Post-Traumatic Stress Disorder and changes in clinicians' understandings of PTSD over time, specifically, which symptoms were deemed valid.

In the First and Second World Wars, PTSD was known as shellshock, with veterans often describing somatic symptoms such as “contractures, tics, movement disorders and paresis” (Jones, et al., 2003, p. 163). Jones et al. (2003) explains the variance of PTSD symptoms as relating to an advancing technological society, which tends to depict dominant conceptions of PTSD within the media. They argue that individuals experience PTSD differently now because of the changing cultural conceptions of typical reactions to traumatic events. Specifically, more attention to portrayal of the flashback, which they described as a “visual device practised in the cinema to introduce immediate dramatic tension” (Jones, et al., 2003, p. 162) have contributed to the flashback becoming identified as a hallmark of PTSD (Burnstein, 1985). This causes me to suspect that Jones et al.'s (2003) argument was referring to the possibility that increased media visibility of the flashback functioned as a device that allowed PTSD sufferers to more readily identify the symptoms they were experiencing, rather than a catalyst for symptom portrayal and development on a subconscious level. This literature shows us that the singular definition and diagnostic criteria of PTSD does not universally describe the distressing post-traumatic experiences of individuals across time and across cultures. Just as PTSD symptom expression varies cross-culturally, the diagnostic criteria have varied as well.

It is evident within this literature that the Western model of PTSD does not have cross-cultural validity due to the variance of symptoms and meaning attached to trauma. This is because sociocultural factors affect these understandings and meaning-making processes. It is important to develop a deeper understanding of PTSD among Western soldiers and veterans in addition to PTSD in other cultures, as the Western military has a culture of its own which factors into the ways those within the military experience and understand the world.

The majority of the literature on this topic is either written within medicine or psychology. The literature tends to focus on specific barriers to care, utilizing quantitative approaches. I will be utilizing a sociological, qualitative approach to address the impact of the stories medical practitioners tell both about PTSD and about their profession. It is my goal within this study to address the assumptions and meanings within the help-seeking process rather than follow the majority of current research in taking a positivist causation-focused approach. My analytic focus will utilize a narrative analysis in order to develop an understanding of the meanings present and stories being told about PTSD among the practitioners offering care. The complexity present in the mental health seeking processes within the military needs to be explored more deeply which is why I am utilizing a sociological approach. This type of approach will allow me to probe the effect of the meanings of these illness narratives and the processes by which they are created.

Masculinity

The notable interaction between masculinity and PTSD is evident in a variety of contexts, with masculine identity being utilized by soldiers as cultural capital (Lahelma, 2005) and affecting soldiers' conceptions and experiences of PTSD (Caddick, Smith & Phoenix, 2015;

Elder, W. B., Domino, J. L., Mata-Galán, E. L., & Kilmartin, C., 2017; Shields, 2016).

Masculinity refers to “behaviours associated with success dedication, restrictive emotionality, inhibited affection and exaggerated self-reliance” (Snell, 1989, p. 749). Men are more likely to adhere to these outlined behaviours due to the notion that these behavioural tendencies are the acceptable way for a man to act, they function as male gender norms (Snell, 1989). Typically, it is the men who identify with hypermasculine norms that are likely to join the military, contributing to the gender norms present within the military institution (Garcia, Finley, Lorber & Jakupcak, 2011). Moreover, within the military, men feel the need to adhere to these behaviours due to social pressure to fit in, with military training further emphasizing and relaying the need for traditional masculine gender norms (Brooks, 1990; Garcia et al., 2011).

Hale (2012) found that not only were masculine identities constructed through military practice, masculinities were practiced as a way for soldiers to fit in and “meet the aims of the process of militarization” (Hale, 2012, p. 699). Similarly, Lahelma (2005) argued that masculinities are performed within the military as a means of practicing group solidarity. Group solidarity is a process that is emphasized within the military, functioning as a way for soldiers to transcend their differing cultures and backgrounds through such homogenous performances (Lahelma, 2005). This need for masculinity as a way to fit in and practice normative military roles is carried on to soldiers’ experiences with trauma, and in some cases, PTSD. With soldiers being expected to “be a man” and “suck it up” in the face of stressors ranging from physical exertion to trauma, such an identity or performance is likely to have an effect on how a soldier experiences, understands and responds to stress.

Adherence to traditional masculine behaviours has been negatively associated with help-seeking behaviours (Garcia et al., 2011; Lane & Addis 2005; Berger, Levant, McMillan,

Kelleher & Sellers, 2005). With the military fostering greater adherence to these norms, it is vital that the effect of these norms be studied in relation to health-seeking behaviours, namely because Western soldiers underutilize mental health care (Molendijk, Kramer and Verweij, 2016; Hoge et al, 2004; Kim et al., 2010). According to Berger et al. (2005), civilian men “who score higher on measures of gender role conflict and traditional masculine ideology tend to have more negative attitudes toward psychological help seeking” (p. 63). This describes the masculine norms adhered to by civilians, a population that does not have the added pressure to act out masculine behaviours as experienced within the military (Garcia et al., 2011). Lane et al. (2005) were able to expand on these findings, showing that restrictive emotionality and restrictive affectionate behaviour related to decreased willingness to seek psychological health care. Komiya and Eells (2001) supported these results, stating that fear of emotional closeness was associated with reduced willingness to seek out psychotherapy. Garcia et al. (2011) explains these findings, stating that

Men’s fear and avoidance of emotion may exacerbate avoidance of memories or discussions associated with psychological trauma. Importantly, avoidance of trauma cues comprises one of the three symptom clusters essential to a diagnosis of PTSD (American Psychiatric Association, 2000). Thus, male Veterans who experience distress as a potential threat to their masculinity may be more likely to avoid behaviors associated with trauma recovery, such as emotional processing , coping, and social outreach (p. 56).

These socialized behavioral norms clearly affect men’s psychological help-seeking behaviours. This could be largely due to the integration of these behaviours into one’s identity, therefore causing reduced willingness in the individual in distress to behave in a contradictory way to these norms that they identify with. It could also be due to fear that contradicting or behaving in opposition to these norms could result in an act of reprisal from their fellow soldiers, or simply a process of stigmatization. Barriers to care among Western soldiers need to be understood in

depth, as the many working parts within the military institution may affect these behaviours in ways which must be documented in order to be ameliorated. Rather than focusing on risk factors for failure to seek care, it is instrumental that attention be paid to the social processes and narratives which cause these factors to be in place.

Barriers to Care

It is an evident trend in Western society for soldiers with PTSD to underutilize health care (Molendijk, Kramer and Verweij, 2016; Hoge et al., 2004; Kim et al., 2010). Hoge et al. (2004) found that between 23 to 40 percent of active duty soldiers with a mental health issue sought professional care within the span of a year (Hoge et al., 2004). This means that the majority of soldiers who were experiencing a mental health issue did not seek care, showing a trend of underutilization of health care. Kim et al. (2010) confirmed that soldiers underutilize mental health care, concluding that 13 to 27 percent of National Guard soldiers sought health care for mental distress. Vogt (2011) has similar findings, demonstrating that only 42 percent of Operation Iraqi Freedom (OIF) soldiers who were referred to mental health care programs sought care. It is clear from current research that a significant number of Western soldiers fail to seek mental health care, however, the barriers to care which cause these trends are not universally agreed upon or well understood. Research within this area typically gives importance to identifying a causation for this issue, rather than understanding the complex relationships between these factors.

The desire to handle mental distress on one's own is one of the most important factors associated with barriers to care among Western soldiers (Naifeh et al., 2016). This is likely associated with the high prevalence of masculine gender norms within the military, specifically

the masculine trait of exaggerated self-reliance. With many men within the military feeling as though they must handle their issues on their own, this would likely extend to behaviours surrounding health-seeking. Engrained in the military institution are narratives of masculinity that emerge within training, with soldiers feeling as though they must exhibit restrictive emotionality (fighting through the pain of basic training) and exaggerated self-reliance (pulling one's weight so as to not be a strain on the group). Once soldiers have practiced these traits and lived these narratives, it makes sense that these behaviours would be carried on to their reaction to mental distress whether that be because the masculine traits are part of their inherent identity, because they do not want to contradict these masculine performances and become stigmatized, or a combination of the two.

Wright, Britt & Moore (2014) found three factors to be the leading impediments to mental health treatment among soldiers: perceived stigma, practical barriers, and negative attitudes towards care. Perceived stigma refers to a soldier's concern of judgement by others based on use of mental health care, and concern for the implications care may have on their career (Wright, Britt & Moore, 2014). Practical barriers refer to difficulty obtaining treatment, specifically not knowing how to seek treatment and not having the time for treatment (Wright, Britt & Moore, 2014). Negative attitudes towards care refers to the distrust soldiers may have towards the mental health system and mental health care providers (Britt et al., 2008; Hoge et al., 2004; Kim et al., 2010; Wright, Britt & Moore, 2014). Of these three barriers to care, researchers often claim that perceived stigma is the most significant correlate of underutilization of mental health care (Hooyer, 2015; Kim et al., 2010; Schreiber & McEnany, 2015; Vogt, 2011). Vogt (2011) reviewed 15 empirical studies which took place within the past 10 years, and echoed the finding

that stigma is the most important barrier to care. They found that active duty soldiers and veterans tend to fear that others will judge them negatively should they be suffering from a mental health issue or receiving care for one (Vogt, 2011). This fear of stigmatization is a common trend in Western soldiers and veterans within the United States, Canada, Australia, the UK, and New Zealand (Ben-Zeev, D., Corrigan, P. W., Britt, T. W., & Langford, L., 2012). Literature within this project will be from many different Western countries so as to speak to the shared findings and similar cultural factors within Western militaries.

Stigma as a Barrier to Care

As conceptualized by Goffman (1963) in his book *Stigma: Notes on the Management of Spoiled Identity*, stigma can be defined as a process by which negative labels (e.g., being weak) become associated with a category (e.g., PTSD or help-seeking). When an individual behaves in a way that causes them to be attached to a certain category (for example, if a soldier seeks help for mental distress, or even expresses that they are experiencing potential psychiatric symptoms), they will in turn be associated with the negative labels associated with that category.

Furthermore, the barrier between the individual and the category to which they belong becomes faint, and the individual becomes associated directly with the negative labels (Goffman, 1963). This breaking down of barriers causes the individual's socially and self-perceived identity to be tied to those negative labels, with the category in which they belong becoming integrated into their identity (Goffman, 1963). This association between the individual and the negative labels would be described by Goffman (1963) as a "spoiling of identity". This ruined or spoiled identity is built upon notions that those attached to certain categories and certain labels are outsiders, they are unlike the majority of others in their group, they are outliers (Goffman, 1963). This notion is similar to the notion of mental disorders portrayed within the medical discipline as pathological

variations from a 'normal' mental state (Rose, 2001). A spoiled identity within the military can result in many issues, namely loss of military position, social exclusion, and self-stigmatization (Hooyer, 2015).

Stigma is typically broken down into three forms: public stigma where social groups stereotype and react negatively towards mental distress; self-stigma, where individuals lose self-esteem based on their own negative stereotypes of mental distress; and, label avoidance, which is when individuals attempt to avoid the stigmatization process by avoiding labels associated with stigma, failing to acknowledge and seek help for mental distress (Ben-Zeev et al., 2012). It is important to note that label avoidance may be a direct result of public/self-stigma and may foster attitudes of distrust towards the mental health care system. These multiple forms of stigma are often overlooked within research, with researchers typically directing attention to stigma in general, while referring to what appears to be public stigma, or fear of others' judgments, and failing to address the innerworkings of this complex phenomenon. By gaining a deeper understanding of stigma and its counterparts we can begin to understand why stigma is so commonly claimed to be the defining factor in underutilization of mental health treatment. By directing attention to specific forms of stigma, we can therefore develop and improve upon the current knowledge surrounding barriers to care.

All three forms of stigmatization - public stigma, self-stigma, and label avoidance - adhere to a specific stigmatization process which ingrains forms of stigma within the individual (Ben-Zeev et al., 2012). I will be applying this 'stigmatization process' concept to those experiencing stigma within the military. In the first stage of stigmatization, "mental illness is inferred from explicit cues, such as experiencing salient psychiatric symptoms (e.g. significant emotional distress, flashbacks)" or from receiving a formal PTSD diagnosis (Ben-Zeev et al., 2012, p. 266). This

means that once soldiers begin experiencing mental distress, they may assume that they are experiencing a mental illness, causing them to practice avoidance by failing to acknowledge the problem.

The second stage of stigmatization is when “stigmatizing cues elicit negative beliefs or stereotypes – knowledge structures that the general public or individuals with mental illness learn about a marked social group” (Ben-Zeev et al., 2012, p. 266). This takes place because individuals or social groups have learnt the stigmas associated with mental distress, such as “mental distress means that you are weak”, “the mentally disordered are dangerous and incompetent” and/or “it is the individual’s fault for developing a mental disorder” (Ben-Zeev et al., 2012). This may interfere with soldiers’ help-seeking behaviours, as they may attempt to over-compensate for these perceptibly un-masculine narratives by practicing their exaggerated self-reliance and attempting to “suffer through” their distress.

The culture of masculinity and toughness that is present within military structures can impact the severity of stigma. For example, a commonly held belief within the military is that it is one’s own responsibility to remain resilient in the face of trauma and stress; therefore, when an individual develops PTSD, it is commonly assumed that it their own fault for not being tough or resilient enough (Vogt, 2011).

Suffering is a common theme within the military, as soldiers are expected to deal with the both physical and mental suffering experienced throughout their military training by “sucking it up” and being resilient (Molendijk, Kramer & Verweij, 2016). It is when mental disorders begin to be perceived as a failure of the individual to “suck it up” or be resilient that we can see the process of stigmatization taking place. Essentially, the victim is being blamed for the illness, whether that be by themselves, or by others.

The third stage of stigmatization takes place when prejudiced individuals ratify negative stereotypes, thus, when the cognitive and emotional processes of prejudice take place, behavioural signs of prejudice appear shortly after (Ben-Zeev et al., 2012). These behavioural signs of prejudice can emerge as discrimination such as not being promoted or being treated differently based on one's perceived mental state (Ben-Zeev et al., 2012). In order to avoid the stigmas related to psychological distress, soldiers may deny that signs of mental distress are present and stay away from military hospitals and medical centres as to not be affiliated with an institution which could give them a stigmatizing label (Ben-Zeev et al., 2012).

Not only does stigmatization affect soldiers' likelihood of seeking mental health treatment both when directed inward and experienced outwardly, it adds to the distress experienced by cultivating emotions of fear surrounding their current struggles over worries that others will stigmatize them. It comes as an added burden on top of their distressing psychiatric sequelae, causing them further stress when deciding whether to seek mental health care, and therefore impacting their ability to recover from their disorder.

Most frequently, when researchers discuss stigma as a significant barrier to care, they are referring to public stigma or self-stigma (Schreiber & McEnany, 2015; Hooyer, 2015; Kim et al., 2010; Vogt, 2011). Label avoidance and negative attitudes towards mental health care are often overlooked as a significant factor which operates as a barrier to care, even though they are closely tied to the process of stigmatization (Hooyer, 2015). Once a soldier becomes tied to a certain diagnostic label (e.g., PTSD) the process of stigmatization could begin to take place with the stigmatic label being tied to the perception of the individual, and discrimination stemming from these negative assumptions about the individual. Not only can labels result in stigmatization, but medical practitioners who have the ability to label or diagnose a soldier may become

perceived as the stigmatizing force due to the result of their diagnosis (Hooyer, 2015). Soldiers often assume that medical practitioners will be quick to diagnose, and often do not understand that they are highly educated on the diagnostic criteria of PTSD and are careful to make accurate diagnoses (Hooyer, 2015). Medical practitioners may also contribute to the skepticism about patient diagnosis, as they tend to favour biological markers of illness over a patient's ability to articulate and explain their symptoms; however, this will be explored further in the theory chapter. It is important to understand the assumptions present regarding the diagnostic process as they could be a direct result of public/self-stigma, which is indicated by many as the most important barrier to care.

Research suggests that other factors such as negative attitudes towards care and/or distrust of the mental health system may be propitious in explaining why soldiers underutilize mental health care (Britt, 2008; Fikretoglu, Guay, Pedlar & Brunet, 2008; Kim et al., 2010; Mackenzie et al., 2004; Stecker, Fortney, Hamilton & Ajzen, 2007; Vogel, Wester, Wei & Boysen, 2005). In a large cross-sectional study conducted by Kim and colleagues (2010), data showed that 25% of soldiers reporting a mental health problem (n=881) expressed distrust of mental health professionals. Fikretoglu and colleagues (2008) found that the most important factor associated with utilization of mental health services was individuals' perceived need for said services. These findings show the correlation between attitudes towards mental health care and utilization of said care. If soldiers are distrusting of mental health care, they may be self-stigmatizing, concerned about public stigma of mental distress, or avoiding mental health labels. This could have a large impact of whether or not they seek care, as demonstrated by Fikretoglu et al. (2008). Kim et al. (2010) found that a quarter of mentally disordered soldiers have distrust in mental health care; this causes it to become even more reasonable to infer that underutilization is likely

impacted by negative attitudes towards the mental health system whether those attitudes are related to either distrust or lack of perceived need for services.

Stecker et al., (2007) found that soldiers often felt that they had to handle their mental distress by themselves rather than through utilization of professional health care services. This reflects dominant military attitudes which place the responsibility on the individual for their psychiatric sequelae (Ben-Zeev et al., 2012). It reflects possible self-stigmatization, concern for public stigmatization, and label avoidance (Ben-Zeev et al., 2012). It also reflects the dominant masculine norms practiced within military culture, specifically the masculine behaviour of exaggerated self-reliance (Snell, 1989).

Lack of trust in the mental health care system, though not as prolific in current literature as stigma, has also been described as being an important barrier to care (Hoge et al, 2004; Kim et al., 2010; Iversen, A. C., van Staden, L., Hughes, J. H., Greenberg, N., Hotopf, M., Rona, R. J., ... & Fear, N. T., 2011; Molendijk, Kramer and Verweij, 2016). Soldiers' beliefs about the health care system are important, as this is a factor which affects whether or not they may seek medical care for their psychiatric distress. Beliefs surrounding health care come from personal narratives which may be influenced by cultural stigmas and broader institutional narratives. These beliefs can also be affected by mental health stigmas, and encouragement to enact the military's cultural masculine norms. Many programs within the military attempt to mitigate stigma surrounding health-seeking behaviours among soldiers by framing such behaviours as signs of strength (Molendijk, Kramer and Verweij, 2016). This is ultimately an attempt to reframe soldiers' individual notions of masculinity in regard to mental health and treatment. These anti-stigma programs, however, are not successful, with many soldiers viewing them as "useless" (Schipholt, 2007; Bouma, Waaijers, and Sellies, 2014) and "bullshit" (Molendijk, Kramer and Verweij, 2016).

; Hooyer, 2012). These programs actively contradict military narratives of suffering through stress and discomfort, which may be related to the lack of value soldiers see in these programs. Soldiers may feel distrusting or skeptical of these programs because they contradict the very institutional narratives which soldiers learn throughout their training.

The next section in this literature review will dissect these military narratives, and will analyse the potential consequences of conflicting narratives, specifically referring to how they may foster distrust.

Health Related-Beliefs

Expectations and attitudes towards treatment influence whether soldiers do or do not seek treatment (Kim et al., 2010; Britt, 2008; Mackenzie, Knox, Gekoski, & Macaulay, 2004). Medical beliefs and understandings can be broken down into five categories: “identity of the illness (label and symptoms), causal explanations of the illness, perceived illness controllability, perceived course of the illness, and the consequences of the illness for the person’s life” (Spoont, Sayer & Nelson 2005 p. 515). Spoont, Sayer & Nelson (2005) focused on causal explanations of the illness, hypothesizing that if soldiers had a more biologically rooted understanding of PTSD, they would be more likely to adhere to treatment plans i.e., medication. It is likely that this was hypothesized due to medical trust of biologically-based explanations of illness; therefore, this feeling of trust was inferred to be present in the military population.

Military institutions contain dominant discourses which label soldiers as weak if they cannot handle their mental distress on their own. This resulted in Spoont and colleagues (2005) hypothesis that a biological understanding of PTSD would function to take the blame of the disorder away from the individual’s mental prowess, and instead situate the cause within the individual’s biology. Spoont et al.’s (2005) findings opposed their original hypothesis, showing a

“fourfold increase in the likelihood of medication underuse” (p. 521) among military sufferers of PTSD who were educated on their disorder through use of a biological model. Clearly, education on PTSD may affect adherence to treatment; however, the reasons for this relationship are not fully understood.

Spoont and colleagues (2005) theorized that these findings could be the result of the development of less typical beliefs surrounding PTSD, emerging alongside the biological educatory model. This would mean that the less typical beliefs that emerged acted as barriers to care. I suspect that a biological model of PTSD could negatively affect soldiers’ health-seeking behaviour. Similar to institutional understandings of PTSD within the military (Hooyer, 2015), biological causal explanations also place the individual in a uniquely stigmatizing situation, now directing specific blame to the individual’s lack of strength in managing their biological reactions. The individuals learning these biological models may also feel as though their biological responses that reflect psychiatric sequelae prove that there is an innate ‘weakness’ within them, at the core of their biology. Although these biological models may take the ‘blame’ away from the soldier’s psychological responses to trauma, the blame is still being shifted to their biology which appears to be functioning unusually or unsuccessfully in order to result in PTSD. Illnesses themselves are portrayed within medicine as being pathological anomalies, so it is possible that patients suffering from PTSD could conceptualize themselves as flawed extensions of these variants.

Most soldiers may experience a biological-based fight or flight reaction to stress or trauma, but the majority (90%) do not experience PTSD symptoms (Difede, Olden & Cukor, 2014; Stein et al., 2007). This over and underactivity within regions in the brain, while subconscious and out of the individual’s control, may come with the question of “why is my body reacting this way to

trauma, while most others' are not?" effectively displaying patients' conceptions of their biology as being abnormal. These types of biological explanations could create further stigmatization, as some soldiers may liken this unique biological state to constitutional weakness. With such a strong focus on mental toughness and resilience within the military, such biological phenomenon could result in discourses of not only mental, but biological weakness in individuals who are suffering from PTSD. Explanations of PTSD which place the cause of the disorder within the individual could result in stigmatization (Hooyer, 2015), as these explanations function as implicit victim-blaming models which further isolate and ostracize the sufferers.

Narratives of PTSD

Institutional Narratives of PTSD

Dominant medical research tends to focus on the cause of PTSD, with much attention towards individual susceptibility (Molendijk, Kramer & Verweij, 2016). For example, soldiers who have suffered from childhood abuse have a higher risk of developing combat related PTSD (Zaidi & Foy, 1994).

Although childhood trauma (also called Aversive Childhood Experiences or ACES) increase risk of developing PTSD (Zaidi & Foy, 1994), this relationship emerges differently within the military community. Men within the military are more likely to have experiences ACES than men with no previous military service (Blosnich, Dicher, Cerulli, Batten & Bossarte, 2014), meaning that there may be an association between ACES and likeliness of joining the military. Moreover, military service members are exposed to more traumatic events within their lifetime than civilians with 76.1% of Canadian civilians reporting exposure to 1 or more traumatic events (Van Ameringen, Mancini, Patterson & Boyle, 2008) while 85.6% of Canadian individuals with military experience reporting exposure to one or more traumatic events (Brunet et al., 2015).

Not only do military service members experience a higher rate of childhood trauma than civilians, they also experience a higher prevalence of exposure within their lifetime. However, increased lifetime exposure to trauma could reflect higher exposure to ACES among military service members. With this increased rate of traumatic experiences among military personnel, it would be reasonable to assume that they would have a higher rate of PTSD, especially due to the risk of ACES to PTSD development (Zaidi & Foy, 1994). 9.2% of Canadian civilians will experience PTSD within their lifetime (Van Ameringen et al., 2008); however, research places Canadian military lifetime rates of PTSD at between 6.6% (Brunet et al., 2015) and 11.1% (National Defence and the Canadian Armed Forces, 2016). Furthermore, most health care seeking military service members with PTSD (83%) have had ACES (Applewhite, Arincorayan & Adams, 2016). Further research is needed in this area in order to understand the contributing variables. This research tends to reflect a positivist framework in referring to potential individual factors and susceptibilities to PTSD; however, qualitative research focusing on the broader military system could be of use in explaining such similar rates of PTSD among such different populations.

This attention towards the individual, and the understanding of PTSD as the “response of an individual to an event” (Molendijk, Kramer, & Verweij, 2016 p. 7), reflects the notion that “stressful events can disorder the mental mechanism of soldiers” (Molendijk, Kramer, & Verweij, 2016, p.12). I would like to move beyond the understanding of the individual, as individual susceptibility does not adequately explain the reason why some soldiers develop PTSD (Perilla, Norris & Lavizzo, 2002; Finley, 2011). More attention should be paid to the broader military and medical structures which affect soldiers’ understandings, experiences, and beliefs about PTSD. Instead of focusing specifically on stigma, masculine behavioural traits or negative attitudes

towards health care, we should understand that these phenomena are all intertwined, and observe which structures cause these factors to emerge. To better understand the barriers to care we must move beyond dominant theories of health behaviour which seek to explain why individuals are not seeking mental health care, and instead focus on which structures are causing these behaviours and processes (Hooyer, 2015). This requires a shift in analytical framework within future research towards a more qualitative, constructivist approach.

The Development of Structural Narratives within the Military

Within Western military institutions soldiers are socialized to view stress, pain and exhaustion as positive experiences, being taught to fight their initial reactions to these experiences, and act tough throughout (Molendijk, Kramer, & Verweij, 2016). Soldiers are taught to discipline their emotions through many mental health interventions which are a critical part of military infrastructure (Molendijk, Kramer, & Verweij, 2016). They begin by completing a pre-enlistment screening in which soldiers fill out a psychological section within their initial application (Molendijk, Kramer, & Verweij, 2016). This section is designed to screen out individuals who suffer from mental illness and appear unfit for service (Molendijk, Kramer, & Verweij, 2016). Next, they must participate in a basic training program which functions to teach soldiers to discipline their emotions in situations involving pain, exhaustion and stress (Molendijk, Kramer, & Verweij, 2016). Soldiers then experience a more explicit mental health intervention prior to deployment – they receive a mandatory educational session which teaches them “what stress is and can do, and where to receive further help” (Molendijk, Kramer, & Verweij, 2016 p. 11). During deployment, soldiers have access to a mental health professional or religious counsellor, and once home they must attend another mandatory educational session which seeks to inform them of the potential difficulties associated with integration back into the

civilian world (Molendijk, Kramer, & Verweij, 2016). Lastly, months post-deployment, soldiers are screened for mental and psychosocial problems through an individual meeting and survey with a mental health professional (Molendijk, Kramer, & Verweij, 2016).

Country-specific PTSD interventions were noticeably absent from the current literature on this topic. To provide a Canadian context to the broadly identified Western PTSD Infrastructure (Molendijk, Kramer, & Verweij, 2016), I reached out to Veterans Affairs Canada and received an explanation of Canadian PTSD interventions in more detail.

1) Pre-Enlistment Screening:

Personality is currently assessed in general CAF selection, but the focus is on normal personality factors - Conscientiousness and Emotional Stability, because of their established link to training and job performance. This testing is not medical, is not diagnostic and is not used for any medical or health purposes. There is a medical screening process which covers both physical and mental health history however, the medical screening process does NOT involve any form of psychological screening.

2) Pre-Deployment:

This is part of the Road to Mental Readiness (R2MR) training. The Road to Mental Readiness (R2MR) is a mental health training and education program developed by Directorate of Mental Health to increase mental health literacy and enhance resiliency. Using evidence-based research and influenced by the principles of sports psychology, R2MR is designed to demystify mental illness, provide individuals with tools for managing stressful situations and reduce the risk factors associated with mental illness. The main goal of R2MR training is to improve well-being and short-term performance, while mitigating any negative long-term mental health problems for CAF personnel and their families. The R2MR program (launched in 2007) encompasses all resilience and mental health training that is now embedded throughout CAF members' careers, including the deployment cycle. It is designed to ensure that the most appropriate training is provided to CAF members in order to prepare them mentally for the challenges they may encounter. All CAF personnel now receive mental health education during Basic Training (BMQ, BMOQ), throughout leadership courses (PLQ, ILP) as they progress during their careers, and at key points before and after they deploy on military operations. The R2MR model provides insight into the varying degrees of mental health issues and offers guidance for identifying appropriate supports along the spectrum of mental health concerns.

3) During Deployment:

Depending on the nature of deployment, and the duration, members may have direct access to CAF healthcare providers, or they may rely on other allied nations for medical (physical and mental health) support. Mental Health support may be provided by primary healthcare providers (family physicians, physician assistances) or specialists such as social workers, mental health nurses or psychiatrists (if available). In certain situations,

support can also be provided remotely (e.g. by phone). Religious or padre support is similar to healthcare support- it may be available in-person by CAF padres or allied nation padres, OR it may be available remotely when required.

4) Post-Deployment: This is correct part of the R2MR program. The content is specific to potential reintegration and post-deployment challenges. There is also a version available for families which can be taken online.

5) Month Later: The Enhanced Post-Deployment Screen (EPDS) is done 4 to 6 months post-deployment. This includes a questionnaire and a one-on-one interview. (Thompson, J., personal communication, March 13 2019)

It is clear that Canadian-specific mental health interventions differ from the more broadly identified Western mental health interventions (Molendijk, Kramer & Verweij, 2016), omitting a psychological screening pre-enlistment, and utilizing the R2MR program which goes beyond a resilience training in that it educates military personnel on coping techniques and provides supports throughout the deployment cycle.

At first glance, Western mental health interventions appear to adequately identify individuals who are fit for duty, prepare them for the stress potentially experienced during deployment, and address re-integration concerns upon return. However, Sharpley, Fear, Greenberg, Jones & Wessely (2007) have concluded that debriefing and educational programs have shown no evidence of reducing psychological distress post-deployment. It is through critical analysis that implicit side effects of these programs begin to emerge and appear to contradict dominant medical narratives of trauma-related distress (Molendijk, Kramer & Verweij, 2016). Soldiers are being told within the military “these programs will help you deal with trauma” and once they experienced post-trauma related sequelae, they feel as though they must be at fault for not coping properly or being too weak to handle combat. The lack of success of these programs sets soldiers up for failure in that they may feel as though it is their fault for experiencing mental distress because they had the tools to cope but experienced distress despite the interventions given to them. These contradictions are caused by opposing narratives within the military and medical

structures, and it is through these opposing narratives that soldiers develop implicit understandings and beliefs about combat related distress and medical intervention.

Soldiers are being told that they can train to handle trauma, while medical narratives say that PTSD emerges from within the individual's biology which causes psychological response. When socialized to view mental distress in a particular way within the military, soldiers may be distrusting or skeptical of medical narratives which portray mental distress in a contradictory fashion.

Within the medical system, PTSD is dominantly viewed as a normal response to an abnormal event (Molendijk, Kramer & Verweij, 2016). This understanding seeks to label trauma as an abnormal experience which cannot be easily integrated into one's mental system. It defines the responses and symptoms of this difficult integration as normal; however, through medicalizing and labelling these responses as psychiatric sequelae of a disorder, this very definition is contradicting itself by portraying these "normal" responses as ineffective and dysfunctional (Molendijk, Kramer & Verweij, 2016). The medical discipline is essentially measuring pathological behaviours against an elusive baseline model.

This understanding is in direct contrast to military research, which has found an average of 11 traumatic combat related events to be reported by the average military participant who has experienced deployment (Wright, Britt & Moore, 2014). Of the participants who had reported experiencing a traumatic event, 70.8% reported experiencing an attack or ambush, 77.2% reported experiencing incoming artillery, rocket or mortar, and 65.1% reported seeing human remains or dead bodies (Wright, Britt, & Moore, 2014). The definition of trauma as 'abnormal' within the medical community opposes the experiences of military personnel who view these experiences as "part of the job". Dominant medical constructs of PTSD appear to lack cross

cultural validity, and even fail to address the experiences of Western soldiers. Although traumatic events may be rare in Western society, such events can be considered normal or part of the job among Western soldiers (Wright, Britt & Moore, 2014; Hooyer, 2015; Molendijk, Kramer & Verweij, 2016).

It is evident from institutional practices within the military that emerging structural narratives play a role in contradicting the idea that trauma is an abnormal event. The multiple mental health interventions constituting screenings, emotional discipline training and educational sessions reveals an expectation of violence and portrays a requirement for mental toughness which will be used to address this anticipated violence or trauma. The various mental screenings are evidence of a narrative of “there will be violence, and that as long as they are psychologically ‘normal’, they should be capable of managing violence.” (Molendijk, Kramer & Verweij, 2016, p. 14).

Soldiers are encouraged to view violence positively, as a challenge in which they can practice emotional discipline resulting in mental toughness. It is when they experience psychiatric sequelae too distressing to “discipline” that they begin to self-stigmatize, feeling as though they failed to live up to the dominant image of the “good soldier” within the military (Hooyer, 2015). According to Chamberlin (2012), “soldiers suffering the effects of trauma show an inability to exhibit the virtues of the ideal male, by failing to meet expected gender norms and fulfil male gender roles” (p. 359). This shows a failure to not only meet the ideals held within the narratives of military infrastructure, it also shows to failure of the soldier to meet the high expectations of gender role norms held within the military.

Jakupcak, Osborne, Michael, Cook & McFall (2006) explain that “military training may foster even greater adherence to traditional male gender norms, contributing to the development of a hypermasculine subculture that can shape men’s emotional and interpersonal behaviours

long after they have left military service” p. 203 (Brooks, 1990; Brooks & Good, 2001). The experiencing of psychiatric sequelae is a failure of the soldier on many levels, possibly leading to increased hesitance to explore medical narratives which explicitly oppose the familiar military narratives which they have failed to embody.

Contradictory Narratives and Implications for Soldiers

Many veterans criticize the medical narrative of PTSD, claiming that their ‘normal’ reactions to combat are being translated into psychiatric sequelae which are used to label them as disordered and a failed soldier subject (Hooyer, 2015). Reactions to combat-related trauma such as emotional numbness, increased arousal and hypervigilance can sometimes be conceptualized by soldiers as markers of good military training (Molendijk, Kramer & Verweij, 2016). It can be argued that “when framed as ‘symptoms,’ these normal reactions may well appear to psychiatrists, or those conducting community epidemiological surveys, as indicating a high level of undiagnosed psychiatric disorder in the general population (Rose & Abi-Rached, 2013, p. 129).

Emotional numbness relates back to the resilience trainings soldiers partake in, being encouraged to discipline one’s emotions is an important part of military culture (Hooyer, 2015). Resilience trainings often communicate the message that reacting to stressors is a matter of right or wrong mindset, when soldiers experience hypervigilance once home, they are encouraged to return to a civilian mindset (Schipholt, 2007).

Increased arousal and hypervigilance are often looked at by soldiers as an important tool once home from combat (Molendijk, Kramer & Verweij, 2016). Once home, soldiers may feel as though their reactions of hypervigilance and increased arousal are realistic based on the events that they have experienced during their deployment (Molendijk, Kramer & Verweij, 2016).

Medical practitioners view these reactions as dysfunctional: They do not see that the civilian world as a dangerous place; therefore, they view soldiers' perceptions of a dangerous civilian world to be unrealistic (Molendijk, Kramer & Verweij, 2016).

These medical narratives contradict veterans' narratives of reactions to combat; many veterans view these reactions to be helpful, as viewing the entire world as dangerous allows them to feel as though they are prepared for danger, and "seeing the world as it really is" (Molendijk, Kramer & Verweij, 2016). Some veterans describe this perception of danger as putting them at ease (Molendijk, Kramer & Verweij, 2016). Such a gap between the narratives within medicine and military structure is likely to foster distrust, or at least misunderstanding of medical narratives with which they are likely less familiar.

Medical professionals tend to view this newfound understanding of the civilian world as a dysfunctional mindset, which dismisses the transformative experiences that caused this new understanding (Molendijk, Kramer & Verweij, 2016). By attempting to re-route the (dysfunctional) thinking which is involved in these new perceptions, soldiers are implicitly being told that the learning processes stemming from their experiences in combat are negative, dysfunctional, and lack value. Subsequently, by being diagnosed with PTSD - a medical phenomenon with a clinical solution - they are being told that these (negative) learning processes are part of a curable or manageable disorder (Molendijk, Kramer & Verweij, 2016). When traumatic experiences are labelled as stressor criterion for PTSD, these life-changing memories which may hold significant meaning are being reduced to a marker of a disorder (Hooyer, 2015).

As explained by Hooyer (2015), "the very idea of post-traumatic stress as a disorder misapprehends the experience of war and the effect these experiences have on an individual's self-understanding." (p.6). The narratives within the medical community are inherently

explanations of symptoms and behaviors which have been created by a group of individuals who have no conception of the situations in which they emerge (Hooyer, 2015). The contradictions between medical and military narratives are problematic in that they are rarely acknowledged, further cementing them as contradictions. According to Molendijk, Kramer and Verweij (2016), Such narrative silence would give the impression that the message that violence is abnormal and PTSD normal is seen as an uncomplicated fact from the institutional side. What is left, then, is the soldier who is complicated. When the institutional paradox is not voiced, soldiers may feel they are told that the cause of their struggles lies completely within themselves. (p. 351-2).

This exemplifies dominant medical narratives which place understandings of Post Traumatic Stress Disorder within the functioning (or lack there of) of the individual's mind.

According to Finley (2011) soldiers hear 'We can help!' from mental health providers, while at the same time being told, 'If you're broke, we'll kick you to the curb,' from the rest of the military community" (p. 216). The lack of integration of military narratives within the medical system may cause soldiers to distrust the foreign medical narratives claiming they can help, as these narratives clearly do not reflect the experience of the military soldier subject. It is important to understand the difficulty one may have in integrating narratives which distort their realities or 'explain away' their experiences. Violence is abnormal within medical narratives, while being 'part of the job' and 'to be expected' within military narratives. PTSD is 'normal' in medical narratives while being 'weak' and 'failure of the soldier' within military narratives (Molendijk, Kramer & Verweij, 2016).

It is important to note that while Western themes of stigma and masculinity are present in most Western countries, so are fears that psychiatric distress will result in job-loss (Ben-Zeev et al., 2012). Although these fears are present in numerous Western countries, the policies which relate to these beliefs differ quite drastically. For example, a policy within Canadian Armed

Forces states that, “since Feb 2000, *all health information concerning CF members* is strictly confidential, and is not accessible to the chain of command without the permission of CF members.” (National Defence and the Canadian Armed Forces, 2004, para 17). This means that soldiers will receive specific accommodations within their positions; however, the diagnosis relating to their need for accommodation will be kept confidential. This allows the soldier the ability to keep their job while caring for themselves and keeping their disorder confidential.

The prevalence of the dominant conceptualization of PTSD within medical literature needs to be questioned. Questions need to be asked such as “does this dominant conception adequately address and explain PTSD among veterans?”, “how does this conception fit within military culture and infrastructure?” and “how do dominant narratives compare to military narratives?”

While dominant literature aims to understand Post Traumatic Stress Disorder, it fails to take a deeper, more critical approach in understanding the structures in place that function to produce our understandings of this disorder. Critical literature begins to analyze PTSD on a deeper level, explaining medicalization, historical, sociocultural and structural processes which shape our understandings of the disorder. While both dominant and critical literature each play an important role on the development of knowledge in this area, it is critical that these two frameworks engage in a collaboration rather than a debate (Molendijk, Kramer & Verweij, 2016).

Theories of Medical Narratives

The medicalized nature of PTSD means that it reflects the biomedical assumptions of the medical discourse. One of these assumptions is that medical illnesses or disorders have “an objective existence in the world, whether discovered or not, and exist independently of the gaze

of psychiatrists or anyone else” (Summerfield, 2001, p. 95). This would also describe the “strong realist” framework as outlined by Phillips et al. (2012) who broke down medical ontology and epistemology into three frameworks: 1) Strong Realist, 2) Strong Realist/Weak Constructivist, and 3) Strong Constructivist. Phillips et al. (2012) argued that not all medical professionals are indoctrinated in strong realism. Foucault (1973) argues that medicine is largely made up of biomedical assumptions that align with a strong realist framework, which is supported by Phillips et al. (2012) as they argue that medicine comes from a positivist past. In this argument, however, Phillips et al. (2012) are identifying frameworks held by psychiatrists within an individual basis on a micro level, while Foucault (1973) is acknowledging frameworks within the medical discipline in a macro sense. It is important to note that Foucault (1973) is using a “bottom up” perspective to give voice to the positivism within the medical discipline. He speaks to specific “biomedical assumptions” which are evidence of a positivist framework (Foucault, 1973). He provides an interesting critique on these biomedical assumptions, summarizing these assumptions using the term the “medical gaze” to describe how doctors view patients as objects of knowledge (Foucault, 1973).

Doctors use their medical gaze to uncover the ‘absolute truths’ about the diseases they are studying by examining patients through a biomedical lens and filtering out all other information that does not fit within this framework (Foucault, 1973). The medical gaze is problematic because it causes patients to be displaced from the social into the pathological (Foucault, 1973). With this framework, doctors attempt to learn about the disorder through its symptoms and signs rather than the conditions which caused it (Foucault, 1973). These symptoms and signs are viewed as an extension of a natural entity within the body – the disorder (Smith, 2011). The individual who is suffering with the disorder is merely viewed as a canvas through which this

disorder displays itself (Smith, 2011). This biomedical model is problematic, as it does not differentiate between the disease and the patient's experience of the disease (Stein, et al., 2007). It delegitimizes the patient's suffering and the other stressors within the patient's life by focusing on the more medically or biologically interesting symptoms (Kleinman & Kleinman, 1991).

In the past, mental disorders were typically understood to appear on a 'sick body' (Rose, 2001). The body was where the disorders of the mind were located; however, that began to change in the Freudian era when the medical discipline came to understand these disorders as being located within the mind, an entity separate from that of the body (Rose, 2001). Doctors were able to take a glimpse into this elusive mind through the words spoken by patients, from disorders being understood as something visible, to something that was heard (Rose, 2001). Psychiatrists were given the authority to observe and interpret the individual's inner space, their mind; however, issues within the psychiatric discipline arose when these practitioners were not able to demonstrate their diagnoses through organic correlates (Rose, 2001).

We now have access to technologies which function as tools to allow practitioners to demonstrate and display this molecularization of disorders. Some of these technologies include; Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI) and Functional Magnetic Resonance Imaging (fMRI) (Rose, 2001). These technologies produce digital data that are interpreted as a visualization of the individual's mind, understood to be synonymous with the functions of one's brain (Rose, 2001). According to Rose (2001), "when mind seems visible within the brain, the space between person and organs flattens out—mind is what brain does" (p. 202). Rose (2001) describes this new development in psychiatry to be characteristic of a new psychiatric gaze, allowing practitioners to show 'evidence' of their diagnoses and diagnostic criteria.

Given this ability to visualise the mind, medical practitioners utilize these simulacra of the brain to distinguish between normal and pathological functioning (Rose, 2001). Pathologies represented within imaging technologies are often depicted as variations from a “normal state” (Rose, 2001). An example of this representation would be in depression. Depression is often depicted as being a pathological condition resulting from low levels of serotonin, an oversimplification aimed at identifying how this condition deviates from the ‘typical’ state of the brain, and the ‘typical’ levels of serotonin (Rose, 2001).

The DSM-5 does not account for context. It is up to the practitioner administering the psychological evaluation to determine whether or not the patient is exhibiting normal or pathological symptoms, and then sort said symptoms into a diagnostic category. The judgment required from practitioners may vary between individuals, causing the diagnostic system to be far from generalizable and accurate, potentially resulting in many false positives (Rose & Abi-Rached, 2013). This a concern among the psychiatric community, bringing about a further desire to improve upon biological measures and explanations of disorders so as to mitigate the chance of human error present when diagnosing through patient assessments (Rose & Abi-Rached, 2013).

A common belief within the psychiatric discipline is that biological markers of disorders function as ‘ultimate truths’ which portray the reality of the state within the patient’s mind. This is evidence that the psychiatric community holds biological explanations of illness to be the privileged modes of understanding, over the explanations of the patient themselves. These narratives of objectivity and ultimate reality within biological models of illness give authority over mental disorders to the psychiatric community, effectively allowing the discipline to hold the ultimate power on defining and understanding these phenomena. Doctors have the authority

to distinguish whether or not a patient's behaviours are normal or pathological, taking the power within the process of help-seeking away from the patient, and into the hands of the doctor.

Along with the molecularization of mental disorder, comes the dehumanizing and delegitimizing of patient experiences. By dehumanizing the subject of the disorder, Foucault (1973) argues that medical professionals are missing a key piece in understanding disorders – the impacts that sociocultural influences have. Positivism and instrumental reasoning are “privileged modes of persuasion” in our Western World; therefore, it is very difficult for other voices to appear as legitimate and be heard (Summerfield, 1999, p. 96). Smith (2011) explains how biomedical assumptions translate into treatment, she states,

In the biological tradition, psychiatrists are immersed in a diagnostic system, and it is assumed that the root of illness (biology) is the same across patients so the treatment (medication) will be the same. For biological treatment, it matters little how the patient understands her illness or navigates the experience of being ill. Whether one understands their symptoms as the result of a growing up experience, a trauma, or genetics, treatment remains the same. (p. 356)

It is often the sociological or anthropological sciences which explore the innerworkings of PTSD from an experiential level. This has been done through developing ties between institutional structures and understandings of PTSD (Molendijk, Kramer & Verweij, 2016) or finding links between masculine behavioral norms and likeliness of seeking treatment (Berger, Levant, McMillan, Kelleher & Sellers, 2005). This is not to say that the social sciences should not be exploring these parts of mental illness, instead it is an example of the medical discipline's proclivity towards individual susceptibility and biological markers of illness (Molendijk, Kramer & Verweij, 2016). It would be difficult to apply a medical framework to these factors relating to experiences of PTSD; however, more attention to social sciences research could be useful in transcending current dominant medical assumptions and shedding light on the relationships

between these previously valued individual factors.

I am hesitant to argue that Foucault's (1973) theory of medical gaze can be applied to Western psychiatrists in general because, as evidenced in Phillips et al.'s (2012) piece, frameworks in medicine can be quite divisive; medical practitioners have many different ontological and epistemological perspectives. Rather than applying Foucault's (1973) medical gaze to psychiatrists in general, this theory would be much more functional within a systemic context, speaking more broadly to the structures within the medical system itself.

The value of deeper structural analysis within the medical system is reflected by Mills' (1959) theory of a Sociological Imagination. Mills (1959) believed that a Sociological Imagination should be used as a tool to gain a deeper understanding of the relationships between the individual and the society. He argued that individual afflictions (such as PTSD) must be understood through larger societal structures and cultures; as such, individualized afflictions represented an issue with the system or society as a whole rather than an issue with the individual (Mills, 1959). An example of the sociological imagination would be the understanding that masculine identity within the military is not an individual soldier's characteristic; rather, it is a behavior that is influenced by sociocultural forces namely masculine gender norms and heightened attention to these norms within military structures. Mills (1959) uses a top-down perspective, understanding that structures influence individuals within society. This perspective is useful to this research as it allows the identification of specific social forces, specifically military structural narratives, that affect soldiers' health seeking behaviors. It is through this perspective that we can begin to understand that culture and society are made up of groups of people who share understandings of what is and is not real, just as military personnel are a group of people with shared military understandings. By analyzing these institutional narratives, we can

begin to understand why these narratives are in place; through an understanding of how these narratives were constructed, we can begin to learn how these agreed-upon notions affect soldiers' health-seeking behaviors.

In contrast to structural narratives in the military, we can also seek to understand the illness narratives of PTSD. Patients often give shape to their suffering through narrative form (Kleinman, 1988). According to Frank (1996) "ill people learn by hearing themselves tell their stories, absorbing others' reactions and experiencing their stories being shared." (p. 1). It is important to acknowledge and pay attention to narratives in all forms due to the many narratives present in the construction of both patient and practitioners' understandings and experiences of illness. As described by Kleinman (1988) "Each patient brings to the practitioner a story. That story enmeshes the disease in a web of meanings that make sense only in the context of a particular life" (p. 96).

Similarly, the medical discipline brings its own set of illness narratives to collaborate with, if not overshadow the patient's narratives. Medical narratives often appear as the dominant understandings of illness and are foreign to patients' experiences of illness (Frank, 1996). Frank (1996) describes the patient's experience of learning medical narratives:

The modern experience of illness begins when popular experience is overtaken by technical expertise, including complex organizations of treatment....folk now go to paid professionals who reinterpret their pains as symptoms, using specialized language that is unfamiliar and overwhelming. As patients, these folk accumulate entries on medical charts which in more instances they are neither able nor allowed to read; the chart becomes the official story of the illness. Other stories proliferate. Ill people tell family and friends versions of what the doctor said, and these others reply by telling experiences that seem to be similar: both experiences they have had themselves and ones heard from others. Illness becomes a circulation of stories, professional and lay, but not all stories are equal. The story of illness that trumps all others in the modern period is the medical narrative. The story told by the physician becomes the one against which others are ultimately judged true or false, useful or not. (Frank, 1996, p. 5)

This unfamiliar set of dominant medical narratives affect the patient's understanding of their illness, interfering with the patient's narrative forming process. It is important that the medical practitioner recognizes their privileged set of narratives, and in turn, gives validity to their patient's narratives (Kleinman, 1988). Kleinman (1988) describes the role of the medical practitioner in utilizing illness narratives, he explains:

The role of the health professional (which can easily lend itself to a dangerous kind of voyeurism) as it is to assist to chronically ill and those around them to come to terms with – that is accept, master, or change – those personal significances that can be shown to be operating in their lives and in their care.” (p. 43)

While previous research (Molendijk, Kramer, & Verweij, 2016) focuses on the indirect narrative forming processes through observation of the contradicting personal and structural narratives of combat PTSD, this research will focus on the direct collaboration of narratives by medical practitioners and patients. From data it will analyze broader medical narratives present in the medical structure and evident among practitioners. Good (1994) explains, “the narrators—the person with an illness, family members participating in their care, medical professionals—are in the midst of the story they are telling.” (p. 153.)

With added stigma attached to the narratives surrounding mental illnesses such as combat PTSD, narratives are often reshaped to include elements of guilt and or shame. This adds an extra layer to the narratives present and causes interference with health-seeking behaviors. This research will utilize a qualitative content analysis to the address the findings of research included in this literature review. A dialogical narrative analysis will be used in conjunction with the content analysis in order to address the findings of Molendijk, Kramer and Verweij's (2016) preliminary study, and provide added analysis to direct practitioner-patient narrative construction as described by Kleinman (1988) and Frank (1996).

Kleinman (1988) and Frank (1996)'s definitions of narratives do differ from the way that the term narrative is used within some of the literature within this research (Molendijk, Kramer & Verweij, 2016). Kleinman (1988) and Frank (1996) identify narrative as stories being told and identify these stories within patient/practitioner dialogue. Molendijk, Kramer & Verweij (2016) analyzed mental health interventions within Western militaries, and from that analysis developed their own set of narratives which they felt could accurately represent the interventions in place. I used Kleinman (1988) and Frank (1996)'s conception of narrative by focusing on participant's stories of PTSD and their profession, however much of the data collected could more accurately be classified as statements rather than narratives, so I will be focusing broadly on the assumptions and beliefs portrayed within participants' statements.

The sample of this study, psychiatrists who have treated patients with PTSD, allows for analysis of both broader medical structural narratives, as well as narratives produced within patient-practitioner sessions. The participants' own narratives could be evidence of broader medical narratives that they developed in past medical training, which will present a thorough framework from which to address the considerations raised by Molendijk, Kramer and Verweij (2016).

Medical Narratives of PTSD

Within the DSM-5, PTSD is labelled as having cross-cultural validity, meaning that PTSD appears and can be diagnosed in individuals within many diverse cultures; it is not a Western-centric diagnosis (American Psychiatric Association, 2013; Hinton & Lewis-Fernandez, 2011). Kleinman (1987) used the term 'cultural fallacy' to describe the assumption that a diagnosis

conceptualized in one culture is applicable to others in different cultures. This ignores the possibility that societal and cultural factors may affect how individuals experience and understand trauma which leads to PTSD (Stein, et al., 2007). Cultural fallacy is present within the medical discipline as it relates to the logical positivist framework which identifies disorders and diseases as natural entities that can be observed cross-culturally, independent of the culture they develop in or the individual afflicted (Kleinman, 1987). Stein et al. (2007) explains why the cultural fallacy of PTSD is problematic:

A weakness of this model, however, would be that it might encourage the view that trauma responses are entirely universal and fixed, and thus the variable ways in which society can influence the subjective experience of trauma, and the expression of subsequent symptoms, are ignored (p. 140)

Because different societies and cultures experience and understand trauma differently, they should not be treated with the same approach. Just as there is a difference in symptom understanding and expression across cultures, many argue that symptoms and symptom expression vary within Western culture (Berger, et al., 2005; Garcia, Finley, Lorber & Jakupcak, 2011; Jakupcak, Osborne, Michael, Cook & McFall, 2006). This is why it is important to understand the differing military and medical narratives. With other literature focusing on military narratives surrounding PTSD, healthcare, and masculinity (Molendijk, Kramer & Verweij, 2016), it is important to begin to focus on medical narratives in order to understand how these varying narratives affect one another.

Summerfield (1999) explains how sociocultural factors could affect those with PTSD. He states, “many ethnomedical systems have taxonomies which range across the physical, supernatural and moral realms, and do not conceive of illness as situated in body or mind alone”

(p. 1455). This is evident in the opposing cultural conceptions of trauma. Because the events viewed as traumatic vary cross-culturally, PTSD resulting from trauma would therefore be understood differently in different sociocultural settings (Kleinman, 1987).

PTSD is a highly individualized disorder with many different factors affecting the sequelae present, the meaning of the traumatic event, and the experience of the disease. The DSM functions as a taxonomic categorization tool, which may create misdiagnosis (Adeponle, Thombs, Groleau, Jarvis & Kirmayer, 2012) and requires educated medical practitioners to understand PTSD within specific sub-groups such as sufferers within the military.

While the DSM-5 attempts to provide an inclusive symptom criterion for PTSD, some scholars believe that these symptoms cater to a specific Western civilian cohort, failing to direct enough attention to the common symptoms expressed by veterans with PTSD such as guilt and shame (Shay, 2010). Although PTSD does not speak specifically to veterans, the symptoms embodied in the diagnostic criteria apply both to civilians as well as to veterans (Friedman, 2013). The PTSD criteria does not cater specifically to veterans' symptoms; however, it does apply to this cohort. In the DSM-4, criteria A2, "the person's response [to the traumatic event] involved intense fear, helplessness, or horror" (American Psychological Association, 1994, p. 428) was commonly absent among the veteran cohort as a result of military training causing soldiers to be non-reactive to trauma (Adler, Wright, Bliese, Eckford, & Hoge, 2008). This criterion was removed in the DSM-5 which shows that attention is being paid to the accuracy of the diagnostic criteria to all populations (American Psychological Association, 2013).

Differing cultural understanding of symptomatology are evident in Somasundaram's (1996) study in which he concluded that many Sri Lankans were suffering with PTSD after experiencing

aerial bombings. These individuals experienced the symptoms of PTSD; however, they did not view these symptoms as problematic. Instead, they understood them to be a natural result of the traumatic experience of the bombing (Somasundaram, 1996). Somadundaram (1996) portrayed the individuals within his study as misled and attributed their lack of concern towards their symptoms to a reluctance to face the stigmatization that came with the diagnosis of PTSD. He did not take into account the participants' cultural understandings of trauma or PTSD and was quick to make his own judgements (Somasundaram, 1996). Instead of considering the participants' sociocultural backgrounds, Somadundaram (1996) interpreted their experiences through a Western lens, overlooking and dismissing their beliefs. This biased perception is potentially present across the medical discipline, as value is typically given to biological markers and psychiatric sequelae over context and individual experience, as demonstrated in various editions of the DSM (Rose, 2001).

Due to the competing experiences of trauma cross-culturally and influencing cultural and societal factors of psychiatric taxonomy, many scholars (Fajarito & De Guzman, 2017; Fox & Pease, 2012; Hinton & Lewis-Fernández, 2011; Shields, 2016) advocate for critical analysis of diagnostic practices. Phillips et al. (2012) responded to this demand for critical analysis with a large collaborative effort that resulted in six questions about diagnosis. I will be addressing only the first question as it relates to biomedical assumptions. Question one addresses the nature of a mental disorder, asking "do they identify real diseases, or are they merely convenient (and at time arbitrary) ways of grouping psychiatric symptoms?" (Phillips et al., 2012, p. 26). Phillips et al. (2012) frames this question in terms of epistemology and ontology in relation to mental disorders, utilizing epistemology to question "what there is" and ontology to question "can I know it" (Phillips et al., p. 26, 2012).

The different possible epistemologies/ontologies are broken down into three groups: 1) Strong Realist, 2) Strong Realist/Weak Constructivist, and 3) Strong Constructivist. The Strong Realist position perceives mental disorders to be abstract entities that can be observed independent of psychiatric gaze. They manifest within individuals and can be studied and observed for what they truly are. The Strong Realist/Weak Constructivist position perceives mental disorder to exist despite psychiatric gaze; however, medical professionals might not always understand mental disorders for what they truly are. Finally, the Strong Constructivist position perceives psychiatry as describing their perceptions of mental disorders as accurately as possible; however, there are no ultimate truths or abstract entities to which their perceptions can be compared (Phillips, et al., 2012). As discipline as a whole, psychiatry typically takes the strong realist position; as a discipline within the medical sciences derived from the more biology-based body-sciences, psychiatry attempts to understand pathologies and biological markers of the disorder (Foucault, 1973; Phillips, et al., 2012).

Biological Psychiatry

Historically, biological psychiatry 40+ years ago took the strong realist position, while skeptics critiqued biological psychiatry from a constructivist perspective (Phillips, et al., 2012). Strong realism was associated with medicine, while constructivism only appeared in opposition to medicine (Phillips et al., 2012). Phillips, et al. (2012) argues that this has changed, with the psychiatric discipline being “chastened due to the failure of biological psychiatry to produce, but still convinced of the reality of psychiatric illness” leaving most psychiatrists to gravitate towards a strong realist/weak constructivist position (Phillips et al., 2012 p. 27). A colleague within Phillips et al.’s (2012) review takes an opposing stance, stating, “I accept the realist

position, that is, that diseases exist independent of me and you that are expressed as psychiatric symptoms like the chronic delusions of schizophrenia, or the mood states of manic-depression. I don't see how one can reject the reality of psychiatric disease, and still practice psychiatry, especially with the use of harmful drugs." (p. 7). It is clear that this individual is of the essentialist stance, assuming that mental disorders have innate presences in the world, and overlooks the assumption many individual, societal, structural and biological factors come together to create what we as humans perceive to be the disorder. This is evidence of Foucault's (1973) medical gaze in practice. It exemplifies the notion that some medical practitioners place the utmost value on absolutist understandings of biology and taxonomy.

Gary Greenberg within the Phillips et al., discussion (2012) is in direct opposition to this strong realist perspective, explaining

To question diagnosis is not to question the existence of suffering, or of the mind that gives us the experience of suffering, or of the value of sorting it into category. It is merely to point out that before we can do that sorting, we have to posit those categories. Where do they come from? Are there really diseases in nature? Naming the suffering, we bring it into the human realm. By inventing categories like this one, we give ourselves a way to get hold of it, which in medicine means among other things a way to talk to other professionals about it, a way to determine treatment options, and a way to provide a prognosis to the patient and family. (p.11).

It is clear from this literature that there is not one overarching epistemological/ontological position within the field of psychiatry as a whole. Many psychiatrists take up the strong realist position, whereas others take up the strong constructivist position; consequently, others feel that there is truth to all positions (Phillips et al., 2012). With its roots in positivistic biomedical science, psychiatry is a disciple which clearly cultivates differing epistemic and ontological perspectives across the board, indoctrinating its practitioners in strong realism but allowing them to expand and grow once they begin practicing medicine on their own.

Phillips and colleagues (2012) also address the question of whether or not scientists are able to develop an adequate definition of a mental disorder. Although the diagnoses within the DSM serve the important function of allowing clinicians to study and treat various distressing experiences and psychiatric sequelae, many practitioners have debated whether or not these definitions should be in place due to the belief that they may not be entirely accurate.

Within Phillips et al.'s (2012) analysis, Jerome Wakefield argues that through use of the notion of harmful dysfunction, we can develop an accurate definition of a mental disorder. Essentially, Wakefield is arguing that attention should be paid to the deviations from 'normal' states, he is saying that attention to the pathological is important in order to understand it. It is this very idea of the 'pathological' which can be problematic and constructed in itself. Warren Kinghorn is in direct opposition to this idea, stating that the definition of a mental disorder is useless and should be abandoned based on his belief that one definition cannot accurately cover the entirety of what a mental disorder encompasses (Phillips et al., 2012). This speaks to the failure of the DSM-5 to take context into account. It appears that Kinghorn understands that there is no way for the DSM-5 to fully embody all varieties of experience. Joseph Pierre falls within the middle of these two schools of thought, arguing that such a definition is impossible to develop due to "poor science, value intrusion, (and) ever broadening parameters of practice" (Phillips et al., 2012 p. 27). Although he believes in the impossibility of defining a mental disorder, he believes that such definitions are vital within the medical field, causing him to conclude that a definition is needed, however inadequate (Phillips et al., 2012).

When observing taxonomic practices within medicine, we may begin to notice the medical classifications often come with the assumption that the phenomenon pathologized as a disorder is present cross-culturally, independent of psychiatric gaze (Kleinman, 1987; Stein et al., 2007;

Summerfield, 1999). It is important to understand the limit of this perspective, although it can better explain phenomena with biological roots, mental disorders absent of a biological cause are less likely to be explained by one fixed set of diagnostic criteria or causal factors. Furthermore, the focused attention on finding biological markers of these disorders takes value away from more holistic approaches which utilize qualitative research. As argued by Shay (2010), although the DSM attempts to be inclusive of all PTSD experiences, it does not direct enough attention to PTSD symptoms commonly experienced by soldiers, e.g., guilt and shame. This displays the lack of context present within DSM-5 criteria and shows the potential issues that may arise when conducting patient assessment and interpreting potential symptoms.

Biological dysfunction is a marker of PTSD; Stein et al (2010) explains, “certain factors can predict vulnerability and resilience after exposure to trauma, including those that predate the trauma (e.g., genetic variation), those during the trauma (e.g., severity and duration of the trauma), and those that are present after the trauma (e.g., social support)” (p. 140). Although there are predicting factors and biological markers of this diagnosis, PTSD does not come with one inherent biological cause or set of biological similarities across all sufferers. There are many biological as well as social components that come together in different ways to cause this disorder to present uniquely in individuals. It is the simple solution to allow one discipline (medicine) to label this set of sequelae as a medical problem which medical professionals address. It is also a logical result of this singular medical gaze for researchers within other disciplines to step forward and attempt to engage with this disorder, but it is this labelling of PTSD and conceptualization that I argue must be addressed in order to analyse medical narratives.

Hacking (1991) explains that society has a proclivity for sorting things into kinds and classifying different behaviors and interactions in a way that is the easiest to deal with and

control. By labelling and classifying phenomena, we are attaching cultural and societal expectations and understandings which constrain the way that the phenomena can be understood. These expectations and categorizations cause bias in understanding the phenomenon for what it is, a feat Hacking (1991) would say was futile.

Taxonomic practices, while they represent social constructs and biased observations, do present positive effects. They allow for a certain set of distressing symptoms to be more easily studied and treated; they have positive economic effects, such as the ability for veterans classified as having PTSD to receive benefits; and, they allow veterans to be recognized as experiencing suffering stemming from their jobs. Unfortunately, it is important to look at the negative effects of the PTSD classification as well, as this classification may not accurately represent all of those suffering; therefore, some individuals who cannot be diagnosed may have more difficulty seeking medical coverage or treatment for their distress.

Due to the influence of societal factors on individual taxonomies such as PTSD, classifications may vary cross culturally (as seen in the previous section) or even within one culture (as seen with the differing institutional narratives). It is clear that many veterans suffer from distressing sequelae post-combat, and it is important to recognize this suffering in order to treat it. It is logical that the distress resulting from trauma is classified in order to effectively help those suffering; however, with this demand for classification, must come critical study. Because PTSD is classified as a medical disorder, this means that it is studied and treated most dominantly by the medical profession, and the medical profession is the ultimate authority on the matter. However, limiting dominant analysis of disorders to one discipline presents the issue of that discipline's paradigmatic influence upon the treatment and understanding of the disorder. The effects of a singular paradigmatic conception also interfere with the conceptions and

representations of the disorder within other disciplines and institutions which govern that disorder. This is why it is important to use critical analysis to understand the ways in which different institutions and disciplines treat the classification of PTSD, thus allowing for a more thorough understanding of how these classifications affect the suffering soldier.

I analyzed the conceptions of PTSD within the disciplines of the social and medical sciences because these sciences present the most frequent analyses of this subject; instead of continuing to present continually competing understandings, these sciences must collaborate. It is within this collaboration that we can begin to develop stronger understandings of veterans' issues, such as barriers to care.

The majority of the literature within this field takes a psychological or medical perspective in defining the causes for barriers to mental health care among veterans. They readily accept the medical claims of the PTSD symptom criteria, therefore placing the authority of PTSD in the hands of the medical discipline. The dominant research in this area attempts to model a medical framework by utilizing a positivistic perspective when analyzing data. This research is determined to find one ultimate causation, with many studies arguing for stigma to be the main barrier to care (Ben-Zeev et al., 2012; Hooyer, 2015; Kim et al., 2010; Schreiber & McEnany, 2015; Vogt, 2011), or negative attitudes towards the mental health system (Britt et al, 2008; Hoge et al., 2004; Wright, Britt & Moore, 2014). Other studies argue that desire to deal with symptoms on one's own is the more important barrier to care (Naifeh et al, 2016). This is a very clear positivistic model as the objective of the researchers is to find the causation of lack of help-seeking, when in fact their findings indicate that there are many correlates rather than just one individual causation.

This research format tends to come with some analytical rigidity, as the factors indicated to correlate with lack of help-seeking are explored individually. An exploration of the conditions which create such factors is not deeply understood, and respectively, the interconnectivity of said factors has not been thoroughly explored.

Some recent studies have attempted to address this gap in the literature, utilizing a narrative analysis to explore the contradicting narratives of the military and medicine (Molendijk, Kramer and Verweij, 2016), and others utilizing a narrative analysis to explore illness narratives of veterans suffering from PTSD (Caddick, Smith & Phoenix, 2015). These studies have begun to target the interconnectivity of previously found correlates of barriers to care. Whether they address the relationship between a militarized masculinity and illness stigma (Caddick, Smith & Phoenix, 2015), or the relationship between military beliefs about health and medical beliefs about health (Molendijk, Kramer and Verweij, 2016), they are utilizing a more holistic approach which attempts to develop an understanding of the processes by which these factors arise, rather than the individual factors responsible for lack of help-seeking. I will address this gap in the literature by building upon recent constructivist studies and will seek to understand how correlates of failure to seek help such as stigma and label avoidance interfere and how they emerge within the medical discipline. By analysing the stories that medical practitioners tell both about PTSD and about their profession, I will be gaining insight into one aspect of the process of help-seeking, and hopefully shedding light onto the conceptions and constructions of the current factors said to play a role as barriers to care among veterans with PTSD.

Chapter 3: Research Methods

Social Constructivist Theoretical Framework

Qualitative research is able to provide insight into both organizations and cultures, and this is often done through a narrative analysis (Tracy, 2013). Qualitative research methods were used within this research in order to study the social processes which interfere with soldiers' mental-health seeking behaviors. As explained by Tracy (2013), "qualitative data provide insight into cultural activities that might otherwise be missed in structured surveys or experiments...[It is] well suited for accessing tacit, taken-for-granted, intuitive understandings of a culture... Qualitative research can uncover salient issues that can later be studied using more structured methods." (p. 5). This explanation is supported by Lee (2012), who stated "Qualitative inquirers take issue with the conventional realist view that 'there exists a reality *out there*, driven by immutable natural laws." (p. 403). Much of the research surrounding barriers to mental health care among the military cohort take on a positivist view of looking at an ultimate causal factor for reduced health-care seeking through use of quantitative methodologies.

In order to develop a more thorough understanding of barrier to care among soldiers, I utilized a social constructivist framework in order to develop a top-down analysis of institutional narratives of PTSD. The literature review chapter focusing mainly on deductive literature due to the lack of inductive research on the major barriers to care among military members with PTSD. The literature review itself was inductive in nature as to be compatible with the social constructivist framework (Yin, 2016). The research interviews were conducted using an inductive framework, with attention being paid to the narratives present among individual psychiatrists, therefore giving light to a larger and broader set of institutional narratives.

Essentially, this research seeks to understand the stories psychiatrists tell surrounding PTSD and their profession.

This social constructivist framework allowed for study of the meaning-making processes that were reflective of shared institutional narratives (Bauer, 2000). In the social constructivist paradigm, personal narratives of PTSD function as vehicles for the qualitative methodology to observe beliefs and expectations held by the broader medical discipline (Langellier, 1989).

I chose to use a social constructivist approach rather than a radical constructivist approach as the former focuses on “collective generation of meaning” while the latter suggests that “the individual mind is active exclusively in the meaning-making activity” (Lee, 2012, p. 405). The objective of this research is to study the ways in which collective meanings or narratives emerge as personal narratives among medical professionals. This study functions under the assumption that knowledge is not “disinterested and apolitical” (Lee, 2012, p. 405) and is able to provide an analysis of these PTSD narratives in a thorough manner.

Narrative Analysis

People are more likely to retain information if it is in narrative form, and often express their beliefs, opinions, expectations and experiences in narratives (Tracy, 2013). These narratives provide researchers with a window into how individuals understand the situations and structures surrounding them. As explained by Bamberg (2012), “it is commonly held that narratives serve the purpose for passing along and handing down culturally shared values, so that individuals learn to position their own values and actions in relationship to established and shared categories and, in doing so, engage in their own formation process as a person.” (p. 11). This study used a literature review to obtain secondary data pertaining to the PTSD narratives present within the military. It utilized primary data through one-on-one interview methods to make observations on

the ways in which medical professionals understand and function under medical narratives.

Through learning of the narratives present among medical professionals, the values, beliefs and expectations of the medical discipline began to emerge. According to Langellier (1989)

Personal narratives participate in the ongoing rhythm of people's lives as a reflection of their social organization and cultural values... Storytelling is embedded within larger social processes, such as the literacy practices of pre-adolescent urban culture, the maintenance of families, and the public and private debates on abortion in the US studies of the social uses of narrative spring from a variety of disciplines, among them Anthropologie, sociolinguistics, rhetoric, and communication studies (p. 261).

In the case of this study, the secondary data obtained was able to give light to the narratives embedded within the social processes of the military structure, with structural practices affecting personal PTSD narratives of soldiers. The primary data was able to speak to the personal PTSD narratives of medical practitioners, a piece of information that is not captured within current research. Narratives contained within this data were representative of professionals' beliefs and understandings surrounding their clients' experiences with PTSD, their profession and the medical discipline.

Some difficulties did emerge in conducting a narrative analysis with science-based informants . Frequently, participants felt the need to justify their responses with scientific and/or research-based evidence. They were hesitant to respond in narrative form which may have required deviation from their scientifically held assumptions and education.

Furthermore, the narrative analysis conducted did not always produce the kind of data which was being sought out. Although Kleinman (1988)'s definition of narrative is very broad, the statements made by the participants differ from narrative statements in that they were often fact-based and followed a scientific or biomedical model of reasoning.

Coding was used to sort through the data, it can be described as “a categorizing approach used for exploring large amounts of textual information unobtrusively to determine trends and patterns of words used, their frequency, their relationships, and the structures and discourses of communication” (Vaismoradi, Turunen, & Bondas, 2013, p. 400). Following the gathering and transcribing of interview data, I began by open coding the data into the general themes or meanings which emerged (Tracy, 2013). I began to develop first-level codes which sought to ascertain the general essence of the data collected. Throughout the coding process, I ensured that I was constantly transforming codes to be more specific.

I used the constant comparative method in order to compare the emerging codes, therefore establishing new, more accurate codes (Tracy, 2013). To practice this method, I created a systematic codebook which listed the codes present, definitions of the codes, examples, and showed key similarities or collaborations between codes (Tracy, 2013). I revisited my research questions in order to confirm that they were still pertinent in light of the data collected and began the secondary coding cycle in which I developed second-level codes. Second level codes serve “to explain, theorize, and synthesize... Second-level coding includes interpretation and identifying patterns, rules, or cause-effect progressions. Second-level codes often draw from disciplinary concepts” (Tracy, 2013, p. 194). Certain second-level codes identified fell in line with the literature reviewed within this study, i.e. “Contradicting PTSD Narrative” or “Fear of Career Loss”.

To include data that did not fit into to any of the second-level codes, axial coding was used to re-group codes, for example, data regarding 'PTSD as a fashionable diagnosis' was paired with data regarding 'medical narratives' (Tracy, 2013). Hierarchical coding was then used to assemble codes under broader codes such as “medical narratives” and medical training” (Tracy, 2013).

Analytic memos were used to keep track of “the meaning of codes and on the connections among them” (Tracy, 2013, p. 196).

Finally, a dialogical narrative analysis was conducted in order to analyze interview data in an iterative manner (Frank, 2012). In a dialogical narrative analysis (DNA), “stories are considered to be more than simply passive representations of people's lives; they are active players that can affect those lives in both ‘positive’ and ‘dangerous’ ways” (Caddick, Smith & Phoenix, 2015, p. 100). In this study, narratives will be defined as “spontaneous acts of meaning-making that take place and interweave through many moments of discursive time and space”. (Cunliffe, Luhman & Boje, 2004, p. 262).

Two key sets of questions in DNA which are notably pertinent to this study are “what multiple voices can be heard in any single speaker's voice; how do these voices merge, and when do they contest each other?” (Frank, 2012, p. 33) and how well do stories serve those involved with them (Frank, 2010). Frank (2012) recognizes that “any individual voice is actually a dialogue between voices” (p. 34). Which is why I will be focusing on the stories that medical practitioners tell and how they may shape the experiences of those that are experiencing the illness.

Research Focus

Post-Traumatic Stress Disorder within the military is a highly researched topic with many studies concluding that Western soldiers underutilize mental health care (Molendijk, Kramer and Verweij, 2016; Hoge, et al., 2004; Kim et al., 2010). Many studies find that this is due to stigma (Schreiber & McEnany, 2015; Hooyer, 2015; Kim et al., 2010; Vogt, 2011) or negative attitudes/beliefs about mental health care (Britt et al., 2008; Hoge et al., 2004; Kim et al., 2010;

Wright, Britt & Moore, 2014). Within the literature, stigma and negative attitudes or beliefs about health care are explained to be barriers to care, with the researchers focusing on how to ameliorate the effects of these factors, or how to reduce their prevalence.

There is a gap in the current literature as attention is not given to the structures that put stigma and negative attitudes/beliefs in place. By understanding military and medical structures and how they contribute to these barriers to care, we can begin to develop a more well-rounded understanding of the process that takes place when soldiers in need fail to seek mental health care.

Molendijk, Kramer and Verweij (2016) conducted a preliminary study on the narratives present within Western military institutions. They conducted a literature analysis on conceptual scientific literature, reports, and program materials as they were unable to locate empirical data on the specific PTSD-interventions in each Western country (Molendijk, Kramer, & Verweij, 2016). The literature they analysed refers to the US, UK, and/or Dutch armed forces, with the authors stating that Western-armed forces tend to have very similar, if not identical, PTSD-infrastructures (Molendijk, Kramer & Verweij, 2016). Molendijk, Kramer and Verweij (2016) concluded that Western PTSD infrastructure reproduces narratives of PTSD (discussed in the literature review chapter) which contradict dominant Western medical narratives. It is due to the contradiction in narratives which the scholars feel to be the reason why soldiers are hesitant to seek mental health-care (Molendijk, Kramer & Verweij, 2016).

Molendijk, Kramer and Verweij's (2016) literature analysis begins to address the gap in the current PTSD literature; however, they conducted a preliminary study with secondary data. This

study utilizes a qualitative approach to study medical PTSD narratives present among psychiatrists within the Ottawa area. I have designed this research model to address the gaps in the current literature, and to address the PTSD narratives present in the military and medical systems. Rather than conducting another literature analysis, I felt that it was important to gather primary data from individuals complicit in medical narrative reproduction. This research focuses on narratives surrounding PTSD from a micro level perspective among individuals with a medical background and education. Addressing this topic from a micro level perspective is very important because broader medical narratives emerge and are reproduced within micro level interactions (Bauer, 2000). However, this perspective is noticeable absent from current literature. Although the sample I used was from the same geographical area, medical education remains largely homogeneous despite location (Hunter & Montgomery, 1993), which is why the literature in this study focused on Western PTSD narratives rather than Canadian PTSD narratives.

Preliminary Research Question

When beginning this research, I developed a preliminary research question and set of sub questions which influenced the format of the research methods used. Careful attention was paid to this step as strong research questions are critical in ensuring that the data obtained within the study is useful (Guest, Mitchell & Namey, 2013). To ensure I developed a strong research question, I considered the compatibility, yield, suitability, and feasibility of this project, which are “key considerations to entertain before diving into a qualitative research project “(Tracy, 2013, p. 11). I practiced reflexivity to ensure that I, as the research instrument, would be *compatible* with the demographic of individuals participating within this research. I questioned

whether or not this research question and sample population would *yield* a desired research outcome. In this case, I addressed the gap in the literature surrounding structural narratives of PTSD as barriers to care. *Suitability* was questioned, as I ensured that my research questions and objective were compatible with my theoretical foundations – that being social constructivism. Finally, the *feasibility* was not an issue, as participants were easily recruited through publicly listed contact information.

I based my interview questions on the preliminary research question. Although the questions asked of participants changed throughout the research as a response to what worked or did not work in previous methods. The preliminary research question (as stated below) drove my research.

The question that drove my research was as follows: How could a neuroanthropological approach improve military PTSD treatment and understanding within the medical discipline? Further sub-questions include: How do medical practitioners treat PTSD, and do they use a holistic approach? Is the idea of masculinity present in current medical treatment methods?

Through writing this literature review and beginning to complete interviews, I began to stray away from these research questions. Neuroanthropology as a discipline attempts to combine the fields of sociology, psychology, biology, anthropology and neuroscience in order to produce holistic understandings of phenomena (Lende & Downey, 2012). Through my research I found that this is a very new field, with little research and literature explaining how to put it into practice.

Instead of focusing on this niche understanding of PTSD, I looked at PTSD from a familiar sociological perspective rather than attempting to combine numerous perspectives which I did

not have any experience with and did not know how to put into practice. This sociological perspective included attention to the meaning making processes and epistemologies surrounding PTSD help-seeking processes involving both the military and medical disciplines respectively. I conducted the literature review and noticed a gap in the literature, with little attention being given to a constructivist perspective on PTSD narratives. This allowed me to focus on the military and medical institutions from a narrative perspective – a unique framework which allowed me to address the question of how military PTSD is viewed within medicine and how these understandings affect those that are suffering.

Final Research Question

Emerging from the literature review and preliminary research came a new set of research questions, as follows: What narratives of PTSD emerge within the medical discipline? Further sub-questions include: How might these narratives compare to military narratives of PTSD? What are the consequences of conflicting narratives of PTSD within the military and medical institutions? How do medical PTSD narratives impact care-seeking behaviour among military personnel?

The influence of masculinity on PTSD is what drove me to ask my first research questions. I was interested specifically in the ways in which PTSD affected military personnel's interpretations of masculinity. Caddick, Smith and Phoenix (2015) conducted research which built upon the interaction between PTSD and masculine perception/performance among individuals with military experience. This study was conducted by social sciences researchers, which interested me because I was curious about how medicine and social sciences could be

used in tandem to develop holistic knowledge on PTSD. I reflected on this interaction between PTSD and masculinity in the first section of my literature review; however, after noticing the gap in the literature, I decided to focus the interview questions on medical narratives of PTSD, as I felt that questions in this area of inquiry would be most productive within this research.

Participants

The sample consisted of five psychiatrists who each had experience treating Post-Traumatic Stress Disorder and practiced within the Ottawa Area. It was important that the participants were psychiatrists, as this meant that they had formal medical training from medical school alongside medical training specific to mental health.

A degree of generalizability and representativeness is important within qualitative research (Guest, Mitchell & Namey, 2013), which is why I ensured that the sampling frame included individuals familiar with PTSD from a medical perspective and had extensive formal medical training. All participants had been asked if they had treated PTSD previously, and all participants responded that they had. This ensured that all participants would have knowledge of structural PTSD narratives within the medical discipline. All of their training and experience in treating patients caused them to be complicit actors within the medical institution. Their involvement within the medical system meant that they are involved in creating and reproducing medical narratives, and their experience with PTSD meant that they were involved in the (re)production of medical PTSD narratives.

To ensure representativeness, the sampling frame included all psychiatrists in Ottawa as to ensure that the sample was not made up of individuals educated at the same institution or

employed at the same facility.

Although most participants did not have experience with military PTSD (n=3), they were able to speak to military PTSD narratives from the perspective of professionals within the medical discipline. This allowed me the unique opportunity to observe the proposed contradictions of the PTSD narratives between the medical and military structures from a solely medical perspective. Other participants (n=2) who had experience in treating military PTSD were still able to address military narratives, but from an experiential as well as a medical perspective. In addition to a vast experience in treating military PTSD, one participant had past military experience, meaning that within this sample, many voices emerged allowing for a degree of generalizability.

According to Guest and colleagues (2013) “purposive, non-probabilistic sample sizes should be determined inductively: That is, sampling should continue until *theoretical saturation*—the point at which no or little new information is being extracted from the data—is reached” (p. 59). These five participants had all confirmed their interviews at the beginning of the study. A larger sample was originally intended; however, the data obtained from the five participants provided theoretical saturation. Their various experiences in treating PTSD provided this research with a rich array of perspectives and voices which gave light to many narratives, while allowing for generalizability due to similar educational backgrounds.

The five participants consisted of a relatively small sample; however, I feel that I was able to begin to address this research question due to the similar medical backgrounds of the participants . All participants had been to medical school in Canada and were registered psychiatrists with experience treating PTSD. In Canada, medical doctors practicing in provinces outside of Quebec

must be registered with the Royal College of Physicians and Surgeons, while practicing physicians in Quebec must be registered with the Collège des médecins du Québec (Collège des médecins du Québec, 2018; The Royal College of Physicians and Surgeons of Canada, n.d.). This means that practicing psychiatrists in Canada have successfully completed the curriculum required of them, meaning that these participants' medical educations would be very similar. The medical discipline is built upon the curriculum that physicians must learn, and it is the narratives that emerge among the physicians that give insight into the ways in which medicine is being taught, learned, and understood. I believe that the size of my sample allowed me to successfully begin to uncover the PTSD narratives present within the medical community; however, in light of the data collected, I noticed a variance in the narratives expressed. Future research would be able to address this wide variety of narratives by developing a research model that included a larger sample which could more precisely pinpoint the prevalence of the narratives found within my current research.

Sampling Process

The research population was psychiatrists who had experience treating patients with PTSD and lived in the Ottawa Area. I was looking for medical narratives of PTSD, and knew that individuals within this population could provide me with that.

All participants were medical experts on PTSD, completing many years of education and practice within the medical discipline. The interviews could also be labelled as 'informant interviews', as the participants were able to provide information relating to medical narratives that came from their unique places within the medical field (Tracy, 2013).

To recruit participants, I searched “psychiatrist, PTSD, Ottawa” on Google.ca and also searched through psychiatry professors affiliated with University of Ottawa – the only university with a medical school within Ottawa. This geographical location was chosen based on convenience and feasibility within this MA level thesis. Most of the participants (n=3) were recruited based on their affiliation with University of Ottawa, and the rest (n=2) were found through a Google search for “psychiatrist, PTSD, Ottawa”. By searching on Google and the University of Ottawa website for psychiatrists, I was able to reach out to individuals with publicly listed contact information. I contacted each individual whose contact information was available through my two search techniques, which yielded five participants.

I made first contact with the participants by emailing their publicly listed email addresses, explaining my research objective, and asking if they would be interested in participating in this study. If the participants did not have a publicly-listed email address, I would call the telephone number listed, and would speak to them about my research over the phone. In these cases, I would also request their email address in order to send them further information (Appendix E). Once verbal consent was obtained, I would schedule the research interview, asking the participant to choose a location most convenient for them. Most of the interviews (n=4) took place at the participant’s office; however, one interview took place at the participant’s home.

I utilized the ‘voice memo’ app on my personal iPhone to record the interviews, which were approximately one hour in length. Each participant provided both their verbal and written consent (Appendix D) to be recorded.

Methods and Data Collection

Semi-Structured Expert Interview

I chose to utilize a semi-structured interview technique in order to gather data that could be used within a narrative analysis. The semi-structured format allowed me to ask questions which related to my research question, while allowing the participant to provide insight and take the interview in their own direction (Tracy, 2013). The semi-structured interview method was quite successful because in many cases, the participant would answer the questions in other ways than what I had in mind. This allowed for use of probing questions to ensure that the interview was as thorough as possible in collecting data aimed at understanding their perspectives. This was especially important due to the sample – the participants were experts in an area that I have no education in (medicine), so probing questions allowed the interview to flow smoothly while ensuring that the participant and I understood one another.

A focus group method could have been useful in gathering information on the narratives shared between medical professionals; however, it was not the method chosen due the loss of confidentiality it would require, and planning restrictions producing time constraints. All of the participants were highly busy individuals, so schedules would not align in order to book a focus group. Furthermore, the time constraint of this research project caused the semi-structured one-on-one interview to be the most feasible qualitative research method.

Not only was this method successful on a practical level, it was also imperative in gathering data for a narrative analysis. Due to the relaxed nature of the semi-structured interview participants went into detail about their beliefs and views within medicine without requiring prompts, which provided me with the data needed in order to address my final research questions .

In preparation for the interviews, I ensured that I was up to date on qualitative interview practices. I paid careful attention to Tracy's (2013) list of criteria of qualitative interviewers, specifically to be:

- knowledgeable about the topic and the person – especially if the participant is well known or belongs in an elite group;
- gentle and forgiving – allowing interviewees to pace and respond the way they desire, and providing smooth transitions between topics;
- sensitive – paying attention to the emotional tone, in addition to the message;
- open-minded and not quick to judge (verbally or nonverbally);
- probing – not taking everything at face value, but rather asking critical questions about inconsistencies;
- attentive – supportively listening and referencing earlier answers;
- interpreting – clarifying and extending the interviewee's answers (e.g. "when you say abc , do you actually mean xyz?"). (p. 161)

Interview Questions

I began by asking the participants an experiential question, specifically about the process of becoming a psychiatrist or what their practice was like, and then I asked them to define PTSD in order to provide a baseline for the topic we were discussing. I then asked a series of generative questions. One of the first questions sought to pinpoint the participant's positionality as a medical professional. This allowed me to situate the participant's answers to future questions in relation to their positionality, allowing deeper understanding of the framework that informed the participants' answers. I asked the participants questions relating to the DSM-5 criteria of PTSD in order to understand how the categorization of PTSD is conceptualized within the medical discipline. I then asked questions about culture in relation to PTSD, shortcomings of medical understandings of PTSD, barriers to care and PTSD within the military. I then closed with the catch-all question, "are there any other questions that you feel I should have asked you today?" in order to elicit a catch-all response to close to interview.

Many of the questions included in the interview guide (Appendix B) were perception questions, as participants of qualitative interviews often assume that they “are supposed to stick with ‘just the facts’, so if finding out about perceptions is one of [the] research objectives, you need to ask questions specifically aimed at learning your interviewees’ feelings, interpretations, and opinions.” (Guest, Mitchell & Namey, 2013, p. 138). This was very evident in the interviews that were conducted as many of the participants felt the need to clarify if their answers were supported by research.

The questions I prepared for the interviews were sufficient in gathering data on the participant’s medical understandings of PTSD and their profession, generating many medical PTSD narratives which were useful within the narrative data analysis. The participants were forthcoming with medical narratives and their thoughts about these narratives. In future research, I think it would be important to ask specific questions in relation to medical narratives. Many of the questions asked were successful in eliciting responses which included narratives, and some of my probing questions did specifically address medical narratives, however there were no questions about narratives within the interview guide (Appendix B). When asking probing questions about medical narratives, it appeared that the majority of the participants were not familiar with the concept of structural narratives, so it is also possible that the inclusion of such questions would not have elicited a helpful response. Probing questions targeted medical narratives, while allowing participants to answer based on their perceptions. The informal nature of the probing questions allowed the participants to think about medical narratives in an unstructured, ‘unscientific’ way, causing them to grasp this concept easily.

Reflexivity

Prior to my interviews, I used Pillow's (2003) notion of uncomfortable reflexivity when preparing for my interview. I began by reflecting on my positionality as a young, female, with a sociological background and on my participants' positionalities as older (in relation to my age), physicians with advanced education in psychiatry and experience practicing medicine. I documented all of my assumptions, fears, and expectations for the interviews, and I then listed all the questions I had for myself, such as "how might my position influence my participant's answers". I modelled this reflection after Pillow's (2003) description of uncomfortable reflexivity, as she explained,

This focus interrupts any notion of construction of a seamless and objective text and makes visible the personal construction of the text while taking responsibility for the knowledge being produced as well as to study the so-called postcolonial self itself as a site where multiple centers of power inscribe. (p. 189)

I found this type of reflexivity to feel very natural due to my position as an inexperienced researcher. Instead of attempting to come up with solutions to the possible biases that could arise within this research, I allowed myself to reflect on the power relations within my research without judgement. This judgement-free reflection allowed me to think through many of the potential conflicts and biases within my research.

As Beuthin (2014) explains, interviews can never be fully free of power relations, it is not the researcher's job to ameliorate all of the potential conflicts that may arise, it is their duty to reflect on them. While reflecting on my own positionality, I related to Beuthin's (2014) notion of insider tempered by outsider, which she describes as the researcher being "both a knowing insider and a not knowing outsider" (p. 129). I knew that I was an outsider because I do not have any medical education or military experience, whereas the participants were highly educated in the medical discipline, and one participant had military experience. I found this positionality as

an outsider to be a hinderance, as many of the responses elicited from participants were delivered with a hesitancy caused by their uncertainty as to whether or not I would understand their medical language. At times, it felt as though there was a language barrier, with the participant explaining something outside of my knowledge, or vice versa.

Conducting sociological research on a medical topic proved to be difficult based on the different educational backgrounds of myself and the participants. I tended to take a more constructivist perspective on medical issues, while the participants for the most part needed explanations as to what constructivism is. Reflexivity was useful in allowing me to consider how I may interpret participants' answers based on my sociological background; however, the most useful way of ameliorating my outsider status was through altering my interview guide (Appendix B) after each interview. This allowed me to include the questions easily understood by participants and exclude or alter questions which were more sociological in nature.

In reflecting upon my social location as a sociological researcher, I realised that I used qualitative methods within my study design as that is the type of research that I felt I had the most training on within my education. Interview methods were utilized within previous course projects, allowing me to feel confident in my interviewing skills. Consequently, I feel like this study design allowed for a unique perspective on this topic. With previous research in this area focusing on quantitative methods, I felt as though my research design contributed new forms of data to this field in the form of narratives obtained through interviews.

Role and Position of the Researcher

In some of the interviews, it was quite obvious that I and the participants were of two very different positionalities. While I did reflect on my positionality as a student within the social sciences and the participants' positionalities as professionals within the sciences prior to

conducting the research, I did not anticipate such a clear divide that emerged in a couple of the interviews. It was clear in one of the interviews that the participant did not see value in my social sciences approach, evident from their incredulity towards my questions and very short responses. This could have been a good opportunity to probe that participant's reasoning behind their perspective; however, I did not foresee that response, so I was not prepared with probing questions. It is important to note that in revising this research, it is very evident that I myself have a realist perspective and hold the assumptions that PTSD is a valid diagnostic category, and psychiatric treatment is beneficial and should be accepted by military personnel.

I considered my positionality as a young researcher when preparing to conduct this research, as I felt that this age characteristic as well as my educational background would cause me to assume an outsider status with the participant. The participants were mostly middle aged, with a couple being older in age. I suspected this due to their extensive educational backgrounds, so I prepared using reflexivity; however, I was not aware of their ages until I met them face to face.

It is difficult to understand all of the biases that emerge due to my positionality as a young, female researcher; however, my position as an outsider gave me the opportunity to request detailed explanations from the participants that they may not have given to someone they understood to be an insider. My positionality as a young, social sciences student with no military experience distanced me from the participants' shared positionalities as older (than myself) psychiatrists. One participant had military experience which caused them to assume outsider positionality due to my lack of military experience. Although my positionality caused me to feel very unsure of myself, and out of place among these individuals, I also felt that it aided in my research. As Beuthin (2014) stated,

This not knowing affords me some naiveté and a genuine openness, concern, and ability to be surprised; it supports my ability to not lead so much as to follow. But do I miss key threads in the

interview story that I might have focused on more in the moment if I was more of an insider? (p. 129)

I attempted to ameliorate the missing of key threads by educating myself on medical practices and treatments of PTSD, as well as military structure and culture. However, I feel that my lack of experience in the sciences discipline caused me to be confined in understanding the production of medical narratives. I was able to research medical narratives, but it is how they emerge and are built that I do not have any insider experience with.

In reflecting on this research, I realise that I could have made more rapport building comments in order to reduce the visibility of my position as the researcher and situate myself in a more personal and friendly position (Tracy, 2013).

Human Subjects Protection

This research was approved by the Carleton University Research Ethics Board. Participants provided their informed consent by signing a consent form (Appendix D). The consent form explained that they were not required to answer any questions and could stop the interview at any time. Participants could withdraw from the study up until 10-weeks from the interview date and were told that they could change or redact any answers that they had given. Participants were reminded not to share any confidential patient information as to uphold the ethics within their discipline. Furthermore, participants were given pseudonyms in order to provide them with confidentiality. Although this research project did not concern any personal or private information, participants tended to give personal answers, expanding on their medical understandings by way of their personal beliefs. Participants' beliefs and opinions were kept strictly confidential in order to protect participants' identities. No identifying names or characteristics were using in describing the participants to uphold this standard.

Rigor, Credibility and Trustworthiness

To ensure rigor, careful attention was paid to each aspect of this research. The sample size was large enough to draw significant findings, interviews were conducted according to past qualitative interviewing training, and data was analysed using an appropriate constructivist framework and narrative analysis (Tracy, 2013).

In order for this research to be credible, I used multivocality which Tracy (2013) described as “analyzing social action from a variety of participants’ points of view and highlighting divergent or disagreeable standpoints.” (p. 237). The sample consisted of psychiatrists from many different educational and professional backgrounds, although they were all registered psychiatrists who had completed medical school and psychiatry training, their training on how to treat PTSD varied. Some participants had careers prior to their psychiatry career, and some specialized in different fields of mental health care. This allowed for a rich analysis of medical narratives of PTSD from a variety of voices.

Member reflections were used in the last couple of interviews to gain critical feedback from participants on the current findings of this research (Tracy, 2013). One of the participants who had past military experience expressed agreement towards the findings of the literature review chapter which addressed the contradictory PTSD narratives of the military and medical institutions. Prior to that, participants were asked for feedback on answers that others in the study had given. This ensured that there was a dialogue present within the research process and resulted in a form of collaboration in interviews, between the participants and between the participants and researcher.

I chose to conduct an iterative analysis of the data collected in order to hold myself accountable for my personal interests and priorities in relation to this research. As explained by

Tracy (2013),

An iterative analysis alternates between emic, or emergent, readings of the data and an etic use of existing models, explanations, and theories. Rather than grounding the meaning solely in the emergent data, an iterative approach also encourages reflection upon the active interests, current literature, granted priorities, and various theories the researcher brings to the data. Iteration is “not a repetitive mechanical task,” but rather a reflexive process in which the researcher visits and revisits the data, connects them to emerging insights, and progressively refines his/her focus and understandings (p. 184)

This was fundamental in ensuring that I produced a trustworthy data analysis and conclusion section, as qualitative research (as with quantitative) can be skewed due to bias or researcher priorities.

Trustworthiness and credibility were achieved within this research by practices of reflexivity. As explained by Bruner (1991), “Unlike the constructions generated by logical and scientific procedures that can be weeded out by falsification, narrative constructions can only achieve “verisimilitude.” Narratives, then, are a version of reality whose acceptability is governed by convention and “narrative necessity” rather than by empirical verification and logical requiredness...” (Bruner, 1991, p. 4-5). The narratives observed within this study, though not “provable” as true or false, give light to the greater meanings and practices within the medical discipline. It is through analysis of this data that we can make trustworthy and credible conclusions. The narratives present are the vehicles for doing so.

Chapter 4: Data Analysis

Participants' Personal Development and Development of the Psychiatric Discipline

Medical Frameworks – Strong Realism, Strong Realism/Weak Constructivism, Strong Constructivism

The medical discipline tends to practice within a strong realist framework (Foucault, 1973; Phillips et al., 2012; Summerfield, 2001). As explained by Philips et al. (2012), this means that the biomedical assumptions which make up the medical discipline relate to absolute narratives, such as “There are [symptoms] and there are [mental disorders] and I call them as they are.” (p. 6). Philips et al. (2012) go on to explain this realist positionality which they argue is found in psychiatry,

This tends to be the position attributed to psychiatry. Psychiatry’s rhetoric, if not the actual commitments of all practitioners, says both that mental disorders are abstract entities that exist in the world and manifest in individual persons, and that these processes can be intersubjectively appreciated and elucidated as they truly are. (p. 6)

The link between a strong realist framework and the medical discipline is often evidenced within research, with doctors tending to focus on the disease or disorder rather than the individual suffering from it (Kleinman & Kleinman, 1991; Smith, 2011; Stein, et al., 2007). The belief that a disorder exists as a natural, innate entity may be very enticing to medical practitioners. This may be due to the added pressure felt within the field of psychiatry to produce biological markers of mental disorders (Rose, 2001). This reflects the molecularization of disorders as defined by Nikolas Rose (2001) who stated that,

To diagnose through the brain rather than through the visible symptoms, life changes, or course of the condition—this is the dream: a mode of diagnosis that, they admit, is very likely to radically revise existing classifications, linking disorders currently separated by superficial symptomatology, and dividing disorders illegitimately lumped together. In this style of thought, then, it is unthinkable that diagnosis—like treatment, and like the illness itself—should not be best when and if it can become a “brain” matter (p. 208).

The pressure upon the psychiatric community to identify organic correlates of the disorders which they have governance over will be a re-emerging theme in this coming chapter.

Soldiers hear military narratives within screenings and resilience trainings that reassure them that they “should be able to handle combat” (Molendijk, Kramer & Verweij, 2016). Subsequently, they hear “we can help you” and “it’s not your fault” from the medical discipline, potentially causing them to become confused or distrusting of the help being offered (Molendijk, Kramer & Verweij, 2016). It is important to understand what narratives are present within the mental health care system. The frameworks and assumptions that are behind these narratives will allow for a better understanding of the processes resulting in currently identified barriers to care.

I targeted the findings of my literature review, focusing on themes of military masculinity, stigma, medicalization, and diagnosis within my interview questions. The analysis of this study will seek to build upon the findings within the literature review. Namely, the literature review addressed current medical research on military barriers to care, stigma of PTSD, diagnostic processes, and medicalization and medical understandings of PTSD. Furthermore, I will utilize a dialogical narrative analysis to ask questions such as “what multiple voices can be heard in any single speaker's voice; how do these voices merge, and when do they contest each other?” (Frank, 2012, p. 33) and how well do stories serve those involved with them (Frank, 2010). These questions will allow me to analyze whether or not the narratives present among individuals in this study represent the broader structural narratives of the medical discipline. I can then move on to analysing how well the medical narratives relayed in the data serve military members with PTSD who are perceived as requiring medical assistance to treat their condition.

To begin to understand medical narratives specifically relating to PTSD, I asked the participants in this study a question relating to their medical framework/positionality. The intention behind this question was to provide a baseline for how each participant understood medical disorders, namely PTSD, in order to frame their responses to the questions which followed. The participants were asked:

The psychiatric discipline as a whole tends to practice within a Strong Realist framework. Would you say that your medical understandings fit within this framework? And, if not, which framework would you place yourself in:

- i. **Strong Realist:** Mental disorders are abstract entities that can be observed independent of psychiatric gaze. They manifest within individuals and can be studied and observed for what they truly are.
- ii. **Strong Realist/Weak Constructivist:** Mental disorders exist despite psychiatric gaze; however medical professionals might not always understand mental disorders for what they truly are.
- iii. **Strong Constructivist:** Psychiatrists describe their perceptions of mental disorders as accurately as they can; however, there no ultimate truths or abstract entities from which their perceptions can be compared.

In constructing this question, I reflected on my own positionality in order to ascertain whether I was motivated to receive similar responses from the participants. I fall under the strong realist/weak constructivist position because my sociological education causes me to be skeptical of positivist claims and assumptions; however, my desire for the existence of an absolute truth causes me to have lingering beliefs of a strong realist. My position as a researcher causes me to desire an obvious result, or a discovery within this project, while my educational background causes me to hope for the finding that medical practitioners have more of a constructivist framework than typically depicted within research.

Furthermore, in revising my analysis, it was evident that I hold a more blatant realist position than I previously realised. My analysis originally functioned with the perspective that PTSD is a valid diagnostic category and assumed that PTSD sufferers should seek medical care. Further

revisions of this section resulted in direct attention to this perspective and attempts to reduce the visibility of my own bias.

The majority of the participants (n=4) reported falling within the strong realist/weak constructivist position. Three of the participants (Doctors Williams, Allen and Jones) clearly stated "I am in the strong realist/weak constructivist position" while another participant, Dr. Miller, described her positionality instead of blatantly stating it. She said

I went to a talk recently. The fellow was quoting some research that shows that the way we conceptualize people that become suicidal is very much in terms of coming from a major depression and having a major life crisis. We have these kinds of facilitating events that occur. But one of the things that he was saying is that whole issue of having a mental illness and becoming suicidal works the higher the socioeconomic status. He was saying [that] cultures, or parts of society where people are very poor, [being suicidal] is less to do with mental illness and it's more to do with cultural issues, social issues. So I think it's complex and it is all related to society.

This coincides with the strong realist/weak constructivist position. Dr. Miller was explaining that some phenomena are too complex to define or explain; however, she does believe that said phenomena exist, causing her beliefs to coincide with that of a strong realist/weak constructivist position. The final participant, Dr. Smith, fit within a strong realist position. She did not blatantly state her positionality; however, it was clear from her response to the question of her positionality that she fit within this a strong realist framework. Dr. Smith stated,

I think that these are constructs that you're talking about, and I'm not quite sure [what positionality I fit into]. My bias is [that] I was a neuroscientist before I became a psychiatrist. There [are] four quadrillion neurons in the brain, and we use those four quadrillion neurons to develop an understanding of the world around us. They're all related. So where you put that in there, I'll let you do that. But all of us need to survive, and that's what our cortex is there to do, is to make sense of what goes on around us to enable us to survive. And so it's much more of a "I construct my knowledge of the environment based on my prior experience, as well as my current perceptions". Whether that actually fits with quote 'reality', that doesn't matter, as long as it ensures my survival.

Later in the interview, Dr. Smith was asked “does PTSD as a diagnosis allow for accurate treatment of patients who have developed PTSD from a variety of situations?” to which she responded,

I think so, because it's the same brain, it's the same brain that is having trouble integrating into the memory the traumatic experience, and I think that results in really quite consistent symptoms.

This cements Dr. Smith’s stance as a strong realist as she believes in absolute reactions and responses within the brain which can be classified as disorders. This participant was not interested in the potential of the inability to define or explain phenomena. She had a positivist education coming from a neuroscience background and seemed most comfortable with the notion that there is the potential for science to explain all phenomena. It is also evidence of the pressure within the psychiatric community to ‘prove’ the existence of mental disorder through biological markers or simulacra from brain imaging tools (Rose, 2001). These narratives that are relayed in Dr. Smith’s responses represent items that she would have been taught in medical school, specifically medical terms, ideas and statistics. The dominant voice in her narratives is likely coming from broader medical structures and the pressure within psychiatry to be held to the same positivist standards as other medical disciplines.

Dr. Allen was the only participant within this study who was both a registered psychiatrist and a psychoanalyst. This positionality allowed Dr. Allen to have a unique perspective which consisted of a biomedical education alongside a more constructivist training in psychoanalysis.

When asked if he felt that his training in psychoanalysis led him away from a strong realist framework, he responded,

I don't know that it's teared me away. Though it's been around for well over a hundred years now , I think psychoanalysis is still so much a descriptive science, and a science very much based on the individual experience. We are a bit cautious in trying to find things in an absolute manner, even though we do [find things in an absolute manner]. I think that there is a skepticism in trying to describe something universally. I think we are more interested in the nuances, and I think, by

some people's definition, that would take me away from that strong realist position. But then again, I don't necessarily see it that way, I see the importance of individual experience and I don't think mental disorders necessarily type definitions, some [do] more than others. The experts on schizophrenia would probably caution on saying that it's a single illness, they would probably say it's a group of illnesses. I certainly know one expert that would advocate that, and he certainly was an expert on schizophrenia. I think [with] other conditions, it becomes more complicated, like a question for me and Post-Traumatic Stress Disorder is, or sort of a thought experiment is, two people can experience the same trauma, one person develops the illness the other person doesn't. What makes one person more vulnerable? Or what makes the other person more resilient? There may be biological factors, that's an area I'm less aware of, but I would say there are factors in the person's mind, not just biological, but what their experience of their psychological development has been through childhood. I think certain people's childhood makes them more resilient, and some people's childhood makes them more vulnerable. So I don't think it can be boiled down very absolutely to a specific neurological pathway or something like that. Not that those aren't important, these need to be understood as well, but I would be very skeptical saying we know exactly what Post-Traumatic Stress Disorder is.

It was interesting to see that the participants' backgrounds influenced their positionalities. Dr. Smith's narratives were largely evident of those present within medicine, whereas Dr. Allen's narrative of PTSD is more ambiguous. I suspect that Dr. Allen's conceptualization and narrativization of PTSD is an amalgamation of a medical school education (see the references to biology) and training in psychoanalysis (see the thought experiment reference). It appears as though these two voices contest each other in Dr. Allen's understanding of PTSD; however, the medical voice is becoming somewhat more marginalised due to his focus on psychoanalysis rather than biological-based psychiatry. Dr. Smith's narrative is much more marginalizing of other voices of PTSD as it appears that she feels as though the voice of medicine has the most merit within the field of psychiatry.

It is possible that this sample was somewhat skewed, as it is likely that their participation indicates that they saw value in this type of sociological research (also called a self-selection bias). It is possible that the individuals who would see value in a study which views the medical discipline from a sociological perspective would fall within the constructivist framework. Other

individuals within the strong realist position may not have seen any value in a non-scientific understanding of medicine due to its lack of focus on reaping obvious findings and absolute answers.

As the only participant within the strong realist position, Dr. Smith was also the only participant who may not have known that I was coming from a social sciences background. In the recruiting email I sent, it stated that I was a master's student in Sociology. However, when meeting Dr. Smith, she asked about my education in trauma and asked what type of trauma training I had. She then asked what my hypothesis was for this study. It was possible that she had read that I come from a sociological background but assumed that I had training in trauma. However, most qualitative sociological research does not utilize a hypothesis that one attempts to prove, which caused me to believe that she assumed I had an education in the sciences. This would support the possibility that this research attracted mainly individuals of more of a constructivist positionality.

Like Philips et al., (2012), Dr. Jones believes that the strong realist/weak constructivist framework is a growing trend in the psychiatry community, she explained:

I think that there is still a group of people who are trying to narrowly define psychiatric disorders as discrete entities. But I think most people, and it's coming through in the DSM-5 as well, are saying that there's a lot of blurred boundaries that are happening. I'm not biologically based, I don't have a pharmacologically based practice, so I will give medications as needed if I feel that might help with symptoms. And if I need complex medications, I will refer to another psychiatrist who is more versed in the array of medications. But I would say even those psychiatrists, in the talks that I've been to lately, were expanding beyond a discrete formulaic black and white diagnosis, we're moving to a more general constructivist type of way of seeing things.

This observation would support Phillips et al.'s (2012) argument that there is a trend towards constructivism within the medical community. It would also support the data within this study that shows that most participants fell into a strong realist/weak constructivist framework. It

appears that Dr. Jones sees value in a broader understanding of psychiatric disorders rather than a strongly biological based understanding. This could point to the possibility that Dr. Jones' experience in medicine is presenting as the dominant voice within this narrative, rather than a narrative reflected from an education in medicine.

It is possible that the previous trend of realism within medicine functioned as a justification for the taxonomy of PTSD. By stating that PTSD is a valid diagnostic category, practitioners are further cementing their status as the authority on treating this illness by treating their conception of disordered soldier experiences as a valid category. The recent trend towards constructivism in psychiatry could affect the authority that practitioners and the medical discipline have as a whole on this phenomenon. This could potentially result in a more patient-focus individually based treatment or conceptual model, with less attention to one perceptively 'accurate' category of experience.

Within military structures, narratives of "you should be able to handle combat" may portray a strong realist framework in regard to PTSD. With soldiers having to pass through mental health screenings, interventions, and trainings, they are being told that they have the tools and the training to handle combat. Therefore, the assumption is present that they should be able to deal with aftermath of a combat experience without developing PTSD. Within this assumption, PTSD is simplified through the misconception that mental health screenings will be able to filter out those that are vulnerable to mental illness. The individuals who put these screening in practice likely knew that they could not filter out every vulnerable individual; however, the use of these screenings portrays a narrative of "those vulnerable to PTSD will not be allowed in". This directly contradicts the finding that a higher concentration of individuals with ACES joins the military than present in the general population (Blosnich, et al., 2014). With ACES being a

known risk factor to PTSD (Zaidi & Foy, 1994), it is evident that soldiers may be assuming that they have been cleared of risks to PTSD, when in fact many of them have ACES.

A constructivist framework may allow the medical discipline to move beyond current approaches and practices. Consequently, it may also hinder military trust of medicine, causing individuals within the military to feel skeptical of a discipline with a framework that does not attempt to provide absolute answers and concrete explanations of why one developed PTSD. Furthermore, it may also reduce the fear of being categorized into a subject position commonly associated with constitutional weakness.

Medical Training on PTSD Treatments

An interesting insight into the innerworkings of the medical discipline and the narratives produced can be found by looking into the medical training for PTSD. There is currently no specific medical school training on how to treat PTSD. According to Dr. Williams,

I would say training is quite sparse. I think there isn't a lot of understanding, and [in] psychiatry probably, we get a bit more training, but even then we were taught, "these are the criteria to look for". When you see it, you can diagnose it, we're not going to teach you what to do with it. So most people, if they want to treat [PTSD], then afterwards [they will] search out different resources on their own.

Dr. Williams' recollection of medical school is evidence of the presence of a psychiatric gaze (Foucault, 1973) within medical training. Careful attention is paid to markers of an illness and lack of attention is directed to the individual sufferer and their treatment. The goal is to view an ultimate reality of a disorder on a molar level through the sufferer's biology (Rose, 2001).

This experience also reflects a realist perspective within medical training. All of the participants had been practicing psychiatrists for a number of years. None of the participants were recent psychiatry graduates, so data obtained within this study do not refer to current medical school practices. This data is important, however, as 79% (n=1654) of psychiatrists within Ontario (n=2070) have graduated from medical school 16-30 years prior (Kurdyak, Zaheer, Cheng, Rudoler & Mulsant, 2017). This means that there are a large number of ageing psychiatrists in Ontario. It is important to look at data of psychiatry training from this demographic as it reflects the majority of psychiatrists who currently treat PTSD within Ontario (Kurdyak et al., 2017).

Dr. Allen also reflected a similar experience reflecting a lack of PTSD training in medical school, he stated,

When I first learned about Post-Traumatic Stress, it was again very much of "the soldier affected in the battlefield" and "here's what happens once they're home". So probably I would have been

more [of] a reductionist at that point and might have been, in fact, leaning towards a more biological, “okay something happened, and creates the biological event, and a cascade, and then everything can be explained that way.” If I get very meta on this, then in the end everything can be explained biologically because all of our experiences; behavior, perceptions, and symptoms with things like this start in the brain. They have effects in the body as well, and we are biological beings, but I don't think it's practical at this stage. We only have a tiny percentage of an understanding of this sort of meta thing, so I think from a practical perspective, where my understanding shifted was away from very specific biological pathways or biological events. I think they're still very important to research, to understand, I don't want to take away from that at all. But in terms of my personal interests, it's going to be still probably generations before we understand it on a biological level, on a physiological level. Which is our experience, the mind rather than the brain. That's where my interest shifted, and I think in part because, again, that very narrow definition, that was my first understanding of Post-Traumatic Stress. [My first understanding] just brought it so immensely to “trauma is more common than that battlefield experience”. How people respond to trauma can be quite varied. Yes, there's going to be a group that fit the symptoms of Post-Traumatic Stress, but there's also going to be people that have big problems because of traumas, whether that be with a capital T, or a small t, in many different ways.

Dr. Allen seems to be moving away from medical narratives of PTSD due to the lack of clear organic correlates of the disorder and consistent accuracy of the DSM-5 diagnostic criteria.

Consequently, Rose (2001) argues that lack of biological markers of an illness may lead to increased realism by medical professionals, as pressure to demonstrate biological aspects of illness lead practitioners to lean on already developed tools such as fMRIs and PET scans. These scans allow psychiatrists to open their gaze to another human organ – the brain, through simulacra attempting to reflect the brain's biology. Lack of organic correlates of disorders appeared to have the opposite effect on Dr. Allen; however, his psychoanalyst background could have caused him to subscribe to more of a constructivist perspective when faced with lack of biological scientific data.

This biologically-based understanding of trauma within medical training could be a hinderance to those seeking care as it portrays the realist idea that PTSD exists as a complication in one's biology (Rose, 2001). This narrative would not serve the interests of military personnel

suffering from PTSD. Spoont and colleagues (2005) argued that a biological understanding of PTSD may allow victims of the disorder to feel less at fault and allow them to place blame on a biological component of the disorder. Spoont et al.'s (2005) findings opposed their original hypothesis, showing a "fourfold increase in the likelihood of medication underuse" (p. 521) among military sufferers of PTSD who were educated on their disorder through use of a biological model. If a biologically modeled education on PTSD can negatively affect military members' use of medication, it is likely that this biological model within the medical discipline could affect likeliness to seek care, or attitudes towards mental health-care.

Lack of certainty in regard to PTSD treatment in medical school could have a negative effect on the biologically framed PTSD model. Participants in this study expressed that they had to seek training for PTSD treatments on their own. Dr. Williams stated,

I went through medical school, we didn't really talk much about PTSD except that there's physical symptoms that we might see in our office. And then in psychiatry, again, we learned the criteria and how to diagnose it - but not how to treat it.

Dr. Williams went on to explain the reason behind the demand for improved trauma treatment training in medical school, she explained,

You're taught really how to treat the bread and butter of psychiatry, but the reality is, most people who are needing significant psychiatric help who've been traumatized - it might not be the only thing, they might also have schizophrenia, they may also have bipolar disorder. But often we find there's a lot of trauma, and we are not taught how to treat it. So from the biomedical, for sure medications help, for sure they don't cure PTSD. People say they feel maybe calmed and numb, and they can sleep a little better, and maybe don't feel quite so depressed or hopeless, but they're not cured. So we need that whole other piece to move things through. I don't know if the conception has really changed, I think that through the years kind of observing it from those different perspectives, there's for sure a brain and a medical component to it that we are still trying to learn about.

It is clear that Dr. Williams is still hopeful for an improved biological understanding of PTSD; however, she understands that biology is not the only way to understand this disorder. This still

comes with the assumption that PTSD is a valid category, but does not dismiss the potential for changes in medical understandings resulting in new PTSD treatment precedents.

The ways that medical understandings changed have been seen firsthand by some of the participants in this study. Dr. Allen talked about a change in medical PTSD narratives brought on by real-world events:

I can say in medical school we barely learned about Post-Traumatic Stress Disorder, it was a diagnosis that existed. The model was very much the idea of how the diagnosis evolved, intended to be around veterans from wars; from the World Wars, shell shock, that kind of thing. And if my recollection is correct, then through the Vietnam War, the diagnosis [was] being refined, and then [came] the birth of a more modern understanding of Post-Traumatic Stress Disorder. But it was very much the start of [the] previous 'soldier model' that they hear a car backfire and suddenly they're back in Vietnam, and behaving as if they were there, kind of thing.

Dr. Allen is describing a change in the medical narrative of combat PTSD; first came the biologically based understandings of PTSD, and then context was added, namely due to the Vietnam War. This context shaped the narratives present and affected the ways in which medical practitioners at that time viewed PTSD. Dr. Miller, had a similar experience during her time in the military, she explained,

I think that the military world, and especially in Canada - our history of the deployments in the 1990s. I'm talking about Rwanda, Somalia, and the former Yugoslavia, basically, which were horrendous. People came back with a lot of problems, including PTSD, which went unrecognized for a long time. And then our involvement in Afghanistan. Because there was so much PTSD happening because of those kinds of events, it was like it became pushed into consciousness. It was almost like against people's wanting to not see it, they had to start seeing it because it became so obvious. So I think it was military experience that raised society's consciousness about PTSD. However, PTSD has been around for a very long time, and one of the places it has existed (and still exists), is among children who are abused - which we do not recognize. Even now, even though there is more recognition, it is nowhere near. So I was a nurse before I became a psychiatrist; I worked in psychiatry and I remember back then when a psychiatrist or psychologist would do a diagnostic assessment in like the 80s or 70s. They didn't routinely ask questions about childhood abuse, childhood sexual abuse, childhood neglect. They weren't even on the form where you would ask the question - that's how buried it was, nobody wanted to see it and you know who changed it? The Women's Movement. The Women's Movement changed it, it was not psychiatry, it was not the whole mental health field, it was the Women's Movement in the 60s and 70s pushing this issue. So that whole issue of child abuse and sexual abuse came from the Women's Movement pushing, and then mental health. The mental

health world had to start recognizing it. And then the whole thing with military was, yeah, PTSD became recognized that way.

This demonstrates the potential for change within medical understandings due to outside sources.

With the growing amount of research on PTSD and treatments, it is plausible that medical training will begin to adapt to include training on trauma treatments that appear to be proven and supported by research. Clear treatment training – while positive in allowing for more accurate trauma-related care, may also cause more emphasis on a more constructivist framework. Current psychiatry professionals are moving towards a more constructivist framework (Phillips et al., 2012), and new research may continue to allow the medical discipline to “open their minds” to understanding PTSD in a new light. If new research in this area is conducted within the positivist medical paradigm through use of quantitative methodologies, this research could function to reinforce the medical discipline as the authority on PTSD. Furthermore, if the social sciences and medicine disciplines collaborate to create new knowledge in this field, this may reduce the authority of the term PTSD and the singular authority of the medical discipline on treating and conceptualising this category. Social sciences research could function to develop new ways to integrate medical research into practice, serving to keep the medical discipline’s authority in place, while establishing effective ways for soldiers to seek health care. However, this brings about the question of “how important is it for the medical discipline to be the ultimate authority on this matter?”. Collaboration with the social sciences does not mean that researchers in this area will attempt to take over treatment; however, it may allow each discipline to restructure their research methods in order to view PTSD with a new perspective.

The Diagnostic Process

It has been found that many veterans and individuals with military experience are unlikely to seek mental health care as they fear diagnoses of mental disorders and ramifications within their careers (Hoge et al., 2004). A veteran's account in Scandlyn and Hautzinger's (2013) book explained this fear, he stated:

If I go in, and I tell you "I've been blown up 40 times and I saw three of my best friends die" a psychologist or a psychiatrist is gonna be like "Wow, he does have PTSD, he's been through horrible experiences..." So I think it gets misdiagnosed because they just don't really know what happened over there. (p. 51).

A diagnosis is not only a potential impediment to one's identity as "masculine", a contradictory identifying label which comes into conflict with one's perceived status as a 'good soldier' or 'man'; a diagnosis often results in fear of losing one's career (Hooyer, 2015; Hoge et al., 2004).

A veteran in Hooyer's (2015) study expanded on this,

Many receive medical discharges for mental illness. Those rumors spread and other soldiers get afraid to express their problems. It becomes an unwritten rule... everyone pretends to be strong. They want to keep their careers in line (Hooyer, 2015, p. 108).

Diagnosis of mental illness is often associated with mental health seeking behaviours, as veterans commonly believe that their experiences of trauma will become medicalized as a set of disordered behaviours (Hooyer, 2012; 2015). This is a common misconception; medical practitioners must abide by the DSM-5 criteria of Post-Traumatic Stress Disorder. This allows practitioners to justify their diagnoses and utilize dominant medical understandings of the disorder's symptomology to explain the presence of the diagnosis (American Psychiatric Association, 2013). Whether medical practitioners follow the strong realist framework or strong constructivist framework in conceptualizing disorders, they must justify their diagnosis just the same. This practice ensures that there are guidelines which function to provide a baseline explanation for the behaviours and experiences associated with the illness and allow practitioners

to work within those strict guidelines (American Psychiatric Association, 2013). In other words, medical practitioners cannot diagnose anyone they want with PTSD, and are trained to take the utmost caution in carefully choosing whether or not a patient a) has symptoms which interfere with their daily ability to function, and b) if these symptoms can be classified or categorized into one disorder (American Psychiatric Association, 2013).

The practice of PTSD diagnosis, however, does come with a set of assumptions. The symptom criteria of PTSD require interpretation by the medical practitioner in regard to the context in which they were experienced. The symptom criteria, or psychiatric sequelae, are understood to be negative, lacking in value, and harmful to an individual's wellbeing. Individuals with a certain number of symptoms are defined as having PTSD, an illness interpreted as a set of symptoms which affect the individual's functioning within their everyday life. Furthermore, PTSD is viewed as a disorder which can be treated through medical and/or psychiatric intervention. These interventions are perceived to be the more effective forms of alleviating the negative symptoms resulting in patients' ability to function 'normally' in everyday life, with the ability to complete their required tasks and duties throughout the day. Overarching this set of assumptions is a realist perspective that there are right or wrong ways of existing, and a certain amount of distress evident from lack of daily functioning which requires professional intervention.

The hidden realism that is emerging within myself causes me to easily accept these assumptions and feel as though they are the best and possibly only way to help individuals who are experiencing distress. I will continue to explore the notion that these assumptions are the "only or best way" forward in the upcoming sections.

Challenges of Treating PTSD

Differentiating PTSD from Other Disorders

Participants within this study were asked a number of questions which sought to address their understandings and beliefs about PTSD from a diagnostic perspective. It was clear from the way that these participants spoke about PTSD diagnoses that they took the diagnostic process very seriously and showed a great deal of care towards the act of providing a patient with a diagnosis.

Dr. Miller, a psychiatrist who has spent her career working in the Canadian Armed Forces, stated

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Certainly in our Canadian Armed Forces and Veterans Affairs funded clinics, the diagnosis is made pretty rigorously, meaning that we really document that people meet the criteria. Whereas (again this was quite a few years ago), in the civilian world, sometimes people making a diagnosis of any mental health condition are not quite as stringent about making sure people met the criteria. That could have changed, and you know I had a certain experience, so my impression could be skewed by that.

This demonstrates that the military assumption of over-diagnosis is potentially a misconception, as clearly in the Canadian Forces, diagnoses are made very stringently and the process is documented. Dr. Miller did elude to the less stringent diagnostic practices within the civilian world, and the other participants did not describe such a stringent diagnostic process; nonetheless, they explained that a great deal of care went into diagnosis. The fear of misdiagnosis could be a result of a skepticism towards PTSD as a valid categorization tool; however, more research needs to be done in this area.

With many soldiers fearing that their traumatic experiences cause them to automatically be diagnosable with PTSD (Hooyer, 2015; Scandlyn & Hautzinger, 2013), it is clear that this sample understands the difference between trauma and PTSD. Dr. Smith was asked “can one experience significant distress or impairment resulting from a traumatic event but not have PTSD?”. She described the difference between an experience of trauma and a diagnosable condition of

PTSD, she explained,

Absolutely, that happens more often than not. Because we have [an] innate mechanism that allows us to make sense of what happened, [and] learn from it in order to continue living in a way that increases our survival. And those people who have a traumatic experience, especially a single trauma, we're not talking a developmental trauma when you're young and you have consecutive ones - do not develop PTSD. And that's the interesting thing, what goes on when people do.

Dr. Smith's statement reflects her understanding of the difference between an experience of trauma and PTSD itself. If presented with a patient who had been in combat, Dr. Smith likely would not jump to a diagnosis based on the experience itself; rather, she takes care in the diagnostic process. Dr. Allen also reflects an understanding that trauma does not always equate to PTSD. He shared a personal narrative of trauma experienced by his grandfather who was a soldier in World War II:

The diagnosis of Post-Traumatic Stress Disorder, in the end, it's a descriptive diagnosis of a collection of symptoms. So if somebody has enough of the symptoms, they made the diagnosis. But with someone like my grandfather, he probably didn't meet the criteria, and some would argue, no, it didn't interfere with his life. I would argue that from a little bit of personal knowledge of some of the dynamics in my family, but he wasn't somebody who was obviously affected. But he was affected, so that's the cautionary aspect of the diagnosis, it's a diagnosis, it's descriptive and you have to accept the limits of that. Find someone [who] meets the criteria, you got the diagnosis, but it doesn't mean that there aren't other ways of being affected by trauma.

In other words, Dr. Allen has firsthand experience of someone who was affected and distressed by a traumatic experience; however, that individual most likely would not have been categorized as having PTSD. When asked "is it possible for someone to experience a traumatic event and experience a huge impact in their daily functioning without being to be diagnosed with PTSD?"

Dr. Allen went on to explain,

Oh absolutely. I think in where I became interested in trauma, where the experience is, and childhood, I think an argument could be made for some of these people that it's not Post-Traumatic Stress Disorder. Certainly, given some of the more rigid definitions of Post-Traumatic Stress, like the DSM-4 is still somewhat more restrictive in its definition of trauma. I think some of the people I work with would not meet the criteria of that definition. They might meet better the DSM-5 criteria, but there are certainly people who won't meet the criteria where the trauma

has still had an effect, but not with those symptoms. At that point there's a debate, does it need to be called Post-Traumatic Stress Disorder? I don't think there's necessarily a need for that, I think there needs to be a recognition that trauma can have an effect in multiple ways and there's not only one diagnosis that deserves treatment, there's not only one form Post-Trauma symptoms that require [treatment].

Dr. Allen is aware that PTSD is a useful category and may not require medicalization at all.

Constructivist elements of PTSD as a taxonomy rather than an absolute reality and pathological affliction are entering into Dr. Allen's narrative of PTSD. While this fits with his strong realist/weak constructivist framework, it is also further evidence that the realist medical frameworks are not passed down uniformly to all practitioners within the discipline.

While PTSD could be a beneficial diagnosis which allows sufferers to find the correct help, experiencing trauma in itself does not constitute a PTSD diagnosis. This is evidence that the medical practitioners in this study accept the limits of PTSD construct. If these understandings of trauma and PTSD were shared more frequently, the fear of PTSD over-diagnosis may not be prevalent among veterans. The presence of this fear of overdiagnosis within the military could be due to mistrust of a stringent psychiatric taxonomy, functioning to categorize and sort soldiers' experiences into conveniently labelled and researched disorders.

PTSD is a label that is utilized within mental health clinics to help classify the distressing symptoms a patient is going through. It allows practitioners to determine the type of help the PTSD sufferer requires, and allows for convenient documentation of their distress to ensure it is covered by insurance. Dr. Williams likened a DSM diagnosis to a recipe, stating,

I'm not hearing of a lot of contention about it. I think when [the] DSM-5 came out there were experts who were arguing that certain things should be included, and certain things shouldn't. I think it was certainly an improvement, but I'm not hearing a lot of debate about that now. Sort of like "okay this is what the recipe is that we use now to diagnose".

The utilization of this metaphor frames Dr. Williams' perspective in a particular way. A "recipe" is a tool marked by stringent measurement and attention to specific details observed as objective truths. For example, there are not many debates over the existence of "1 cup of flour". Use of this metaphor shows that Dr. Williams is framing diagnosis as a tool requiring stringent measurement and attention to absolute truths. With her metaphor, comes the assumption that once a scientific category (i.e. PTSD in the DSM-5) is accepted within the medical discipline as a whole, individual practitioners too will accept it as valid.

I then went on to question Dr. Williams' opinion on the accuracy of the DSM-5 in reflecting soldiers and veterans' experiences. She believes that the PTSD diagnosis functions as an accurate diagnostic category for veterans, she went on to explain,

Yeah, I would say it fits. I would say most people hit most of those symptoms or all of them. I tend to see people who are quite severely affected who have had multiple traumas in childhood, growing right up until they are adults and then on to that adult-onset. But I also see veterans that have had a lot of combat, and often what I see with the veterans who really struggled, [is that] they also have childhood trauma. But they were able to compensate, the military kind of provided a safe structure because it was so structured. Of course, more and more stress and the wheels fall off, so yeah, I would say it fits. I see a lot of people with even more dissociative symptoms than are shown in [the DSM-5 PTSD] criteria. I would say diagnosis in the dissociative spectrum. So, they have PTSD with dissociative features, but they have so much dissociation, but they end up having a Dissociative Disorder as well, and then on top of that, they might have maybe Substance Abuse, maybe Panic Disorder. You can end up with seven different diagnoses, so as much as possible we try to find the one diagnosis that kind of holds it all together. I think that because the new DSM has combined the depression piece and the dissociative piece, that helps so that we're not saying, "yes, they have major depression, and they have this, and they have that". But even still, people often do meet criteria for other things too.

The practice of diagnosis could come with many issues. With many symptoms present on the criteria within many different disorders, individuals with wide range of symptoms could theoretically fit into many different diagnostic categories. A realist perspective may exacerbate this issue by viewing all medical categories as ultimate realities and valid categories of valid experiences. This is why collaboration with other, more constructivist perspectives could

ameliorate such problems as patients being able to be classified as having a multitude of psychiatric disorders. In the creation of the DSM-5 and the restructuring of diagnostic categories as described by Dr. Williams, it would be interesting to note whether an increasing constructivist presence within psychiatry led to the ability for the categories to be restructured in such ways.

Dr. Miller also expressed satisfaction with the PTSD diagnosis as seen in the DSM-5. She too felt as though it accurately captured the many symptoms which military personnel experience as a result of living through a traumatic event.

Overall, yes, they fit very well. One of the very important changes for military populations (in terms of the DSM-5) is they took out the criterion that there had to be a reaction right away, because in soldiers, you often do have no reaction. "The person's response involved intense fear, helplessness, or horror", as soldiers you often don't get that response. In the Canadian military we discussed this at great lengths, because at first, we were not diagnosing PTSD in people who had everything else. People we knew had PTSD, and needed treatment for it, but they didn't meet [the diagnostic criteria] because soldiers are stoic. If you ask them to, they will not describe [their symptoms], "well I didn't feel any horror, I didn't feel that", so there was a movement among the psychiatric community to have that removed, and fortunately, it was. Because for some people, it was preventing them from getting the diagnosis they needed. One thing we did in our clinics is we made the diagnosis anyway. Like after a while we realized that "this is crazy", I mean, it's more important to help our soldiers than to slavishly look at the DSM and what they're saying, because we knew they had all the symptoms and needed treatment.

This is an interesting response, as Dr. Miller is stating that soldiers can have PTSD, but did not fit within the DSM criteria. This brings about the question that, if PTSD is not what is being represented in the DSM, what is it? Clearly Dr. Miller believes PTSD to be a valid construct, but if it cannot be described by the DSM, what is it characterized by? It is important to remember that Dr. Miller was referring to the inaccuracy of a previous version of the DSM-5, meaning that she may feel as though the current edition of the DSM-5 accurately represents what she perceives to be PTSD.

The changes and updates to the DSM allow for new information to come forward and impact the symptoms and definitions to reflect current literature. As explained by Drs. Williams and

Miller, steps are being taken within the medical community to develop the most up-to-date, accurate PTSD diagnosis, and it is reflected within the Diagnostic and Statistical Manual. Dr.

Allen also has this view, explaining his experience of changing medical narratives of stigma of mental illness within his medical school education:

During medical school, I think it was starting to be recognized that childhood sexual abuse was far more prevalent than it had been previously recognized, and that was contentious. I know that there were psychiatrists who dismissed it, saying, “no this isn't the case, these are people's fantasies”, things like that. I know that was contentious. I think then, when I was doing my psychiatry training, that was still somewhat contentious, though the recognition was moving towards, “oh yes, this has been a bigger societal problem than we have realized”. I think there in my training, the issue was around certain disorders, particularly certain personality disorders. Personality disorders is a class of disorders in the DSM. Some of these disorders, when they are severe, they can be very destructive people, and [can] certainly be very taxing on the medical system; whether it's emergency rooms, in-patient stay, and standard treatments not working. And I did note among some colleagues, not all, but some, very resistant to the idea that these could be long term effects of trauma, it was more, “they are behaving badly, they're attention-seeking” - which some of them were, but maybe for not the reasons they understood. They could be dismissive of sort of the types of people... I mean I was in part growing an interest, because of the standard things I was learning were not necessarily effective for these people.

Dr. Allen is describing a change in narrative regarding child sexual abuse. He describes some of the training he was receiving as “not necessarily effective for these people”, demonstrating an interest in patient care over adherence to medical protocols and narratives.

Despite Drs. Miller and Williams satisfaction with the current DSM-5 in general terms, there was notably a contradictory tone in some of the participants' comments. Although Dr. Miller seemed satisfied with the current DSM-5 PTSD criteria, there was some hesitancy in her comments:

It fits well for veterans and military members. There's actually some political debate in the psychiatric community about that change that occurred. Part of it is that this new category of negative cognitions and mood is not really well defined and it kind of clumps several things together. For example, it takes out amnestic episodes and sticks it in with [the] negative cognitions and mood section. Amnestic episodes are re-experiencing, they fit with re-experiencing and with flashbacks because [of] their dissociative symptoms, that's how I understand them, and actually, that's how most people who have worked at all with people who dissociate understand them, they are very closely connected. So when something like this is

created, of course, it also is political. You have people in APA [American Psychiatric Association] who come from different interests, so there's actually been some unhappiness with how this was defined and recategorized. But having said that, overall, yes, they fit very well.

It seemed as though both Drs. Williams and Miller feel as though the DSM-5 functions as an accurate diagnostic tool for PTSD in general; however, when asked if she felt that the PTSD construct accurately captured soldiers' experiences of PTSD, Dr. Williams stated,

I think [the DSM-5] tries to when it says "somebody being killed or maimed", or "flashbacks", or "nightmares". I think it does capture it to some extent from what I understand with veterans... In terms of [the] DSM-5, there are some criteria that veterans don't experience as much of - some of the reliving symptoms. They're trained to be very calm; [in] situations where there is lot of stress, they typically will appear very calm even when they are reliving these experiences like flashbacks and nightmares. They may not express it the same way [that] we might see in civilians. I think it accurately [captures the military experience], but the military is trying to create treatments and also diagnostic tools that capture it a little better.

This is a positive sign that Dr. Williams is cognisant of military narratives. She addresses the need for soldiers to be stoic and recognizes that their training teaches them to handle trauma in particular ways. This finding goes against the notion that military and medical narratives of PTSD are completely contradictory (Molendijk, Kramer & Verweij, 2016). Although the medical system may produce dominant strong realist beliefs in regard to mental disorders, it must be remembered that medical practitioners are individuals with their own beliefs and narratives. Their narratives of PTSD are important in bridging the gap between medicine and military structures. A hesitancy to fully support or abide with the DSM-5 is evidence that medical practitioners are not fully bound by their educational roots; they develop their own frameworks as they acquire experience. This is a contradiction in the way that Dr. Williams understands PTSD. She has some realist beliefs in viewing PTSD as a valid diagnostic category which represents individuals suffering in a particular way; however, her lack of full support for the DSM-5 criteria contradicts this potentially implicit notion that PTSD should be accepted for

what it is.

Dr. Smith also expressed hesitance to fully support the current DSM-5 criteria for PTSD, she explained,

It's not that black or white. Sometimes you work with an individual who has experienced a trauma that is objectively quite minor, and yet, for them subjectively (because of their story), it has a profound impact and can result in full PTSD symptoms. And so that criterion is saying "that person must have witnessed [death] or feared that their life is in danger". That, in my opinion, doesn't actually quite fit. So that's the one [criterion] [that] I have [an issue with], but in terms of reexperiencing and numbness, that's pretty consistent. It's more, I think, that we have to be more flexible with what we define as a trauma. I had somebody who fell off a chair and had full PTSD falling off of that. But that linked to an earlier experience in her life. But she had full PTSD. But at the time, I couldn't quite say it because she didn't meet that one criterion (the stress that she had feared for her life in that moment).

Contradictory understandings of PTSD are also emerging in Dr. Smith's narrative, with constructivist elements of the PTSD experience as "not black or white", potentially challenging PTSD as a scientific category. Furthermore, it causes the question of "if PTSD is not what is defined in the DSM-5, then what is it?" to re-emerge. Dr. Smith went on to express further disagreement with the current model of diagnosis and treatment for PTSD. She stated

I think that understanding ways that we can minimize the impact of traumatic events in a big way, it's absolutely important. Looking at this model where we wait for them to have these clear criteria [in the] DSM-5, then bringing them in to see one mental health professional who delivers treatment - [that] is not the way to go.

This idea that the DSM and other medical conceptions of PTSD are 'too rigid' has been reemergent throughout this data. This may demonstrate an increase in individual medical practitioners' voices in medical narratives; it could be evidence of a trend of more emergent individual voices stemming from medical experience rather than dominant structural narratives. Medical education enforces realist perceptions of disorders as discrete entities with a valid set of related symptoms; however, it is possible that practitioners' direct experiences with patients challenges this notion and results in a contradictory understanding of this phenomenon.

It is important to note that the participants hold the shared belief that the DSM-5 is able to accurately categorize the majority of individuals experiencing a disorder but cannot accurately categorize everyone. While grand narratives of the DSM and disorder diagnosis within medicine are in favour of this tool and speak to its efficacy, it is obvious from this literature that military diagnostic narratives diverge from these dominant medical understandings (Molendijk, Kramer & Verweij, 2016). The perception within the military that there is a large margin of error in this diagnostic process could come from the lack of (complete) generalizability of the DSM-5. It may also stem from the potential human error present in all professional fields. Medical practitioners are humans who are prone to make errors when interpreting patient symptoms and symptom context; the lack of a perfectly generalizable tool could inflate the fear of diagnostic stigma among military personnel.

The clear rigour of the military diagnostic process as demonstrated by Dr. Miller shows that medical diagnoses are not categorizations applied lightly; rather, it is with great attention to detail that they are documented and thought out. It is possible that this is a fault of the medical system. Dr. Miller's belief is that in some cases, the DSM-5 is too narrow of a categorization. She argues that some sufferers of PTSD may fall through the categorical 'cracks' because they do not fit the so narrowly assigned model of the dominant medical 'PTSD'. The participants within this study do not discuss the diagnostic measures of PTSD as an ultimate reality of each patient's experience. This challenges the DSM-5's categorization of PTSD as a scientific category, and feeds into the pressure medical professionals experience to prove a physical reality of a disorder (Rose, 2001).

The doubts of the diagnostic generalizability of the DSM-5 is a potential concern to sufferers within the military; once the 'PTSD' label is applied to these individuals, they are being situated

in a specific subject position – the PTSD sufferer. This takes away their perceived ability to manage their distress on their own and places the authority of this task in the hands of medical professionals deemed “better equipped” through use of “research-based” treatments. The very phrasing of “research-based” treatments comes with the assumption that these treatments are of more value to a PTSD sufferer than what they can achieve on their own, due to the scientific association of research.

Practitioners appear to be skeptical of the DSM-5 and mindful of the implications a label such as PTSD has for individuals in distress. These contradictory voices are emerging as medical voices within the medical discipline. The emerging individual voices of practitioners who discuss the faults of the DSM may have an impact on the dominant narratives present in medical structures as this change in narrative has occurred previously in medicine. This may function to bridge the divide between medical and military conceptions of the diagnostic process; however, more research is required to speak to this possibility.

Medicalization

Many veterans have described their PTSD symptoms (often in terms of hypervigilance) as natural reactions, arguing that these symptoms are a normal response to a traumatic experience (Hooyer, 2015). They believe that these normal symptoms are being medicalized into a diagnosis of PTSD (Hooyer, 2015). Participants in this study were asked to speak to their perspectives of the perceived medicalization of psychiatric sequelae associated with PTSD. Instead of asking specifics about the diagnostic process, they were asked about how they understood the difference between a ‘normal’ experience of trauma and an experience that fell within the confines of the PTSD diagnosis. This question attempted to address research completed by Hooyer (2015) which argued that the PTSD diagnosis may hinder rather than help veterans’ recoveries due to its

medicalizing nature. In reference to a specific veteran's experience in feeling as though his combat experiences were medicalized, Hooyer (2015) explained, "PTSD is not a medical problem and the label does a disservice to those who are trying to make sense of their suffering and of their military identity. This outcome runs counter to the good intentions behind the professional design of this diagnostic category." (p. 7). Hooyer (2015) goes on to explain,

For many of the veterans in this study PTSD was not understood as a mental disorder but as a collection of experiences that made them who they are: military training, deployments to foreign lands and war. It was the cultural dissonance between their military experiences and their return home to the civilian world that created conflict for vets. From a biomedical perspective, this cultural dissonance is translated as "symptom criteria." (p. 7).

Molendijk, Kramer and Verweij (2016) echo this analysis, coming to the question of "whether mental health approaches in western armed forces, which draw on dominant scientific conceptions of PTSD, may at times conflict with the experiences and perceptions of soldiers. If so, this might help to understand their care-avoiding behavior and complaints." (p. 2). Dr. Miller had experience with this type of concern among members of the Canadian Armed Forces. She addressed it in her response, stating,

If you have some hyper-vigilance, and you come back [from combat], and it doesn't prevent you from taking your family to Walmart on the weekend, probably it's not going to be medicalized because you're not going to go get help for it. People who have PTSD, their hyper-vigilance is not like normal hyper-vigilance. And they talked about this, and they'll talk about looking for like white bags or the white Toyotas because in Kandahar City it was white Toyotas that used to come alongside and blow people up. It's interesting, you know, in PTSD what people can do. I spent quite a few years treating people with schizophrenia and other psychotic disorders who couldn't do this, but in PTSD, what people can do is they say to you "I know that the white bag on the ground is not an IED, but I can't stop believing it when I'm in the situation". So they have insight into what they're thinking, whereas people who have a psychotic disorder, they can't do that, they can't see separated out, they think the white bag has explosives in it. So that's a really interesting aspect of PTSD because people can have very strong and sometimes bizarre symptoms and they can have this insight into [it], they have this ability to step back from it and say "yeah, I know that's actually not really normal, I know that those guys in the crowd with the turbines are not there to kill me, but I can't stop believing it". Again, it's always a diagnosis based on functioning too, so again, ruling out other psychiatric or medical conditions, and then inability to function. So if a person can function with his hyper-vigilance, then he probably doesn't have a diagnosis. Well at least that isn't part of the diagnosis. But absolutely, again, it is a skill that is

also trained into people in the military, and it is a survival skill in the military. When it's a problem is like I say, when you come back home and you can't take your family to Walmart, you can't go anywhere where there are crowds even though you would like to, or you would have liked you before. In fact, maybe you can't even leave the house and you have to stay in the basement because if you are up in the open-air, a sniper may get you, all of that stuff. So, it doesn't become survival anymore, it becomes interfering with your life.

It is obvious from her response that Dr. Miller has a clear understanding of the difference between distress resulting from combat, and PTSD symptoms resulting from combat. Her insider experience has afforded her the knowledge of the military from both a military member and medical professional's mindset. This response speaks directly to Molendijk, Kramer and Verweij's (2016) argument that medical PTSD narratives could conflict with soldiers' experiences, causing them to feel ostracized based on medical understandings of PTSD. Dr. Miller seems very aware of this potential divide in understandings, which could serve to ameliorate the contradictory experiences that veterans describe.

PTSD as Fashionable Diagnosis

Another concern about potential diagnosis of PTSD, is that PTSD is a fashionable diagnosis (Das-Munshi, 2005). This would mean that PTSD is a diagnosis highly present on practitioners' minds, causing them to find it in individuals that may not PTSD as defined by the DSM-5. Dr.

Allen expanded on this notion:

Psychiatry goes through fads. I know when I was training [the fad] was Bipolar Disorder, then Attention Deficit Disorder became very fashionable. So I think when [a disorder] is in fashion, it can probably be (in my opinion) overly diagnosed to some extent. I certainly think people are much more liberal with a diagnosis. The positive side is that I think some people who weren't recognized as having Post-Traumatic Stress Disorder do get a diagnosis. But the negative side is, I think, some people where it might not be the most appropriate diagnosis: they get a diagnosis.

Dr. Allen could have been referring to PTSD as a diagnosis among civilians given that his practice caters to civilians and he has not treated any patients with military experience. However, his depiction of PTSD as a 'fashionable diagnosis' makes it probable that this idea may be

present among some medical practitioners within the medical field. Because Dr. Allen does not have any experience in treating military personnel, his personal views may not have an impact on military members seeking mental health care, although these views do result in a questioning of authority of the medical discipline. His narrative of PTSD as a fashionable diagnosis challenges the authority of medical professionals and the perceived validity of PTSD as a scientific category. Effectively, Dr. Allen is explaining that the diagnostic measures are not iron-clad and have the potential to be misused or misinterpreted by practitioners.

In later interviews, I ensured to bring up the narrative of PTSD as a fashionable diagnosis which was raised by Dr. Allen. I wanted to find out if the participants' patient demographic played into their views on this subject; findings indicate that patient demographic could be related to opinion on whether or not PTSD is a fashionable diagnosis. Dr. Jones was the only other participant who responded to this question and had no experience in treating veterans. Like Dr. Allen, she explored the possibility of PTSD as a fashionable diagnosis in her response, she explained,

I have seen that, I've seen presentations where people have talked about something that I would probably more label as an uncomfortable or unsettling experience, but they weren't necessarily having full-blown flashbacks or sleep disturbance. So, yes, they may have minor sleep disturbances, or be a bit upset, but often just [by] talking to a friend or someone, most of the symptoms disappear. I actually don't mind it [PTSD being a fashionable diagnosis] because it keeps the diagnosis alive in people's minds. People will be more sympathetic if they see [PTSD] as a spectrum and [as a disorder] that they had a touch of at one point (as long as they don't think that then anybody can just get over it).

Dr. Jones seemed to be open-minded to the possibility that PTSD is a fashionable diagnosis and stated that she had seen over-diagnosis of this disorder within the medical discipline. Contrarily, Drs. Williams and Miller, both having patients who were veterans, felt strongly that PTSD is not a fashionable diagnosis.

Dr. Williams felt that the diagnostic process had the opposite effect of a fashionable diagnosis . She felt as if PTSD is under-diagnosed – a belief that is also in opposition to the authority of the scientific category of PTSD.

Probably under-diagnosed I would say. In the military, I think a lot of times people have PTSD [which] goes undiagnosed because they are afraid to lose their career - that's a huge risk. So sometimes, they will go and see a civilian therapist and won't tell anybody. They're limping and struggling and hanging in there for years, but they absolutely won't tell their physicians because they don't want to have it on the record. There's something wrong with that, but at the same time, I can understand if they go to their military psychiatrist, [they would say] "I can't send you back to the front in this condition, you have two broken legs, or a broken brain. How can I possibly send you back". But for the soldier, that just feels like a rejection: "you're kicking me out on the curb?" So they don't tell anyone and it goes on for years, they go in and out of combat and they just pile on the stress. One concussion after the other and it just accumulates, until finally, the wheels fall off. So I would say in that environment it is under-diagnosed: that would be my guess .

The possibility that PTSD could be underdiagnosed may be further evidence of the constructivist view that PTSD as a scientific construct is not accurately capturing the distress experienced by those who are suffering as a result of trauma. Furthermore, Dr. Williams utilized the metaphor of PTSD as a "broken bone", likening the 'invisible' disorder to an affliction which can be physically observed and diagnosed most accurately through biological markers. She is likening the medical understanding of PTSD to that of a broken bone, implying that medical practitioners view PTSD as an illness which should hold no stigma due to its roots in one's biology. This metaphor implies that anyone can get PTSD; just like anyone can break a bone, it is not inherent weakness which she perceives to affect development of PTSD, it is a biological affliction.

Having the most military experience in the sample, Dr. Miller felt the strongest about the 'PTSD as a fashionable diagnosis' narrative. She stated, "I don't know what psychiatrist would consider it a fashionable diagnosis, do you know somebody that does that?". When explained that previous participants had made comments about PTSD being a fashionable diagnosis, Dr.

Miller went on to state, “oh, you should tell them to call me because I will disabuse them of that very quickly. I think that that is stigma, I think that they are perpetuating stigma”. When prompted to continue to explain her beliefs about the ‘PTSD as a fashionable diagnosis’ narrative, Dr. Miller discussed her experiences with medical professionals who thought this way in the past. Like Dr. Williams she tied this notion to fear among veterans of losing their military careers

But let me say, in 2003, when I first I went to work as a civilian in the Canadian Armed Forces Mental Health Clinic, there was a lot of that kind of belief in the system among the mental health providers, and boy did we need to get disabused of that. Because think about how we describe these patients. They are afraid of losing their career, they self-stigmatized, their buddies stigmatize them, and then you have your health care system, the people that are supposed to help you are also thinking this way? So I would say people that say that have not treated PTSD, I think that is ignorance and that is stigma. That is really, oh, I don't know what to say about that.

It is important to note that the other participants were not discussing PTSD as a fashionable diagnosis within the military, as this may have affected Dr. Miller’s response. Consequently, when considering the possibility that the idea of PTSD over-diagnosis perpetuates stigma, military narratives must be taken into account. With soldiers being told that they must be tough and suffer through discomfort, the idea that something they are struggling with is ‘over diagnosed’ may cause them to feel as though it is not a valid construct to seek help for. Furthermore, ‘fashionable diagnosis’ in general could refer to a greater societal consciousness of a specific phenomenon, the potential for over-diagnosis being an implicit assumption that comes with this notion.

The presence of stigma within the medical discipline is not explored within the literature I have encountered. This is a notable finding which would be important to address in further research, as it could have a large impact on how comfortable veterans are in reaching out to the mental health system. I suspect that the belief of PTSD as a fashionable diagnosis would not be

as prevalent among military health practitioners, as seen in this data with Dr. Miller's interview; however, veterans seek civilian health care quite frequently (Waitzkin, Cruz, Shuey, Smithers, Muncy & Noble, 2018), so it would be worthwhile to explore the conceptions of PTSD as a fashionable diagnosis within this cohort as well. Furthermore, Dr. Miller's aversion to this perspective comes with the underlying assumption that PTSD diagnosis is a helpful tool to identify PTSD sufferer subjects and without it, PTSD sufferers are less likely to receive the help they need to deal with this type of distress. Additionally, placing soldiers in this subject position allows for structural help in the form of work accommodations and insurance coverage of medical treatment.

Career Loss

In current literature, fear of career loss is associated quite frequently with failure to seek mental health care within military populations (Wright, Britt & Moore, 2014). With much experience with this common military fear, Dr. Miller was able to explain in detail both how she addresses this concern with patients, and what occurs when military personnel seek mental health care.

I can only go by my personal experience. I think there is still a lot of distrust. When people are serving, a lot of that distrust around "if I go forward for care is that the end of my career?" and that's always the big question, always the big question. So as a psychiatrist, when I would see people for the first time, I would always address that question right up front with them because I knew they were thinking that. So there's distrust, I would say not so much for the medical community as for the system, and thinking "I'm going to get kicked out". So I'll tell you something else (and this is always what I would tell my patients). Unfortunately, it's not known as well as it should be known, it makes me think there's teaching that really should be done around this and maybe there is. So much of what we learn [comes] from the US, and we are so bombarded by US media that a lot of what people believe in Canada (including our own members of our military) is based on the US military. It's crazy, because there's actually a few differences. We do not have, for example, an epidemic of suicides in the Canadian Forces at all. I just read that this morning, you know I get this media thing every two days or something, and there was some guy on a radio station (or an article or in the paper), talking about the epidemic of suicides in the Canadian Forces, that actually does not exist. There is not an epidemic. The rate of suicides in the Canadian Armed Forces for many, many, many years, actually, since we

have been checking them, since we've been following them, is no higher than the Canadian general population, so there isn't an epidemic. Once they leave though, once we look at veterans, it is higher; the rate is higher than the general population. Oh yes, the system; this is how the system works in Canadian Armed Forces, and it isn't like this in the States in fact. I'm not sure [that] there's any other military in the world that does this, okay? So we used to, (like any other military), have a medical system that was kind of embedded within the chain of command. Therefore, if you as a military member went in to see the doctor and let's say your CO was worried for whatever reason. Let's say they saw you limping, and I asked, and you said, "no I'm fine sir", but they thought maybe something wrong. That CO has the right to go into the doctor's office and ask for your medical file and record. Almost every military in the world, I believe, still functions that way, our military does not. It changed, I don't know how long maybe the 80s or 90s, I think, and what we did was we put a system in place where we separated our health services from the chain of command. So CF Health Services Group is now a separate entity within the military, [it] reports to the Surgeon General, and it is a separate group, so what does that mean practically? [A military member] goes in to see his family doc, family doctor talks to him, thinks he has PTSD, family doc makes a referral to the mental health clinic, and the guy comes in and sees me. I make a diagnosis and say he is PTSD. He has to come in for the next six months: once a week therapy. That's what I sent back to the family doctor. What the family doctor sends to the CO is what are called 'medical employment limitations'. They state, "this person has a medical condition for which he needs an appointment once a week at 3 p.m. for the next six months". That's it. That's the information. If the CO wants to talk to someone medical to try to get more information, they found the family doc. They do not have access to directly to us, if they tried calling us, we don't talk to them without our patients' permission, we never have contact for mental health for chain of command again. In fact, many of my patients (if they had a supportive chain of command), would say to me "Doc will you call my CO because he really understands, and he wants to help me". Those were great cases because people really did well then. So we had this system which separates any kind of healthcare, they got these medical employment limitations so that's all they need to know. What they need to know, it will be about [a certain amount of] time away, and it'll also be about limitations in duty. So, again, if somebody has hurt their back, say they can't do heavy lifting for the next 6 weeks, that will be it, but it won't say they have a back problem: it will say they can't do heavy lifting. So that is the system we put in place so that our members didn't have to worry that their chain of command... Because that would prevent them from coming for care, right? If they thought "oh my God my CO is going to know that I have a mental health problem" and nobody tells him nothing.

This detailed explanation of the process of seeking mental health care was not found within any of the literature in this literature review. Most literature argues that 'Western Military Infrastructures' are made up of largely the same protocols and elements (Molendijk, Kramer, & Verweij, 2016). However, this is clearly not the case with the Canadian Armed Forces. The Canadian Armed Forces governmental website did articulate that "*all health information*

concerning CF members is strictly confidential and is not accessible to the chain of command without the permission of CF members” (National Defence and the Canadian Armed Forces, 2004, para 17). Unfortunately, this is not made clear enough based on the experiences of these participants in encountering clients fearing career loss and lack of confidentiality. When asked if Dr. Williams thought that a PTSD diagnosis may harmfully affect combat veterans, she stated, They would say so. They would say so especially initially, it affects their career if they end up being released, if they end up then having to struggle with getting a pension with having that as a label.

Dr. Williams went on to explain that the veterans that she has treated were also fearful of career loss when seeking health care within the military. Dr. Williams is a civilian psychiatrist, so her military patients are seeking civilian care when working with her. She explained,

What I've seen and what people have told me is [that] they are medically released, and they're just suddenly kicked out of their experience. [They are] part of the Boy Scouts, and suddenly, they're rejected. And that's the feeling they have rather than being guided towards Wounded Warriors, or, “okay, we don't want you to get hurt. If you go to the front again, and again, and again, this is what can happen”. If they could maybe educate them, spend some time really kind of helping them to understand, “the impact on your brain is such that every time you go and experience more stress, this can affect your future in a really, really negative way, so we want to protect your brain”. If they could even use that kind of language, that this isn't about being weak, this is your brain having experienced a number of assaults. Just like if you broke your leg in multiple ways and you want to get back and run a marathon, and we're saying to you: “that leg can't, you have the willpower, but that leg will not hold up so we need to find another profession for you so you're not running all the time”. And I think they do try, they try to move people into some other area of the military, maybe now more than in the past. But I have fairly young veterans who were [said] they were just released. And they just felt so devastated, so rejected. Especially the ones who started young because that's all they know, that's their identity. I think [the military] could do a better job of that.

What Dr. Williams is describing is very closely tied to the actual protocol that Dr. Miller stated to be in place within the Canadian Armed Forces (CAF). Although these cutting-edge policies allow for confidentiality and produce specific accommodations rather than strict career change

requirements, it is still possible that CAF members may feel concern about confidentiality.

It is possible that career loss is a very real possibility as perceived by military personnel. Even though there are very cutting-edge policies not present within other militaries, the possibility exists that a military member may require an accommodation that involves temporary withdrawal from current duties such as combat. This may resemble loss of career to a soldier when in fact it is a temporary necessity functioning to assist in the individual's recovery.

To avoid the potential career loss often associated with health-seeking in the military, military personnel often seek mental health services within the community, as seen in Dr. Williams civilian treatment of military patients (Waitzkin et al., 2018). When asked if military members tend to seek civilian health care services, Dr. Miller explained that she has noticed this trend, and explained the potential harm with this type of treatment”

So sometimes they do [seek civilian health care services]. Certainly when I worked in the clinic, but also when I worked in headquarters, I really worked to educate members so that they would come in. It doesn't work well when they go outside for care. First of all, we are the absolute experts in Canada for treating PTSD, hands down. There is no psychologist in the community, there is nobody in the University, there is nobody that has had more experience treating PTSD in this country than Canadian Armed Forces Health Services, and by extension, our Veterans Affairs funded OSI clinics. Because we see hundreds and hundreds of patients a year, we have become the experts, we know. When I was saying before about experience, it doesn't take long, you go through the whole diagnostic criteria, but you're with someone for a few minutes and you know. So that's one reason they should come for care in their own clinics, the second reason is that (this was especially important while we were in Afghanistan), if there's a reason that you should not deploy overseas, (i.e. you are suicidal), we should know that. People who were seeing an outside psychologist who we were paying for, those outside psychologists would not always report to us, there was a bit of a hostile relationship sometimes - not with everybody, they would end up doing things, like first of all, they were civilian, they didn't really understand about the military, they didn't understand why it was important that we knew when people were having a lot of difficulty, because we would deploy them. If we don't know, they get medically cleared and they are deployed, and that is terrible, that is terrible. Early on, when I worked in the clinic, we would have psychologists in the community, you know, good people seeing our patients who would be saying to them things like, “you shouldn't wear your uniform because it triggers you”. Well, that's a career-ender, talk about ending a career. We didn't do those things in the military clinics, but these psychologists would put that kind of suggestion to one of their patients. Well ya , if you can't wear your uniform you ain't in the military anymore - you're leaving.

The voice present within this narrative is that of Dr. Miller's professional experience. She is explaining that there is more to the treatment of military PTSD than medical experience, she is advocating for experience in treating this specific type of PTSD.

Identity

A lot of current literature on military PTSD discusses the possibility that masculine identity enforced by the military infrastructure affects veterans' experiences with PTSD (Caddick, Smith & Phoenix, 2015). Caddick, Smith and Phoenix (2015) performed a narrative analysis on veterans in a PTSD recovery surfing group and argued that "masculine performances in the surfing group had important effects both on and for the veterans' wellbeing" (p. 97). The diagnosis of an individual places them in a new subject position as the PTSD sufferer, resulting in new power dynamics. They are placed in a new position as the help-seeker, expected to seek help from medicalized approaches. This unequal power relation between the patient and practitioner may feel as a challenge to a soldier's masculinity – a trait cultivated throughout participation within the military (Brooks, 1990; Garcia et al., 2011). This lack of personal power in treating one's own distress and the perceived need to seek help from the medical profession may result in a "spoiled identity" (Goffman, 1963), self-stigmatization or stigmatization by peers .

Diagnostic Label and Identity

I asked participants in this study about the issues that they came across when attaching a distinct label to one's already stigmatizing symptoms. Dr. Smith felt that diagnostic labels often have a negative effect on patients, causing them to feel a conflict with their individual identity. Dr. Smith explained that she only uses diagnostic labels when it is absolutely required. In response to the question of "How does a diagnostic label that comes into conflict with one's

identity impact the recovery process?" she stated,

Well that's not only for PTSD right? And I think that's a huge issue. So I personally don't use DSM. I tell my patients, if I have to fill out a form for you, we are going to have to put a label on it, but when I'm talking and conceptualizing with them their difficulties, I don't use the DSM. Because for some people it can be stigmatizing, and that hinders recovery.

Dr. Allen went into deeper detail on how he addresses a patient's distress from a diagnostic label.

He explained that in his work as a psychoanalyst, he devotes extra time to discussing a patient's issue with a diagnosis and feels that this type of dialogue between practitioner and patient is vital in the recovery process. Dr. Allen explained that this type of dialogue is not often explored by other psychiatrists due to lack of time.

I mean, certainly, there is a number of people who I have given [a] diagnosis to, [which] they don't like, it doesn't suit their conception of themselves. That's problematic, now given what I do, sort of fodder for the therapy, that could be something I work on for a long time with an individual. And the complication, not just that it challenges their identity, but in the type of work I do these are very intimate treatments. It's one on one, it's for a long time. Often, even though patients don't necessarily know me as a person they definitely develop a sense of me, and there is a closeness of some form or another whether they acknowledge it or not, and if I tell them something they don't want to hear, not only [may] it challenge their identity, but it's going to challenge their experience of me. And then that ends up being part of our work, "how did I make you feel when I said this to you?", "How does it make you feel that you don't like this?" And the work is to try to integrate, to try and find a way that makes sense to them. And for me as a practitioner, it's that challenge that I want to have some diagnostic, not rigidity, but honesty in some way. [I'm] not going to withhold from people I am working with, but then when it's out there I need to deal with it, and I think that that may be a weak point in some parts of psychiatry. It's an overburdened system. The type of work I do, it's not available to a lot of people, we're fortunate that we can have even a corner of depth [in] looking at trauma. There's a lot of practitioners that don't have the time to, "well you don't like the diagnosis? Well let's talk about it". They simply don't have the time for that, and I think that could cause problems in the treatment. It won't with everybody, some people won't like it, but they'll still do what's recommended and hopefully that has a positive effect. But in some cases, I think it could make people more resistant to treatment. Not just engaging in treatment, but eventually even having an effect on the efficacy of treatments. Whether someone takes an antidepressant as prescribed, if someone is completely on board with the diagnosis, and comfortable with the prescribing, there's going to be that added effect of them wanting it to work. Some people call it the placebo effect or related to the placebo effect. Spell benefit and they're not just going to benefit from the neurochemical action of the antidepressant, they're going to benefit from the idea of it. But then if it doesn't fit with the person, they may even downplay some of the benefits that they're getting, and they may be more preoccupied with the side effects of the medication, for example.

I was very surprised when Dr. Allen began describing the new subject position resulting from a diagnosis, and the altered power relations brought about by this new position. This perspective deviates from the assumption that the PTSD category is the best way forward to patient recovery, and explores the possibility that a diagnosis could have more effects on the individual than intended within medicine. Although Dr. Allen went into deep explanation on the importance of a practitioner-patient dialogue on a diagnostic label, he also feels that a challenge to an identity, i.e . a challenge to one's masculinity, can in fact yield a therapeutic result.

Challenges to our identity are very significant in my work, and not always due to trauma. Just being with certain realities of the world. I don't think it could be narrowed down to [a negative impact from a diagnosis], because challenges to one's fundamental sense of reality or identity can in fact be therapeutic. I'm thinking of one of the treatments that's starting to be explored for people with terminal cancer who suffer what's called 'death anxiety'. Just an overwhelming anxiety that they know that they are going to die, and one of the treatments being explored is the use of psychedelic medications in the realm of LSD and so on. Which definitely can challenge a person's sense of reality. The treatments are done in a very controlled way, but just the experience alone can really fundamentally challenge a person sense of reality, a sense of themselves, but in some cases, can be immensely therapeutic. It can be kind of be THE treatment . So I guess it's a long winded way of saying: challenges to one's identity do not have to be traumatic but they can be traumatic, absolutely.

This exploration of the ramifications of PTSD diagnosis as well as the potential ameliorating factors sheds light on a potential collaboration between realism and constructivism within the medical discipline. While PTSD is understood as a valid diagnostic category, constructivist perspectives may emerge to target the effects of this realist model and propose potential improvements. As described by Dr. Allen, constructivist frameworks could be of use to medicine , rather than directly challenging the authority of this discipline. Moreover, the question of 'what negative implications could appear if the medical discipline becomes challenged by opposing perspectives' emerges once again.

Macho Culture in the Military and Diagnostic Labels

Challenging one's identity as a masculine soldier has been a widely explored topic within the field of military health research. Research has focused on how masculine performances affect one's PTSD recovery (Caddick, Smith & Phoenix, 2015), while others argue that masculine traits increase likelihood of experiencing symptoms associated with PTSD (Garcia et al., 2011).

With experience treating veterans and military personnel with PTSD, Drs. Williams and Miller both shared their experiences of patients feeling as though their masculinity was being challenged through the help-seeking process. Dr. Miller explained that there is shame associated with mental illness in the military due to the macho culture; she feels as though the military culture functions as a protective factor, with a shared identity that allows soldiers to get through hardship.

Overall, they feel a great deal of shame. It's a pretty macho culture, you're supposed to be strong, you're supposed to be stoic, you don't really spend a lot of your time thinking about your own personal psychology, trying to analyze it. That doesn't tend to be the kind of people that are in the military, though, again, I am making a big generalization, because of course there are a lot of people who are lawyers and doctors, very senior administrative people who are very sophisticated and have a lot of education, who are in the military, and who are in senior positions. So it's a bit hard to generalize, but I would say overall. And I think especially young people who are more in infantry, quite often (like a lot of young men), they are looking for something to do that's exciting, and I think the other thing that the military really does a good job of instilling in people is a sense of a mission, the sense of doing something for the right reason, and we're all in it together. It can be very powerful, and I think it's very protective.

Dr. Williams also shared the reactions of military personnel to seeking mental health help. Her response reflected many of the findings of this literature review, reflecting an increased sense of masculine performance within the military, a performance which some believe interfered with PTSD recovery (Caddick, Smith & Phoenix, 2015). As Dr. Williams explains:

The veterans really struggle with this whole issue of vulnerability and courage and being a warrior. Being a soldier, one can't feel fear. One can't be vulnerable, and what I say to them is, in fact, "you are a human being first, you are trained as a soldier, but a human being part of you is experiencing all kinds of feelings and reactions to what's happening." And so to feel that vulnerability doesn't make you any less of a soldier, in fact, it might make you smarter in that situation. You know we need to be careful here, I'm getting a feeling like "ah there's danger

there” so that's part of your tools, they see something that's wrong with them. So a lot of the work we do is on helping them to see that being vulnerable in the face of fear, there is a lot of courage to do what you do, feel the fear, and do it anyways.

There is a large gap between the medical understanding of ‘PTSD as a disorder that anyone can develop, despite mental fortitude’ and the military narrative of ‘being vulnerable and having symptoms is a sign of weakness’ (Molendijk, Kramer & Verweij, 2016). To lessen this ontological gap, practitioners within this study often describe using a biological approach to explain the symptoms of PTSD, an approach that was found to negatively impact veterans in Spoont et al’s (2005) study.

One component of this biological explanation of PTSD was expressed by participants as a likeness to a physical injury. Dr. Miller likened PTSD to a broken leg, displaying her medical understanding of PTSD to be an abstract medical disorder that does not reflect a failure of the individual, as many soldiers seem to feel.

We have the term ‘Operational Stress Injury’ because we want people to see this as the same way as you could injure your leg. You could break your leg on deployment, you can have a mental health injury. And there's no more shame in it, it's a true injury and its individual, just like the broken leg - but no one feels bad about the broken leg. I mean, it may hurt, but they may feel proud of it actually, so in a way that's how we tried to contextualize PTSD or other mental health injuries that people suffer from [during] deployment. “You went, you did a good job, and you suffered one of the injuries that people get from it”, and I think one of the things that the military is a bulwark against what you say, is [that] there's a lot of people with PTSD in the military. [It’s] common (even though it's still not the major mental health illness we have). There's a lot of people with PTSD in the military, so you kind of know you're not alone, and there's been so much publicity about this in the last decade, 15 years. It's kind of like some people say, what are the words you use? It's fashionable. Common people hear about it, military members get PTSD, in a way it's like, “okay I've got what Joe Bloggins has over there too”, and I think one of the most powerful things in that situation is being able to bring together people who have suffered from PTSD, with people who are newly diagnosed, so that they can see they're not alone. The most powerful thing is when you bring them together with people who have gone through treatment and are good to go now, it instills a very great deal of hope in people.

Dr. Williams shared a similar “broken leg” narrative when describing how she helped her patients come to terms with a PTSD diagnosis.

To help them to see that you are injured, and you are mad, it's not one or the other. "Do you know any other men in your life that have been injured?", "Oh well", "how's it different from having your leg broken, how is it different from any other injury? Do they stop being men because they have a broken leg?" So kind of helping them to see that it's not this or that, because I find, especially veterans (and some men) very black and white in their thinking. "It's this or it's that", "well can't it be this and that?". You say that and you can just see their brain kind of struggling with that. So yeah, helping them to see that they can be both masculine and vulnerable . That just blows them out of the water and I sometimes spend on and off years helping them.

This metaphor of PTSD as a physical affliction has been emergent throughout this data. It may tie back to the pressure psychiatrists are under to prove a biological basis for mental disorders, causing them to perceive biological conditions as being more easily accepted as valid (Rose, 2001). It also may tie into a larger societal phenomenon of the assumptions that things which can be seen are more real than those which cannot (Rose, 2001). The use of this metaphor when treating patients comes with the assumption that patients too will perceive physical conditions to be more 'valid' and less of a reflection of one's constitutional weakness.

Chapter 5: Discussion

This next section will summarize the findings of the previous chapter, it will direct attention to the limitations of this study, and potential directions for further research.

The questions that drove this research are as follows: What narratives of PTSD emerge within the medical discipline? Further sub-questions include: How might these narratives compare to military narratives of PTSD? What are the consequences of conflicting narratives of PTSD within the military and medical institutions? How do medical PTSD narratives impact care-seeking behaviour among military personnel?

A Trend Towards Constructivism within the Psychiatric Community

I began all interviews by asking participants about their ontological and epistemological frameworks. Four out of the five participants were strong realists/weak constructivists, while one participant was a strong realist. The realism present within the medical discipline is even more heavily weighted within psychiatry (Rose, 2001). With a history of an inability to locate organic correlates of mental disorders, the psychiatric discipline is under pressure to follow the path of the rest of the medical discipline in producing biological markers of the disorders it governs. This framework emerges within the teachings of medical school and affects the ways in which emerging psychiatrists learn about medicine. Within this research, many of the participants' narratives of PTSD reflected the voice of the realist framework in the medical discipline, speaking to neurons within the brain, and biological bases of the disorder. Reemergent within the data was a likening of PTSD to a broken body part, a metaphor used in order to portray the similarities between these seen and unseen ailments.

Additionally, the participants did reflect the trend towards constructivism within the medical discipline (Phillips et al., 2012). Constructivist elements emerged within the participants' narratives, causing me to notice that this was the voice of their professional experience coming through. It appeared as if the participants received a realist education, followed by direct professional experience which either caused them to reevaluate their original realist assumptions or develop new constructivist perspective alongside their long-held medical assumptions.

The realist medical framework frames PTSD as an objective entity requiring medical intervention, while military narratives advocate for self-reliance and "toughness". These differing narratives could potentially lead to mistrust of the medical discipline due to its perceived "outsider" understandings of mental illness. It is still unclear as to how the emerging constructivist perspective will contrast with military narratives.

The Construction of PTSD as a Scientific Category

PTSD is a diagnostic category which was developed within the medical discipline in order to classify individuals experiencing a variety of negative symptoms caused by traumatic events in World War II (Summerfield, 2001). This category is perceived to be a scientific category which comes with the assumptions that the symptoms within the PTSD criteria are negative, lack value, and deviate from a 'normal' state of functioning. These symptoms, together, constitute a mental disorder which requires medical intervention in order for the sufferer to successfully 'recover'. Finally, PTSD is perceived as a valid scientific phenomenon, rather than a convenient taxonomic tool.

Participants described the changing medical understandings of this disorder as being based on societal context (i.e., the Women's Movement or the Vietnam War) or on pressure from a group

of practitioners petitioning for change. These changes in the scientific notion of PTSD and its symptom criteria weaken the strength of this construct and challenge PTSD as a scientific category. Emerging with these changes is potentially a new perspective that PTSD is not an objective entity; rather, it is just a convenient taxonomic tool.

Moreover, the participants in this study tended to have vague and/or conflicting notions about this scientific category. Most participants viewed the DSM-5's PTSD criteria to be far from perfect, while it was clear that most participants viewed PTSD as a valid characterization of experience more so than a convenient taxonomic tool. Other participants had vague notions of PTSD, stating that the DSM-5 did not capture what PTSD really is, which begs the question of "if the DSM-5 does not effectively describe PTSD, what is it?" Furthermore, these conflicting notions of PTSD as deviating from the DSM-5's definition function as constructivist elements. They enter into the biomedical discourse of PTSD, resulting in a challenge to the scientific rigidity that comes with a disorder present in the DSM-5.

Additionally, the issue of PTSD as a fashionable diagnosis was raised by one of the participants. In total, two participants agreed that PTSD could be a fashionable diagnosis, and two others were strongly opposed to this notion. The other participant was not asked for her opinion on this issue due to the timing of her interview taking place in advance of the other interviews. Two participants believed that PTSD was likely over-diagnosed within the general population. The other two participants felt that PTSD was likely underdiagnosed, especially within the military. One of these participants who had many years of prior military service believed that this notion of PTSD as a fashionable diagnosis would likely be stigmatizing to those in the military.

PTSD: A Medical Problem with a Medical Solution?

The “problem” of PTSD is framed as a medically scientific problem due to its roots within the medical discipline. The framing of this problem results in a need for a particular kind of solution, causing the medical discipline to govern over the categorization as well as treatment of this phenomena. Practitioners within the medical discipline are given authority over this disorder, being trained to understand medical conceptions of this problem, and therefore having the resources to learn the medical solutions.

It was commonly stated within the data that medical school offers no training on PTSD treatments; the medical training in itself left the participants qualified to seek out further training on this type of treatment on their own. Furthermore, it was implicitly assumed within the interviews that medical treatments of PTSD are the best treatments for this disorder, most likely to offer the most optimal results possible due to support from previous research.

The assumed requirement of medical treatment which comes with a PTSD diagnosis is in opposition to the structural narratives within the military. Military training fosters beliefs that soldiers should act tough and fight through distress. Military culture and training put the responsibility on the individual to deal with whatever distressing event they are experiencing. This is in direct contrast to the medical assumptions behind PTSD, which put the responsibility on medical professionals to deliver the appropriate medical treatment. This contradicts the “deal with it on your own” mentality within the military. Additionally, it opposes the common masculine trait of restrictive emotionality (Snell, 1989), causing military members to be hesitant to be emotionally vulnerable and resulting in the individual’s attempt to deal with their distress on their own – a common barrier to care as discussed within the literature review chapter (Naifeh et al, 2016.)

The Power Implications of Using the Concept of PTSD

With the diagnosis of PTSD come new power relations associated with the new subject role of the PTSD sufferer. Patients are perceived as passive, requiring aid from a medical professional in managing symptoms causing them to not function 'normally'. This may feel emasculating to military members whose masculinity is engrained and enforced in them within the military structure and as a form of cultural capital among their peers (Brooks, 1990; Garcia et al., 2011; Lahelma, 2005). Furthermore, this expected passivity may lead to self-stigmatization, or stigmatization by others due to its opposition to traditional gender norms within the military.

There is also fear of career loss associated with a PTSD label. While mental diagnoses are kept confidential within the Canadian Armed Forces, soldiers may mistakenly assume that a diagnosis will bring about ramifications within their career. Subsequently, soldiers may fear that career related accommodations will isolate them from others or direct them away from their desired career path. This is why many Western soldiers seek civilian health-care services (Waitzkin et al., 2018).

The effects of a PTSD diagnosis far exceed the reach of the medical profession. PTSD and the subsequent effects of this category are rarely questioned, with most research relying on quantitative research methods utilizing realist narratives; the power relations, constructions, and frameworks of this phenomenon are rarely questioned. I was able to shed light on these constructivist aspects of PTSD through use of qualitative research methods – namely interviewing and narrative analysis. By analysing the narratives present in the medical community, I was able to understand the ways in which PTSD is conceptualised and understood within the discipline with the most authority on the topic. While this research caused me to deeply consider a constructivist perspective, I must acknowledge that I emerge from this study with some lingering attachments to a realist approach. Although I was critical of realism

throughout this study, it is clear that I hold some unwavering realist assumptions such as “PTSD requires medical intervention” and “PTSD is a valid taxonomic category”. I believe that these assumptions come from a desire to solve the ‘problem’ of PTSD with a simple, straightforward solution. These lingering assumptions are demonstrating the strong pull of the realist approach despite critical questioning and a constructivist education.

Medical narratives were compared to military narratives of PTSD depicted within the literature review chapter. This comparison provided a baseline to observe the ways in which medical narratives may work either with or against military narratives. Finally, this research sought to address the issue of barriers to care among military members with PTSD. As the research progressed, so did the constructivist framework, at first attempting to better understand barriers to care among this cohort and moving on to question the validity of the category and the authority of the medical discipline surrounding it.

Limitations

Three main limitations were found within this research. Firstly, there may have been a sample selection bias, as about 30 Ottawa-based psychiatrists were contacted and invited to participate in this study, and only 5 agreed to participate. It is possible that individuals with constructivist theoretical frameworks were more likely to offer their participation, as these individuals may have been more likely to see value in this type of sociological research. This was the most feasible sampling methods due to the time constraint of this study. In future research, larger samples may be beneficial as to reduce the likelihood of sample selection bias and provide more data generalizability. Bias is always present in research, and qualitative methods aim to be cognisant of this fact.

There are limitations present within the data analysis methods utilized within this study. While narrative analysis was appropriate in addressing the stories told about PTSD by practitioners, this method is comprised of considerable variation and a lack of consistency among researchers (Wells, 2011). The very definition of a narrative tends to vary, with some scholars defining it as “a story with a beginning, a middle, and an end” (Elliott, 2005, p. 7), while others provide a broader definition, describing narratives as products of individual circumstances and meaning making processes (Kleinman, 1988). Additionally, there are limitations within the coding cycles of content analysis. Tracy (2013) explains,

Both *lumping* your data into large bins and *fracturing* them into smaller slices have advantages and disadvantages. Fracturing takes a lot of time but provides a vivid, multi-textured picture of the data. In contrast, the entire excerpt could have been lumped together with [one] code...Such a code is just as “correct” and would have been much quicker. However, lumping large swaths of data into big general categories may not lead to as insightful interpretations as fracturing the data into smaller slices, each with a more specific code (p. 190).

Care was taken to address and/or ameliorate any biases or limitations that arose. In conducting qualitative research, it is important to be reflexive of the potential limitations of one’s study rather than to seek out research methods that might not fit as well with the research questions and theoretical framework (Tracy, 2013).

Further Research

Furthermore, further research is evidently needed in constructing a meta-analysis of PTSD interventions present in specific Western countries. Current research tends to paint all Western countries with the same brush, arguing that there is a homogenous ‘Western PTSD Infrastructure’ (Molendijk, Kramer, & Verweij, 2016). Subsequently, more research must be conducted on the stories medical practitioners tell about PTSD and about their profession. This research must include larger sample sizes in order to provide more generalizability to the

findings of this study. To gain a deeper understanding of the broader military system and the impact it has on soldiers' mental-health seeking behaviours, research must be conducted to target the meanings constructed and contested within the personal narratives of soldiers. Most current research on this topic is directed specifically at influencing factors of barriers to care, and stigma; however, more research is needed to understand the processes in which these factors come into play.

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List of Appendices

Appendix A - Acronyms and Abbreviations

ACES - Aversive Childhood Experiences
APA - American Psychiatric Association
CAF - Canadian Armed Forces
CF - Canadian Forces
CO - Commanding Officer
DNA - Dialogical Narrative Analysis
DSM - Diagnostic and Statistical Manual of Mental Disorders
fMRI - Functional Magnetic Resonance Imaging
IED - Improvised Explosive Device
LSD - Lysergic Acid Diethylamide
MRI - Magnetic Resonance Imaging
OIF - Operation Iraqi Freedom
OSI - Operational Stress Injury
PET - Positron Emission Tomography
PTSD - Post-Traumatic Stress Disorder
R2MR - Road to Mental Readiness
UK - United Kingdom
US - United States
VA - Veterans Affairs

Appendix B - Interview Questions

Interview Guide

2. Could you please define and explain Post Traumatic Stress Disorder?
 - a. How do understandings of PTSD differ within the medical community?
 - i. Are there any points of contention regarding the PTSD definition/diagnostic criteria within the medical community?
3. The psychiatric discipline as a whole tends to practice within a Strong Realist framework, would you say that your medical understandings fit within this framework, and if not, which framework would you place yourself in:
 - i. **Strong Realist:** Mental disorders are abstract entities that can be observed independent of psychiatric gaze. They manifest within individuals and can be studied and observed for what they truly are.
 - ii. **Strong Realist/Weak Constructivist:** Mental disorders exist despite psychiatric gaze; however medical professionals might not always understand mental disorders for what they truly are.
 - iii. **Strong Constructivist:** Psychiatrists describe their perceptions of mental disorders as accurately as they can, however there no ultimate truths or abstract entities from which their perceptions can be compared.
4. I have with me the diagnostic criteria of PTSD within the past 5 DSM editions
 - a. How well does the current definition of PTSD fit within your practice?
 - b. How well do the previous definitions of PTSD fit within your practice?
5. Does PTSD as a diagnosis allow for accurate treatment of patients who developed this condition from a variety of situations?
 - a. Would having specific subgroups of PTSD allow for more successful treatments or understandings of this disorder?
6. How do cultural factors affect the ways in which patients experience PTSD?
 - a. How could the social sciences be of use to the medical community in understanding these cultural factors?
 - b. What are your thoughts on the biomedicalization of PTSD? Do you perceive PTSD to be more of a medical issue rather than a social issue?
7. What is the difference between PTSD and a normal human response to trauma?
 - a. Can one experience significant distress or impairment resulting from a traumatic event, but not have PTSD?
8. How have your conceptions of PTSD changed from when you were in medical school to when you were able to practice PTSD treatments and have engage with individuals with this disorder?
9. What is your assessment of the current medical understanding of PTSD

- a. Are there any issues or shortcomings?
 - b. What needs to be done to improve upon the current knowledge of PTSD?
10. Do you think that being diagnosed with PTSD may harmfully affect combat veterans?
- a. How does a diagnostic label that comes into conflict with one's identity (masculinity) impact the recovery process?
 - b. How important is it to keep one's self-perception/identity intact, and at what point could this begin to interfere with the recovery process?
11. In the social sciences, trauma is often looked at as one being faced with an event that challenges their fundamental perceptions of the world. In other words, they experience an intrusion of the real within the symbolic system. Could a challenge to one's identity as 'masculine' be a trauma that could result in PTSD?
12. If one is aware that they may be entering into a traumatic situation, are there any steps that could be taken to prevent the onset of PTSD?
13. Could you share some feedback as to how you felt about the questions I asked you today?
- a. How do you feel about research being conducted on this topic?
 - i. Do you think research like this could make a positive contribution to the field of PTSD?

Appendix C - Ethics Approval



Consent Form

Neuroanthropological Understandings of PTSD Among Canadian Combat Veterans

I _____, choose to participate in a study on masculinity and PTSD. This study aims to understand how medical professionals conceptualise masculinity within PTSD treatments specific to Canadian combat veterans. **The researcher for this study is Elle Reid in the Carleton University department of Sociology and Anthropology.** She is working under the supervision of Dr. Neil Gerlach in Carleton University's department of Sociology and Anthropology to complete a research requirement for a Master's thesis.

This study will involve one 60-minute interview, which will be audio-recorded with your consent. This recording will be destroyed once the data has been transcribed. You are not required to answer any questions and may stop the interview at any time.

You have the right to withdraw from this study at any point, for any reason, until (10-weeks from interview date). To withdraw, please phone or email the researcher with the contact information listed below. Once you withdraw from the study, all information you have provided will be destroyed (Electronic data will be erased and hard copies will be shredded.)

Should you choose to participate in this research, please ensure that you uphold the ethical standards related to your profession, and abstain from using clients' identifying information whether that be name or other indicators.

You may have been referred by another participant within this study, however care will be taken to keep your participation and responses confidential.

Once the data has been transcribed, pseudonyms will be used to protect participants' identities, and no identifying information will be included in the final research product. A master list linking the pseudonyms to the participants will be kept on a password protected USB key, which will only be accessible to the researcher and research supervisor. After the interview, you may request that certain information you have provided be omitted from the final research product.

All research data, including audio-recordings, the master list of pseudonyms, and any notes will be encrypted. Any hard copies of data (including any handwritten notes or USB keys) will be

kept in a locked cabinet at Carleton University. Research data will only be accessible by the researcher and the research supervisor.

Once the research project is completed, data will be kept for possible future use using the same secure protocols as outlined above.

If you would like a copy of the finished research project, you are invited to contact the researcher to request an electronic copy, which will be provided to you.

This study is to be completed as an academic requirement for a Master's thesis. The researcher has received ethics clearance from Carleton University's Research Ethics Board to complete this project.

Contact Information:

Elle Reid, Researcher, Department of Sociology and Anthropology at Carleton University

Phone: [REDACTED]
Email: ellereid@cmail.carleton.ca

Dr. Neil Gerlach, Course Instructor, Department of Sociology and Anthropology at Carleton University

Phone: 613-520-2600 x1331
Email: neil.gerlach@carleton.ca

Carleton University Research Ethics Board – A (Protocol Number 109487)

If you have any ethical concerns with the study, please contact Dr. Bernadette Campbell, Chair, Carleton University Research Ethics Board-A

Phone: 613-520-2600 ext. 2517
Email: ethics@carleton.ca

Do you consent to being audio recorded? ____ Yes ____ No

Signature of participant

Date

Signature of researcher

Date

Email Invitation

Subject: Invitation to participate in a research project on Neuroanthropological Understandings of PTSD Among Canadian Combat Veterans

Dear Sir or Madam,

My name is Elle Reid and I am a Master's student in the department of Sociology and Anthropology at Carleton University. I am working on a research project under the supervision of Prof. Neil Gerlach.

I am writing to you today to invite you to participate in a study entitled "Neuroanthropological Understandings of PTSD Among Canadian Combat Veterans". This study aims to address the role of masculinity in current treatments of PTSD being conducted by medical professionals in the Ottawa area.

This study involves one 60 minute interview that will take place in a mutually convenient, safe location. With your consent, interviews will be audio-recorded. Once the recording has been transcribed, the audio-recording will be destroyed.

You may have been referred by another participant within this study, however care will be taken to keep your participation and responses confidential. Once the interview has been transcribed, your data will be associated with a pseudonym, and no identifiers will be present within the final research product.

This project does not involve any professional or emotional risks, as identifying names and characteristics will not be included in the final research project. This will be done by keeping all responses anonymous and allowing you to request that certain responses not be included in the final project.

Should you choose to participate in this research, please ensure that you uphold the ethical standards related to your profession, and abstain from using clients' identifying information whether that be name or other indicators.

You will have the right to end your participation in the study at any time, for any reason, up until 10 weeks after the interview. If you choose to withdraw, all the information you have provided will be destroyed.

All research data, including audio-recordings and any notes will be encrypted. Any hard copies of data (including any handwritten notes or USB keys) will be kept in a locked cabinet at

Carleton University. Research data will only be accessible by the researcher and the research supervisor.

The ethics protocol for this project was reviewed by the Carleton University Research Ethics Board (CUREB-A), which provided clearance to carry out the research. (Clearance expires on: October 31st 2019.)

CUREB-A:

If you have any ethical concerns with the study, please contact Dr. Bernadette Campbell, Chair, Carleton University Research Ethics Board-A (by phone at 613-520-2600 ext. 2517 or via email at ethics@carleton.ca).

If you would like to participate in this research project, or have any questions, please contact me at ellereid@email.carleton.ca

Sincerely,

Elle Reid