Conflicting Notions on Violence and PTSD in the Military: Institutional and Personal Narratives of Combat-Related Illness

Article *in* Culture Medicine and Psychiatry · August 2015

DOI: 10.1007/s11013-015-9469-0 · Source: PubMed

CITATIONS
9

READS
187

3 authors, including:

Tine Molendijk
Radboud University/NLDA
26 PUBLICATIONS **55** CITATIONS
SEE PROFILE

Desiree Verweij
Ministry of Defense, Netherlands
28 PUBLICATIONS **214** CITATIONS
SEE PROFILE

Cult Med Psychiatry
DOI 10.1007/s11013-015-9469-0

ORIGINAL PAPER

Conflicting Notions on Violence and PTSD in the Military: Institutional and Personal Narratives of Combat-Related Illness

Tine Molendijk[1] · **Eric-Hans Kramer**[1] · **Désirée Verweij**[1]

Abstract Research indicates that soldiers struggling with PTSD under-utilize mental health care. Quantitative studies of barriers to care point to the importance of soldiers' beliefs about mental health and mental health interventions in their care-seeking behavior, yet these studies still struggle to understand the particular beliefs involved and the ways they impact care-seeking behavior. This preliminary study makes a start in examining these questions through qualitative literature analysis. It maps out dominant messages surrounding PTSD in military mental health interventions, and explores how they can both shape and conflict with soldiers' personal notions. It does so by analyzing these messages and notions as institutional and personal (illness) narratives. Institutional military PTSD-narratives, which draw on mainstream scientific and clinical models, appear to communicate contradictory notions on the meanings of violence and its psychological consequences, often without acknowledging these contradictions. As such, these narratives seem to shape struggles of soldiers, both within themselves and with the military institution. The identified conflicts indicate, contrary to the individualizing and decontextualizing focus of dominant PTSD-understandings, that soldiers' struggles also have social and moral dimensions. This has important implications for both research into PTSD-interventions and understandings of PTSD as such.

Keywords PTSD · Military · Barriers to care · Illness narratives · Military culture

✉ Tine Molendijk
tinemolendijk@gmail.com

Eric-Hans Kramer
FJ.Kramer@nlda.nl

[1] Section of Military Management Studies, Faculty of Military Sciences, Netherlands Defence Academy, Breda, The Netherlands

Published online: 25 August 2015

Introduction

Over the years, many western armed forces have implemented programs to promote help-seeking among soldiers who might suffer from post-traumatic stress disorder (PTSD). In line with the chief findings of many psychological studies of military "barriers to care" (Hoge et al. 2004; Kim et al. 2010; Iversen et al. 2011; Ben-Zeev et al. 2012), these armed forces have focused on fighting self-images of weakness or fear of such views. Education programs are developed to deal with stigma, which emphasize, for instance, that seeking help is a sign of strength (Iversen et al. 2011). To date, such interventions only seem partly successful. Quantitative studies still identify considerable under-utilization of mental health care services (Hoge et al. 2004; Kim et al. 2010). At the same time, soldiers have been reported to say that anti-stigma efforts are "bullshit" (Hooyer 2012), and that psycho-educational sessions are useless (Schipholt 2007; Bouma, Waaijers, and Sellies 2014). This raises the question of how these reactions should be understood. Do these responses reveal a lack of taking personal responsibility for one's well-being? Are they avoidance behavior, symptomatic for PTSD? Or are there perhaps other factors at play?

The studies that identify stigma as a significant factor in care avoidance behavior also point to—without pointing out—the possibility that current mental health care practices may be connected to soldiers' reluctance to seek help. These studies find a lack of trust and confidence in mental health care among soldiers, but at best barely reflect on this finding (Hoge et al. 2004; Kim et al. 2010; Iversen et al. 2011). Importantly, it remains unclear how and why soldiers would hold negative attitudes toward mental health care. A deeper understanding is thus needed of soldiers' conceptions of mental illness and mental health treatment, and the ways in which these conceptions relate to current military mental health interventions.

The current intervention programs in western armed forces such as the US, UK, and Dutch armed forces draw on mainstream scientific understandings of PTSD (Mulligan et al. 2012; Adler et al. 2013; Steenkamp, Nash, and Litz 2013). The dominant PTSD-concept defines post-traumatic illness as a set of psychiatric symptoms that develop due to exposure to threatened or actual violence (American Psychiatric Association 2013). However, the concept is not uncontroversial in science. For instance, research demonstrates that the PTSD-model, which originated in the US, often does not correspond with the experiences of non-western war-affected populations (Summerfield 1999; Kienzler 2008; Suarez 2013). While these studies aim to show the difficulties of applying 'PTSD' in non-western contexts, their findings also point to the possibility of more general differences between the medical disease-model of PTSD and personal illness experiences. Studies in western contexts on other disorders have shown such differences to be the case (Kleinman 1988).

These findings lead 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. This preliminary

study makes a start in exploring this question. It will first more elaborately discuss the existing literature on PTSD in general, and explain how it led us to explore dominant institutional understandings versus personal understandings of PTSD through a study of conceptual and ethnographic literature. The second section contains an explanation of the literature study conducted and the analytic approach used; the institutional and personal accounts surrounding deployment-related illness that arose from the literature were analyzed as 'illness narratives' (Kleinman 1988). The third section maps out the institutional narratives that are reflected in and produced by military PTSD-interventions, which in turn appear to draw on mainstream scientific conceptions. In the fourth section, these institutional narratives are juxtaposed with two themes in soldiers' narratives, which concern the meanings attributed to military violence and psychological difficulties by soldiers. In doing so, this article reveals several ways in which institutional narratives surrounding PTSD shape as well as differ from personal narratives, and as such may lead to conflicts. The last part of this article discusses how such conflicts may help to understand care-avoiding behavior, and argue that these conflicts also imply that certain illness experiences fall outside the mainstream PTSD-concept, while they can be key to understanding the struggles of soldiers. These conclusions will show the necessity of in-depth empirical research into both military PTSD-interventions and soldiers' personal narratives.

State of the Art: Dominant PTSD-Models and Personal Illness Experiences

The Mainstream Conceptualization of PTSD

The dominant, 'mainstream' conceptualization of PTSD is reflected in the official classification guide of psychiatrists, the Diagnostic and Statistical Manual of Mental Disorders (DSM). 'PTSD' was introduced in the DSM in 1980. Since the introduction, post-traumatic illness is defined by two main criteria: exposure to a traumatic event, and a set of psychiatric symptoms that develop because of this exposure. The symptoms include, among others, re-experiencing of the event, and avoidance of confrontation with the event or situations that may trigger it (Young 1997; Jones and Wessely 2007).

Before 1980, the prevailing view of (military) psychiatrists and doctors was that exposure to war violence could not be the cause of long-term problems, but a 'trigger' at most (Jones and Wessely 2007). It was well established that stressful events could cause short-term psychological problems. However, a long-term failure to recover from war was predominantly seen as due to individual predispositions. For instance, disorders such as depression, schizophrenia, or childhood problems, which already existed before the war or were merely 'triggered' by it, were thought to have been the root cause of long-term problems after war. The suffering of Vietnam veterans led several psychiatrists to re-examine this notion, and to advocate the introduction of 'post-traumatic stress disorder' in the DSM-III in 1980. 'PTSD' officially shifted the etiology of persistent war-related

psychological problems from the internal, namely the person's background, to the external, namely a traumatic event (Jones and Wessely 2007).

Since its introduction, the PTSD-concept has changed in a few ways. In the DSM-III, the traumatic event was defined as "outside the range of usual human experience" (Young 1997:107). In the latest edition, DSM-V, it is defined more specifically as exposure to "actual or threatened death, serious injury, or sexual violence"(American Psychiatric Association 2013). Another important change concerns the identified role of pre-existing individual vulnerability in the development of PTSD-symptoms. The DSM-III stated that some events would provoke "significant symptoms of distress in most people" (Young 1997:107), turning the pre-PTSD notion of war-related problems on its head in its focus on external rather than internal causes. Today, attention is redirected to the importance of individual susceptibility (Nash, Silva, and Litz 2009). For instance, it is found that childhood abuse may increase the risk of developing PTSD-symptoms among soldiers (Zaidi and Foy 1994). Notwithstanding these changes, the essence of the concept, namely that an event causes symptoms in an individual, has not changed.

The introduction of 'PTSD' fueled research on the phenomenon. This research is predominantly orientated toward the etiology and treatment of PTSD. The dominant approach in psychological PTSD-research appears to be cognitive psychology and cognitive behavioral therapy, as opposed to, for instance, psychoanalytic and psychodynamic approaches. This focus is in line with broader developments within the fields of psychology (Robins, Gosling, and Craik 1999; Pilgrim 2011). Different cognitive behavioral therapies have been improved and developed. Cognitive behavioral therapies are, simply put, based on the idea that our thoughts and actions are a result of our interpretative schemes of the world. For PTSD, cognitive behavioral therapy is often exposure-based (Difede, Olden, and Cukor 2014). Exposure therapy is rooted in the idea that traumatic events result in the patient's learning to avoid danger. To 'relearn' the lessons that the current world is safe, patients would have to confront their traumatic memories and/or external triggers of stress (Finley and Erin 2009). Exposure-based cognitive behavioral therapy has been validated for different types of traumatic events, among which combat experiences (Difede, Olden, and Cukor 2014).

More recently, and again in correspondence with broader developments, mainstream PTSD-research also focuses on the search for genetic and neurobiological aspects of PTSD. Extensive research is being conducted on specific biological markers that could indicate the existence of PTSD in an individual, and thus validate the objective existence of the PTSD-classification. Until today, no unequivocal 'biomarker' has been found for any psychiatric disorder (Nesse and Stein 2012), yet progress has been made in the neurobiological field. Studies have found that specific psychobiological changes may occur among people with the diagnosis of PTSD, which are different from normal stress responses (Stein et al. 2007). These changes mainly involve fear, in which the brain areas called the amygdala and hippocampus seem to play a critical role (Difede, Olden, and Cukor, 2014). Scientific research also provides insights into the question of possible biological susceptibilities to the development of symptoms typical for PTSD. For instance, findings suggest that an inability to produce enough cortisol may increase

the probability of developing PTSD-symptoms (Yehuda 1999; Yehuda and Bierer 2007). Such findings have valuable implications for understandings and treating soldiers' problems.

Critiques on the Concept of PTSD

While no scholar seems to dispute that the problems of PTSD-diagnosed individuals are real, the concept of PTSD itself is surrounded with controversy.

First, many scholars as well as the DSM itself warn against the reification of mental disorders in general. They explain that a disorder is a standardized collection of clinical descriptions of behavior, not an objectively identifiable 'thing' (Faust and Miner 1986; Radden 1994). In a similar vein, some scholars take the fact that extensive research has failed to result in the identification of a specific 'biomarker' for any disorder to argue that psychiatric nosology is not "tidy" but instead blurry (Nesse and Stein 2012). Yet other scholars reject the idea entirely that 'biomarkers' could ever validate a disorder, saying this idea is a fallacy (see e.g., Morse 2008; Dehue 2011). Even when a biomarker would be found, they argue, it would not prove the independent existence of a disorder. One can only identify a marker of the disorder after having defined the disorder first, that is, after having designed a concept first. A biomarker then would only tell us something about differences between people with and without a diagnosis, not something about the disorder itself. In short, these scholars argue, a disorder necessarily remains a *concept*.

Starting from this notion, other scholars critically examine the genealogy of the scientific conceptualization of PTSD, thus taking on an approach radically different from the dominant one. Young (1997) argues that in essence 'PTSD' only differs in one aspect from syndromes that are covered by other classifications in the current DSM: the requirement of a traumatic event. Without such an event, the disorder cannot be diagnosed (which is possible for other disorders). Young sees the specific emphasis on the event not as scientific progress, but as the product of particular political processes. Here, he mentions the work of Scott on the introduction of PTSD in the DSM-III (1990). Scott shows how the introduction was the result of anti-war veterans' and anti-war psychiatrists' efforts during and after the Vietnam war. They sought medical recognition of the potential psychological consequences of the "horrors of war," not only for victims, but also for perpetrators in the war. Fassin and Rechtman (2009) further argue that the introduction of PTSD also came as a solution to the government and society in general because it conceptualized veterans' suffering as a medical disorder. PTSD allowed the government to take responsibility for the suffering of its veterans by setting in place medical programs, making it possible to acknowledge the veterans' problems without being condemned for sending soldiers to war with possible tragic consequences. Taken together, these different studies show how PTSD has arisen in specific contexts, which led to a view of war-related suffering as an *individual pathology* caused by an *event in war*. This view of war-related suffering took the suffering out of the social, political, and moral arena. It made recognition for veterans' suffering possible without judging either institutional authorities or the veterans who had committed or witnessed actions for which they now felt remorse.

Another line of research problematizes the cross-cultural application of 'PTSD.' Studies show that among culturally and socio-economically different groups, some PTSD-symptoms are more rare while others are seen more often (Perilla, Norris, and Lavizzo 2002; Stein et al. 2007). Studies in non-western settings also describe 'symptoms' not captured by the PTSD-concept. Post-war problems here are often inseparably linked to social, political, and economic circumstances. For instance, persons may report to suffer most, not from individual experiences of violence, but from the splitting of pre-war communities in conflicting groups (Summerfield 2000; Kienzler 2008; Suarez 2013). Social reform and collective recovery then may be considered more important for healing than individual therapy (Summerfield 2000). Cross-cultural research does suggest that there seems to be a universal 'core' of what we call PTSD, namely that events of violence may result in personal struggles (De Jong 2005). However, it also suggests that different illness experiences are not merely different representations of the same disease (the disease plus cultural notions to explain it), but actually different ways of suffering.

In comparing the dominant with the critical literature on PTSD, it becomes clear that the former is mainly focused on better understanding the phenomenon of PTSD, while the latter investigates PTSD at another level. The critical literature problematizes PTSD as an objective phenomenon, either by tracing the socio-historical processes that have shaped scientific developments or by describing how different socio-historical contexts can shape essentially different illness conceptions.

Toward a Contextualizing Approach of PTSD

Until today, the dominant and critical approaches of PTSD still seem mainly involved in an unproductive debate instead of a collaboration. Critical approaches can, however, be meaningful for better understanding the phenomena that the PTSD-concept aims to describe. It leads to an approach of disorders not as distinct entities, but as concepts which can be useful in understanding different kinds of suffering. Such an approach acknowledges that historical and social circumstances can shape the kind of suffering that 'PTSD' aims to describe, and, moreover, that they can thus also shape the PTSD-concept itself. A better understanding of these circumstances will lead to advanced knowledge of the suffering we now call PTSD.

The current mainstream PTSD-concept, with its focus on trauma exposure and individual susceptibilities, frames PTSD as the response of an *individual* to an *event*. The critical literature on PTSD deconstructs this concept as arisen in specific contexts, and draws attention to the possibility that it fails to capture important elements of a person's suffering. Personal experiences of post-war suffering can also be shaped by circumstances other than the event, and by actors other than the sufferers themselves, namely the *pre- and post-war social environment*.

Such attention to factors beyond the individual and the event actually resonates with recent findings in mainstream research on PTSD. Epidemiological research also shows that trauma and individual susceptibility do not sufficiently explain the development of PTSD-symptoms (Perilla, Norris, and Lavizzo 2002; Finley 2009). Social and cultural factors appear to be involved as well in the problems people can

develop after having been exposed to certain events (De Jong 2005). Such factors are especially important in that they shape the meaning of events and subsequent experiences. As such, they shape what events are experienced as traumatic, and how post-traumatic stress and distress is understood and dealt with (Finley 2009). However, epidemiologists still struggle to understand the specific socio-cultural factors involved. Also, their focus mainly lies on the role of such factors among non-western populations.

The preceding discussion raises the question of whether and how the socio-cultural environment of the western military has a role in potential struggles among soldiers, and also how this might better inform dominant scientific PTSD-understandings. In the following sections, we will conduct an exploration of these questions drawing on literature study. More specifically, we will explore what notions surrounding PTSD are contained in military mental health interventions, and subsequently compare these notions to two themes in soldiers' personal narratives. This will provide a preliminary analysis of how dominant institutional notions surrounding PTSD may shape and/or conflict with soldiers' experiences, which will lead to a formulation of its implications for research into care-avoiding behavior as well as PTSD itself.

Before proceeding to our exploration, below we will discuss the analytical approach and the data collection methods that were used.

A Narrative Analysis of Institutional and Personal Notions

Personal and Institutional Narratives

A narrative analysis is a fruitful method to examine institutional and personal conceptions of PTSD. It allows for systematic comparison and it simultaneously enables to grasp a sense of how potential conflicts between conceptions may affect soldiers, because it analyzes conceptions as important means to make sense of experiences.

Scholars such as Arthur Kleinman (1988) and Byron Good (1994) have been of great influence with regard to narrative analysis in the context of the medical professions. As these authors explain, narratives are interpretive accounts of experiences such as illness. Narratives give answers to questions such as: what has happened and is happening now?; what are the causes and effects?; what does this say about me and the world? (Kleinman 1988). Narratives structure experiences into an explanatory and appraising story in order to make sense of them and communicate them to others. As such, they also judge; they tell what certain experiences say about someone, and how one ought to deal with experiences (see e.g., Good 1994). Narratives are thus ways of sense-making as well as performative and normative accounts.

The creation of narratives is never a purely individual enterprise, which occurs in a social vacuum. The process of meaning-making is something that always occurs in interaction with our social and cultural environments (cf. Kleinman 1988; Good 1994). An institution forms such an environment. Just as individuals maintain

narratives, institutions also have stories (Herman, Jahn, and Ryan 2005:243). These institutional narratives similarly answer questions like the ones mentioned above. Because of this, institutional narratives can also hinder the process of interpreting and articulating one's personal experiences, for example, when dominant notions conflict with one another or with the experiences of the individual.

While many different narratives may exist within an institution, this study will focus on the *formal* narrative of the Armed Forces on PTSD, as reflected in and produced by the series of military interventions directed toward PTSD. Although the informal narratives that are produced in daily practice are certainly important, an analysis of the formal language and practice of military mental health interventions is considered to be an important first step. Such an analysis gives insight into the ways in which the PTSD-concept has been institutionalized in the Armed Forces. Also, formal narratives fall in the category of narratives that are repeated by many tellers, which means that they have a relatively stable and extended life in an institution (cf. Herman, Jahn and Ryan 2005:243). This relative stability, however, does not mean that the formal military 'PTSD-narrative' is necessarily a coherent one. Indeed, the formal 'PTSD-narrative' will turn out to contain conflicting notions, which may be related to the resistance of soldiers toward several mental health interventions.

Literature Analysis

For our investigation into military institutional and personal narratives, we drew on literature. As such, this article is limited to secondary data. It may be of worth to note that we are familiar with the military context due to our research experience. However, as will be discussed, the findings of this study do call for primary empirical research.

The exploration of the institutional PTSD-narrative was conducted by an investigation of standard mental health interventions in present-day armed forces. It turned out that the range of mental health interventions implemented in different western armed forces is to a great extent similar (Vermetten et al. 2014). This seems to be due to the fact that most mental health interventions draw on psychiatrist and psychologist models and the fact that the policies of different armies have influenced one another (see e.g., Boermans et al. 2012; Mulligan et al. 2012). As such, we can say that many contemporary western armed forces have developed what might be named a similar 'PTSD-infrastructure,' by which we refer to the structure of military interventions oriented toward PTSD. Although we acknowledge that differences exist in the practices of different armed forces, for the purposes of this exploratory study, we focused on the interventions that most armies have implemented and the basic similarities in this infrastructure.

Despite an extensive search, we did not find elaborate empirical data on the different PTSD-interventions. The analysis mainly relied on conceptual scientific literature and reports (e.g., Cardona and Ritchie 2007; Sharpley et al. 2008; Mulligan et al. 2012) and to a lesser extent on program materials (e.g., WRAIR Land Combat Study Team 2006; MGGZ 2008). Each of these sources concerns the US, UK, and/or Dutch armed forces. We found Schipholt (2007) and Finley (2009)

to provide empirical material, namely on the internationally used post-deployment 'battlemind' program and the treatments used in the Netherlands and the US. Also, some of the ethnographies cited below contain commentary of soldiers on PTSD-interventions.

The exploration of soldiers' personal narratives surrounding mental health issues could draw on a considerable amount of empirical material. Since the corpus of studies of 'war stories' is abundant, a selection was made based on relevant material (i.e., ethnographic material on mental health issues) and recentness. A number of the most recent ethnographic studies dealing with mental health issues among soldiers were selected (Finley 2009; Wool 2011, 2012; Hooyer 2012; MacLeish 2013; Hautzinger and Scandlyn 2013), as well as the empirically rich works of practitioners Shay (2010) and Lifton (2005), who have treated numerous veterans.

As discussed, we analyzed our secondary material through a narrative analysis and on the basis of our research questions. A comparison between soldiers' personal accounts and the practice and language of the 'PTSD-infrastructure' was thus central in our analysis. In the analytical process, several narrative patterns and themes emerged. It will become clear that two thematic differences between institutional and personal narratives stood out, which therefore formed the focus of our analysis.

The Military PTSD-Infrastructure and Its Institutional Narrative

The Military PTSD-Infrastructure

This section will start with a description of what we call the 'PTSD-infrastructure.' We have divided the PTSD-infrastructure into five categories: pre-enlistment screening, basic training programs, counseling during deployment and pre- and post-deployment psycho-education, post-deployment screening through a survey and a meeting, and therapy. A number of the sources cited below focus on different national armed forces and find that they are similar regarding a particular intervention. When more than one source is cited after a single statement, it is because the different sources speak of different national armed forces.

The first intervention every soldier has encountered is the psychological selection in the application procedure. The screening procedure includes educational achievement and a brief psychological evaluation, and is aimed to screen out applicants with clear psychological problems (RTO 2000; Cardona and Ritchie 2007). It appears that, currently, applicants are not screened specifically for vulnerability to PTSD due to lack of evidence on screening for this purpose (Jones, Hyams, and Wessely 2003; Rona et al. 2005). However, the screening instruments are used to filter out applicants with a current psychological disorder as well as those who seem to be unfit for military service for other reasons (Jones, Hyams, and Wessely 2003; Rona et al. 2005).

If individuals successfully pass the selection, they start their basic training, in which they encounter a second kind of mental health intervention. They will go through several trainings, in which they endure pain, exhaustion, and stress. The aim

of these trainings is not just to increase physical strength, but also to give soldiers the mental capacity to deal with difficult situations and emotions. Currently, armed forces are implementing programs orientated toward the so-called resilience, under names such as Comprehensive Soldier Fitness (Casey 2011; Boermans et al. 2012). Such trainings draw on the so-called positive psychology (Eidelson, Pilisuk, and Soldz 2011) and cognitive behavioral models (Steenkamp, Nash, and Litz 2013). The particular approach of resilience trainings entails that it focuses on strengths. As such, the trainings aim to enhance soldiers' ability to recover or even grow after hardships. Also, resilience trainings are packaged as training and mental 'fitness,' not as mental health interventions.

Currently, additional resilience interventions are being developed based on a neuro(psycho)logical approach. For instance, in 'serious gaming' with 'biofeedback,' soldiers are confronted with simulated stressful situations while equipped with receptors that monitor physical changes within them. Afterwards the soldiers receive biofeedback, which focuses on the physiological aspects of stress responses like heart rate. As such, they are made aware of such reactions. Also, the soldier is informed on the coping strategies that he or she tends to use, and the possible alternatives. The idea is that through biofeedback soldiers learn to develop better cognitive coping strategies (Cohn et al. 2010; Kamp and Binsch, 2012).

Soldiers will encounter a third set of interventions surrounding their deployment, which more explicitly focuses on mental health. During deployment, mental health professionals and a humanist or religious counselor are present, to whom soldiers can go if they desire support or advice (Schipholt 2007). A pre-deployment and a post-deployment psycho-educational session is mandatory for all soldiers. Both sessions are group sessions, and usually last from less than an hour to a few hours (Mulligan et al. 2011). The pre-deployment session informs soldiers on what stress is and can do, and on where to get further help (Sharpley et al. 2008). After deployment, soldiers again collectively attend a psycho-educational session led by a mental health professional, sometimes called debriefing. This session aims to inform soldiers on possible difficulties after home-coming (Mulligan et al. 2011; Mulligan et al. 2012; Boermans et al. 2012). In the 'battlemind' approach, used by different armed forces, soldiers are asked to talk about stressful experiences during their deployment. They are informed about the importance of transitioning from the 'battlemind' to the civilian mindset, and told that difficulties in this adaption process are normal. Also, soldiers are encouraged to talk with others and display emotions, while it is emphasized that this "is not unmilitary and doesn't mean you are weak" (WRAIR Land Combat Study Team 2006; see also Schipholt 2007; MGGZ,2008; Boermans et al. 2012). In addition, the US army has recently implemented specific anti-stigma campaigns, which tell the soldiers that "help-seeking is a sign of strength" (Iversen et al. 2011).

The last mental health intervention the soldier usually encounters is the individual meeting and the survey. Several weeks or months after home-coming, an individual meeting is arranged with a mental health professional. Soldiers also receive a letter with a survey they have to return, which screens for medical and

psychosocial problems through questions about topics such as adaption at home and at work, alcohol use, depression, and PTSD (Martens and Zijlmans 2003).

If a soldier seeks help, the usual treatment is a type of cognitive behavioral therapy that includes exposure (Schipholt 2007; Finley 2009). The basic aim of those therapies is to let the individual 'relearn' a view of the world that is considered to correspond better with the current environment. An important goal is to help the client see that the civilian world is usually a safe one. In some cases, traumatized soldiers may receive Eye Movement Desensitization and Reprocessing (EMDR) therapy (Finley 2009). Here, the soldier does not have to share the event extensively with the therapist, but this therapy also centers on exposure, in order to neutralize accompanying thoughts and feelings.

The Institutional PTSD-Narrative at First Sight

The interventions discussed above correspond with mainstream scientific notions on mental health and trauma. The focus lies on the individual; post-deployment problems are seen as symptoms following stressful events. The dominant approach is a cognitive behavioral one, and in addition, we see a growing emphasis on neurobiology. This is in line with scientific trends as well. Both approaches are based on the idea that stressful events can disorder the mental 'mechanism' of soldiers. They aim to facilitate the development of mental systems or cognitive schemata through which the individual can effectively manage potentially traumatic events, either through proactive or reactive interventions. In the military PTSD-infrastructure, the programs that focus on resilience after trauma are somewhat an exception in that they flip around the focus from illness to growth. But in doing so, these cognitive behavioral programs maintain the underlying idea of post-traumatic change as (dys)functional cognitive responses.

Although rooted in scientific research, most of the interventions discussed above have provoked scientific criticism on their usefulness. For instance, resilience trainings have been implemented without convincing evidence on their effectiveness, while the few studies of comparable programs have shown only modest positive effects, and sometimes harmful consequences (Eidelson, Pilisuk, and Soldz 2011). Similarly, psycho-education would have little or no effectiveness in preventing PTSD (Mulligan et al. 2011). This lack of effectiveness might have many reasons. For one, it is not clear to what extent practices are in line with scientific research and to what extent they actually correspond to the policy voiced in the Armed Forces. Another reason, and the one on which we focus, could lie in the narratives that these interventions communicate.

It seems that the interventions discussed above communicate an unambiguous narrative of PTSD, which echoes the mainstream PTSD-conception in clinical literature. In this narrative, the cause of post-traumatic problems is a stressful event, and the impossibility to integrate this event into one's mental system. The event is abnormal, and the resulting mental health problems are normal. Indeed, while researchers have now redirected attention to the importance of individual vulnerability to PTSD, the clinical slogan that "PTSD is a normal reaction to an abnormal event" still seems to be widely used, at least in military contexts (Nash,

Silva, and Litz 2009; Meichenbaum 2011:325).[1] That is, in this narrative, post-traumatic problems are a normal response to the event. But they are not normal in another sense; they are an ineffective response. The answer is then redeveloping a functional 'mindset' or cognitive scheme that is effective in integrating the event as much as is possible. In this narrative, the meaning of PTSD is a-moral and a-political. Neither the soldier nor anyone else is to blame for PTSD. It is an individual illness, which consists of dysfunctional thoughts and behaviors.

However, soldiers have been reported to criticize psycho-education and anti-stigma programs because these interventions did not change their experience of not being understood and helped (Schipholt 2007; Hooyer 2012; Bouma, Waaijers, and Sellies 2014). Bouma, Waaijers, and Sellies (2014) and Schipholt (2007) do not reflect on this critique. Hooyer (2012) explains the complaints of soldiers in arguing that anti-stigma efforts are isolated interventions within a stigmatizing system; the interventions are directed toward individual soldiers and do not change the structural forces causing fear of jeopardizing one's career and perceptions of weakness. Taking this argument one step further, we argue that soldiers' complaints may have to do with the fact that military trainings and programs, including mental health interventions, simultaneously communicate the narrative outlined above as well as notions that directly contradict this narrative. This becomes clear in the following discussion of several elements in the personal narratives of soldiers.

Personal Narratives and Conflicts with Institutional Narratives

As has been well documented, traumatic memory often consists of isolated details, which cannot find a place in a meaningful context. These fragmented memories are often ones of sensory experiences, such as the sensation of heat caused by the sun, the sound of a mortar, or the sight of a dead body now looking "like spaghetti" (Wool 2011; MacLeish 2013). Psychoanalysts have depicted such traumatic memories, which can hardly be articulated and do not have interpretive frames, as 'prenarrative' (Sturken 1998). As explained, without narrative it is hard to make sense of personal experiences.

When traumatic experiences do find narrative, they often tell raw stories of war. Events now are glued together into an account, but remain rather dry descriptions of the violence soldiers have experienced—and which they have sometimes committed themselves (Lifton 2005; Shay 2010; Finley 2009). The narratives are sometimes not much more than a summary, for instance: this happened, then I did this, then he did that, then this happened, then I saw blood, and I thought 'fuck,' and then he died on me. This record-keeping style can also be seen in the narratives of non-traumatized soldiers (Wool 2011; MacLeish 2013).

Such narratives partly seem to show the 'battlemind' soldiers have learned to develop: if you want to fight, kill, and survive, then being emotional and figuring out

[1] See also e.g., http://www.ptsd.va.gov/apps/AboutFace/questions–what-ptsd-is.html [A website of the US Veteran Affairs National Center for Posttraumatic Stress Disorder]; http://www.pdhealth.mil/wot/fact_sheet2.asp [A website of the US DoD Deployment Health Clinical Center]. (Accessed at 08-04-2015).

the point of what is happening is not helpful. The raw narratives seem to express something else as well. As also observed by practitioners Lifton (2005) and Shay (2010), with these narratives, soldiers seem to tell that they conceive some of their acts as a far cry from deeds of heroism or sacrifice. The meaning of such acts then is that they are not particularly meaningful. At least in the case of struggling soldiers, narratives of traumatic events are often also stories of the pointlessness or even injustice of what soldiers have done or have neglected to do. In such narratives, their own troops were killed for "no fuckin' reason at all," and the killing of other people, in the name of ideology and politics, are narrated as "ridiculous" as well (Lifton 2005:178, 195). Soldiers may recall themselves thinking: what are we doing here? Such narratives often tell stories of guilt (Lifton 2005; Shay 2010). In relation to this, soldiers may speak of a radically transformed perception of themselves and the world. They have lost their innocence (Shay 2010), and now perceive the world as a potentially dangerous place (Wool 2012).

These narratives reveal some of the perceptions of soldiers on violence and psychological change, which partly conflict with the institutional narrative of PTSD outlined above. In juxtaposing soldiers' narratives to the analyzed institutional PTSD-narrative, two themes stand out, both of which concern the narrated '(ab)normality' of post-deployment difficulties. In the following section, these two themes are discussed, which will reveal how institutional narratives can both shape and conflict with the personal narratives of soldiers.

Violence as Abnormal and PTSD as Normal Versus the Reverse

In the personal narratives of soldiers sketched above, the meaning of violence seems a lot more complex than the word 'abnormal' suggests. Violence is not just exceptional, but 'part of the job.' This is also what soldiers learn in the military, basic training programs and psychological selection included. The psychological selection tells them that there will be violence, and that as long as they are psychologically 'normal,' they should be capable of managing violence. In their trainings, soldiers learn to positively view stress, pain, and exhaustion, or at least 'suck up' their initial reactions to it. A widely used phrase in the Dutch armed forces is: "[pain/fear/cold] is an emotion; emotions can be switched off." Also insightful is the way in which US commanders explain how they train their soldiers. Finley quotes them saying similar things. "Whenever I'd see someone limping, I'd be like, 'Pick your ass up and move. You better be bleeding or your bone better be sticking out before you quit on me'." This particular commander explained that he did this because since Afghanistan "I knew what the consequences were if you're unprepared" (Finley 2009:213). Soldiers thus learn "disciplining the emotions" (Bourke 1998). For the soldier, violence is something that good soldiers have to be able to deal with, and which can even 'toughen' them up.

Soldiers do not seem to deny that deployment can, at least for a while, create psychological difficulties. The fact that they have to be trained already tells them that violence can cause psychological responses. At the same time, they know that not every one of them develops severe problems, even when having been through almost the exact same events as a squad. Soldier may feel that non-soldiers are not

'tough' enough to be able to understand their experiences. "Combat is fun," a US soldier is quoted by Macleish. The soldier explains that combat does not give someone PTSD. "Being subliminally told by a 27-year-old woman therapist that 'you were in a terrible situation' and you should feel bad about what you did is what gives you PTSD!" (MacLeish 2010:163). A number of other soldiers saying roughly the same about service provides are quoted by MacLeish, as well by Hautzinger and Scandlyn. The latter quote a US soldier who believes that when you have experienced a lot of combat, "a psychologist or a psychiatrist is gonna be like 'Wow, he does have PTSD, he's been through horrible experiences'" (2014:51). Hauzinger and Scandlyn also quote soldiers who call those who seek help a "pussy," and believe that soldiers should just "suck it up" (2014:55).

We may safely assume that practitioners experienced in treating soldiers would not just diagnose anyone who has been exposed to violence with PTSD. But the point is that it is a present belief among soldiers. Statements such as the ones above reveal that, in a way, violence is normal in the soldier's world—perhaps even "fun"—which is conceived as something that non-soldiers do not understand. And importantly, psychological problems because of violence, or at least the incapacity to "suck them up," are then failing as a soldier. Indeed, a soldier who gets sick because of violence is not useful to the military. Finley quotes a US chaplain who says that 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 (Finley 2009:216). So, although the official PTSD-message is that PTSD is a normal reaction to an abnormal event, there is a distinct way in which being confronted with violence as well as being able to cope with it is considered to be 'normal.' Moreover, this view is embedded in the formal institutional narrative as reflected in psychological selection and basic training programs.

This tension in institutional narratives might help in understanding why soldiers often struggle with inner conflicts regarding the (moral) meaning of potential psychological problems. The discussion above reveals a paradox, an apparent contradiction in terms. Soldiers have learned that exposure to violence can harm a soldier, and that PTSD-like symptoms are not unusual. However, at the same time, they have learned that violence and stress are inherent to a soldier's job, and that 'good soldiers' should be able to deal with it. It is in the institutional narrative that this paradox emerges. It is not just an error that the institutional narrative sends paradoxical messages; the nature of being a soldier seems to *be* paradoxical in this way. Violence is exceptional *and* normal, PTSD is normal *and* it contradicts with being a good soldier.

Notably, the formal institutional narrative does not seem to make this paradox explicit. The different messages about violence and PTSD are conveyed in isolated interventions and as such do not directly speak to one another. When the apparent contradiction of these messages is not acknowledged, it is actually turned into a real contradiction. At the same time, 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.

Redeveloping a Normal Mindset Versus Transformational Knowledge

The war narratives of soldiers point to a second conflict. Some soldiers speak of having gone through a fundamental transformation after war, including radically changed perceptions of themselves and the world. Afghanistan and Iraq veterans told anthropologist Wool that to them, everything does not just *look* different, but that "Everything *is different"* (emphasis in original) (Wool 2011:214).Vietnam veterans told psychiatrist Lifton about their changed view of man: "Whatever you psychologists call it, there is only one word for it—evil. … At a time like that you find out what man is like. You learn that this is what man is" (Lifton 2005:105). Psychiatrist Shay argues that when soldiers have experienced morally disturbing acts, performed by themselves or others, this will forever change them morally. "The word innocence has the double meaning of having done no harm and of being unacquainted with evil and malevolence," Shay states. And "the knowledge of evil" within others or oneself, "brings irreversible change" (2010:185). Soldiers have seen that the world and its people, including themselves, can be a terribly unjust world. Wool (2012) observed that some soldiers who have gone through transformational experiences perceive themselves as having "a newly educated eye, the one that allows [them] to see that 'everything is dangerous'," also in the civilian world. In an ostensible contradiction, some of them feel that this even allows them "to feel comfortable and 'not like everything is dangerous'" (2012:417). That is, 'knowing' that the entire world is dangerous can actually make them at ease.

Such narratives of viewing the world as dangerous and/or unjust do not speak of pathological thoughts; they speak of new *knowledge* or *awareness*—an understanding that soldiers have learned through certain events, and one which is irreversible. However, institutional narratives tell something else about soldiers' changed views. In resilience trainings, soldiers essentially hear that dealing with violence and other stressful events is a matter of the right or wrong mindset. Post-deployment psychoeducation educates them about the importance of returning to the civilian 'mindset' (Schipholt 2007). Their superiors may also tell them after deployment to "remember how you were [and] be like that" (Wool 2012:415). And the cognitive behavioral therapies that traumatized soldiers receive, although more nuanced, also focus on altering cognitive schemes that are considered dysfunctional in the civilian environment.[2] The message that soldiers can hear in these interventions then is that they should separate their deployment experiences and the civilian home to which they returned, and to redevelop a view of the civilian world as a safe and just one.

Many soldiers may be helped by this approach, yet others may feel that it violates their experiences. The soldier quoted by Wool saying that she was told to "remember how you were" found out that her transformation made it impossible to

[2] To be sure, cognitive behavioral therapies do not simply aim to restore pre-deployment cognitive schemes. They may aim to help altering cognitive schemes. But the premise of, for instance, exposure therapy is still that soldiers' thoughts and behaviors are changeable interpretations of the world rather than 'knowledge.'

"be like that" again (2012:415). A soldier quoted by Hautzinger and Scandlyn states about his issues: "It's REALITY stress … They tried to tell me I had PTSD because I was angry. …[But] I'm assessing a situation realistically" (2014:46). The institutional narrative seems to be tended to portray the development of "negative" views as a dysfunctional interpretation of the civilian world, perhaps even an illness. However, some soldiers see it as a new and real *understanding*, an understanding which is not immediately comprehensible for those without similar experience. Those soldiers feel that they cannot see the world as safe and just anymore, because they now know it is not. For some of them, being aware of the world as a dangerous place can even be a way to re-inhabit the post-deployment world again; the experience that danger can be expected any time becomes a way to feel comfortable and secure. Soldiers may then feel that, in the institutional narrative, their transformed perceptions are explained away as merely an interpretation of the world, which can be retransformed. Soldiers may feel they are told that their transformation is a matter of mindset rather than a fundamentally and irreversibly changed understanding of themselves and the world.

Here again, we see a conflict that is part and parcel of the military world. No soldier seems to deny the existence of PTSD as a post-war pathology. Many of them will recognize in themselves PTSD-like symptoms such as jumpiness shortly after home-coming, and see that this jumpiness is unhelpful in a civilian context. At the same time, a soldier can find that deployment has given him or her real, not pathological, awareness of the world. In a way, this paradox is embedded in the institutional PTSD-message that says that post-traumatic disturbance is normal, and simultaneously that it is a disordered mindset. This may lead soldiers to struggle with the question of whether feelings such as those of insecurity and guilt are wrong and unhelpful or right and logical, rather than whether they might be both. Here again, while the two messages do not have to contradict one another—post-war understandings can be reasonable and simultaneously unhelpful—they can become an actual contradiction when they are each presented in separate interventions as an unequivocal message. This paradox indeed seems to be unaddressed in the formal institutional narrative. Again, such narrative silence may make soldiers feel they are told that their struggles are just in their heads, which can be experienced as a denial of the truth of what a soldier has seen and done, and the painful but real change in knowledge this has brought about.

Implications for Conceptions and Interventions Concerning PTSD

Barriers to Care and the Limits of 'PTSD'

The conflicts within and between institutional and personal narratives can help to understand the complaints soldiers have about some PTSD-interventions, and deepen our understanding of care-avoiding behavior. On the one hand, there is the PTSD-message that violence is abnormal and psychological problems normal. But this message can be felt as a denial of the other institutional message that the soldier has learned to embody: that violence is normal, or even the norm, and that

psychological problems are abnormal, or even taboo. The same goes for the message that perceiving the world as dangerous and unjust is mainly a matter of mindset or dysfunctional thinking, with the solution of seeing the civilian world as safe and just again. While soldiers will recognize that to an extent they can change their mindset, an uncomplicated focus on subjective interpretation may feel as a denial of how deployment events can radically change people, including their perceptions of the civilian world.

A feeling that official PTSD-messages do not deal with the soldier's paradoxical reality—a reality that is part and parcel of the military world—may contribute to the lack of trust and confidence in mental health care that other studies have found to prevail, and to perceptions of several PTSD-interventions as rubbish. That is, a soldier may feel that some messages conveyed by PTSD-interventions do not correspond to their experiences.

The narrative analysis also has implications for understanding PTSD itself, or rather that which is labeled as PTSD. It becomes clear that soldiers' struggles can contain aspects of moral meaning-making—what is (ab)normal, what is (un)just—and that these aspects are of a social nature. However, the current PTSD-interventions appear to deal too little with these social and moral elements of soldiers' problems. Based on the dominant scientific PTSD-model, the PTSD-interventions address the individual soldier, but not the military environment. The paradoxical military world itself shapes particular and conflicting meanings of violence and its psychological consequences, and thus shapes the problems that are called PTSD, but the current PTSD-interventions fail to take this into account. To be sure, clinical concepts cannot take every single aspect of an individual's life struggles into account. But it appears that the PTSD-concept *is* currently employed to deal with it all: socially and morally shaped emotions such as guilt and shame *are* encompassed, but translated instead into problems lying in the individual soldier.

By 'explaining away' certain elements of a soldier's problems, PTSD-interventions may even hinder the process of healing, and instead become additional social and moral factors with which the soldier struggles. As stated above, narratives are crucial for structuring one's experiences and making sense of them. Typical for PTSD is that the overwhelming nature of traumatic experiences can make those experiences initially 'unspeakable': incapable of being turned into narrative. Neurobiological research is currently providing valuable insights into the role of neurological malfunction in the difficulties some people have in describing traumatic events (Hull 2002). But a sole focus on neurological and psychological responses risks overlooking the importance of the social environment in constructing narratives. A lack of available narratives in which soldiers can recognize their experiences can contribute to the unspeakability of traumatic memories. The concept of PTSD, as found in PTSD-interventions, constitutes the dominant, if not only, narrative of post-war suffering. When soldiers feel that this narrative distorts their reality, and when they hear no other narrative that resonates with their personal experiences, it can become incredibly difficult finding words to express their experiences to others and even to themselves. This can seriously complicate their ability to articulate and make sense of their experiences: to turn 'prenarrative' traumatic memory into narrative as a way of healing.

Conclusion and Reflection

This preliminary literature study explored several of soldiers' notions on violence and mental health, and the ways in which they relate to such institutional notions. The findings have implications for the practice of mental health interventions as well as our understandings of PTSD as such.

The narratives that are reflected and produced in military PTSD-interventions may both shape and conflict with soldiers' personal experience. This seems partly due to the fact that the institutional narratives are to some extent internally contradictory with regard to the meanings of violence, psychological suffering, and soldierly transformations. Since the different messages are conveyed in isolation from one another, namely in different interventions, it seems that the narrative contradictions are not explicitly acknowledged. As such, the PTSD-narrative can give soldiers the feeling that important elements of their problems are not taken into account, or that they are translated into an individual problem. If so, soldiers then hear no narrative through which they can understand and articulate their experiences and potential inner struggles about the meaning of these experiences.

This also has implications for our understandings of PTSD. Post-war suffering involves processes of giving meaning to stressful experiences and to the psychological struggles that may follow, which is of a social and moral nature. The dominant PTSD-concept tends to individualize the social and moral, which may be experienced as explaining away. 'PTSD' then not only seems too limited in considering soldiers' problems, but also seems to explain too much.

These findings call for more empirical research into both PTSD-interventions and the personal narratives of soldiers. This article is based on the literature study and has only focused on two of the many elements in institutional and personal narratives. Empirical research dedicated to this subject will help to gain more insight into soldiers' experiences of their well-being as well as into their perceptions of current mental health interventions. Moreover, it will help to better understand how soldiers and other military actors in practice co-construct meaning and negotiate and contest over meaning. Indeed, the reality of narrativity is inevitably more complex in social (inter)action than in the messages that are conveyed in written texts (see e.g., Mattingly 1994).

This article did reveal the necessity of more attention to the scholars who deal with social and moral factors in soldiers' problems. One of them is psychiatrist Shay and Jonathan (2010), who analyzes how experiencing 'evil' can radically transform a soldier. In doing so, he pays attention to the role of the military and societal environment in experiences of betrayal among soldiers. Shay uses the concept of 'moral injury' to depict this phenomenon. A small number of psychologists have taken up this concept for further examination (Litz et al. 2009). They argue that current PTSD-models deal too little with shame and guilt. However, most of them again do not deal with the *social* nature of moral emotions such as guilt, betrayal, and shame. A second important scholar who, like Shay, does deal with the social aspects of moral struggles is psychiatrist Lifton (2005). Already during the Vietnam war, Lifton describes the struggles of veterans who have seen and done things in the

context of war, which they come to experience as absurd and sometimes immoral. At the same time, these experiences of violence are rationalized and justified by the military, military psychiatrists, and society at large, which the soldiers experience as 'counterfeit.' Lifton calls attention to the social, political, and moral factors in soldiers' suffering, which he locates not just 'over there,' in the war, but also in the home country of soldiers. It is striking that Lifton was a key figure in the introduction of PTSD into the DSM, yet his findings dealing with the social and the moral at the level of the larger body politic seem to have disappeared.

Because important aspects of soldiers' suffering lie in factors that go beyond the individual soldier, its preventive and reactive interventions should also be focused on that. The findings in this article already hinted at one suggestion for PTSD-interventions. The conflicts in institutional narratives cannot be eliminated. On the contrary, they point to the paradoxical nature of the military and of being a soldier. Violence is normal and abnormal at the same time; psychological problems are against the norm and simultaneously normal; becoming a soldier requires altering one's worldview, while switching between mindsets is also important. Society's values and political demands undeniably contribute to the paradoxical meanings of violence and suffering, but the paradox seems inherent to the military world. One could say that the military itself is caught in a 'struggle' with violence and suffering. Any effort to narratively smoothen out such conflicts can contribute to feelings of alienation among soldiers. Perhaps one way to make soldiers feel recognized in their struggles is to acknowledge the paradoxes of the military world.

Compliance with Ethical Standards

Conflict of interest Tine Molendijk declares that she has no conflict of interest. Eric-Hans Kramer declares that he has no conflict of interest. Désirée Verweij declares that she has no conflict of interest.

Ethical approval This article does not contain any studies with human participants or animals performed by any of the authors.

References

Adler, Amy B, Roos Delahaij, Suzanne M Bailey, Carlo Van den Berge, Merle Parmak, Barend van Tussenbroek, José M Puente, Sandra Landratova, Pavel Kral, Guenter Kreim, Deirdre Rietdijk, Dennis McGurk, and Carl A Castro
2013 NATO Survey of Mental Health Training in Army Recruits. Military Medicine 178(7): 760–766.

American Psychiatric Association
2013 The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition: DSM 5. Arlington, VA: American Psychiatric Association.

Ben-Zeev, Dror, Patrick W. Corrigan, Thomas W. Britt, and Linda Langford
2012 Stigma of Mental Illness and Service Use in the Military. Journal of Mental Health 21(3): 264–273.

Boermans, Sylvie, Roos Delahaij, Hans Korteling, and Martin Euwema
2012 High-Risk Environments: Towards a Strength-Based Approach within the Military. *In* International Handbook of Workplace Trauma Support. Rick Hughes, Andrew Kinder, and Cary L. Cooper, eds., pp. 313–322. John Wiley & Sons.

Bouma, Kaya, Charlotte Waaijers, and Leonie Sellies
2014 "Je Bent Veilig Terug, Waar Zeik Je Nog Over" ["You Are Back Safely, What Are You Nagging About"]. Volkskrant, April 26.
Bourke, Joanna
1998 Disciplining the Emotions: Fear, Psychiatry and the Second World War. *In* War, Medicine and Modernity. Roger Cooter, Mark Harrison, and Steve Sturdy, eds., pp. 225–238. Thrupp, Stroud: Sutton Publishing.
Cardona, Robert Andrew, and Elspeth Cameron Ritchie
2007 US Military Enlisted Accession Mental Health Screening: History and Current Practice. Military Medicine 172(1): 31–35.
Casey, George W.
2011 Comprehensive Soldier Fitness: A Vision for Psychological Resilience in the U.S. Army. American Psychologist 66(1): 1–3.
Cohn, Joseph, Gershon Weltman, Raj Ratwani, Don Chartrand, and Rollin McCraty
2010 Stress Inoculation through Cognitive and Biofeedback Training. Arlington, VA: Office of Naval Research.
Dehue, Trudy
2011 "Ik Maak Drukte Want Ik Ben Een Druktemaker". De Medicalisering van "Ongewenst Gedrag". ['I Make Trouble Because I Am a Troublemaker'. The Medicalization of "Unwanted" Behavior'.]. De Groene Amsterdammer, November 3: 30–33.
Difede, JoAnn, Megan Olden, and Judith Cukor
2014 Evidence-Based Treatment of Post-Traumatic Stress Disorder. Annual Review of Medicine 65: 319–332.
Eidelson, Roy, Marc Pilisuk, and Stephen Soldz
2011 The Dark Side of Comprehensive Soldier Fitness. American Psychologist 66(7): 643–644.
Fassin, Didier, and Richard Rechtman
2009 The Empire of Trauma: An Inquiry Into the Condition of Victimhood. Princeton, N.J.: Princeton University Press.
Faust, David, and Richard A Miner
1986 The Empiricist and His New Clothes: DSM-III in Perspective. The American Journal of Psychiatry 143(8): 962–967.
Finley, Erin P.
2009 Fields of Combat: Understanding PTSD Among Veterans of Iraq and Afghanistan [Ph.D. dissertation]. Department of Anthropology, Emory University.
Good, Byron J.
1994 Illness Representations in Medical Anthropology: A Reading of the Field. *In* Medicine, Rationality and Experience: An Anthropological Perspective. B. J. Good, ed., pp. 25–64. Cambridge University Press.
Hautzinger, Sarah, and Jean Scandlyn
2013 Beyond Post-Traumatic Stress: Homefront Struggles with the Wars on Terror. Walnut Creek, CA: Left Coast Press.
Herman, David, Manfred Jan, and Marie-Laure Ryan
2005 Routledge Encyclopedia of Narrative Theory. New York: Routledge.
Hoge, Charles W, Carl A Castro, Stephen C Messer, Dennis McGurk, Dave I Cotting, and Robert L Koffman
2004 Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care. New England Journal of Medicine 351(1): 13–22.
Hooyer, Katinka
2012 Going AWOL: Alternative Responses to PTSD Stigma in the US Military. Field Notes 4(1): 106–128.
Hull, Alastair M
2002 Neuroimaging Findings in Post-Traumatic Stress Disorder Systematic Review. The British Journal of Psychiatry 181: 102–110.
Iversen, Amy C, Lauren van Staden, Jamie H Hughes, Neil Greenberg, Matthew Hotopf, Roberto J Rona, Graham Thornicroft, Simon Wessely, and Nicola T Fear
2011 The Stigma of Mental Health Problems and Other Barriers to Care in the UK Armed Forces. BMC Health Services Research 11(31): 1–10.

Jones, Edgar, KC Hyams, and Simon Wessely
2003 Review: Screening for Vulnerability to Psychological Disorders in the Military: An Historical Survey. Journal of Medical Screening 10(1): 40–46.
Jones, Edgar, and Simon Wessely
2007 A Paradigm Shift in the Conceptualization of Psychological Trauma in the 20th Century. Journal of Anxiety Disorders 21(2): 164–175.
Jong, De, and TVM Joop
2005 Commentary: Deconstructing Critiques on the Internationalization of PTSD. Culture, Medicine and Psychiatry 29(3): 361–370.
Kamp, Ellen, and Olaf Binsch
2012 Serious Gaming and Bio Physiology as a "Way In" for Resilience Training. Paper Presented at the 54th International Military Testing Association Conference, Dubrovnik, Croatia, November 5-9.
Kienzler, Hanna
2008 Debating War-Trauma and Post-Traumatic Stress Disorder (PTSD) in an Interdisciplinary Arena. Social Science & Medicine 67(2): 218–227.
Kim, Paul Y, Jeffrey Thomas, Joshua Wilk, Carl Castro, and Charles Hoge
2010 Stigma, Barriers to Care, and Use of Mental Health Services Among Active Duty and National Guard Soldiers After Combat. Psychiatric Services 61(6): 582–588.
Kleinman, Arthur, K
1988 The Illness Narratives: Suffering, Healing, and the Human Condition. New York: Basic Books.
Lifton, Robert J
2005 Home from the War: Learning from Vietnam Veterans. New York: Other Press.
Litz, Brett T, Nathan Stein, Eileen Delaney, Leslie Lebowitz, William P Nash, Caroline Silva, and Shira Maguen
2009 Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy. Clinical Psychology Review 29(8): 695–706.
MacLeish, Kenneth T
2013 Making War at Fort Hood: Life and Uncertainty in a Military Community. Princeton, N.J.: Princeton University Press.
Martens, Wil, and Ad Zijlmans
2003 Psychological Support Pre- During and Post-Deployment. Amersfoort: Dutch Department of Defense.
Mattingly, Cheryl
1994 The Concept of Therapeutic 'Emplotment'. Social Science & Medicine 38(6): 811–822.
Meichenbaum, Donald
2011 Resilience-Building as a Means to Prevent PTSD and Related Adjustment Problems in Military Personnel. *In* Treating PTSD in Military Personnel: A Clinical Handbook. Bret A Moore and Walter E Penk, eds., pp. 325–344. New York: Guilford Press.
MGGZ
2008 De Overgang van Uitzendgebied naar Thuis [The Transition from the Deployment Area to Home] [Instruction Guide]. CDC/BGGZ/MGGZ/Zorglijn Uitzendingen, Dutch Department of Defense.
Morse, Stephen J
2008 Vice, Disorder, Conduct, and Culpability. Philosophy, Psychiatry, & Psychology 15(1): 47–49.
Mulligan, Kathleen, Nicola T Fear, Norman Jones, Helen Alvarez, Lisa Hull, Ulrike Naumann, Simon Wessely, and Neil Greenberg
2012 Postdeployment Battlemind Training for the U.K. Armed Forces: A Cluster Randomized Controlled Trial. Journal of Consulting and Clinical Psychology 80(3): 331–341.
Mulligan, K, NT Fear, N Jones, S Wessely, and N Greenberg
2011 Psycho-Educational Interventions Designed to Prevent Deployment-Related Psychological Ill-Health in Armed Forces Personnel: A Review. Psychological Medicine 41(4): 673–686.
Nash, William P, Caroline Silva, and Brett Litz
2009 The Historic Origins of Military and Veteran Mental Health Stigma and the Stress Injury Model as a Means to Reduce It. Psychiatric Annals 39(8): 789–794.
Nesse, Randolph, and Dan Stein
2012 Towards a Genuinely Medical Model for Psychiatric Nosology. BMC Medicine 10(5): 1–9.
Perilla, Julia L, Fran H Norris, and Evelyn A Lavizzo
2002 Ethnicity, Culture, and Disaster Response: Identifying and Explaining Ethnic Differences in

PTSD Six Months After Hurricane Andrew. Journal of Social and Clinical Psychology 21(1): 20–45.
Pilgrim, David
2011 The Hegemony of Cognitive-Behaviour Therapy in Modern Mental Health Care. Health Sociology Review 20(2): 120–132.
Radden, Jennifer
1994 Recent Criticism of Psychiatric Nosology: A Review. Philosophy, Psychiatry, & Psychology 1(3): 193–200.
Robins, Richard, W., Samuel Gosling D., and Kenneth Craik H.
1999 An Empirical Analysis of Trends in Psychology. American Psychologist 54(2): 117–128.
Rona, Roberto J, Kenneth C Hyams, and Simon Wessely
2005 Screening for Psychological Illness in Military Personnel. Jama 293(10): 1257–1260.
RTO
2000 Officer Selection. Papers Presented at the RTO Human Factors and Medicine Panel, Montery, USA, November 9-11.
Schipholt, Ingrid L.E.
2007 Sommigen Voelen Nu Nog Niks, Anderen Huilen [Some Still Feel Nothing, Others Cry]. Medisch Contact 19: 816–818.
Scott, Wilbur J
1990 PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease. Social Problems 37: 294–310.
Sharpley, JG, NT Fear, N Greenberg, M Jones, and S Wessely
2008 Pre-Deployment Stress Briefing: Does It Have an Effect?. Occupational Medicine 58(1): 30–34.
Shay, Jonathan
2010 Achilles in Vietnam: Combat Trauma and the Undoing of Character. New York: Simon and Schuster.
Steenkamp, Maria M., William P. Nash, and Brett T. Litz
2013 Post-Traumatic Stress Disorder. Review of the Comprehensive Soldier Fitness Program. American Journal of Preventive Medicine 44(5): 507–512.
Stein, Dan J, Soraya Seedat, Amy Iversen, and Simon Wessely
2007 Post-Traumatic Stress Disorder: Medicine and Politics. The Lancet 369(9556): 139–144.
Sturken, Marita
1998 The Remembering of Forgetting: Recovered Memory and the Question of Experience. Social Text(57): 103–125.
Suarez, Eliana Barrios
2013 Trauma in Global Contexts: Integrating Local Practices and Socio-Cultural Meanings into New Explanatory Frameworks of Trauma. International Social Work 6: 1–13.
Summerfield, Derek
1999 A Critique of Seven Assumptions Behind Psychological Trauma Programmes in War- Affected Areas. Social Science & Medicine 48(10): 1449–1462.
2000 War and Mental Health: A Brief Overview. British Medical Journal 321(7255): 232–235.
Vermetten, Eric, Greenberg, Neil, Boeschoten, Manon, Delahaije, Roos, Jetly, Rakesh, Castro, Carl, and McFarlane, Alexander
2014 Deployment-Related Mental Health Support: Comparative Analysis of NATO and Allied ISAF Partners. European Journal of Psychotraumatology 5.
Wool, Zoë H
2012 On Movement: The Matter of US Soldiers' Being After Combat. Ethnos 78(3): 403–433.
Wool, Zoë Hamilton
2011 Emergent Ordinaries at Walter Reed Army Medical Center: An Ethnography of Extra/Ordinary Encounter. Toronto: University of Toronto.
WRAIR Land Combat Study Team
2006 Battlemind Training I: Transitioning from Deployment to Home [Instruction Guide]. http://www.ptsd.ne.gov/pdfs/WRAIR-battlemind-training-Brochure.pdf, accessed February 20, 2015.
Yehuda, Rachel
1999 Biological Factors Associated With Susceptibility to Posttraumatic Stress Disorder. Canadian Journal of Psychiatry 44: 34–39.

Yehuda, Rachel, and Linda M Bierer
2007 Transgenerational Transmission of Cortisol and PTSD Risk. Progress in Brain Research 167: 121–135.
Young, Allan
1997 The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder. Princeton, N.J.: Princeton University Press.
Zaidi, Lisa Y, and David W Foy
1994 Childhood Abuse Experiences and Combat-Related PTSD. Journal of Traumatic Stress 7(1): 33–42.