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Breaking Ranks: How Medically Released Canadian Military Veteran Men Understand the PTSD Diagnosis

RESEARCH

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ABSTRACT

This paper examines posttraumatic stress disorder (PTSD) among veterans through the lens of hegemonic military masculinity (e.g., emotional toughness, strength, courage) as the overarching social ecology of military life in which mental distress is experienced by service members. Three themes emerged from a focus group with medically released Canadian veteran men: (a) PTSD as a medically decided injury among male soldiers reporting mental distress is experienced as more than an individual or medical problem, but as a social problem—a form of "breaking ranks" with fellow soldiers; (b) the PTSD diagnosis creates intrapersonal and interpersonal dilemmas for medically released veterans that are directly a result of hegemonic military masculinity norms; and (c) veteran efforts to restore accepted masculinity, including resistance to a PTSD label, underpin their relationships with veteran peers and family members. We argue that applying a medical diagnosis of PTSD ignores the social ecology of military life and further erodes treasured masculinized identities among distressed service members. By recasting them as injured patients, male soldiers are separated from accepted demonstrations of masculine agency in re-establishing themselves as worthy members of the military institution. The analysis of veteran men's first-hand narratives speaks to the importance of understanding military/veteran PTSD diagnoses within the gendered social ecology of military life. The results of this study can facilitate an understanding of how hegemonic military masculinity, medical regulatory policies, and relational and individual processes within the military interact to shape experiences of injury for military and veteran men.

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The social ecology of military life centers on hegemonic masculinity. According to Connell (1987), hegemonic masculinity is defined in opposition to femininities and subordinated masculinities and is central to the maintenance of practices that institutionalize men's dominance over women. As a gendered phenomenon, the emotionally tough, strong, and courageous soldier norm of masculinity is co-created with other male soldiers (we are using the term "soldier" generically to refer to military service members across elements). Yet, hegemonic masculinity is also tenuous. Accepted masculinity must be demonstrated repeatedly through specific acts and following expected behavioural norms (Callaghan, 2014; Shields et al., 2017). While these qualities may be useful and even required in certain contexts (e.g., warzones), soldiers who "break ranks" by demonstrating failures to overcome distress threaten institutionalized masculinity (Gray, 2015; Landry, 2016; Whitworth, 2008). These men must re-establish trustworthiness by re-asserting self-control, or they end up being removed from service in the interests of the military institution (Russell & Figley, 2021).

Paradoxically, the diagnosis and treatment of traumatized military members and veterans recasts central features (e.g., emotional avoidance, rigid behaviours, rumination over perceived errors) of the idealized warrior as cardinal features of posttraumatic stress disorder (PTSD). We argue that applying a medical diagnosis of PTSD ignores the social ecology of military life and further erodes treasured masculinized identities among distressed soldiers. By recasting them as injured patients, male soldiers are separated from accepted demonstrations of masculine agency in re-establishing themselves as worthy members of the military institution.

We contrast the accepted medical view of PTSD as a problem of brain dysfunction with conceptualizations, which argue that mental health issues are a consequence of complex, layered social, and individual factors. The medical perspective presumes that all psychopathology is caused by malfunctioning brain structures, neurotransmitters, genetics, and endocrine systems, similar to physical problems like type 1 diabetes or Down syndrome. In the case of PTSD, overwhelming, unexpected events are believed to damage key brain processes and structures associated with memory and physiological arousal (Jones & Moller, 2011; Yehuda et al., 1991). The goal of recommended medication and technical solutions is a rebalancing of disrupted brain neurochemistry and the management of symptoms (Alexander, 2012; Schumacher et al., 2018). Persistent criticisms, however, portray this perspective as mechanistic and reductionistic—ignoring the context of people's experiences (Ledoux, 2015; Lieberman, 2013). Indeed, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5) has acknowledged that in the absence of clear biological markers, it is not possible to separate normal and pathological reactions (American Psychiatric Association [APA], 2013).

By contrast, a social determinants of mental health perspective prioritizes experiences across the life span as central to the genesis and prognosis of physical diseases and mental problems. Here, even though psychological distress can lead to temporary biological changes through epigenetic adaptations and brain neuroplasticity, impaired biology is not a root cause (Compton & Shim, 2015; Sapolsky, 2017). In fact, the World Health Organization (2008) proclaimed that informed healthcare policies must move beyond a pathology focus and begin addressing specific conditions (e.g., deprivation, violence, and discrimination) into which we are born, grow, work, live, and age. The focus is on reducing/eliminating environmental demands. This social determinants of mental health perspective serves as our starting point for an exploration of the social ecology of Canadian military life in understanding PTSD among veterans.

During the 1990s in Canada, as elsewhere, institutional shifts contributed to the acceptance of the PTSD diagnosis to explain the difficulties of distressed military members (e.g., suicides, violence, and substance abuse) returning from overseas deployments, including Somalia, Rwanda, Bosnia, and Iraq (see Taylor et al., 1998). Since then, tens of thousands of Canadian military members and veterans, combat and non-combat experienced, have been diagnosed with PTSD leading to renewed public and research interest in military/veteran PTSD (e.g., Fulton et al., 2015). Dominant approaches to the study of PTSD among veterans view it primarily as a medical and individual problem. The scholarly literature tends to portray traumatized military members and veterans as patients, with little room for acknowledging their perspectives, agency, or social context. Biomedical models, in particular, categorize mental distress, including PTSD, as neurobiological disorders recognizable in the DSM, and in isolation from an individual's social and cultural context (Ledoux, 2015; Lieberman, 2013).

Interventions in the field of Critical Military Studies have questioned the medical framing of veteran research, and the subsequent objectification of veterans. Bulmer and Jackson (2016) have argued that leading research methods neglect the first-hand voices of veterans by prioritizing medical descriptions of injury that can be dealt with according to algorithms and set protocols. Indeed, through the practice of othering (see McIntosh, 2021)—redefining distressed soldiers as incompetent patients—the military may unwittingly cause additional distress through narcissistic wounding (Dalal, 2020). Russell and Figley (2021) are blunt in their appraisal: Military responses to PTSD (e.g., shaming,

ridiculing, and releasing members from service) represent institutional self-preservation tactics to purge perceived weakness. A PTSD diagnosis creates a sharp divide between the experiences of military members and veterans and their external environments (Bulmer & Jackson, 2016; Fox & Pease, 2012). A purely medical approach, we argue, ignores the social ecology of military life, and removes considerations of military wide inclusivity approaches and unit level responses to distressed soldiers that could head-off downstream consequences.

This paper draws on original research conducted in the Canadian context to offer an analysis of military/veteran PTSD by examining the experiences and perspectives of a group of veteran men. We believe that our approach can provide an important contribution towards a more holistic social science based and culturally informed understanding of PTSD in the context of veteran health research. We do not dismiss the fact that a PTSD diagnosis can legitimize soldier distress and pave the path for necessary treatment. However, the goal of our research was to foreground the voices of veterans by asking:

- How do veteran men experience and understand injuries such as PTSD?
- How do they describe dealing with notions of mental injury and diagnostic labels?
- What paths do they see for moving towards healing?

Our study found that living with a diagnosis of PTSD has profound impacts on the identity of our participants. Among these medically released veterans, PTSD is experienced as a consequence of "breaking ranks" with hegemonic masculine values by expressing or disclosing their inability to overcome distress (Landry, 2016). Thus, we argue that resolving PTSD encompasses more than a medical and individual diagnosis and has profound implications for how the military institution interprets and responds to member distress following deployments.

BEYOND PATHOLOGIZATION: A MILITARY CULTURAL APPROACH TO MILITARY/VETERAN PTSD

The Canadian military, as militaries elsewhere, has seen its demands on serving members and their families dramatically increase in the post-Cold War period (Howell & Wool, 2011; Norris et al., 2015). Medical releases were rare before the 1990s, but by 2006, at the height of Canada's war in Afghanistan (2001–2014), 25% of military members were releasing for medical reasons (Aiken & Buitenhuis, 2011). It was in this context that PTSD gained momentum as a major concern in Canadian practice and research (Boulos & Zamorski, 2013; Montgomery, 2017). Recent studies have shown that Canadian Armed Forces members who released after 1999 have more mental health diagnoses than veterans of earlier eras and the general Canadian population (Thompson et al., 2016). Findings from Veterans Affairs Canada's *Life After Service Studies* (*LASS 2016*; Van Til et al., 2017) showed that 14% of veterans who released from service between 1998 and 2015 live with a diagnosis of PTSD. Over 65% of Canadian veterans who served between 1998 and 2007 and received government benefits from Veterans Affairs Canada are diagnosed with PTSD (Thompson et al., 2011). As these numbers show, there is an urgent need to understand the challenges and needs of Canadian veterans diagnosed with PTSD.

PTSD is widely recognized as a psychiatric disorder based on its introduction in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), a nosological classification system maintained in the current, fifth edition (APA, 2013). In keeping with the DSM, beginning in the 1990s, the Canadian military began to reconceptualize post-deployment distress among military members as a medical disorder caused by specific traumatic warzone exposures and characterized by particular symptom clusters (e.g., re-experiences of trauma, avoidance of distressing memories, negative cognitions and moods, and hyperarousal; Veterans Affairs Canada [VAC], 2019). The evidence-supported approaches to treatment by the Department of National Defence and Veterans Affairs Canada emphasized medication management and cognitive behavioural therapies (CBT), Prolonged Exposure (PE), and Cognitive Processing Therapy (CPT) along with Eye Movement Desensitization Reprocessing (EMDR). However, concerns over lackluster outcomes from these interventions has led to a revival of interest in psychedelic drug treatments as a possible way forward in the treatment of PTSD (e.g., Luoma et al., 2020; Thomas et al., 2017).

While PTSD is widely recognized as a medical problem, its conceptualization is contested within the health sciences. Prominent academic researchers (e.g., Davidson & Begley, 2012; Ledoux, 2015; Lieberman, 2013; Porges, 2011) have argued that neurobiological explanations of PTSD are based on incorrect assumptions about the role of structural damage to key brain regions. Other critics describe PTSD as "faddish" by pathologizing normal distress (Duckworth & Follette, 2012) and ignoring the impacts of institutionalized military masculine norms (Fox & Pease, 2012; Jakupcak et al., 2006). Mobbs and Bonanno (2018) contend that

moral injuries (defined as reactions to perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations; Maguen & Litz, 2012) and transitional strain (e.g., loss of military identity; Whelan & Eichler, 2019) are the main sources of mental distress facing military veterans, not PTSD.

There is also a growing social science literature on military/veteran PTSD extending beyond medical considerations and conceptualizing the causes of soldier distress as predictable by-products of the social ecology of military life (e.g., group rejection for failing to live up to military ethos). This literature emphasizes the social construction and lived experience of mental health diagnoses such as PTSD (Finley, 2011; Wool, 2013). The meaning of PTSD is not only socially constructed, but often contested, as public policy debates on prevalence rates and the framing of PTSD have shown (Fisher, 2014; Purtle, 2016). Gender and gendered military culture are also recognized as central in shaping understandings and experiences of PTSD (Christiansen & Burke, 2020). Fox and Pease (2012) and Shields et al. (2017) argued that men experience trauma as a fall from grace for failures to conform to masculine ideals. Other scholarship has shown that while aspects of military hegemonic masculinity contribute to emotional distress and lack of help seeking, other aspects of military hegemonic masculinity such as camaraderie and caring can act as protective factors (Caddick et al., 2015; Green et al., 2010). These examples of social science scholarship underscore the importance of understanding PTSD not simply as a medical problem, but as a military culture problem where soldier distress is constructed in certain ways. In particular, medical understandings of trauma deemphasize elements of the social ecology of military life that quash legitimate reactions to distressing experiences (e.g., witnessing atrocities, the death of comrades, inability to offer assistance because of restrictive rules of engagement, requirements to remain silent over operational errors that caused death or injury).

In this paper we aim to contribute to the emerging body of literature that employs a social science approach to examining PTSD among military veterans. Our unique contribution lies in foregrounding the social ecology of hegemonic masculine military life in interpreting the results of our focus group with medically released veteran men diagnosed with PTSD. In doing so, we respond to the calls from other scholars for a less pathology focused and a more social understanding of PTSD and its meaning.

We build on existing scholarship that has applied a social ecological approach to our area of study: Harvey's (1996) ecological view of psychological trauma and Elnitsky et al.'s (2017) ecological model of community reintegration of military service members and veterans. Harvey discussed recovery from psychological trauma as a multidimensional experience defined by person-community relationships in specific contexts. That is, trauma experiences are shaped through "the combined attributes of those communities to which s/he belongs and from which s/he draws identity" (p. 5). Elnitsky et al. conceptualized military members' and veterans' reintegration experiences within a social ecological framework, demonstrating how they are grounded in interactions between intrapersonal, interpersonal, community, and societal levels. We expand on Harvey's and Elnitsky et al.'s work to present a study of how Canadian veteran men experience PTSD in the context of their social ecology. Our approach broadens how military/veteran PTSD is predominantly understood through medical models, which, largely, consider the individual in isolation from these broader ecological factors (Caplan, 2011; Fox & Pease, 2012). The social ecological framework highlights the interdependencies between veterans' interactions with the military and medical systems and their experiences of transition out of the military. By using a social ecological framework, we highlight how the meaning of PTSD among veteran men takes shape across time and contexts: in experiences of distress during military service, in their interactions with other soldiers and the military medical system, in their interactions with the Veterans Affairs bureaucracy, and, more broadly, within military and civilian cultures.

METHOD

DATA COLLECTION AND ANALYSIS

This paper presents qualitative research, emphasizing the first-hand narratives of our study participants. Qualitative researchers rely on data containing in-depth meanings found within language, images, symbols, and social interactions. Information is collected through interviews, observations, text and discourse analyses, or ethnographies where researchers are the instrument for analysis (Starks & Brown, 2007). Ethical clearance for this study was obtained through the University Research Ethics Board at Mount Saint Vincent University. We collected first-hand narratives through a focus group with veterans living with PTSD. Participants were eligible for the focus groups if they spoke English and were at least 19 years old (age of provincial majority). Additionally, participants met inclusion criteria if they identified as the following: a Canadian Veteran who: (a) had served after 1990, (b) had released or was in the process of releasing, and (c) who was diagnosed with an operational stress injury (such as PTSD)

at least one year prior to study participation. Two members of our research team moderated the focus group, which were audio-recorded and transcribed verbatim. We imported focus group transcripts into MAXQDA computer software (VERBI Software, 2017) to organize the data and identified common themes using Braun and Clarke's (2006) 6-step thematic analysis: (a) familiarizing with the data, (b) generating initial codes, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes, and (f) producing the report.

RESULTS

The seven male veterans who participated in this study had served between 15 and 30 years. One had served in the Royal Canadian Mounted Police (RCMP), the rest in the Canadian Armed Forces. All but one veteran had been medically released. This veteran chose to voluntarily release rather than disclose a mental health issue because of his reputation and rank. Participants' narratives converged around three dominant themes: (a) PTSD as a multidimensional injury to masculine identity with multilevel impacts, (b) the dilemmas of a PTSD diagnosis in the context of changing military masculinity norms, and (c) moving forward from PTSD through (re)connection under a revised masculinity. The first two themes describe how the injury and diagnosis are understood and experienced by veterans. The third theme describes obstacles and possibilities that participants named for moving beyond an injury identity.

THEME 1: PTSD AS AN INJURY TO MASCULINE MILITARY IDENTITY AND A FORM OF "BREAKING RANKS"

Our participant narratives showed that the diagnosis of PTSD is not easily narrowed to a medical level *or* an individual level. Participants voiced deep skepticism over descriptions of PTSD as an honorable injury; instead, they saw it as hiding the military's agenda of getting rid of them: "I was a piece of shit, no good to anybody." For these veterans, imposed injury to define their distress was broader than a medical diagnosis, as it impacted their core identity as military men and their military cultural meaning-making system.

One Navy veteran described reactions to sailors for not measuring up this way: "They used to eat their young, now they just stomp on them." An Army veteran summed up military masculine identity this way: "So, you're wearing that armour, when you're in that job, regardless, if you were the number one soldier, or whatever." In this context, the men in our study reported a shared experience of a diagnosis of PTSD as a "tear down of all your fundamentals" in the sense that "the diagnosis rattles you."

Facing the diagnosis and a medical release from the military, another participant commented, "I was done; I was a piece of shit." Veterans experienced ambiguity resulting from multidimensional loss—loss of their moral code, career, financial security, certainty about the system, family status as breadwinner, independence, and masculinity. As one participant described, "I thought they would have my back and give me time to decompress, we all drank the Kool-Aid, but none of that happened." Another participant shared, "when you get diagnosed [with PTSD] people automatically think you're out of control…" And another stated, "I am still the same me as before …. But now everything gets blamed on PTSD." These veteran men fundamentally understood the PTSD diagnosis as a challenge to their military masculine identities and a loss of their former status and identity as military men. They experienced their medical release as a consequence for "breaking ranks."

THEME 2: THE DILEMMAS OF THE PTSD DIAGNOSIS IN THE CONTEXT OF CHANGING MILITARY MASCULINITY NORMS

Participants highlighted that the PTSD diagnosis comes to define them in ways that are perceived as limiting and ignores their capacities. One participant described the experience of undergoing treatment in the military for PTSD: "The biggest snag was my colleagues … now there [were] words that imply limitation floating around [me] like bees at a hive, right." These veterans described how rumor-spreading by male colleagues undermined their credibility as soldiers and as competent men. Participants described being the unbreakable, unshakeable soldiers and the threats to their established reputations by telling others that they "are a bit broken now." This represented a dilemma where the diagnosis both helped and hindered aspects of participants' daily experience and well-being. "I knew something was wrong but …. It's a label, like its tattooed." While they knew help was available, accessing care was often difficult:

> The Chain of Command is not educated. It's not educated on anything. We have DAODs [Defence Administrative Orders and Directives] but they just say well that's not how we do things here. The chain of command requires you to beg to access care.

For participants, their identity became completely defined by PTSD, "Just everything, like, everything of how you're viewed." This label can be overwhelming for veterans,

particularly as it is experienced as an identity that precludes a meaningful future, leaving them frozen in time, "I have no clue about what the future holds, you know? I'm dependent on somebody else. I can't make my own future, anymore. You know what I mean?" These accounts conflict with their adopted military masculine value system. Further, the PTSD label was viewed as stigmatizing, "When you get diagnosed, people automatically think you're out of control." Participants also viewed the PTSD label as degrading. As one participant noted," I hate the word PTSD. Or phrase, or whatever you want to call it. It should be PTSI [post-traumatic stress injury]." From another: "Well, to me a disorder is exactly what we feel, is that there's something wrong with us and we're a piece of shit and we're weak." These dilemmas of diagnosis are heightened for veterans in the context of a gendered military culture as diagnosis led to medical releases for our study participants. It was equated with failure and shame, and a loss of masculinity. As one veteran put it, "That medical release. I mean, there's so much shame involved and so much [self] blaming and feeling like a failure. You know, there's just such huge baggage with that."

Participant accounts described that formal recognition of PTSD occurred during abrupt shifts in accepted military behaviour in the mid-1990s: "You can't do this anymore." Participants discussed the implications of the military's first diversity initiative in the mid-1990s to address harassment and discrimination in federal workplaces:

> SHARP [Standard for Harassment and Racism Prevention] was a program they went through to tell us there we were, had to be nice people. You were no longer allowed to touch people, even if I, as a Chief came up and you had a hair on your uniform.

This veteran recounted that under the new policy, physically touching another member without explicit permission was prohibited: "So we're chasing, we're trying to learn, I'm trying to change myself from the old boys to over here where I'm not allowed to touch you or remove a hair from your uniform." Another referred to the consequences of "SCONDVA [Standing Committee on National Defense and Veterans Affairs] where they desegregated everything including the PMQs [Private Military Quarters]. So, like the structure, that hierarchy that wasn't there, it got lost, right." For participants these changes left them psychologically unmoored following deployments by eroding predictability and cohesion from the accepted military system. They described needing "just a little bit of structure where you can consolidate, regroup, and then just move forward."

THEME 3: MOVING FORWARD FROM PTSD THROUGH (RE)CONNECTION UNDER A REVISED MASCULINITY

Veterans needed the PTSD diagnosis in order to seek available supports, but they struggled with the implications of the diagnosis. In particular, participants noted the challenges of dealing with the Veterans Affairs Canada bureaucracy and the paperwork as well as with managing medications and treatments. The diagnosis created possibilities for moving forward, but also kept them trapped in particular identities and relationships defined by a medical narrative of illness.

Social disconnection, alienation from military culture, and erosion of confidence were common effects of living with a diagnosis of PTSD. As one participant stated: "Well, to me a disorder is exactly what we feel, is that there's something wrong with us and we're a piece of shit and we're weak." Participants spent considerable time grappling with questions about the unwelcome effects of prescribed medications. One veteran described:

> I used to look at those guys [taking prescriptions] and look at their eyes and it was almost like there was nothing … almost nothing behind their eyes … and it was like looking at a doll's eyes … Does it look like there's a soul behind them?

These veterans engaged in a lengthy discussion of medications: "Why are you on medication? Why? Because someone told you, you needed it …. Because a psychiatrist told them that they needed to be." Several participants stated that they had no choice but to submit to medications: "I was told that if you don't take these medications then you're not doing everything you can to get better … . like self-inflicted [wound]." Another described being told: "No, you either take medication or there's no help … So now, there's 29 pills per day." They described how part of moving forward meant reducing or stopping their medications. "I was completely independent …. and took pride in it. I am completely dependent now, and I hate it. I hate it with every ounce of my being." They spoke to the urgent need for help in transitioning away from military life, equated to elite athletes having to move on and how the PTSD diagnosis precludes these considerations: "We're screaming our heads off, but nobody is listening to us."

Despite the shared views about the PTSD diagnosis and medication regimes as impediments, reconnection emerged as an important theme. It is a key element that enabled these veteran men to advance their lives while living with PTSD. Most participants spoke of the importance of reconnecting with fellow injured veterans through offers

of helping them. This enabled them to re-build aspects of masculine roles by offering help to other veterans. One participant shared that he wears a patch that says, "I'm medicated. I have PTSD," and he explained why:

> So there's, you know, I don't wear it as a badge of honour; I wear it as a way to advertise treatment. There's a future … There's better than doing what a lot of our people have done in the last couple of years: suicide. There's an out. Come to me, I'll help you.

These male veterans emphasized the importance of supporting each other and being there for each other as part of their own path forward. Interestingly, the focus group itself became an opportunity for male peer connection as the veterans exchanged contact information for further meet ups beyond the study.

Some discussion arose in the focus group over how best to support fellow injured veterans. Although all veterans agreed on the importance of fostering safe spaces and connection, not all were comfortable with openly advertising their diagnosis, "I'm just not skipping down the road and, like you said, waving a flag saying, look at me." These men felt safe and valued within the community of other ex-military men to begin redefining their masculine selves in ways that emphasized empathy, support, and connection.

DISCUSSION

The results of this study suggest that abrupt changes to the military's personnel management policies in the 1990s left behind many distressed soldiers without a familiar structure to help them. The common threads linking all three of the above themes together, associated with the shift to medicalizing distress, were damaged masculine identity and the perception of being discounted as a liability. Each theme offers a different angle portraying how the designation of injury, "you're a liability to the organization," shapes identity within and across the boundaries of veterans' social-ecological system. The findings of this study portray PTSD as broader than an individual, medical problem; instead, military/veteran PTSD can be seen as a multi-dimensional by-product of hegemonic military masculine norms, impacting the identity of veteran men.

Applying a social-ecological approach to our findings brings into view how distress reactions may begin at the level of the individual veteran, yet they shape and are shaped by interactions within the military system and its gendered culture. The multifaceted loss veteran men experience leaves an uncertain identity in its wake, in part due to experiencing incongruence with long-held ideals about themselves indoctrinated vis-a-vis the military culture (Whelan, 2014, 2016). In turn, this fundamental struggle extends to social and relational challenges. Thus, military/veteran PTSD needs to be understood as systemic and involving multiple levels.

Our second theme highlights multi-directional influences between levels through accounts of struggle and tension between distressed soldiers, their comrades, and the broader military system. At the broader level, official policies dictate that diagnosis calls career paths into question and it is necessary for medically released veterans to receive benefits and services. Yet, a PTSD diagnosis also risks having to define their identities in ways that reduce their agency and ability to move forward (Wool, 2013). For example, veterans' preoccupation with continued benefits and entitlement to treatment sometimes prevents them from moving beyond the diagnosis despite making treatment progress. Veterans contend with systemic stigma associated with PTSD cultivated through ideologies embedded within military and civilian environments (Arribito & Leung, 2014; Gallagher, 2016). In the military context, entrenched stigma renders PTSD as a sign of weakness and compromised reliability due to cultural and gendered views of reliable solders. In the civilian context, veterans reported that virtually all behaviors and choices are filtered through prevailing perceptions of PTSD. Importantly, our study shows that the struggle with the bureaucracy of Veterans Affairs and the politics of entitlement and treatment extend beyond the individual veteran through continual struggles over control (Finley, 2011; Gallagher, 2016; Whelan et al., 2021). Consistent with existing research on shame and stigma (e.g., Figley et al., 2011), veterans in our study reported shame and self-blame for failure prior to their military release about the PTSD diagnosis that left them feeling isolated from their peers.

The third theme highlighted the importance of re-asserting independence by questioning medication regimes and the interdependencies between self and the broader veteran community via new connections and rebuilding severed connections. For other veterans, openly disclosing their diagnosis put them at risk for being judged harshly by other soldiers and veterans or being shunned by civilian society. Their accounts also showed how connecting with others, despite the impacts of policy, programming, and dominant military and civilian cultural norms around PTSD comes to represent how they see themselves in the world: "we are moving forward." The dialogue that surfaced

among veterans about whether to advertise their PTSD diagnosis or not alludes to the struggle with identity and with stigma. For some veterans, it was an act of resistance to diagnosis by reclaiming it as a way to move forward by helping other injured veterans. We heard accounts of informal support as veterans reach out to other veterans.

IMPLICATIONS: THE SOCIAL ECOLOGY OF MILITARY/VETERAN PTSD

Research and resources are being mobilized to respond to the mental health, and in particular, the PTSD crisis among veterans across Western countries, especially in the US, Canada, UK, and Australia. PTSD has drawn significant interest as a medical issue/condition. Less is known about PTSD as a social construct and a by-product of hegemonic military masculine norms that shape institutional responses to reported distress and gain meaning through social interactions with fellow soldiers and the military medical system. In this paper we foregrounded the social-ecological aspects of military/veteran PTSD by the very design of the study. We offered an inherently social-ecological view grounded in military cultural norms of how distress reactions, described as PTSD, are experienced subjectively and by others within their proximity. The focus group highlighted, surprisingly for us as researchers, the commonalities of repairing damaged identity among all the participants.

Our integration of a military grounded social-ecological approach has highlighted military/veteran PTSD as a multidimensional injury with multi-level impacts. This research provides an important contribution to the social sciences literature on PTSD. This study conceptualizes living with a diagnosis of PTSD as a complex, multi-directional experience. That is, this experience is molded through a web of reciprocal social, structural, political, and cultural relations that begins with the military member's experience of distress and the subsequent breaching of military cultural norms through disclosures or public expressions of distress during military service.

What do our findings mean for how we conceptualize PTSD? Understanding PTSD as a social injury highlights the importance of examining social identities and social relations in the study of health. Perceived injury leads to a fundamental requestioning of identity where diagnosis is linked to a "frozen" identity, and where moving forward is linked to remaking identity through resistance and reconnection. In sum, despite the military's efforts to embrace inclusion and diversity among its members, those who do not fit the "combative masculine warrior" image continue to be discursively constructed as substandard military members (Van Gilder, 2019).

These results also align with veteran research showing identity loss and re-building of identity upon military release (Albright et al., 2018; Bragin, 2010; Castro et al., 2014). Adding the layer of injury compounds veterans' transition from military to civilian life, as mandatory medical release is neither expected nor desired in many cases. Hegemonic military masculinity engenders a mentality of strong dependable soldiers, standing in contrast to notions of injury as perceived weakness. Consequently, veteran distress can be exacerbated by systemic reframing of their experience leading to multi-site disconnection: from the military, from family, and from civilians upon release from the military.

How can we create interventions that consider a revised military masculine culture within which distress occurs? A shift toward inclusivity, mutual support, and collaboration would embody a person-centered approach, often de-emphasized in medicalized approaches (Callaghan, 2014; Cocker & Joss, 2016; Laska et al., 2013; Resick et al., 2015; Spector-Mersel & Gilbar, 2021). Collaboration extends beyond patient-provider relationships. Although maybe not universally needed for each releasing military member, our findings highlight the value of transparent and candid communication with fellow soldiers and leaders about experienced distress without fears of rejection or ostracization before, during, after release. This would, perhaps, help military members resolve trauma distress and regroup while continuing to serve and help them maintain connection to prized military cultural identities. Ultimately, we need to seek novel ways to create conversations and connections between military members, service providers, and also policymakers. We suggest a need to tap the vast potential of military culture (e.g., camaraderie, masculine agency, and mutual caring) to mitigate trauma reactions at their source (e.g., Caddick et al., 2015). We therefore suggest a need for a revised approach in research and treatment for PTSD that goes beyond the individual and beyond medicalization to take seriously the social ecology of military life and consider remediation of military distress reactions through social reconnection.

The findings of this study are based on the experiences of a group of Canadian veteran men. While ex-military women would likely share some commonalities with these men's experiences, the findings of this study cannot be generalized to women. Women's experiences of military/veteran PTSD can be expected to be shaped by their precarious position within the military ranks, and the complex interaction between gender discrimination, medicalization, military culture, and a largely gender-blind Veterans Affairs bureaucracy in Canada (Eichler, 2021; Eichler et al., 2021).

CONCLUSION

Due to the top-down approach of current policy development practices, existing policies to support veterans do not necessarily match veterans' lived experience and are, therefore, often not able to meet their needs (Fox & Pease, 2012; Jakupcak et al., 2006). Incorporating first-hand voices directly from the veterans community, from those who live with recovery day-to-day, is vital for aligning policy with the needs of those whom they intend to support. The bottom-up approach of this study addresses this imperative and critically challenges existing societal and medical narratives of PTSD. Indeed, this study demonstrates that PTSD is experienced as more than an individual, medical condition that can be fixed solely through medical means aimed at the individual. Rather, PTSD encompasses military structure and social relations that systemically permeate across multiple environments including military culture, home, and community.

We also need to recognize the dilemmas that arise out of diagnosis for veterans seeking to transition from military to civilian life: PTSD can become an identity that keeps them frozen in time. Veterans require medical diagnoses to receive services and benefits, but at the same time, paradoxically, they find themselves defined by PTSD to such an extent that it becomes a new imposed identity. As we found in this study, identities need to be redefined and relationships renegotiated between veterans, their peers, and their supportive others in the course of dealing with PTSD as injury and moving towards recovery.

Our data collection strategy represents a strength of this study as it is grounded in a military cultural vantage point in understanding the experience of PTSD. In addition, our bottom-up approach allows those who live the experience day-to-day to describe it in their own words. This approach meant taking the narratives of veterans seriously to hear how they understand and experience the diagnosis of PTSD, and how these experiences are embedded within broader military culture and medical contexts. This study demonstrates that perceived injury extends beyond individuals and beyond medicalization. We also learned that the PTSD diagnosis is paradoxically experienced: simultaneously essential for legitimizing distress but also problematic in its over-determining nature, producing specific dilemmas of diagnosis for veterans. We found that connection and reconnection are perceived as valuable pathways to healing. This study inspires not only furthering qualitative work, but also critical, participatory, and collaborative, bottom-up research approaches informed by the intersecting needs of military members/veterans and the military institution.

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COMPETING INTERESTS

The authors have no competing interests to declare.

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