

May 2015

Mentally Disordered or Culturally Displaced? How the PTSD Label Transforms Personhood in US Military Veterans

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MENTALLY DISORDERED OR CULTURALLY DISPLACED?
HOW THE PTSD LABEL TRANSFORMS PERSONHOOD IN
US MILITARY VETERANS

by

Katinka Hooyer

A Dissertation Submitted in
Partial Fulfillment of the
Requirements for the Degree

Doctor of Philosophy
In Anthropology

at

The University of Wisconsin-Milwaukee

May 2015

ABSTRACT
MENTALLY DISORDERED OR CULTURALLY DISPLACED?
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Katinka Hooyer

The University of Wisconsin-Milwaukee, 2015
Under the Supervision of Professor Paul Brodwin

Medical experts claim that Posttraumatic Stress Disorder among United States military service personnel, who served in Iraq and Afghanistan has contributed to an “epidemic of suicide” in the U.S. However, veterans, military commanders, and mental health providers argue that feelings of grief, guilt, mistrust, rage, and alienation are actually normal moral reactions to the abnormal situations that war creates. Furthermore, they argue that these normal reactions are currently transformed into a psychiatric diagnosis that promises clinical solution – a cure. Recent epidemiologic studies suggest that evidence-based clinical treatments are ineffective for a majority of veterans with PTSD and that the main barrier to seeking treatment is self-stigma by veterans. This ethnography interrogates the failure in care and vectors of blame that surround it by documenting veterans’ own critical reactions to being diagnosed and/or labeled with PTSD. These narratives provide a moment to critically examine the medicalization and commodification of trauma, as well as the bureaucratization of care, that continue

to negatively impact what I describe as veteranhood – a deep constellation of personal and military values. Everyday life for veterans becomes a clash of cultural models, worldviews and various stakeholders of their care. The lack of common ground or “cultural consonance” (versus PTSD/stigma) lies behind the social processes that contribute to veterans’ uneven reintegration into civilian life. This ethnography provides counter-narratives of emergent veteranhood that challenge the dominant cultural script of “stigma as the main barrier to care.” These narratives dismantle concepts of self-stigma by shifting the focus from the standard trauma model of victimization towards a productive veteranhood, where agency remains essential to identity and everyday life. Veterans that reframe the post-effects of war as an issue of *cultural dissonance*, as opposed to a mental disorder, are creating new personal scripts for healing that a medical anthropology and caregivers must account for. Veterans desire solutions for their distress within their communities, their culture(s), not within the confines of a medical clinic or within the categorical parameters of PTSD.

Key Words: PTSD, personhood, medicalization, stigma, military culture, OIF/OEF Veterans

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LIST OF ABBREVIATIONS

DSM	Diagnostic and Statistical Manual of Mental Disorders
DBQ	Disability Benefits Questionnaire
MOS	Military Operational Specialty
OIF	Operation Iraqi Freedom
OEF	Operation Enduring Freedom
PTSD	Posttraumatic Stress Disorder
RCT	Randomized Control Trial
TBI	Traumatic Brain Injury
VA	Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration

ACKNOWLEDGMENTS

I would like to express my special appreciation and thanks to my advisor Professor Paul Brodwin, for mentoring me, well beyond this dissertation, throughout (and in between) my degrees. Thank you for your encouragement and support in both my research and career, and for your honest and pragmatic advice in helping me make important decisions. I would also like to thank my committee members, Professor Erica Bornstein, Professor Michael Oldani, Professor Kalman Applbaum and Professor Amy Harley for providing me with helpful suggestions and advice considering their heavy workloads and multiple academic responsibilities. All of you contributed in different ways to making this huge undertaking possible for me.

I would also like to thank all the participants in this study, especially “Kurt”, “Nikki”, “Sarah”, “Armando”, “Travis”, “William” and “Jim” for taking the time and courage to entrust me with their intimate memories of war and for sharing the sacrifices they made, willingly and unwillingly, in their service to this country.

A special thank you goes to my mom, dad and brother for their unconditional support in this life goal. I would like to also express my appreciation to my partner and Iraq veteran (04-05), Tom Voss, for all those annoying times he had to eat dinner alone and pick up the domestic slack, but mostly for fielding my questions and talking through my ideas at all hours of the day and night.

The research reported herein was performed pursuant to a grant from Policy Research, Inc. as part of the U.S. Social Security Administration’s (SSA’s)

Improving Disability Determination Process Small Grant Program. The opinions and conclusions expressed are solely those of the author and do not represent the opinions or policy of Policy Research, Inc., SSA or any other agency of the Federal Government.

Chapter 1

INTRODUCTION

Does “PTSD” help veterans?

People who have never experienced war are trying to come up with symptoms and explanations for behavior that they have no concept of. That's why these medical interventions don't help.

—William, Iraq Army Vet

I don't think I have PTSD. This is just who I am now.

—Sarah, Iraq and Afghanistan Army Reserve Vet

THE POST TRAUMA PROBLEM

After over a decade of military conflict in Iraq and Afghanistan, Posttraumatic Stress Disorder (PTSD) has become our society's way of talking about the sequelae of war. But for certain veterans and their mental health providers, this diagnostic label is a faulty and inaccurate communication tool to describe the impact of war on the human psyche. Standard biomedical treatment is failing miserably (*Institute of Medicine* 2012) with suicide rates among Iraq and Afghanistan veterans far surpassing their civilian counterparts (*Army 2020* 2012). Stigma, related to veterans' fear of being perceived as psychologically weak, is identified as the main barrier to care (Schreiber and McEnany 2015).

These frontline realities are in stark contrast to the original intent of the PTSD diagnostic category created in the 1980s post-Vietnam political milieu. The intent was to alleviate the suffering of veterans through providing public acknowledgment, options for therapy, financial reparation and ultimately, reducing stigma (Young 1995). It is the failure of the current biomedical approach to heal the psychological and moral wounds of war that led me to question, how does the PTSD diagnosis help veterans? 35 years after its inception, with a new generation of veterans from Iraq and Afghanistan, has the PTSD category achieved what it set out to do? Does it help to relieve suffering? More specifically, how does the diagnosis function in veterans' lives? In other words, how does a PTSD label operate to help or hinder veterans' recovery from trauma and reintegration into civilian society? And finally, what is the relationship of stigma to these social processes?

These are critical considerations if we take into account the current "PTSD Epidemic" and the alarming numbers of military service members who, according to government estimates, will develop this mental disorder. A recent Army Report approximated that 20 percent of over two million service members who deployed to Iraq and Afghanistan will develop PTSD (*Army 2020* 2012). A more recent RAND study found prevalence rates to be slightly lower at 10-14 percent among the recently deployed (Fischer and Schell 2013). Tragically, suicide rates linked to PTSD and repeat warzone deployments have also risen dramatically for Iraq and Afghanistan veterans (enrolled in Veterans Affairs [VA] care): from 26 deaths

per 100,000 in 2006 to 38 per 100,000 in 2008 (*Army 2020* 2012). In 2012, the total amount of veterans who committed suicide in that single year eclipsed the number of soldiers killed in action in Iraq and Afghanistan since the beginning of the war, 2001 (*Losing the Battle* 2011).

Providing the proper care to this growing number of service members is a public health and policy issue, with the main challenge facing the Veterans Health Administration, an agency understaffed and ill-equipped to deal with this new and growing influx of patients (*The Waiting Wounded* 2013). In a report mandated by Congress, the Institute of Medicine reported that mental health staffing increases have not kept up with the demand for PTSD services. Additionally, only about half of service members diagnosed with PTSD seek treatment and of those upwards of half are dropping out (*Institute of Medicine* 2012). Of the portion seeking treatment, only 40 percent recover (Hoge 2011).

Epidemiologic studies suggest that barriers to treatment involve a fear of being stigmatized as psychologically weak (Hoge et al. 2004; Greene et al. 2007). “Acknowledging a problem, particularly anything associated with an individual’s mental health, is frequently perceived as admitting weakness or failure”, according to the most recent military health report *Army 2020: Generating Health and Discipline in the Force* (2012:69). In this biomedical narrative the problem of PTSD lies within the individual, in their beliefs and behaviors.

But the failure of care moves beyond getting veterans into the clinic to the actual treatment itself. In a recent presentation to the Committee on the Assessment of Ongoing Efforts in the Treatment of PTSD, by the National Intrepid Center of Excellence (serving as the US Department of Defense's Institute on research in the pathophysiology, behavior and spiritual damage resulting from comorbid mild traumatic brain injury and PTSD), researchers reported that only 46 percent of 293 patients who took part in a 4-week treatment program had clinically significant improvement. Of these patients 32 percent had minor improvement below clinically significant levels, 4 percent had no change, 14 percent had worsening of symptoms and 3 percent reported clinically significant worsening of symptoms (*NICoE* 2013).

Traditional treatment for PTSD includes psychotherapy, cognitive behavioral therapies, group therapy and pharmaceuticals. One of my ethnographic study participants, a Marine named Louis, described his routine: "I take 9 different pills to go to sleep but it is five different prescriptions and then I take an anti-depressant in the morning, and two other prescriptions at night." During the course of this study he "went cold turkey" to go off all his medications because they were making him feel "like a zombie" and he could not "be himself" around his kids. Another Marine, Kurt, could not bear to do the group therapy suggested as part of his treatment plan because he did not "want to be in a room with guys who were not grunts." Grunt is military slang for those infantry soldiers that fight on foot, engage the enemy face-to-face, and who suffer the most

casualties. Kurt could not share his experiences with those who had not seen what he had.

Even the evidence-based treatments of Prolonged Exposure Therapy (mandated by the VA), were viewed as “torture” by some veterans, who in the safety of a clinical context, were encouraged to relive their traumas to help desensitize their distressful memories. As William, an Army infantryman explained to me: “It just makes you feel even worse about yourself, talking about those personal memories that are sacred and sometimes shameful to you.” A therapist would argue that this discomfort is part of processing trauma.

Current military health research corroborates that PTSD treatments are not working for a majority of veterans. A recent survey commissioned by The American Legion found that 59 percent of veterans reported either feeling no improvement or worse, after undergoing Traumatic Brain Injury (TBI) and PTSD treatment, and 30 percent dropped out of treatment before completion (Brooks 2014). Identifying which treatments are effective is difficult since neither the US Department of Defense nor the Department of Veterans Affairs track treatment outcomes (*Institute of Medicine* 2014). However, in a meta-analysis of the efficacy of treatments for PTSD, including psychotherapies and medications, the studies with more veterans had smaller positive effects (as compared to studies with civilians or those with more women) (Watts et al., 2013).

According to Dr. Charles Hoge, of the Walter Reed Army Institute of Research, the vast majority of randomized controlled trials (RCT) that have

guided PTSD treatment, including pharmaceutical, Prolonged Exposure Therapy and Cognitive Processing Therapy, have not involved veterans. In the largest RCT to date, evaluating the use of second-generation antipsychotic risperidone in veterans with PTSD, no clinically meaningful benefits were found. The results “seriously call into question the use of atypical antipsychotics in PTSD treatment” (Hoge 2011:550) and use of medications in general that interfere with the emotional processing of grief, shame and loss that are necessary to heal from war. This is what one veteran in this study explained as “the un-raveling process.”

These grim statistics and failures of care call into question, is the problem the diagnosis? Or is it the treatment? Or does the issue lie outside of medicine altogether?

Some veterans view post-war trauma and treatment avoidance as a social problem. Take William, an Iraq veteran who deployed in 2004 and has been “processing” his PTSD for a decade now:

The VA, the doctors, they are creating this reality for veterans that they are sick and broken and that their reactions aren't normal. How do you medicalize fear? How do you medicalize grief? It's not a medical problem. My reaction to what I experienced was completely sane. Anyone would have had the same reaction to seeing the lowest humanity can revert to.

What William is implying is that the very idea of posttraumatic stress as a disorder misapprehends the experience of war and the effect these experiences have on an individual's self-understanding. In this case, PTSD is not a medical problem and the label does a disservice to those who are trying to make sense of

their suffering and of their military identity. This outcome runs counter to the good intentions behind the professional design of this diagnostic category.

PTSD TODAY: A BATTLEGROUND FOR IN/SANITY

Medical anthropologists often study the relationships between patients and the biomedical world, looking for those gaps between real life experience and clinical explanations. For many of the veterans in this study PTSD was not understood as a mental disorder but as a collection of experiences that made them who they are: military training, deployments to foreign lands and war. It was the cultural dissonance between their military experiences and their return home to the civilian world that created conflict for vets. From a biomedical perspective, this cultural dissonance is translated as “symptom criteria.”

This ethnography pushes beyond the experiences of disease symptoms and elucidates the cultural dissonance that lies behind the outcomes of PTSD diagnosis. Standard treatments are not effective because they do not fit with veterans’ core cultural values and self-understanding. I will argue that veterans’ perceived lack of common ground with civilians, rooted in society’s disconnect to the effects of war, is the main barrier to care and “getting back to normal”. More specifically, the data provide a counter-narrative to current cultural scripts of “stigma as a main barrier to care.” These findings are in critical contrast to traditional biomedical understandings and interventions that place the breakage

in post-war reintegration within the individual, as opposed to the broader society where the individual must find their place.

In the biomedical model, per the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), PTSD is defined as a trauma or stress-related disorder caused by “exposure to actual or threatened death, serious injury or sexual violation” (*PTSD Fact Sheet DSM-5 Development 2013*). With PTSD the manner in which the body responds to a stressful situation changes and chemical hormones that the body releases continue to release (the reason for this is still unknown), as opposed to returning to normal levels. According to the Center for Deployment Psychology, the neurobiological components of PTSD involve an overactivity of the amygdala and insular cortex of the brain and an underactivity of cortical regions such as the ventromedial prefrontal cortex (*Veterans on Campus 2012*).

As of the most recent DSM edition, PTSD is based on four types of symptom criteria: reliving the event, avoidance, hyperarousal and negative thoughts and feelings. Reliving the traumatic event involves flashbacks, repeated memories or nightmares, and strong reactions to situations that remind one of the trauma. Avoidance includes emotional numbing, feeling detached, unable to remember certain parts of the traumatic event, disinterest in normal activities, avoidance of places and people or thoughts that remind one of the event and feeling hopeless about one’s future. Hyperarousal includes startling easily, trouble sleeping and constantly scanning ones surroundings for danger (hypervigilance).

In 2013, with the revised DSM-5 edition, a new symptom criteria addressing negative thoughts was added. This includes constant guilt about an event, blaming others for the trauma and loss of interest in activities and other people.

In one of my first interviews with a VA Hospital psychiatrist I asked him about these symptom criteria and how they add up to a mental disorder if, in his words, “PTSD is just a normal reaction to abnormal circumstances.” He explained that all symptoms have deeper meanings attached to them:

I don't sleep well at night. Why is that? Well, because I need to get up and check the house. Why is that? For 14 months I was in Iraq and we never got a chance to feel safe. Well, that is good military training isn't that? Is that a disability? ... No, actually that is good military training.

What emerged so compellingly in the course of this research was that PTSD is not a valid form of suffering for the combat veterans in this study precisely because biomedicine reframed “good military training” into a mental disorder. Not only is it the professional skillset of soldiers, but it is also their moral values surrounding sacrifice that get transformed into a set of symptoms.

Vets were afraid that treatment would erase the memories of lost battle buddies that they held so dear. According to Jim, a Marine infantryman, “That's huge because I don't want to forget” and “basically dishonor what they have done.” A PTSD diagnosis challenged those military values of group loyalty, reverence and selfless service that defined veterans through “cheapening the sacrifice” and “diluting the memories.”

As Travis, an Army infantryman so clearly explained, “They [clinicians] don't know what it is like there so to them it is a diagnosis. To you it's your life.”

Transforming “life” into a “diagnosis” corrupted the memories that held significant meaning and defined veterans’ lives:

I don’t feel like telling someone about the people that were killed, you know, dying moments. I don’t feel people deserve to know those moments. Those were my moments. I don’t want people to take that away from me, tell me how to think about it, how to feel about it.

In the bureaucratic context of care (referring specifically to the VA with all its government mandated procedures and immense amount of paperwork), the process of diagnosis and subsequent disability compensation further reframes military experience in a manner that undermines veteran identity. But the problem extends to the public domain, where civilians are so far removed from war that the main experience of a deployment is symbolized by PTSD. As Kurt, a Marine rifleman deployed in 2004 to Iraq explains:

My service, my experience, all of that was for nothing because it [PTSD] is so talked about and so many people claim it. That’s what people ask me! Out of all the questions you can ask me you ask me that?

They don’t ask me what it was like being in another country, what the people were like and how it was not having any communication with family and being under fire, not knowing who the enemy is and if you are even going to make it through the day. What *that’s* like.

It is no wonder that veterans feel alienated from their civilian counterparts.

It is this lack of public recognition of the personal costs of war that drive many vets to seek disability compensation as a secret form of validation for their sacrifices. And it is this financial reparation that can enable opportunities to “get back to normal” upon returning home. PTSD for veterans like Kurt means an opportunity to become the person he envisions himself to become, a disability check allows him this.

In the broadest sense, for these vets, PTSD becomes the sum of the experiences that made them good soldiers and the values that make them good veterans. It is the diagnostics and treatments that tend to redefine these skills and ethos as medical disorder.

THEORETICAL UNDERPINNINGS

This dissertation draws from a broad and interdisciplinary literature and much of the research comparison and corroboration relevant to this project will be embedded directly in chapters 2-7. However, a review of the prefatory literature that directed my thinking, research questions and provided a foundation for my analysis unfolds below.

PTSD and the Function of Psychiatric Categories

It was the work of Allan Young that spurred my original research question, “Does the diagnosis of PTSD really help veterans?” Through his research, the most common anthropological understanding of PTSD is of an illness that is socially and culturally constructed, something made real through psychiatric science and practice. Young (1995), in his account of traumatic memory, questions the timelessness and universality of PTSD. He illustrates that PTSD is presented through psychiatric discourse as a “found object”, much like biological disorders such as cancer, while in fact it is a man-made thing built by therapeutic technologies, diagnostic manuals and vested groups.

In a similar manner, but through trans-cultural counter-example, Lakoff (2005) questions biomedicine's truth claims of universality by detailing how illness does not precede measurement tools (such as the DSM) but co-emerges with these diagnostic tools. In his ethnography of a Buenos Aires mental hospital and its partnership with a pharmacogenetics firm he illustrates how the emergence of psychoanalytic therapy and absence of the bipolar category operate as a form of professional resistance on political and epistemological grounds. Significantly, Lakoff argues that disease and professional expertise are not stable entities and vary according to socio-political environment. Exposing the contingencies of socio-political environments has been the focus of much social science theorizing of PTSD (and other psychiatric categories), providing a continuum of positive and negative social consequences.

Trauma and its relation to PTSD has been theorized as: (1) a process of category creation that turns political struggles into scientific debates, as in the construction of PTSD for the DSM III (Kutchins and Kirk 1997); (2) a form of activism rooted in multi-layered socio-political contexts in which advocates view the category as a tool for promoting the rights of victimized groups (Breslau 2004); (3) as a way of medicalizing distress that overlooks the connection between the individual and the social world, thereby transforming the social into the biological (Summerfield 1999; Fernando 2008) and; (4) a way for professional experts to introduce unrealistic models of personhood that redefine suffering as mental illness, denying people their moral significance (Kleinman 2006).

In contrast to some of these interpretations, PTSD is also viewed as a useful illness construct that identifies the way in which personal suffering becomes named, made sense of, and healing can begin (Finley 2011). Extending the symbolic and practical functions of a diagnosis, James (2011) illustrates how trauma, in the form of a *trauma portfolio*, becomes a form of political and monetary currency through legitimizing the suffering of political violence (but also labeling certain traumas more valid than others).

Pathologizing political violence can also be used as a form of moral resistance by psychiatrists, as in the continued diagnostic labeling of poor mental health patients in post-socialist Romania. These patients are victims of deinstitutionalization with no place to go and no social security net to rely on. Friedman (2009) shows how psychiatrists secretly label patients “social cases” in a manner that recognizes more their poverty and social abandonment than their pathologies. These patients remain institutionalized out of physicians’ moral responsibility, not medical expertise.

The political uses of trauma are further explored by Fassin and Rechtman (2009) who illustrate the practical ways in which trauma is applied to claim reparation, testimony and proof. In all these instances the focus is not so much on eliciting empathy but on claiming rights: trauma is theorized as a tool to demand justice. Rooted in these politics of self, Summerfield (2001) argues that changes in concepts of personhood have led to an individual rights-centered

culture that can lead to a need for restitution of things that used to be considered part of everyday life.

Paralleling this idea in an international humanitarian context, Argenti-Pillen's (2003) analysis of Sri Lankan idioms of distress (culturally sanctioned ways of expressing suffering) suggests that a history of civil war and youth uprisings is just representative of the violence and trauma of everyday life. She ethnographically details how the pathologizing of local customs to deal with violence, brought on by global psychiatric aid after the 2005 tsunami, undermines a peoples' biography of suffering. The implication is that pathologization destabilizes local strategies through labeling life situations as a mental disorder.

Others have argued that this medicalization of everyday experience detracts attention from broader structural and social issues, such as poverty and stigma, by individualizing illness and placing the burden of pathology on the victim (i.e. Castro and Farmer 2005; Coker 2005; Kleinman and Hall-Clifford 2009). This pathologizing of human experience has been criticized as: (1) depoliticizing illness (Scheper-Hughes 1988); (2) increasing the medicalization of everyday behavior (Kutchins and Kirk 1997); (3) a process where problematic behaviors are recast as disease (Balshem 1993); (4) an infringement on personal freedom and a strategy to control people (Szasz 1989) and; (5) as a kind of professional imperialism and economic exploitation (Summerfield 2001).

Where Does Stigma Come In?

The institutional perception of VA is that they (veterans) are coming to the treatment setting with ulterior motives.

—Dr. Luhrson, VA psychologist

I have enough working against me as a female and as an African-American, why would I tell anyone I have PTSD?

—Nikki, OIF Army Vet

PTSD is a mental disorder as defined by its inclusion in the Diagnostic and Statistical Manual for Mental Illness V, and mental disorders “probably carry more stigma than any other illness” with stigmatization being “one of the major—if not the major—obstacles to the improvement of care for people with stigmatized illnesses” (Sartorius 2007:396). Stigma, as part of the experience of PTSD, is presently linked to veterans’ avoidance of help-seeking and the main barrier to care (Schreiber and McEnany 2015). Stigma remains central to contemporary mental health scripts of combat PTSD. This ethnography questions the validity of this framing that places the blame on the individual, challenging current cultural scripts of “stigma as a main barrier to care.”

Historically, the term stigma was understood as a symbolic mark or discrediting physical attribute that branded someone as different. Through the work of American sociologist Erving Goffman (1963) stigma was reconceptualized from a symbol to a process of exclusionary social practices. Goffman’s famous book, “Stigma: Notes on the Management of Spoiled Identity” theorized stigma as a process of stereotyping where negative labels (e.g. unreliable, dangerous) are attached to a category (e.g. PTSD), distinguishing

people as dissimilar or unacceptable and thereby tarnishing their reputation. The “spoiling” of identity in this manner resulted in discrimination, loss of status and social exclusion. As a result these stigmas disqualify persons from being fully accepted by society.

This “spoiled identity” clearly emerges in the US Military’s understanding of stigma: “Stigma as defined by the Red Book is ‘the perception among Leaders and Soldiers that help-seeking behavior will either be detrimental to their career or that it will reduce their social status among their peers’” (*Army 2020 2012:69*). Military research identifies service members’ own perceptions—that depression, anxiety, and PTSD are signs of psychological weakness—as the main barrier to attaining care (i.e., Hoge et al. 2004). The fear is that one will be viewed as weak of character. In other words, self-stigma is the barrier to seeking help. Self-stigma is operationalized as the internalization of negative beliefs associated with a stigmatized condition but also the fear of being exposed to being stigmatized (Bos et al. 2013).

Recent ethnographic studies in psychology (Caplan 2011), sociology (Holyfield 2011) and anthropology (Gutmann and Lutz 2010; Finley 2011) illustrate that the PTSD label is necessary for veterans to claim benefits yet at the same time, this claiming of victimhood conflicts with the very values that military culture embraces (physical and psychological strength and group loyalty). These studies have provided rich narratives surrounding veterans' experiences and post-traumatic stress yet none specifically theorize the impact and relationship of

stigma processes. The assumption is made that psychiatric stigma is experienced similarly in military and civilian contexts, despite changes in moral, financial and political stakes. This research fills this gap through attending to the differences in stigma processes for veterans as they move out of the military context into the civilian world.

In a health-related stigma context, people resist the effects of stigma through hiding their disease status, often foregoing necessary medical treatment. The perception of stigma can be so powerful that even when services are desired and accessible, care is delayed, terminated or even avoided. This exacerbates symptoms and turns treatable (even curable) conditions into hopeless cases and premature death (Keusch et al. 2006). Mental illness stigma also has a significant and under-recognized effect on life chances, influencing employment, housing, personal relationships and health care access (Link and Phelan 2006). Stigma is that added invisible burden, which affects those with illness on multiple levels.

Since the 1960s stigma has transformed from a theoretical interest of the social sciences into a major public health issue. New conceptualizations of stigma in social psychology (Corrigan et al. 2000; Pryor and Reeder 2011), anthropology (Das 2001; Weiss 1998; Yang et al. 2007) and sociology (Link and Phelan 2001) have expanded Goffman's framework, with considerable variations on his definition, to be more practical in its application to health services research. These reformulations retain Goffman's ideas of spoiled identity and social exclusion and will be detailed further in chapters 5-7 in light of veterans and the

PTSD experience.

(NEVER LEAVING) THE FIELD

Participant observation is a cornerstone of anthropological research and typically is carried out through living with the people one is studying. Then you go home and detach for a while, process your experiences, and then start to write. The benefit of this is that the data stops coming in and maybe it becomes easier to theorize peoples' suffering. But when you share your personal and professional life with your "population" the ethnographic process is not so compartmentalized.

I did not carry out participant observation in the traditional sense. I was however immersed in numerous projects in the veteran community between 2011-2014. It began with the support and encouragement of Mark Flower at the local non-profit veteran service organization Dryhootch of America. Here I took part in and earned a 40-hour certification in peer-mentor training. Because of a lack of female peer-mentors at the time, I was asked by Dryhootch to help mentor homeless female veterans who were in transitional housing as part of the Band of Brothers and Sisters program. In this capacity I developed a summer program where I took women on outings at a local nature center and gardened with them at their transitional living space. In these locations I learned much about the challenges of leaving the military and learning a "whole new way of life."

Additionally, I took part in a weekly PTSD support group for male and female veterans for over a year. My role here, per the support group participants, was “Bear’s ride.” Bear is the biggest, furriest, friendliest therapy dog anyone could hope for and as his co-handler I was able to witness the type of wordless healing and unconditional love that only a dog can offer. Bear also allowed me to gain entry into the lives of people, over an extended and consistent period of time, who were still healing from war. As part of the peer-mentoring ethos these stories never left the room but informed my thinking about how to better conduct interviews with my research participants. It also taught me early on about the subjectivity of trauma and significance of contextualizing health services in relation to veterans’ experience of stigma or support.

Through my connections with Dryhooch of America I became involved with a Healthier Wisconsin Partnership Program, managed by Zeno Franco, PhD of the Center for Healthy Communities and Research at the Medical College of Wisconsin. This is a social and technology support project for veteran mental health where we are developing a mobile phone application and peer mentor training curriculum. The goal is to help student veterans more smoothly reintegrate into civilian life. Using a community-based participatory research approach, I get to work side-by-side with academics, clinicians, engineers and veterans to develop these new technologies.

And finally, between all these projects I become involved with an Iraq veteran with a diagnosis of PTSD. In three years of living with him he has taught

me first-hand what it means to be the domestic partner of a veteran, what PTSD means for finding ones place in the world, and what needs to happen to heal the moral injuries of war. While none of the above settings and my locations within them is specifically included in my data, they gave me the insider point of view needed to do better research: a balance of empathy and respect, the technical language, and the preferred responses that allowed me to engage in meaningful interactions with people I had absolutely nothing in common with.

Lastly, I had the honor of being a (civilian) recipient for a writer's residency with the Veterans Book Project.¹ With the support and sensitive inquiries of Monica Haller I was able to work through the emotional reactions I was experiencing in collecting war and trauma narratives. The product of this was an "Object for Deployment" entitled "Surplus Data". This small book of prose, narrative and drawings detailed my early assumptions and political transformations and allowed me the opportunity to share those parts of fieldwork that often remain buried.

ETHNOGRAPHIC METHODOLOGY

Setting

The study took place in a Midwestern city in the United States, at a local VA Medical Center, Veterans Benefits Administration (VBA) offices, VA Domiciliary (inpatient mental health care) and three local non-governmental veterans service organizations sites. Interviews with veterans took place at any location of their choice and I took care to provide options that would not create a

situation where the veteran would view the interview in hierarchical terms. Some interviews took place on VA grounds out of convenience for the veteran and ran the risk that these “patients” would view me as a healthcare professional, which I am not. Veterans had no problem however recounting negative and positive experiences with the VA despite this clinical location. Often I would meet veterans in parks, coffee houses and in private meeting rooms at the local library.

Research Design.

An ethnographic approach was utilized to explore how veterans coped with coming home from war, receiving a PTSD diagnosis and the effectiveness of this diagnosis for veterans returning home from war. The benefit of this qualitative technique over others is that it takes place in the context of participants’ lives as they are engaged in service utilization. Contextualizing the effectiveness of PTSD technologies (specifically diagnosis and disability compensation) and how these processes affected veterans’ lives allowed me to identify the nuanced ways in which a diagnosis enabled or threatened reintegration.

This ethnography combined participant observations (e.g., accompanying veterans to VA appointments), in-depth semi-structured interviews (e.g., with clinicians and VA staff), and document analysis (e.g., diagnostic screening tools and military reports). Collecting data at these three levels allows for establishment and confirmation of facts through constant comparison or

triangulation. In studying sensitive topics, participant observation provides evidence that moves beyond the strictly psychological (what people say or forget to say) to the behavioral (what people do or do not do).

As a first phase in public health services research, qualitative findings can generate hypotheses that inform larger scale research studies such as population-based surveys. The advantage of qualitative methods at this phase in inquiry was the ability to identify how a PTSD diagnosis functioned for veterans and where, when and how stigma experiences unfolded. Due to the scarcity of research in this area (Blais and Renshaw 2013), these stigma processes could not have been postulated a priori.

Participants

In order to accomplish the study objective, I carried out a prospective longitudinal study of Iraq (OIF) and Afghanistan (OEF) veterans (n=15, 10 men and 5 women) who were seeking or had a service connection (the benefits awarded for wounds sustained during military service) for PTSD. One woman who was in the Army Reserves did not pursue a service connection because of her leadership status and fear of losing that status. Two other participant groups were interviewed during this time to gain a broader understanding of institutional practices and perspectives: claims officers and patient advocates (n=7) and VA health care providers (n=7).

Recruiting for veterans was accomplished through flyers at local veteran service organizations and through network sampling. Once the study had 10 participants a stratified purposeful sampling procedure was utilized to obtain more variability on categories of interest and to provide better representation of the OIF/OEF population. These categories included: (1) PTSD diagnosis and gender; underrepresented minority groups; (2) military specialty (combat enlisted, combat officer, support enlisted, support officer) and; (3) veterans' military status (separated from military, enlisted in National Guard or Army Reserves).

Recruitment continued until n=15 to account for dropout. Serendipitously, there was great variability in participants' PTSD and disability claims status including: personal denial of PTSD status, bureaucratic denial of PTSD status, claims being re-opened, claims granted, new claims pending, and old claims being re-evaluated for an increase in rating. Four people dropped out of the study by not returning interview scheduling calls and one person, "Ella", died from drug withdrawal complications.

Of these five participants who left the study, useful data was still collected: two completed one interview and three completed two interviews. Of the remaining 10 participants (retrospective=6 and prospective=4), seven were men, six served in the infantry (combat) and one worked in support (going out to repair and reclaim vehicles after missions). Three of the participants were women (technically "noncombat" although experienced combat), two were in supply (transporting medical supplies from base to base) and one was military police. Of

this sample one was a commissioned officer in the Marines and three were noncommissioned officers in the Army or Army Reserves; three were of ethnic minority status and; two participants were still working in the military (one in the Army Reserves and another in the National Guard).

Claims officers and veterans' advocates were recruited through face-to-face meetings with leaders of veteran service organizations and through their network referrals. Four claims officers and three veterans' advocates participated (n=7). Of these, seven out of eight were veterans themselves. Recruitment of VA health care providers was accomplished through the generous support of VA clinical leaders. With this support I was able to conduct a presentation of the project at a staff meeting and recruited psychologists, a psychiatrist, a clinical psychiatric nurse, clinical nurse educator, clinical nurse social worker, and a chaplain (n=7). Over half the participants were veterans and all worked directly with OIF/OEF veterans.

Procedures

I conducted a series of semi-structured interviews with veterans focusing broadly on military experiences, coming home from war, the "PTSD experience", and then more specifically on the bureaucratic processes and personhood. I covered these topics with all veteran participants to identify variance in multiple perspectives. The claims officers and veteran advocates and VA clinicians took part in one interview lasting approximately 45 to 60 minutes (n=14). Two key

participants, a psychologist and psychiatrist were interviewed twice as a form of “member check” to test my developing theories. Each interview was transcribed verbatim and generated approximately 18 pages of single spaced text.

To identify how the PTSD label functioned for veterans and how stigma surfaced, as well as the effect of the diagnostic and disability-rating process on their everyday life, I conducted a series of four interviews that were administered over 24 months (n=30). Four sets of interviews generated a lot of data and the first phase of interviews functioned more as an ice-breaker that allowed me to establish a rapport with my participants in light of the sensitive topics we would cover. Three of my key participants were interviewed five times. The longitudinal study design allowed for capturing veterans’ experiences as the lengthy bureaucratic process ensued. On average these interviews occurred at three-month intervals. Interviews lasted anywhere between 30 minutes and two hours. The verbatim transcriptions generated on average 14 pages of single spaced text per interview.

Interviews focused on veterans’ lives post-war, thoughts surrounding their self-understanding, the PTSD diagnosis, the experiences and behaviors that are labeled PTSD, the choice to pursue a disability claim and their experiences with the bureaucratic processes of diagnosis, disability compensation and treatment. The topics of stigma were addressed by physical locations (specifically healthcare settings), sociological locations (interactions with service providers, family and public), and through the relationship of diagnosis and compensation

(the claims process). To avoid leading the participants in their responses, questions broadly addressed these topics and probed for specifics through conversational strategies (i.e. “laddering” techniques where the interviewer consecutively asks “why” a person feels a particular way or “how” something is experienced through particular examples). Stigma as a concept was not brought up specifically in conversation unless the participant verbalized it.

Throughout this interview process, interview guide questions were refined at certain intervals to include specific themes that were developing. When new questions were added, follow-up interviews included those revised questions for the participants who interviewed before those intervals. This ensured consistency across data collection. For example, as the new theme of “telling trauma stories to total strangers” emerged I incorporated a set of questions on this topic midway through phase three of interviewing veterans. I included questions that focused on telling these stories, what veterans decided to disclose and why, and how this process made them feel. I then went back and had follow-up conversations with those participants who were not asked this specific set of questions. This refinement process also assisted in developing associations and testing emerging patterns in the data.

In a couple of instances, when a new theme developed early in the interview process (phase one) I elected to incorporate a new question in the next phase of interviews. For example, it was clear after the first interview with veterans that their worldview had significantly changed after being deployed to a

warzone, affecting their perceptions of others and their reintegration into civilian life. As such, in the second interview I specifically addressed this change in worldview and asked veterans how this shaped their social interactions and general wellbeing. I then laddered these questions to drill down into specifics: for example, how did changes in worldview influence help-seeking and claiming disability? Interview questions were refined in every phase of veteran interviews and once in the provider interviews.

Interviews were accompanied by participant observation at the local VA medical center and service organizations where I engaged in informal and work-related interactions with veterans and providers. I attended two Grand Rounds on PTSD and eight public and clinical events surrounding veterans' issues and care. I was able to follow one woman through her claims process from beginning to end, accompanying her to her initial claims appointment and disability and compensation evaluation appointment. She also contacted me at every touch-point she had with the Veterans' Health Administration (VHA) and the Veterans' Benefits Administration (VBA). These observations and interactions were documented through field notes and processed on a computer. Approximately 90 pages of data were generated in these informal observations.

Through this combination of interviewing and participant observation I explored the radical shifts veterans made in their transition to civilian life, with a novel focus on the consequences of authenticating trauma through the medicalization and commodification of suffering.

With 71 interviews and approximately 110 total hours of interview time, the entire project generated over 1200 pages of data. I was able to narrow the scope through filtering and isolating sets of data using qualitative software.

Analysis

Analysis began with a review of the data to create top-level codes. These codes described broad common themes in the data such as VA, PTSD experience, and social life. I then sub-coded excerpts of the data, under these broad themes, related specifically to diagnosis, clinical and claims process, stigma and disability. These sub-codes reflected participants' experiences. In comparing and contrasting these sub-coded categories across data sets I was able to identify patterns and the relationships between them (Denzin and Lincoln 2005). The patterns that emerged were notated through analytical memos that were linked to the coded data. In using this constant comparative method and inductive and deductive analysis themes and variations of themes were discoverable (Glazer and Strauss 1967). As interviewing, observations, and coding proceeded, new codes emerged and established codes went through revisions. The flexibility of this coding process allowed for new theories to develop (Hammersley and Atkinson 1995). Coding and retrieval of excerpts was facilitated early on in the research through DeDoose qualitative analytical software and later transferred to NVivo 10 for Mac for a better user experience.

To ensure validity of data: (1) data was triangulated through comparing interviews, participant observation and official documents; (2) emerging theories were cross-checked with lead informants (veterans, claims officers and a psychologist) to confirm the representativeness in their experience and; (3) the most robust findings had to reflect categories identified in at least half of the participants in their respective samples.

Limitations

This study has a number of limitations. It was conducted in a Midwest state in an urban area with a participant sample that was mostly white and with a majority of male veterans. This northern US region is not very military oriented compared to the southern states where a majority of bases are located. In these southern states many more civilians carry the burden of war and support veterans because they either have family members or friends who have been deployed.

A majority of my participants were combat veterans and six of the 10 participants were deployed for their first time at the beginning of the Iraq war, what I term “first generation Iraq War veterans.” This means, for over half of this sample, their first contact with the VA was at a time when the VA was not at all prepared for a young cohort of veterans (with different needs than the VA was accustomed to serving with their World War II, Korean War and Vietnam War patients). A number of the veterans in this study had first contact with the VA

before more lenient policy changes surrounding verifying traumatic events, in relation to PTSD disability claims, was instituted. Therefore these formative results are not generalizable to diverse veteran populations but may suggest that it takes upwards of 10 years to be able to speak openly about combat PTSD and ones' war experiences.

Self-report biases may have been a limitation due to the nature of the topics explored, as well as the population of study, who tend to be proud and strong in presenting themselves. However, by including four phases of interviews over 24 months, this research design attempted to mitigate these biases. Recollection bias was a limitation in that memory loss itself is a symptom of PTSD and traumatic brain injuries from explosive blasts. Finally, as my findings suggest, the moral differences between veterans' perceptions of the military world and the civilian world, and the cultural dissonance between veterans and civilians, limited the "full story" since I am a civilian. The data, juxtaposing these military and civilian experiences, is based solely on the veterans' point of view and that of their clinicians.

A CHANGING LINE OF INQUIRY

The ethnographic process is inherently an inductive process. Typically in anthropology one goes into the field with a series of questions and then finds out, usually from their research participants, that the questions they had in mind were not really the right questions to ask. While the broad topic of "PTSD experience"

remained the same, my original questions about how and where stigma developed for veterans with PTSD morphed into questions about how veterans experienced war as a change in self-understanding. In particular, was PTSD an accurate portrayal of the problems these veterans encountered returning home from war?

Stigma by definition deals with “difference” and it was searching for how veterans experienced “feeling different” or “being treated differently” that led me down this path of inquiry. From this point I was able to better identify how the PTSD category, intended to help veterans, conflicted with these new, post-military, perceptions of self.

The incommensurate worlds of war and home became my focus mid-way through this research and it emerged that stigma was not the main script for social exclusion and reintegration problems. The issues that veterans experienced as a result of their war trauma was not so much a problem of stigma processes as it was a problem of cultural dissonance. From this point of inquiry I was able to look at how the contrasting cultural worlds of war and home affected personhood and selfhood.

What I found was that the lack of fit between these two worlds was the locus of turmoil for veterans, not PTSD or related stigmas. Upon leaving the military and rejoining the civilian world, vets felt like strangers in their own homeland. Unbelievably, many spoke of how they wanted to return to Iraq, how they felt safer at war than at home. Home was experienced as a clash of beliefs,

morals and expectations. As a reflection of this clash, the significance of traumatic suffering is at the same time erased and validated through a PTSD diagnosis.

This lack of common ground, or cultural dissonance, between the civilian and military world is the thread that links the chapters of this dissertation together. Cultural consonance is operationalized as the degree to which individuals, in their own beliefs and actions, fit the broader shared cultural models in which they live (Dressler 2007). Connected to the concept of cultural consonance are selfhood and personhood. These are two important terms that help capture the context of human action and experience. Selfhood, for the purposes of this analysis is understood as one's personal identity, self-image and self-understanding. Personhood, from an anthropological approach, is conceptualized as who an individual is in a social setting and their role in society. An additional term that you will see throughout this dissertation is "veteranhood." This refers to the personal qualities that make veterans who they are, deliberately different from other civilians and in conflict with their own developing civilian selves.

WRITING ABOUT MISERY

The analytical landscape of the medical anthropologist is that of the suffering body. One of the major challenges of this project was writing about trauma in a way that did not exploit the suffering of the veterans I was studying. I struggled to convey veterans' stories honestly without taking advantage of their

vulnerability, totally paranoid that I might perpetuate the stigmas and stereotypes I aimed to expose.

To understand the transformation of human experience (war) into a category (PTSD) and the impact this has on individuals we must have a sense of some of the various experiences that are being transformed. These are horrific experiences that challenge our deepest understanding of what it is to be human. Naively, I thought that if I avoided asking about specific traumatic events I would not have to contend with them, after all, my main concern was to understand how PTSD and the social process of being labeled was experienced, not the trauma that led to this process. Many veterans did not broach the subject of their trauma in detail and glossed over “those things I don’t want to talk about.” Then there were a number of veterans who really wanted me to know what war and military training was like, all the way down to the different tones and decibel levels various weapons made (and with YouTube, a multi-sensory experience was possible).

I asked all participants why they took part in my study and these particular veterans who went into much detail explained it was an opportunity to help civilians understand “what is really going on.” For some, it was “therapeutic” in ways that validated their experience way beyond “the therapist who was paid to listen” to them. In this way I attempted to move beyond “bearing witness” and theorizing their memories—some gruesome, many painful, and most illogical—to “engaged witness” (Scheper-Hughes and Bourgois 2003). This is reflected in the

style of the writing.

In order to represent veterans' experiences with the most amount of respect, and to push myself to be more than a "scientific spectator" (Scheper-Hughes and Bourgois 2003:26), I include long excerpts from interviews and conversations I had with veterans and their care providers. I favor this form of representation over a third person explanation in many instances as a platform for my analysis, mainly because I feel my own voice interrupts the narrative of veterans' memories and constructions of self. As one veteran Sarah taught me, one really cannot explain what it feels like to be in, and respond to, a situation that defies explanation. So, at every possible opportunity I let my participants explain the unexplainable.

Also, this structure helped me to check myself as I wrote to ensure that I was not imposing my own categories and classifications. Reflecting critically on the impact of the textual images I invoke through these narratives, I made a concerted effort not to sensationalize these veterans' biographies of suffering. In this process I continually asked myself, "Why am I including this and what do I want the reader to do with this?" In this manner I hope to be true to veterans' meanings and provide clear evidence for analysis for the reader.

A PROCESSUAL ETHNOGRAPHY

In addressing my research questions surrounding the function of PTSD in a new-era of Iraq and Afghanistan vets, I organized the chapters to emphasize

veterans' journey as social beings, analyzing the stops they made on their road back to "normal" civilian life. This involved diverse experiences of the self: veteran, patient, government aid supplicant, "malingerer", and finally, civilian. For analytical purposes this is conveyed in a very linear fashion, but in reality these experiences occur in parallel and overlap each other.

The approach to this dissertation is very deliberately processual. I examine how veterans' experience gets categorized and how the process of being diagnosed and labeled with PTSD enables or threatens personhood. The contrasts I make are taken from veterans' own perceptions and those of their healthcare providers. The empirical data are organized analytically through the transformation of self upon returning home from war: from soldier to patient in chapter 2 (the diagnostic process), patient to government aid supplicant in chapter 3 (disability compensation process), supplicant to malingerer in chapter 4 (mental health provider and veteran clash of views surrounding disability compensation), and soldier to civilian in chapter 5 (disclosure of PTSD status, cultural dissonance and 'fitting in' with society). Chapter 6 takes a bird's eye view of these transformations and addresses the subjective possibilities of PTSD in relation to stigma processes and personhood. Chapter 7 concludes with major findings and proposes a new conceptual framework for thinking about posttraumatic stress as an issue of cultural dissonance.

I intentionally juxtaposed veterans' own perceptions of civilian life once they returned home to their previous military lives. This helps to illustrate how

their collective identity, values and expectations are challenged by the diagnostic category of PTSD. Significantly, these are contrasts (e.g., civilians versus military personnel, pre-deployment self vs post deployment self) that veterans consistently made to try and make sense of their world and not lose touch with their self-understanding and memories. Specifically it was the bureaucratization of care (the multi-level procedures and controls that ensure equal treatment) that distorted veterans' intimate and traumatic memories of war. This occurred via the processes of medicalizing and commodifying suffering that alienated veterans from their experiences and service. Each of these chapters illustrates how this distortion of experience and its consequences—social exclusion, non-disclosure and moral self-judgment—are informed by a cultural dissonance, or lack of common ground, with clinicians, bureaucrats, family and friends and the public at large. It is this dissonance that finds veterans at odds with an American civilian culture they were once a part of and makes reintegration so painful.

The broader implication of this cultural dissonance is that the problem lies not within the individual but with a society that is so far removed from the effects of war that we have no idea how to provide proper support for returning veterans. Perhaps the bigger consideration is a society that supports a military that does not “un-train” its soldiers in order to keep them forever “combat-ready.”

Chapter 2

From Soldier to Patient: Categorizing the Human Experience of War

I don't think I have PTSD. I have memories. I'm reminiscing, you know? Yeah, the memories cause me some anxiety. And guilt. Of course they do. That's what memories do. They remind you how you came to be the person you are.

— Tyrone, OIF Army Vet

They don't know what it is like there so to them it is a diagnosis. To you it's your life.

— William, OIF Army Vet

I'm not going to tell a total fucking stranger the deep rooted feeling ... how I lost guys ... how I killed ... that's part of who you are.

— Travis, OIF Army Vet

Medicalization is the process by which human conditions become defined and understood as medical problems. The extent to which this process emerges in everyday life is a concern for medical anthropologists in that it can mystify the real roots of illness. In part, this mystification comes about through the technical language of biomedicine that reduces individual suffering (i.e. bio-psycho-social problems) to a “thing” to be treated or a symptom to be cured. Medicalization may also occur through the pathologizing of normal behavior and the recasting of personal troubles as disease, rather than through established expressions of distress or folk models of illness. One of the consequences of this process is that

it prevents people from making connections between personal illness and wider socio-political hierarchies (Scheper-Hughes 1988; Summerfield 2001; Taussig 1980). Certainly this could be the case for veterans with posttraumatic stress disorder (PTSD) where the consequences of war, foreign policy and a voluntary military become transformed into a personal problem. Even the genealogy of the diagnostic category has signified a move further and further from war and military violence to medicalization: from shell shock in World War I to combat fatigue in World War II and post traumatic stress disorder after the Vietnam War (Young 1997).

This chapter focuses on how medicalizing trauma, specifically through the diagnostic process, ends up corrupting the personal experiences of war and deeply effecting veteranhood. Veteranhood relates to a very specific set of values, worldviews and beliefs contributing to a self-understanding that is different from veterans' pre-military and pre-deployment selves. This self-understanding also, in veterans' own perceptions, differentiates them from civilians. I argue that medicalizing their trauma alienates military members from their veteranhood. This occurs through transforming intimate memories into medical "things" to be quantified but more significantly, through threatening the very military values that make a good veteran: honor and sacrifice. These values make suffering morally significant and any assault on these values undermine a veteran's sense of self.

I will map out how the medicalization of war trauma, intended to ease the suffering of veterans, instead creates conflict for selfhood through recasting military skills and values as a mental disorder. First, this occurs through a bureaucratization of care that requires explanations of experiences that resist description and rationalization. Bureaucratization refers to the multiple appointments and assessments that the Veterans Affairs requires of patients in order to maintain consistent and fair treatment. Second, this bureaucracy necessitates multiple appointments and demands retellings of trauma that desensitize and even shame veterans of their experiences. Third, intricately linked to the issues above, is the systematic reification of traumatic experiences into diagnostic scores and symptoms that disconnect veterans from what they really value. This occurs through a social process that objectifies the intimacy of traumatic memories and personal sacrifice, alienating veterans from their service and their work as soldiers.

I argue that for a sub-group of combat veterans PTSD is not a valid expression of suffering because loss and sadness are rooted in cultural ideas of sacrifice and expressed through remembering. This remembering though, is not a clinical affair. As a result, an opposition to PTSD and its biomedical meanings emerged throughout this ethnography.

The following narratives of Kurt, Armando and Sarah illustrate the layers of life (memories, behavior, selfhood) that get “thingified” (turned into symptoms and diagnoses). These three narratives point out differences in sacrifice and selfhood,

two related aspects that affect how a person handles a diagnosis. Many types of war and military experiences transform into biomedical terms. In fact, every veteran I interviewed and worked with explained that “PTSD is different for everyone” and that “everyone reacts to situations differently.” Despite this subjectivity there are commonalities that emerge as human experience becomes categorized first into symptoms, then statistical scores and finally a diagnosis. The personal vignettes juxtapose the bureaucracy of this process and the reality of war to clarify the impact of medicalization on these individuals’ self-understanding and veteranhood.

KURT

October 18th: I didn't sleep for three days because we were constantly in firefights and getting mortared. I seriously thought I was going to get shot or die. The first couple of days I remember being on rooftops and everywhere I looked there were tracers and people shooting everywhere. We could also see all the mortars falling around us. It was scary as hell. Everything is a blur. Probably the worst living conditions ... A mortar hit second platoon in the building they were in and everyone in the room got hit. Sergeant H got really fucked up, Adam got hit and Starkowski. All I heard was screaming when I got there...

Then my friend Alberto got hit. I was so worried, but he ended up ok. The whole time I have been here I have been wearing the same clothes, I haven't showered, I smell like shit. I'm also sorry to say that Jerome Haroldson from first platoon was killed. He was a very nice guy and it was very hard for all of us.

—Entry from Kurt's war journal

Kurt is a Marine and basic rifleman, or as he proudly refers to himself, a “grunt.” During his first deployment to Iraq he kept a journal as a way to express his feelings and document his experiences. In one of the first military lessons he gives me (and I receive many over three years), Kurt explains that a grunt is

anyone in the infantry whose main job is to fight. The Marine Corps, I learn, is an expeditionary unit, “[W]e're meant to be first ones in, kill everything, destroy everything, push through. We're like the frontline guys, craziness. Once we pull out, the Army is a huge force, it is an occupying force.” Kurt makes sure I understand that there are two types of Marines: grunts and “pogues.” A pogue, (POG) or person-other-than-grunt, is anyone whose military operational specialty (MOS) supports combat arms. Notably, Kurt’s MOS as basic rifleman in the Marines is as grunt as you can get.

The reason why Kurt chose this MOS, at age 17, was to prove to people that he was a “manly man.” In his animated self-deprecating manner he explains to me that:

[O]ur Midwestern state is a very masculine state and you have to prove you're a man - drive a truck, rip your t-shirt sleeves and go hunting and all that stuff. I never did that and I was the only kid in high school that didn't go hunting because I didn't have a dad to take me. I was always with the girls, you know, hanging out, and the guys were like, “Why aren't you hunting? Um, because I don't have a dad?” [laughs]. And so I think that was a huge factor for me. I wanted to prove to people that I was tough and that I could do something hard you know? In society’s eyes or whatever.

Kurt first experienced symptoms of posttraumatic stress after returning from his first deployment to Iraq in 2005. At the time, Kurt was struggling with intense grief and anger, as well as debilitating insomnia and “knew something was wrong.” For five years and through a second deployment he suffered and finally revisited the VA in 2009 after returning from Iraq. The VA had done a “complete 180” and “[W]as ready and waiting for us when we came home. It was completely different than after my first deployment.” He received a diagnosis of

PTSD in 2010, after separating from the military. He served for six years and has been home three years now.

Kurt's first deployment was to Iraq in 2004 to the Al Anbar province for one of the worst battles in the 10-year history of the Iraq War. Kurt and I had many conversations about war and his experience but in our first formal interview he brought his laptop with all his digital photos and videos, a zip-lock bag with a photo and letter he carried with him, along with his journal. He read to me many excerpts from this journal so I could get a "better idea of what war was like." Here he prepped me with the "tempo" of a typical day:

Kurt reads: *I have one more patrol and my company observation tonight*
So when I wrote this I'd already done two patrols, right?

Ethnographer: So a patrol consists of basically walking?

K: Walk the city or walk a specific area outside of the city or in the city or you go through a route they give you.

E: You're looking for IEDs (improvised explosive devices)?

K: Anything

E: Suspicious people?

K: Suspicious people or if we get attacked or draw up the enemy. So you can tell this is like our tempo of three patrols a day and we'd do a company operation at night so we'd like raid-

E: So nine hours of patrol basically.

K: Yeah and then a mission at night which would be like from two in the morning til four or two to five.

E: Sleep like four hours?

K: If that because then when you are not doing anything you have prisoner watch and you, when you have security in every building, we need Marines looking around making sure no one is trying to attack us.

E: I can't imagine what that does. I mean we talk about what sleep deprivation does to the brain.

K: You go crazy, those [first] three days I didn't sleep. You start seeing things, those three days I didn't sleep when we first got to the city, I wrote about it. I specifically remember just being crazy, like you start to hallucinate you start not caring about anything. It's like you're drunk, it's weird. It's scary.

Kurt slowly delved into the personal entries of his journal, reading much of it silently at first. It was difficult to tell if he was censoring the material for my sake, choosing what my civilian ears could handle or if he was relishing in an intimate moment, as if he was rereading some love letter from long ago he wanted to keep private. He admitted he had not looked at his journal in years. It became clear to me, after a while, that Kurt was not protecting me from the horror of war and what he experienced:

November 2nd: Yesterday an IED went off as we were driving ... We dismounted and we were sweeping for IEDs and one went off. It killed Corporal Jon Harrison. It was 20 meters to my right, I saw his body, it was horrible. His head was missing, a lot of the top was charred black and it turned into a jelly substance. Then I had to sit in the Humvee by myself with the body in a body bag with his best friend, another corporal. It was one of the saddest things I have ever done. He was just crying really hard the entire time and I didn't know what to say or do ... I feel very empty. I pulled my cigarettes from my pocket and my lighter and put it in front of him and said take as many as you want. We smoked together and he was blowing his smoke at the head of Corporal Harrison because he smoked also. It was so fucking sad. I was almost crying to myself. It really hit me. That blast was so close. It could have been any of us.

So that was kind of how it went [as he pages through the journal]. We lose a couple more guys and more casualties and my mental state just deteriorates more and more [starts laughing].

I didn't even get to the part [in my journal] where I would see little kids getting killed and innocent people ... The insurgents did awful things. They used children and women against us and just decapitated the people that would not help them ...

It turned out Kurt did keep the worst memories to himself. He did not share in any detail what he witnessed Marines doing to insurgents or what insurgents

did to women and children. Perhaps this was out of loyalty to his fellow Marines and respect to the dead. Or maybe he did not want me to judge him, yet he often insists that he is proud of his service and has no regrets regarding his conduct during that service. These journal entries from Kurt's first deployment to Iraq illustrate what life was like for him as a soldier, experiences that the diagnostic process would later attempt to categorize into symptom criteria and PTSD. I ask him if he thinks these types of experiences caused his PTSD and he tells me "I don't really think I have PTSD. I'm just really, really, really sad because of what I experienced." These events present a complicated picture of trauma that includes brotherhood, loyalty, tactical skill, emotional resilience, interpersonal intelligence, physical strength and morality. Significantly, these are personal characteristics, but also values and skills that the military instills that contribute to how veterans view themselves.

Many of the entries from Kurt's journal are horrific and illustrate what psychiatrists would call a "textbook event" that might easily become transformed into PTSD criteria. There were others though, who "got PTSD" from something more vague; having their fundamental understandings of who they are and how to be a "good citizen" confronted in war.

ARMANDO

Armando joined the Army right after 9/11 at age 19. His reasons were many. The call to service was probably at the top of his list. Armando was going to

college to become a teacher because he felt compelled to serve his community in some way and he did not want to join the trades, a common job track for the people in his small town. Coming from a rural area, Armando grew up with the glorified images of soldiers:

I mean, I don't know, it's kind of like a stereotype. I grew up playing war in the backyard. And seeing, like I remember, I would have been about eight years old when the Gulf War happened, and I still remember all the Desert Shield, Desert Storm posters. And I remember seeing the parade when they came back, it was like ticker tape, you know that hadn't happened since World War II ... the way I was raised, my family's very conservative, they come from a very small rural community ... And so kind of this idea of service to your country and your community was instilled in me from a very young age. And then having relatives that had also gone into the military, kind of the reverence held for people that do that, I think that that kind of drew me as well.

For Armando, the reverence of serving one's country was an attraction. Moreover, he was working full time while going to school full time and the thought of having his college education paid for, let alone being able to devote his full attention to his education, was very inviting:

If I joined the military and I put in the time and I make those sacrifices, on the back end it would be much easier for me. At the same time there'd always been this kind of desire to do it, so now [with 9/11] I had a reason to do it.

Armando scored very high on his military tests and could have chosen to pursue any MOS, but like Kurt he joined the infantry:

When I thought about what a soldier was, it wasn't working behind a desk, it wasn't working on some sort of like technical project. You carried a rifle, you carried a heavy pack, you marched, and you fought. You know, you weren't in a supply, you weren't in some sort of support role, you *were a combat soldier*. So that's, that is the only thing that I ever considered.

Armando's first deployment was early in the war, like Kurt, 2004-2005, although he was four years older, turning 22 while he was in Iraq. He first went to

the VA eight months after returning from his first deployment, on his own accord, because he recognized he was abusing alcohol. He did not specifically seek treatment or a diagnosis for PTSD:

I was unhappy you know? And I knew if I didn't do something I was gonna get in really big trouble. And I didn't want to be divorced and I didn't want to get in trouble like with the police and I still had a few years, three years or whatever on my contract and I didn't wanna get in trouble with the military. So I just said like, well ... I mean I didn't go there thinking like, this is gonna work. I just went there, I didn't know what to expect.

He went to the VA for counseling for a few months but because of a couple of appointment cancellations, “just stopped going” and “didn’t reschedule.”

Armando was not “officially” diagnosed with PTSD until he finished active duty, after his second deployment in 2007-2008. He has been home now four years.

As an infantryman Armando was trained as an expert in the systematic application of violence. His job, as is for all infantrymen, was to “capture and kill.” Armando was deployed during the same time period as Kurt but his trauma stemmed from a different kind of loss. He tells me, “No, I did not lose any friends but did I see a lot of awful things? Yes.” He quietly tells me he did things he was not proud of and that his transgressions, sometimes conscious sometimes not, changed him in ways he cannot affect. He explained it this way:

I spent the first 21 years of my life learning all the lessons on who I was and what it meant to be a citizen and what it meant to be a son and what it meant, like, to be a significant other and all these different things. But all of the emotions and all of the things that are useful in achieving or being successful at those things are not really relevant in a combat zone. And so somewhere along the line, I either consciously or unconsciously made a decision that those types of things, like compassion and love and empathy and kindness and good will, whatever, are not useful to me. But aggression and anger, things of that nature, are very relevant to what I'm doing now. And I found a way to turn off all of the things that weren't useful. And when I came home, I just thought like I'm a chameleon. Like I'm in this environment so I'm this way, then I go to this environment and I have to change to adapt to that ... I'll

be all the things that, you know, I'm expected to be. And I can be as successful at them as I was before. Well, I wasn't.

Armando fully understands the events that led up to his transformation from a loving person to an angry veteran. In detail he described to me the injustice of war and the situations that he had to deal with on missions. These were situations where poor kids were paid by insurgents to plant roadside bombs, to go up “against armored vehicles” and trained American soldiers. And it was Armando’s job to shoot, to protect his troops, from “these children” who were just trying to survive and to make a little money to buy food. Armando cannot forget these things, these sociopolitical situations that were so unbearably unjust. It is specifically these experiences that that have made him unempathetic to the problems of his civilian peers:

And so now I’m home and someone’s bitching about how the internet is not working ... and I hear people bitch about this that or whatever and it’s like what context do you have?

Armando’s contempt for those who are not veterans make it difficult for him to function socially and his war experiences have manufactured a disdain for people he describes as having “American problems.” For everything that is positive in the world Armando can find the negative flipside to it and reveal, in a matter of seconds, a host of ulterior motives and evil consequences for that particular action. And he does so with painstaking detail. This affects his relationships but also in a deeper way, any potential to restore his faith in humanity. What is interesting (and admirable) about Armando is that despite this lack of faith, he tries really hard to find a place in society. He does this through

his dedication to helping veterans reintegrate into civilian life and works with community organizations to facilitate their resocialization. Yet, there is a deep feeling of disillusionment and mistrust, a result of his military experience, that contributes to a relentless unhappiness that even “real happy life events” like the birth of his son, cannot undo.

Armando’s loss is slightly different than Kurt’s because it is very much connected to the person he thought he was: the citizen, the son, the significant other. These two narratives point out fundamental differences in selfhood: Kurt, a proud Marine and Armando, a cynical realist. Armando lost his faith in humanity through witnessing a particular quality in his peers, leaders, and eventually himself to treat people as disposable—people who were already at an unfair advantage. As a result he carries with him an intense loss of self-worth because he feels he did not fulfill his mission. He experiences this as lost integrity and with that, he perceives to lose the reverence that he hoped to earn with his service. He tells me every time I see him that all he wants is *one* day, “[O]ne full day where I can feel some happiness and where I don’t just feel anger and distrust.”

SARAH

Sarah talks loud and fast and is not afraid to express her opinion. She wears her Army gear with pride and is very proud to be an American. It is hard to believe that Sarah joined the military because she felt out of place and wanted to be part of something, mostly because she exudes such confidence and

conviction. She describes her upbringing as middle class. She is the daughter of a city cop and a “typical 1950s mom.” Her and her two siblings went to private Catholic schools and “didn’t fit in” because the other students had money whereas her family was not as well off. Like Armando, she joined the military right after 9/11, during the “patriotic push.” Influenced by military marketing and the desire to serve her country, she wanted to do something different than what her schoolmates were planning for after graduation. She admits to me that in high school she “was constantly vying for peoples’ approval” and part of why she enlisted was to prove herself. She was 17 when she enlisted:

Well when I first got into high school I started, you know, thinking about it [military service] and looking at it and I saw the commercials and thought that would be cool, and everyone said “Man, you could never do that, like you could never handle authority like that”... or “You are a girl, you could never do that.” And I would be like, “Yeah I can, watch me.” You know, so I pretty much did it to show everyone up initially ... And then September 11th happened and I had a recruiter come to my house every single day until my parents signed the papers.

Sarah is now a staff sergeant in the Army Reserves, a single mother and college student. She is 14 years into her military service and the only woman and a leader in her platoon. A self-proclaimed “den-mother,” she is responsible for fifteen soldiers. She deployed at age 19 in 2004 to Iraq, and then to Afghanistan in 2009. It was two years after her first deployment that she sought treatment at the VA because her family and friends complained of her irritability and related anger issues. Sarah did not think these problems were PTSD, even though she experienced nightmares and flashbacks. From her point of view, these symptoms were her depression resurfacing. To this day she has not received a PTSD diagnosis and does not want to risk the consequences of such a diagnosis to her

military record and career. Although in our conversations she refers to “PTSD moments” in her everyday life. She was given a diagnosis of anxiety-depression disorder, has sought counseling and takes medication, which together has offered her some relief.

Even though Sarah’s military operational specialty was a “support” specialty (non-combat), in 2004 anyone who went outside “the wire” (off base) experienced combat due to the nature of the urban warfare and the insurgents’ tactics. Sarah’s specialty was 88 Mike (truck driver) and her duties included transporting supplies from base to base through hostile territory. Part of her coming of age story is that she earned her combat ribbon (denoting active engagement with the enemy, i.e. firefights) while deployed. Sarah does not speak of specific traumatic events but refers to “dying moments.” These are memories that are sacred to her and she does not want people to misconstrue them (especially a civilian like me who has no idea “what it’s like”). Like Armando, her self-understanding, more specifically her reflexive moral action, was challenged in war through the decisions she had to make to protect her battle buddies and herself. She describes this combat scenario for me to drive home the point that one really cannot explain what it feels like to be in, and respond to, a situation that defies explanation:

To see kids playing with an old grenade that had gone off at one point, and [then] wondering if that [grenade] has actually gone off? Or are they going to throw it at us? And you have kids throwing rocks at you and they don’t even know [the gravity of] what they are doing. Are you supposed to consider that a threat? Are you supposed to shoot at them? The fact that you are faced with a kid who has a gun in his hand, the kid may be 10 years old, and you are faced with, do I kill this kid or don’t I? He is just a kid. He doesn’t know any better but he is still going to

kill me because he knows he is supposed to kill me, so I am supposed to kill him?

So all those things run through your mind and you come back and people just have no idea what that feels like and you can't really explain it. You can't ever really know what you would do in that situation. And people say, well I would [do this] and NO, you don't know because I *thought* I would do *this*, and I ended up doing *this* [instead] because you just don't know. You don't know.

Every veteran I spoke with who was in combat had a story like this. Sarah believes it is daily experiences like this, of not being able to relate to people in everyday civilian life, that contribute to her "short fuse" which she describes as her intolerance and quick irritation with people. This has extended to her family life as well, when she exhibits limited patience with her daughter, who cares about things that, according to Sarah are "insignificant." She tells me earnestly, "I just forget that she is just eight years old." Like Armando she gets annoyed with people who take life and take their privileged, safe existence for granted, which, according to Sarah, includes most civilians because they have not witnessed real violence and deprivation in their everyday life.

What Sarah articulates so clearly is that the decisions that war demand and the emotional consequences of those decisions, become intimate, personal experiences that resist description, rationalization and comprehension. And yet, they are experiences that must somehow be explained and articulated to a clinician in order to get a diagnosis and to receive treatment. At the VA this is a long, drawn out process, one filled with endless appointments with healthcare professionals and staff, repetitive assessments, dehumanizing diagnostic scoring systems and rating scales and a confusing configuration of government

regulations.

CHECKING THE BOXES: THE BUREAUCRACY OF DIAGNOSIS

It's real, it something real that's affected me, and now I have some med student trying to you know, match up the symptoms with the name you know, out of their book, and that's like, I never thought it could get like turned around like that.

—William, OIF Army Vet

The richness of experience is left out when you have to mark a box and quantify it...

—Crystal, VA Psychologist

A veteran's overall healthcare and disability compensation have become a tangled web of bureaucracy at Veterans Affairs hospitals and clinics. Receiving a medical diagnosis, as well as a disability rating, requires navigating both the Veterans Health Administration [VHA] and Veterans Benefits Administration [VBA]). To provide some background, every veteran that separates from the military is provided medical care for five years from the date of their separation. During those five years if a veteran can prove that specific illnesses and injuries were a result of military service (e.g., PTSD, hearing loss, traumatic brain injury, etc.) then a "service connection" is granted. This service connection is a benefit that allows the veteran to receive free medical care for life.²

Often, the veteran is automatically processed into the disability rating system. This can happen for a number of reasons. For example, a Veteran Service Officer (VSO), whose job it is to help vets navigate the VHA and deal with all the cumbersome paperwork, may do this as part of their best practices

to provide a vet with access to all their benefits; a concerned social worker may bring a veteran who is in dire straights to the VBA to sign them up for benefits like disability; VBA representatives may sign up veterans at outreach events (one of my participants was signed up at a family day at the zoo) or upon separation from the military (in fact, as newly separated vets get off the plane, representatives from both the VBA and VHA are waiting on the tarmac “to get them into the system”) or; a veteran may just end up in the wrong VA office seeing the wrong person and going through the wrong process.

What can transpire for veterans is diagnostic uncertainty and confusion. Often veterans are seeking mental health care and they end up concurrently in the disability rating process. The consequence is that the number of healthcare workers vets “process through” at the VA, and talk to about their trauma, increases. The amount of intake interviews for mental health is typically three: general enrollment and referral from a primary care physician, diagnosis from the psychologist, and a medication check from the psychiatrist. With compensation that rises to *five*, adding a claims officer who submits the disability claim and the compensation and pension examiner who evaluates the diagnosis (that a VHA expert already made). Some vets have also first seen clinical social workers or peer mentors prior to this process. Others have had follow-up appointments and seen interns who are not familiar with their case—forcing yet another retelling. In order to finally receive a diagnosis, veterans are literally required to retell, over

and over again, their “intense personal experiences ... multiple times to strangers.” Sarah explains it this way:

When I’m told to tell my story time and time again I try to downplay it. I won’t say how bad it was ... tell all the details, because I don’t feel like telling someone about the people that were killed, you know, dying moments. I don’t feel people deserve to know those moments. Those were my moments. I don’t want people to take that away from me, tell me how to think about it, how to feel about it.

These “dying moments”, intense personal experiences of war, were not something Sarah and others wanted to corrupt in any way. They hold significant meaning. So many of the veterans I spoke with cherished these memories, despite their nightmarish aura, because these experiences “make me who I am today.” The personal and private ownership of these experiences revealed that while veterans lost loved ones they did not want to lose the fragments of their memories. And yet, these memories felt like they lost value upon every retelling, as Sarah explains: “Having to tell people over and over makes it fake, not real... it desensitizes you. I don’t want that to happen.” In addition to integrity, pride was at stake in retelling trauma. Armando confided in me that:

I don’t want to admit my most personal disabilities. I’m ashamed of what I did and especially ashamed of how it affected me to the point where I need help and then am labeled.

Travis, also an Iraq veteran who served in the Army, heatedly defends his personal privacy and being:

I’m not going to tell a total fucking stranger the deep rooted feeling ... how I lost guys... how I killed... that’s part of who you are, you don’t just tell these stories ... you don’t talk about traumatic stuff because it brings back bad thoughts and feelings. It’s embarrassing to yourself.

He goes on to explain this sentiment of shame and the private nature of horror:

[T]he stuff you see and do [at war] is not something you want others to see, people getting killed ... you have a persona you have to keep. Pride is a big thing. Even if the person is a health professional they are still human, they are still going to judge you ... Why would you want to talk to so many people about something that you are ashamed of to begin with? They don't know what it is like there so to them it is a diagnosis. To you it's your life.

Certainly, diagnosis is irreducibly a judgment but Travis is referring to having his military actions judged and moralized. Transforming “life” into a “diagnosis” through having their memories transformed into symptoms was a dehumanizing process for all the veterans I interviewed. William, a veteran service provider and Iraq veteran of the Army infantry articulates how his memories became objectified, in a very technical manner, through turning his personal experience of war into professional expertise and medical “jargon”:

William: It's a personal thing you know? It's something you went through with other people and it was terrible and you know, it's your experience and I guess it gets diluted when you keep, you know, when it gets mangled by like doctors and stuff you know?

Ethnographer: So it gets diluted? When you keep what?

W: When you keep having to, I dunno, just like tell people about it, I feel that they break down your experience into clinical terms and that it really feels like it takes away from your experience.

E: Right, because they break it down into?

W: Into medical terms, yeah.

E: And what does that do to the experience?

W: It dilutes it, I mean really you have honor and respect for the people that you deployed with and those are real strong feelings and when they get turned into just like, civilian jargon I guess I could say, it makes you feel like it wasn't [significant], you know? ... It takes away from [that experience], and then you're like, oh that's what you think of what I went through?

It's real, it's something real that's affected me, and now I have some med student trying to you know, match up the symptoms with the name you know, out of their book, and that's like, I never thought it could get turned around like that.

What gets “turned around” or objectified is all the work William and his fellow soldiers did at war, as well as the losses these efforts incurred to the livelihoods of everyone involved. Doctors and the medical systems in which they operate are incapable of translating these experiences with “honor and respect” because the diagnostic process itself is reductionist. In other words, all William’s training and missions as an infantryman—and all the memories, traumatic and happy—are reduced to a “clinical term” (more on this quantifying of experience is outlined below). Transforming his intimate experiences of war into a “matching” exercise diminishes the importance of the work and the sacrifices William and his peers made. One way to interpret this disconnect William feels is through the theory of alienation.

In Karl Marx’s (1927) conceptualization of alienation, an individual loses a sense of connection to their surroundings because (under capitalism) the product of their labors are removed from their control and replaced with foreign products (e.g., money). In William’s case his memories are a product of his labors and they are being replaced by clinical terminology. In this process he loses control over the respect and honor that these memories demand, alienating him from the memories as well as his military service.

Another aspect of military service that becomes objectified is the realness of everyday life in war: Kurt driving in a Humvee with the dead body of Corporal Jon Harrison in a body bag next to him, not knowing how to comfort the deceased’s best friend. It is Sarah having to make a split second decision on

whether or not a child playing with a grenade is threat enough to shoot that child—and then having to live with the consequences, as a mother herself. It is Armando witnessing the blatant disregard of Operation Iraqi Freedom’s tagline, “winning hearts and minds” and then his self-actualization that he, like his leadership, has turned off compassion and love and empathy because these emotions are no longer useful to him.

These experiences are first quantified into scores through a short self-report measure such as the Combat Exposure Scale (CES) (see Appendix), typically administered by a first point of contact like a primary care provider as a screening tool. This scale includes seven questions like:

- 4) What percentage of the soldiers in your unit were killed (KIA), wounded or missing in action (MIA)?:
(1) None (2) 1-25% (3) 26-50% (4) 51-75% (5) 76% or more
- 6) How often did you see someone hit by incoming or outgoing rounds?:
(1) Never (2) 1-2X (3) 3-12X (4) 13-50X (5) 51 or more

The total CES score ranges from zero to 41 and is calculated by using a sum of weighted scores. The scores are then classified into one of five categories of combat exposure ranging from “light” to “heavy.”

Next, after being rated, the experiences are quantified and reframed as symptoms by a mental health specialist. The gold standard for diagnosing PTSD is a structured clinical interview such as the Clinician Administered PTSD Scale (CAPS-5). The PTSD Checklist (PCL) (see Appendix) is also used for a provisional PTSD diagnosis.³ So for example, Kurt’s intense exposure to violence and repeated loss of friends becomes reduced to a “constricted affect and

persistent inability to experience positive emotions” or D-7 (Criterion D in the DSM-V is defined as negative alterations in cognitions and mood); Sarah’s tactical awareness, a skill that her military training instilled, is interpreted by the DSM-V as an “alteration in arousal and reactivity” or “hypervigilance”; Armando’s experience of being cheated out of his humanitarian mission and subsequent disdain for people gets checked off as “emotional detachment.” This reduction of human experience into psychiatric categories and undermining of personal suffering is not specific to PTSD but is a general phenomenon that has been theorized by critics of the DSM (e.g. Kutchins and Kirk 1997).

In this manner, the intimate nature of traumatic memory becomes bureaucratized and objectified through every round of appointments and assessments. The process is further depersonalized through the systematic reification of experience as scores, symptoms and often a DSM-diagnosis. This is done through both “provisional diagnostics” (i.e., the checklists used by social workers) and “clinician administered” diagnostics. Veterans experience this as neglect and insensitive care on the part of the VA. The general consensus is “They don’t care about us.” Certainly, bureaucracies like the VA are engineered to be impersonal in order to maintain consistent and fair treatment for all and to make sure that individual differences do not upset the paper-trail-induced equality. But the providers I spoke with recognized the unfairness and insensitivities of such a system. In fact, the providers I interviewed were well aware and reflexive

regarding the negative effects that the screening tools and assessments had on veterans.

PROFESSIONAL RESISTANCE AND ANTI-BUREACRATIC ETHOS

Fewer and fewer of us whip out these objective scales now because we don't want to put them (veterans) through it. I used to use the PCL [PTSD Checklist]. I don't do it anymore because the whole process is so dehumanizing, I just start out asking, in an organic way, what do you notice—is it bad sleep, nightmares...

—Crystal, VA psychologist

Crystal is a clinical psychologist at the VA and works mostly with Iraq and Afghanistan veterans. She is also on various task forces and does quite a bit of veteran outreach in the community. This is typical of VA mental health providers and part of the expectations of professional service, but through my interviews I came to realize that a personal commitment drives the work for many of these clinicians. Crystal's friendly manner and disheveled appearance remind me of an overworked absent-minded professor. I met Crystal at a conference and we connected a couple of times over coffee to discuss the accuracy of diagnosis and the implications for disability compensation and healing. On this day our discussion bounced around between the limits of diagnostic assessment tools and the DSM criteria and the value of capturing screening data in a system like the VA. Like other providers I spoke with, Crystal expressed a keen awareness of how screening omits much of the post-traumatic experience:

Crystal: Well, I think as with most social categories, it [PTSD] defines and it limits too. I mean my frustration is always that I want to be able to talk about it [traumatic experience] in a way that doesn't draw a box around it, you know? Because it is a much wider, as you are saying, it is a much wider constellation of

kind of potential disruptions than, just you know ... one symptom from re-experiencing, three from avoidance and you know, I see people all the time that are terribly impaired who don't meet those criteria.

Ethnographer: So can you give me an example, like they don't meet the criteria but—

C: You have to have at least one re-experiencing symptom, you have to have three avoidance symptoms, you have to have at least two from hyper-arousal. So say for example you have somebody who is having terrible nightmares, intrusive thoughts all day so they can't focus and then maybe is very angry, very hyper-aroused but they are really not avoiding things particularly.

E: Well because they are coming to see you for one.

C: Right and maybe they are trying. They are going to work. They are staying connected to family and stuff [and] so because they don't have that middle category—

E: Technically they don't have PTSD because they are missing that middle category?

C: Which doesn't make any sense to me so I wish we just called it post traumatic syndrome or something where you could be more descriptive within this big amorphous box you know, I mean I have always hated the DSM book, certainly I can check off boxes. I can record symptoms, but I feel like that you know by doing that you lose a lot of the qualitative richness of each person's experience.

E: Because you don't really have a context, right?

C: No, and you lose a lot of these, I don't want to call them peripheral because that makes it sound like they are not important, but you lose some of these other contributing issues that are outside those check boxes like the guilt, the grief, the changes in identity and world view and that I really, really, really, hate.

Other mental health providers also expressed that screening tools left out important layers of experience. The general consensus was that PTSD could easily present with only a few severe symptoms, rather than have to present in all five of the DSM criteria (see Appendix). The problem, as Crystal explained above, is that the matching of experience to symptom criteria often missed the overall picture.

Another part of this picture is the issue of perceived stigma and underreporting. Marshall, also a psychologist at the VA, tells me that from a clinical perspective they use the DSM for the diagnosis but that these screening tools cannot account for underreporting, where traditional talking can. Veterans and active duty soldiers often underreport symptoms so that they are not deemed unfit when it comes time to deploy. This was the case for Sarah (see above), who did not want an “official diagnosis on paper” to affect her work status in the Army Reserves.

Marshall: Sometimes patients are underreporting how much these symptoms affect their life so we can't just go by a number on the scale so to speak and a lot of times it is not until you talk to somebody and get through the initial sort of resistance or initial impression management that sometimes happens with people that you really get into the detail of what it is that somebody's been through.

Gary, a VA psychiatrist, is also concerned with the limitations of diagnostic criteria and puts it this way:

It seems like diagnosticians or scientists are divided into two camps: the lumpers and the splitters. The splitters are those who are focused on the criteria and are going to split hairs as much as they can and are really focused on that. That doesn't meet these four out of five criteria? Then that does not meet the diagnosis! Sorry. Boom! Move on. Those are the splitters. I am a lumper. Lumpers are, you know, what it looks like, what it feels like. I don't care how many of the criteria this person meets. It's my sort of general feel of that condition.

The implication here is that Gary does not need some list of criteria to assess what is going on with a patient but also that the “splitting” of experience into symptom criteria, again, misses the larger picture.⁴ The “general feel” is something that the screening tools fail to capture, and is really the humanizing aspect of talking to and trying to understand what is going with the veteran.

Ultimately, the failures of these diagnostic technologies are experienced similarly

for these clinicians as they are for the veterans. The screening tools are insensitive in the manner the questions quantify horror and human loss and inaccurate in how they “split” experience and under-diagnose. So much so, that the seasoned clinicians I spoke with do not even use these tools. This is indicative of the adverse effects these screening tools create for veterans. This professional rejection of clinical best practices corroborates with quantitative research done at the VA assessing the practices and attitudes of VA mental health providers and their use of disability assessments. Jackson et al. (2011) found that 59 percent of clinicians rarely or never use screening tools with only 17 percent routinely using them.

This anti-bureaucratic sentiment surrounding the limitations of screening tools is further revealed in some providers’ views on evidence-based treatments. As veterans go through treatment the assessments continue and mental health providers are flagged every three months to administer the PTSD Check List or PCL⁵ (this scale measure PTSD symptoms). The data is then kicked back to the central VA offices to help evaluate their mandated therapies. As Crystal explains:

The push from VA central office is we want to be sure that these people are getting adequate treatment and that someone is watching where their symptoms are going because you know that score goes into their chart, so there’s a way that the [PTSD] label is supposed to provide better care. From my perspective, again the flip side of that coin is, how limiting it [the assessments and diagnostic labeling] can be, especially because the VA has these roll-outs of different treatments that are, you know, empirically supported and are short term, very manualized [therapies] and they are intended to really just address the symptoms that are on that [diagnostic list].

To clarify, the follow-up assessments, limited in their evaluation of veterans’ post-trauma experience in the first place, generate outcomes data that end up

supporting what Crystal views as symptom-focused therapies. These therapies, in turn, are perceived as limited in how they can help veterans:

Crystal: There are two that the VA recommends. One is called prolonged exposure [PE] and then [there is] the CPT, cognitive processing therapy, and you know I think they both serve a purpose but they are very narrowly focused. If you are primarily experiencing nightmares and intrusive symptoms PE will help. It will help but neither one of them takes in this whole broader kind of, you know, this sense of, well PTSD affects so many [parts of your life] ... I am much more interpersonally focused in the way I do therapy and what I believe about some of the disruptions, I think a lot of them are in terms of connectiveness.

And that is part of my problem with the treatment roll-outs we are supposed to be using, these empirically supported treatments are very focused on symptom remission and not much on the kind of holistic how-do-we-create-healthy-stuff that supports you and supports growth.

Ethnographer: So it is like a super medical model?

C: Kind of, yeah, yeah right, it is like psychic chemotherapy you know?

The professional criticism of these evidence-based treatments parallels the resistance of utilizing screening tools and diagnostic criteria (the very technologies that legitimate professional practice): they both focus exclusively on symptoms, not the “holistic” experience of post-traumatic stress. According to these providers, the manner in which the veteran experience of trauma is captured and “boxed” up contributes to incomprehensive treatment.

For the clinicians, this categorizing of human experience functioned to feed a bureaucratic process that supports specific mandated treatments and ironically undermines their own professional expertise. Similar critiques have been made surrounding the increase in “box-checking” and reduction of narrative in psychiatric practice where paperwork and documentation infringe on clinicians’ therapeutic ethos. These cultures of practice are viewed as burdens that impinge

on care, especially for disadvantaged patients who require assistance beyond the medical to the social (Bullon, DeVecchio-Good and Carpenter-Song 2011).

Diagnosis for treatment, also as part of the bureaucracy of disability compensation (chapter 3), is perceived as doing a disservice to veterans who may not cover all the diagnostic criteria and then have to go without treatment.

Routinely, the DSM-category of PTSD is viewed more as a communication tool than a clinical tool for healthcare providers and this was also the case for veterans: PTSD, in a very practical sense, allowed for a civilian society to understand “what’s happening” with vets both individually and collectively.

Regardless, PTSD even when utilized as a tool of communication between vets, clinicians, and civilians was still being resisted because it remains incommensurate with military selfhood (i.e., modern veteranhood).

RESISTING MEDICALIZATION: SUFFERING, SACRIFICE and HONOR

The way veterans perceived of their diagnosis depended on the multiple meanings they attached to PTSD. Most of the veterans I interviewed did not believe that PTSD was an actual mental illness. Their implicit model of mental illness was something permanent, severe, “fucked up”, dangerous, debilitating, “crazy”, “unstable” and fitting with media depictions of schizophrenia or personality disorders. Every time Kurt and I talked, whether it was about his depression, insomnia, lack of concentration or how he felt “behind the curve” when it came to “life in general” (i.e. having a career, wife, home and family), he

told me “I don’t really think about it as PTSD”, rather “I just think I’m really sad.”

Kurt does not view PTSD as a mental illness, nor does Armando:

Physically I'm fine, but mentally it's challenging sometimes. Or I guess more appropriately *emotionally* it's challenging sometimes. And see, look there, that's even an example. Like, I can't look at it as a mental thing. Because I'm not, I don't feel like fucked up mentally.

So many veterans with a diagnosis who had experienced combat had difficulty

compartmentalizing PTSD as a “mental thing”:

Kurt: I don't think it's a mental illness. I just think people are different from what they experience and I guess that's defining what mental illness is in the eyes of the government. Like I hate to say I have a mental illness because I feel fine. Like I'm a pretty realistic person, a pretty level headed person, but do I suffer from anxiety and do I get stressed or am I sad about shit and did stuff affect me? Absolutely. That doesn't make me more [ill]...

But again, you're going to label vets who have done all this fighting and stuff and gone through traumatic events with PTSD, which is a mental illness, but what does that mean? Does that make them dangerous to society? Does that make them dangerous to themselves? I'm not dangerous to society unless someone fucked with me, which is a different story you know what I mean? But I'm a real nice guy, a really easy-going guy. Just because I have some of these issues doesn't make me more different.

I think society or the government or the health administration call it PTSD so that when all these guys who come back and are struggling, feel different in society, and feel sad and feel angry or they feel like something is missing - which is a bad way to say it but I think it sounds right and um, describes it really well, saying something's missing or something's wrong—I think they [society] need a word or some type of label to figure it out, to label people that just because regular civilians, wives, family members and stuff, they don't have it, they don't understand, so I think there has to be some type of label so they're like, “Oh, he has PTSD” and its like “Oh, ok, its some type of problem with the war.”

Ethnographer: So is it a way to talk about the effects of post-war?

K: Yeah, absolutely. Traumatic events or whatever. It's anxiety, its depression, uh, sleep anxiety, hypervigilance [pauses] yeah, I have a lot of that stuff. I have all that [laughs].

E: You're saying it's a way for everyone else—

K: To know.

E: To know what's going on with veterans?

K: Absolutely. It's a way for non-veterans to know what is going on.

What is so glaring about Kurt's definition of PTSD is that he seems to accept the label as it functions in this way in society but for him personally, his problems (anxiety, depression and stress) are not viewed as illness, but an accepted result of his war experiences. Yes they are problematic but they are not considered abnormal.⁶ This reverberates with the common lay definition in the veteran community of PTSD as "a normal reaction to abnormal circumstances."

Kurt's resistance to the PTSD diagnosis is embedded in his conviction that life experiences will change people. He does not surrender to the medicalization of his experience in part because of the very real fear of stigma attached to PTSD (addressed in chapter 6) but also because of professional pride linked to the roots of his suffering. In the introductory vignette, Kurt provided a clear picture of his pride in being a grunt in the Marines. Notably, there were some consequences his military branch and operational specialty imposed on him that were different and could have been circumvented through other positions (i.e., Armando's and Sarah's). For Kurt, the diagnostic category does not function as a form of acknowledgment (Young 1997) and in fact it operates in quite the opposite manner:

I don't want people to know [I have PTSD], especially nowadays because that word [PTSD] is just thrown around so easily. And again, I resent all those guys who weren't in combat and stuff and they get all the same care and all the same money I do but they didn't have to do half the shit I did and they're claiming PTSD and they lived on a base or whatever, and again, I don't want to be categorized with those guys.

The wide application of the PTSD diagnosis remains constantly upsetting because this usage promotes a universal war experience that assumes a common biography of suffering. This “undermines everything” Kurt and his peers did, as a form of professional work and service, and experienced through war. In fact, the very suffering they experienced is a point of pride: not having the comfort and protection of being on a base and living instead in bombed out buildings in enemy territory, no access to running water and showers, uncertainty of food supply and “eating pigeons” for days, no contact with family for months on end and of course, the relentless fighting, killing and human loss. Kurt, labeled with other veterans who have not sacrificed in these ways, experienced the diagnosis as an insult. (This is an inevitable consequence of the bureaucracy and its universalizing and equalizing processes.)

What this illustrates is that professional pride and military identity is inextricably wrapped up in suffering and suffering is honorable. This honor is privileged, it is earned and not just anyone can claim it. But in so many ways these memories did not carry the arrogance of bragging rights; mostly because of their private and personal nature, but also due to the reverence they demand in memoriam of lives lost and destroyed.

This reverence emerged in the very manner Sarah contended with her own diagnosis. Part of her resistance to being categorized related to her self-worth and group loyalty:

I just didn't think I was deserving of a diagnosis like that. I don't think I saw enough or went through enough, I mean some people did [see enough] to be able to have that diagnosis. I didn't really think that I would say I deserved that

diagnosis almost ... it means that you have seen a lot of bad stuff you know? And I feel like the things I have seen are not as bad as some peoples'. So why should I get that?

For Sarah, the PTSD label is a symbol that represents sacrifice, but as I illustrated earlier, the very process of quantifying these traumas and drawing a box around them undermines that very sacrifice. When I asked Sarah if she thought she had PTSD she responded bluntly: "This is just who I am now."

But Armando does not view the PTSD label as badge of honor, for him it is a failure:

What I did do [as a soldier], if I just think about it objectively, is exceptional. But was I successful if I'm fucked up by it? Know what I'm saying? Like did I really achieve all of these things that people say I should be proud about, if I didn't get through unscathed in some way? Like you go through, you do your job and you move on. I can't fucking move on. So I haven't achieved that. So I'm not successful at it ... It [the diagnosis] makes me feel like I am a failure at what I did as a soldier. It makes me think that while I have this new title or new accolade of veteran, it makes me feel like I'm a veteran by title but I haven't achieved what a veteran should achieve.

A "successful" veteran, for Armando is someone who has sacrificed, who can remember, without debilitating disruption. Armando experiences the PTSD diagnosis as a failure of his ability to carry on in a way that does not interrupt his life.

Jim, a Marine infantryman deployed to Iraq early on in the war (2004-2005), is also not convinced PTSD is a mental disorder. Jim served as a Marine for eight and one half years and then worked full-time in the National Guard until 2010. Currently he works in the disability rating office at the VA. Jim experienced symptoms right after he returned from war but then they "toned down." His symptoms returned when his third wife was deployed in 2009. It was she that told

him he needed to get help after a six-month binge of drinking. Jim was well aware of the gravity of the situation:

Well I knew that the drinking had increased and you know it is like, ok, I see that there is an issue, I get it you know and I am not going to lose this one because this one is number three, so it has to work.

Jim has been going to counseling weekly since 2009 when he went to the VA Mental Health Urgent Care (rather than wait three months to “get into counseling”) but did not receive a PTSD diagnosis until 2012. His diagnosis was made ‘official’ through the disability claims process two years after he put in a disability claim and three years into therapy in a VA PTSD clinic. It is not difficult then to see his point of view that the PTSD label is a communication tool (rather than a clinical tool), a way “your family knows what’s going on” and a “neat little box” the VA puts people in:

It is like, why does he have knee jerk reactions, you know? Why does somebody walking up behind him startle him so much? Why can’t he sleep at night? Why? Why? Why? Well, it’s PTSD. There it is, all nice and boxed and here is a little bow.

Ironically, these behaviors are representative of being a combat veteran.

Jim recalls a story of drill practice where a truck backfires and everyone hits the ground, everyone that is “except the newbies who haven’t been deployed yet”— they are still standing. As an expert in combat arms, “straight leg infantry, a machine gunner, an anti-tank assault man” and then a “primary marksmanship instructor and a marksmanship coach” Jim taught recruits how to shoot “everything up to the machine gun” and has extensive experience in combat training. When I ask Jim if he thinks PTSD is a mental disorder he suggests that

those things that become labeled symptoms are really the very skills that are necessary for survival when deployed to a warzone.

Jim: Is it a mental disorder? Good question. Or better yet, is it muscle memory? Is it training? Because you are trained to react, you know? ... And yeah, sometimes you have to react without that thought process we talked about earlier [moral and logical] because that thought process can actually get in the way and can cost you your life or your buddies their life.

Jim is referring to those skills that involve heightened awareness and responsiveness. These skills include “close quarters combat”, foot patrols and IED (improvised explosive device) searches, all of which were part of the urban warfare in Iraq. These military skills are translated into symptoms that are biomedically interpreted as alterations in “arousal and reactivity” as well as “constricted affect” (Armando referred to these affects as “compassion and love and empathy and kindness and good will”).

This idea that PTSD is partly “good training” acted out in the wrong environment, was echoed by other veterans and in a grand rounds I attended at the VA. The psychiatrist that presented explained that the “battlemind”, a military psychology term for the skillsets that soldiers train in that are so integral to survival, are the very behaviors that in the civilian world are considered abnormal.

These skills like targeted aggression translate as anger; tactical awareness translates as hypervigilance or paranoia; functional sleep deprivation as insomnia, and; emotional control as detachment. The point Gary, the VA psychiatrist who also is a combat veteran, so clearly makes is that these skills that make a good soldier become a disability in the civilian context, they in essence become symptoms of PTSD:

I don't sleep well at night. Why is that? Well, because I need to get up and check the house. Why is that? Well, for 14 months I was in Iraq and we never got a chance to feel safe. Well, that is good military training isn't that? ... The problem is, that training is not unconditioned.

According to Gary, veterans are not “reconditioned” for the civilian world because the military needs to keep soldiers in their battlemind state in case they are needed for duty at a later date. The result is that this need for “combat readiness” becomes reframed as PTSD, redirecting the problem to that of the individual, rather than the underlying socio-political issue: lack of troops. Because we do not have a draft, volunteer troops get “reused over and over again.” Medicalization of “battlemind skills” in this way disguises government misuse of human capital but in a more underhanded manner, it turns combat readiness, into a symptom to be cured. This recognition that many PTSD symptoms are a normal and functional response to dangerous and life-threatening situations has been acknowledged for some time (e.g., Cannon 1932) but not really considered in the design of diagnostic technologies and bureaucratic processing (addressed in next chapter).

TRAUMA AS COMMEMORATION, FOR SELF AND OTHER

I end this chapter with an excerpt from my last interview with Jim. It took place during what he half-jokingly calls his “PTSD season”: the time of year he, as a non-commissioned officer, was leading his Marines into combat. He talks about the importance of remembering, sacrifice and how the PTSD diagnosis fails to account for the weight of this responsibility:

The weight. The actual weight of it [is what's missing]. I make sure that every October 5th, November 8th, December 26th, February 8th, I go out and “OK, hey

look, did you know this happened today? In 2004 on this day Richard P. dies or Elias Johnson dies or Garth Williams dies and here's what happened" because I carry that. And it's the struggle of making sure that you do something where you don't cheat them the sacrifice and you don't forget the honor and respect that day is due. It's very taxing. You don't find that on their [clinician's] list anywhere. They're just not there. The weight of having to remember it and having to go ahead and determine what you are going to do with it ... this is why it hurts so much ... And that's, for me, that's huge because I don't want to forget because I don't want to you know, basically dishonor what they have done.

Jim does cognitive behavioral therapy, it helps him to deal with his survivor's guilt through addressing the accountability he feels for the death of his Marines. This accountability is understandable considering the important role of loyalty in a military culture of honor. In the Military Medical Ethics Volume 1, "honor is essential to the effectiveness of a military force" with the main components being integrity and taking care of subordinates (*Army 2003:160*). Honor, expressed through loyalty, operates as form of support for those who have to perform immoral or psychologically aversive acts in accomplishing a mission (e.g., killing or deceiving). In an environment of moral and material chaos, the integrity of an honor code enables military personnel to persevere and protect their character. Every service branch has an honor code and honor is part of the soldiers' job—being loyal to commanding officers, trusting their orders and putting the mission first. Moreover, it is the performance of honorable acts that support the mission but also strengthen individual character (*Army 2003:172*).

I want to emphasize that loyalty is a key aspect of honor and veteranhood. For Jim, "forgetting" the ultimate sacrifice his Marines made (giving up their lives) is equivalent to dishonoring them but also dishonorable of character. Honoring the dead is a way that Jim can continue to connect to and express his

veteranhood. Such rituals operate in contrast to the alienation that veterans experience through the diagnostic process.

Clearly, Jim is concerned that therapy may lead him to forget, breaking his obligation to his Marines (although clinicians I interviewed stated that forgetting memories was not a goal of therapy but that reframing accountability within those memories was). To make sure they do not forget, some veterans wear KIA (Killed in Action) bracelets as a form of commemoration. I know one veteran who has worn his for 10 years now. Others have tattoos that both honor their battle buddies and defend unit mottoes (Figures 1 and 2).⁷

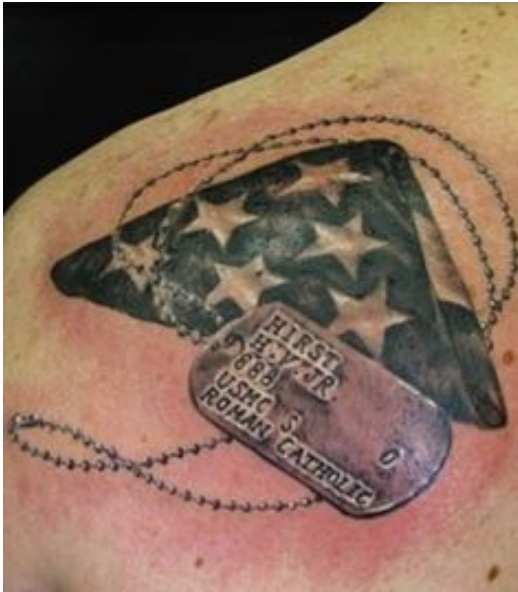


Figure 1. Commemorative tattoo



Figure 2. United States Marine Corps motto

Vets texted me photos on anniversaries to honor the memory of fallen comrades and others posted tributes to “Fallen Heroes” on Facebook. It was difficult for veterans to remember the death of someone without recalling the details of that particular incident or the general context of that death. As one vet explained to me, one memory just spurs a whole string of others, “the good with the bad.” And PTSD, because it’s a disorder, just turns “all memories into something bad.” There is a very real fear of losing accountability and as Jim explains, the responsibility of carrying on the memory of war’s damage and those who died. The perception is that the empirically based therapies, what Crystal

called “psychic chemotherapy”, might corrupt or even erase memories through dampening the suffering.

I began this chapter with the anthropological assertion that medicalization severs the connections between personal illness and broader social-political issues, drawing people further away from their suffering. Certainly this is the case with PTSD and these combat veterans I interviewed and worked with. Their resistance to a diagnosis and the bureaucratic process that envelops it (including mandated therapies) emerges as an expression of their veteranhood. It is a strategy to stay connected to those military values, relationships and personal losses that contribute to “who I am now.” These losses manifest as changes in ones character and selfhood, not symptoms of a mental disorder. The painful effect of this personal sacrifice is viewed as a natural part of life and is grounded in the broader military cultural ideology of honor, service and resilience (see Figure 3).⁸ Honoring allows veterans to maintain and build their individual character.

The “weight” of reverence for fallen soldiers and the ability to live through the impact of all the inhumanities witnessed and engaged, despite the pain, is what makes a successful veteran. Armando articulates this with such conviction and self-deprecation when he says PTSD makes him feel like a failure, “like I’m a veteran by title but I haven’t achieved what a veteran should achieve” because he cannot “move on.” Sarah expounds on this sacrifice in a different way in her

contention that she does not “deserve” the label of PTSD because there are those who have seen so much more than she has.

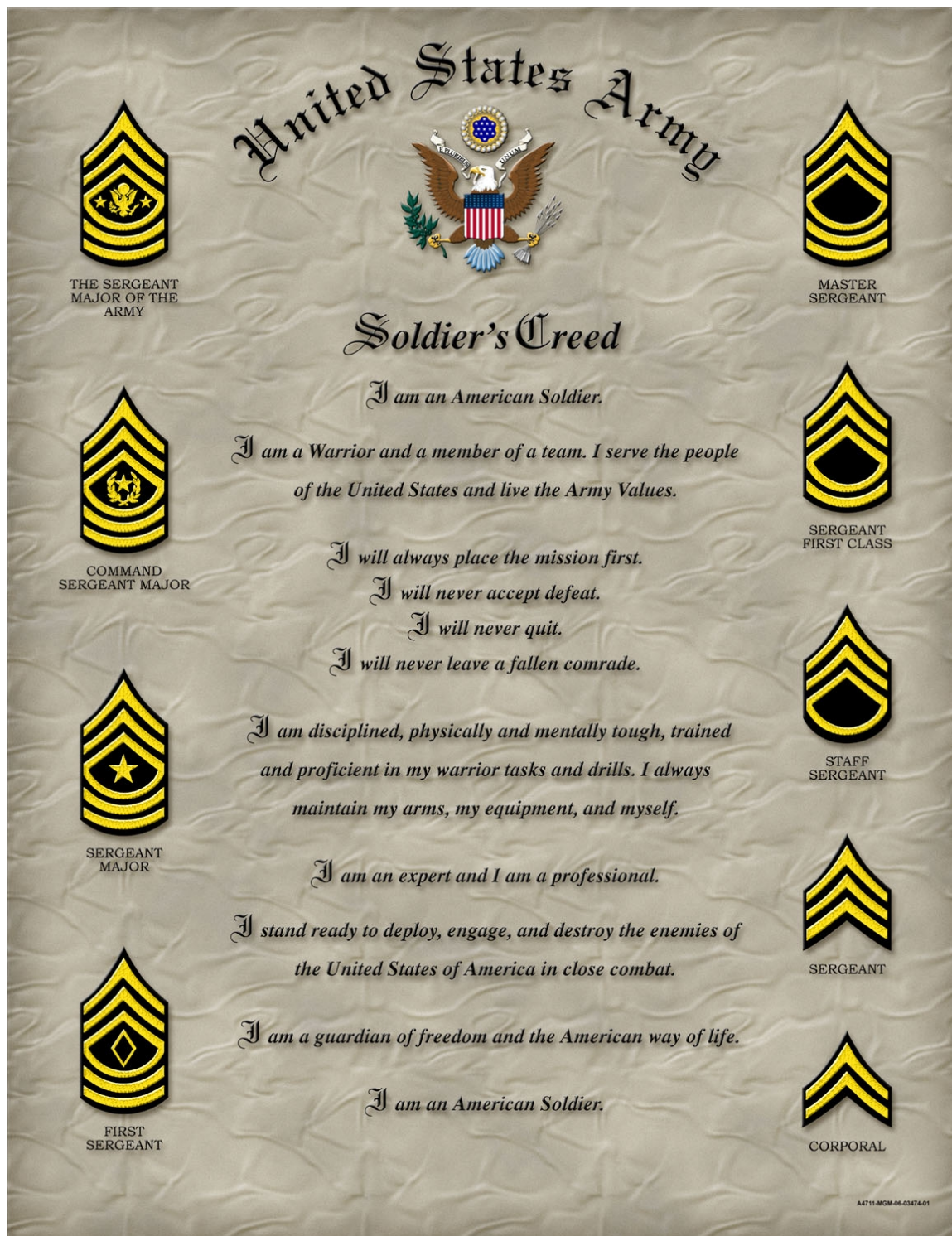


Figure 3. United States Army Soldier's Creed

I'm suggesting that PTSD is not valid for these combat vets because loss and sadness are rooted in cultural ideas of sacrifice and expressed through remembering: remembering one's transgressions, "dying moments" and most significantly, making sure "we don't forget." Obeyesekere (1985) contends that the pathologizing of emotional experiences occurs when emotions are not grounded in broader cultural and philosophical ideologies. For example, he shows how depression, as it is labeled in the West, as painful emotion based in sadness, is "free-floating" and therefore prone to being labeled an illness. He further illustrates that for Buddhists in Sri Lanka, depression is not accepted as an illness because feelings of hopelessness and suffering are representative of being a good Buddhist. To parallel this, I'm suggesting that PTSD is not accepted by this sub-set of combat veterans because honor and sacrifice, expressed through suffering and remembering, are representative of being a good soldier.

PTSD turns remembering "into a bad thing" because the very act brings on behaviors that are re-interpreted by biomedical technologies as abnormal, including other pathologized human experiences like grief and anxiety (Frances 2013). This is not acceptable to these combat vets because there is nothing "free-floating" about sacrifice. Sacrifice represents their military experience and it is part of who they are as veterans. Some keep it private and some share it, but everyone I spoke with, "remembered."

The vignettes and excerpts in this chapter illustrate how medicalization erases the human experience of trauma, thereby undermining the very selfhood

of veterans. This emerged in a number of ways: (1) through the bureaucratization of diagnosis that forced the explanation of experiences that, in reality, resist both description and rationalization; (2) the multiple appointments and retelling of trauma that desensitized and shamed veterans; (3) the systematic reification of experience into scores and symptoms through therapeutic technologies that quantified experience, and finally; (4) turning the skills (battlemind) and values (honor and sacrifice) that are an inherent part of being a veteran, into a disorder.

So what does this move from soldier to patient, this bureaucratization of traumatic experience, accomplish? I argue that for these combat vets it is experienced as an assault on their selfhood through alienating them from their past military efforts. Their opposition to the diagnosis and the collateral damage of biomedical meanings is a form of protecting what defines these veterans, honor and sacrifice. When the diagnostic process and labeling corrupts this honor and sacrifice, alienating them from their past efforts, veterans feel less than veterans.

Personhood becomes more complicated and conflicted as another layer of bureaucracy is added though disability compensation. In order to negotiate their military selfhood with a new civilian personhood many veterans rely on disability compensation. This requires a diagnosis. On one hand this process further bureaucratizes and undermines trauma. But on the other, through commodifying trauma, the compensation process can legitimate suffering and open up opportunities for veterans to develop their personhood. The next chapter

addresses this move from patient to government aid supplicant (i.e., receiver of disability compensation).

Chapter 3

From “Crazy Combat Vet” to “Welfare Queen”: Pricing Out Suffering

Well see, I've wondered if I'm mentally ill. You know? Like do I have some sort of mental disorder or defect? Like what's wrong with me? And I think it's easy for the VA to just give me a number and show me the door and deposit some money. I also think it's easy for me to just accept that and just say okay it is what it is.

—Armando, OIF Army Vet

“So watching my friend’s head blow up gives me \$400 a month for the rest of my life? Great. Thanks a lot.” That’s basically it for a lot of these guys.

—Travis, VA Claims Officer, OIF Army Vet

It’s (disability compensation) a weird touchy subject with vets and civilians. Like I’ve had friends straight up tell me, “That’s where our tax dollars go?”

—Kurt OIF Marine Vet

In the last chapter I illustrated how loss and suffering is rooted in military cultural values of sacrifice and as a moral obligation is expressed through remembering. This chapter asks: can that remembering and its sequelae be validated through the political and monetary currency of the disability rating? What are the consequences of commodifying suffering in this way? And what does a disability rating mean to veterans? By commodification I am referring to the transformation of goods, in this case that of veterans’ service, sacrifice and traumatic memory, into an object that can be exchanged for money.⁹ The object

in this case is a diagnosis and a disability rating that is then exchanged for a disability payment.

Some veterans pursue disability compensation for the very tangible need of survival: a disability award offers them a stable monthly income and provides them with free VA healthcare services. Others seek compensation as a consolation for altered life trajectories, a form of validation of their service or a form of “workman’s compensation.” In a society where there is a widening gap between the military and civilian worlds (brought on by an all volunteer army), the general public is far removed from the personal cost of war (Thompson 2011). As a result veterans seek validation for their suffering in other ways and a disability rating with its related compensation fulfills this function.

A majority of veterans desired this type of validation and yet there existed ambivalence surrounding the bureaucratic process: they sought recognition but felt insulted in having their trauma “rated”; they resisted the PTSD diagnosis but pursued it to receive a disability award; they desired their losses to be honored but felt no amount of payment could do so and; they wanted to share their pain but the depersonalized VA process and repeated sharing of trauma exacerbated it.

This is especially illustrated in the need for veterans to “prove” trauma through mandated reporting mechanisms. While this is certainly reflective of a wider societal ignorance of the professional work of war it is also part of the administrative quagmire. First, a good soldier is fighting and protecting comrades

in arms, not reporting their injuries for future medical claims. Second, as I mapped out in the previous chapter, a disability rating relies on a medical diagnosis and these therapeutic and administrative processes are often intertwined—unbeknownst to the veteran. As a result, personal traumas are recounted anywhere between four and eight times with no therapeutic follow-up. One veteran sarcastically termed this “unplanned exposure therapy.”

Veterans often claim that this disability determination process triggers or exacerbates PTSD symptoms. Another consequence is that in this process of trying to validate their sacrifices veterans’ personal meanings become devalued as traumas are repeatedly shared with “uninterested” and necessarily objective staff. This non-empathetic interaction is part and parcel of bureaucracy: to provide equal and universal care through administrative rules and regulations. But veterans are looking for recognition through a human response. This discord and its consequences I conceptualize as *bureaugenic effects*. Similar to iatrogenic effects (the illness symptoms unintentionally induced by medical treatment or physicians), bureaugenic effects are inadvertently produced by administrative processes and exacerbate illness symptoms. Paradoxically, these administrative processes are intended to alleviate suffering through providing just and fair opportunities for treatment and financial benefits.

While veterans adjusted to the PTSD label in order to pass through a process of recognition and reparation, values of selfless service, pride and personal honor made the experience of sharing their trauma difficult. The

following narratives highlight how trauma becomes authenticated for veterans and the ways institutional validation both enables and threatens selfhood.

WORKMANS COMP

Kurt does not accept his PTSD diagnosis as a symbol of his suffering or as an acknowledgment of the loss of his pre-war self but depends on it to provide him the disability compensation he relies on to develop his new civilian life. He views it as a form of “workman’s compensation.” Kurt and his fellow Marines feel a sense of entitlement to compensation because the injuries they sustained affect all aspects of their selfhood and personhood. Their best selves (who they envision themselves to be) involve multiple subjectivities and intersect the physical, psychological, and as Kurt describes it, spiritual. These best selves have endured much breakage and social defeat: building them back up will take a lot of work and support from others. “Proving” his trauma is the hardest part for Kurt and he hates that he has to spill his guts to get what he “deserves” — especially to people who seemingly do not care or understand what he had to do in his professional capacity as an infantryman in the Marines.

As I sit down to begin to write this chapter I receive a call from him. He calls sometimes to give me updates on all things VA related. Kurt is irritated and anxious and his agitation turns to a guarded panic as he explains to me that he has to go to the VA for a benefits re-evaluation of his PTSD. Kurt first applied for disability benefits upon returning from his second deployment (Iraq, 2009) to

address physical injuries and the trauma he has been struggling with since he returned from his first deployment in 2005. His severe back problems and neck injuries were denied a service connection and still today he is fighting to have these injuries “rated.” In Kurt’s view, this constant battle just exposes the VA’s strategy of denying veterans benefits, especially since “the government actually did physiological testing on Marines to track the damage” that carrying such heavy loads for extended periods of time had on the spine and knees (Marines typically carry 70 to 80 pounds of gear but some weaponry pushes that weight to 150 pounds). He sees a chiropractor up to three times a week when he has a flare-up and pays out of pocket for this in addition to visiting the VA:

I got denied everything for my back and neck but I have gone to PT [physical therapy] at the VA [and] they’ve told me that it’s all documented and that it’s just going to get worse as you get older.

These injuries are not easily compartmentalized as physical or mental and it is important to note that the physical pain can “trigger” what is categorized as PTSD symptomology (in this case, hyper-vigilance):

The other day I couldn’t move my neck at all and that makes me feel really vulnerable, me going into crazy vet mode [overly aware of surroundings] and all, and I get really anxious then.

Kurt views his disability check as a form of workman’s compensation, something he deserves for all the injuries he incurred “on the job.” Disability compensation is viewed as a military benefit (part of the service contract) and as it related to physical injuries it was something that he discussed among his fellow Marines while still serving:

[W]hen you are in the military you are just always jacked up [injured], it was something that was always discussed with my friends, “I’m going to fucking claim this because my shit is jacked.” I mean I never used to have this problem [shoulder issue]. Stuff like that. I already knew I wanted to do it [file a claim] so when I went to do it, I was like “I want to claim disability” but no one helped me. The VA didn’t help me.

These physical injuries will become worse with age. The reason why Kurt’s leadership and battle buddies advised him “to get in the system” was to document all war-related health problems, even if they were not yet bothersome.¹⁰ Many of Kurt’s friends claim disability, “Tom is 70 percent, Art is 80 percent, Pete is 90 percent, all my friends were infantry and they all have high percentages”; a very tangible marker of how damaged these young men are from their deployments (they are all in their late 20s and early 30s). His rating for PTSD is 30 percent and he has other service connections for physical injuries (traumatic brain injury, hearing loss, knees and shoulders) at a 40 percent rating. His lower back has “no fluid in it anymore” from carrying so much weight but he was denied a service connection for this damage. At the current rate, this 70 percent service connection gives him a monthly disability compensation of \$1312.40 a month.

The letter he received last Saturday, with only a one-week notice and a detour in the paper trail that left him without an advocate, stated that he would be reevaluated for his PTSD disability rating. Typically, the veterans service organization or the VBA claims officer who assisted in the original disability claim is contacted ahead of time to help the veteran prepare for the evaluation, advocate for them and even coach them in how to handle the evaluators. These

advocates are key in processing claims that are lengthy and filled with legal jargon. Erica James (2004) conceptualizes these gatekeepers to financial assistance as “trauma brokers.”

In James’ study of Haitian “*viktim*” of political violence, trauma brokers profit from the suffering of others. The brokers’ job depends on *viktim* and is linked to providing *viktim* with monetary aid through providing documentation of trauma. For example, local investigators are paid to collect evidence and compile “trauma portfolios” for their clients who in turn use the portfolios to secure humanitarian assistance. In some cases, *viktim* would pay investigators to assemble false portfolios to ensure political recognition and monetary aid. The profiting of trauma brokers in the VA context is not as direct as in the Haitian context and certainly not falsified (this would be very difficult considering the levels of bureaucracy in place to ensure equanimity in rating disability status). Trauma brokers in the context of my study are not independent investigators but do profit—their jobs depend on their veteran clients.

Kurt’s trauma broker was the American Legion: “I called the Legion and they had no record of it and they were not even notified. Somehow my claim is no longer connected to them.” I referred Kurt to a claims officer I knew to assist him and provide some support. What is so anxiety provoking about this situation is that Kurt depends on his disability rating and the monthly compensation it provides to live:

That is my life right now ... and I’m in therapy and on all the meds they want me on for sleep, depression and anxiety and they want to *screw* me over ... they

want to *reduce* my compensation, and I need that money, especially now with me being in school and all.

While the mission of the VA is to serve and honor war veterans, the bureaucratic and impersonal nature of the institution invokes feelings that are quite the opposite (I will address this later in the chapter). For now, what I want to point out is the contradiction of diagnosis and compensation. Kurt resists diagnosis as a moniker of suffering but at the same time relies on it to pursue the life he envisions for himself. In other words, he does not identify as someone who is mentally ill but someone who should be rewarded for the injuries he sustained that keep him from being his best self. This best self is intricately linked to his spirituality.

For Kurt, his spiritual loss surrounded the killing of innocent people, specifically the children and women who “got in the way and got destroyed.” This is what the military describes as “collateral damage.” In Kurt’s view, there were certain kinds of men that were innocent as well:

I saw little kids and horrible stuff happened and I came back and I was like what kind of god allows this kind of stuff? I mean all these guys got killed, really good men. I don’t know if I told you this, but two guys would go to church with me, and they were good guys, like good morals, good men, and they were the ones who got killed. And not to downplay anyone, or talk badly, [but] there’s horrible Marines, no morals, would do the most horrendous stuff to people, like just crazy criminal killers and nothing happened to them. So why, like why are my buddies, who are good men, getting killed?

The disabling part is the sadness this brings and how it debilitates Kurt, particularly in intimate relationships. In general, this questioning of God and his spirituality affect his demeanor but he finds it especially damaging in his relationships with women, keeping him from maintaining a strong connection with

someone. The feeling of “sadness” is something he cannot control or describe, and to ignore it, as I laid out in the previous chapter, is often perceived as dishonorable. To ignore the feeling is also difficult because it is embodied. It is something that non-veterans “will never understand” and “depression” does not quite cover it:

There’s just this empty feeling in you, this sadness that I can't even explain sometimes. I mean sometimes I get so sad that like [pauses] I guess, depressed. You ever get the feeling where you are so sad that you just feel like you're going to cry but you can't? You know what I mean? And I would feel that so much over there but there was nothing I could do about that.

Linked to the spiritual and moral is the psychological injury. He speaks of these injuries specifically in terms of the temporal:

Kurt: I lost everything, I lost a relationship with a girl I wanted to marry who left me in my second tour in Iraq. I lost friends and I lost time at school. I’m completely handicapped.

Me: So how do you feel you are handicapped?

K: I think I feel like I’m handicapped because I lost so much time and back to the self-critical ... I think I am just really hard on myself. I don't know what path I’m taking in my life. I don't know what I’m doing. I work and I go to school but I do not know what I am doing, I wish it was more clear to me. Obviously going from being a Marine for so many years and knowing your job and being in combat and being with a group of males and knowing a certain type of people for so long and [then] you get thrown back into this world where it’s just like kids who are more open minded, more liberal thinking, and in the Marines you can't be that way because in the Marines everyone is really tough and rough. I just feel really lost and I don't know what I’m supposed to be doing and I feel really alone.

Me: And you feel like that is disabling for you?

K: Oh absolutely because I am hard on myself and I think I can't do stuff so then I don't try.

This “feeling lost” and disconnected rattles self-efficacy and contributes to a version of civilian social defeatism. It is made worse when the very thing veterans rely on to help find their place in the community is threatened. I am referring to

financial aid. For veterans like Kurt, disability ratings are often relied upon for support and survival in the same manner one's squad and the military were relied on at war, especially when these veterans are severed from a way of being in the world and from everything they once knew and were a part of. (This issue of reintegration will be addressed in chapter 6.)

Kurt called me after his re-evaluation and it was not as distressing as he had anticipated. Kurt explained that at first he started to panic because: "All my benies (benefits) are hanging on this one person I have never even met before." During the interview, the evaluator, a female psychologist, put her pencil and pad down and said, "I think I have enough." This was where the anxiety set in for Kurt, when the examiner deemed his story finished:

I was like wait, there's more stuff ... I think she got what she needed though, because I told her two stories about Iraq and at one point she put her pencil down and covered her mouth. I said to her, "You don't see a lot of crazy combat vets do you?" So maybe that was a good thing [her reaction of shock], it seemed like maybe she thought I should have a higher rating.

This silencing of Kurt's story very subtly robs him of his experience, and much like the PTSD diagnostic technologies, is a consequence of the universalizing and equalizing process of the VA bureaucracy.

UNCOVERED LOSSES

While for Kurt, the disability rating is integrally linked to how his injuries affect his ability to become the person he desires to be, for Travis, it is more a form of reparation for who he might have become, but never will. Travis has endured multiple losses (physical, psychological and spiritual) and desires them

to be honored but he would much rather have his health back than receive a monthly check. He views his disability check as a poor consolation for the professional and social life he is now missing out on. Travis does not need his disability compensation to survive, he also realizes he will probably never be able to use the vocational benefits to develop himself professionally because of the nature of his injuries.

Travis is 90 percent disabled, but is able to work full-time as a veteran service officer and helps veterans with their disability claims. Travis has a 50 percent rating for PTSD and 40 percent rating for physical injuries. He filed for disability when he separated from the military in 2008. As a scout in a reconnaissance team for the Army, he did mostly “infantry-type” work in Iraq and is a Purple Heart Medal recipient for wounds suffered in combat. Travis sustained head injuries that now cause seizures and he experiences constant anxiety due to “being blown up seven times.” When we meet in a new place he is tense and continuously makes self-deprecating jokes that are accompanied by his own laughter. He describes his daily existence as “being constantly on edge” and in constant physical pain, which in turn, makes him feel severely depressed but also unsafe. Travis comes home from work every day and closes his blinds and locks his doors. He has been home from war two years. He cannot walk well and no longer runs due to hip injuries that are now affecting his knees, but even more disabling is his anxiety. To understand the context of his disability

(especially in the face of his full time employment) I asked him if his PTSD keeps him from doing new things:

Like seriously? [Laughs] I don't leave my house. I come home from work and I am on the couch with the TV or something ... honestly I got real bad anxiety to where I just yeah, I don't like going into stores. I bought a chest freezer so I could, like, buy hoards of food so I don't have to go to the store as much. I just, you know, I don't go out ...

I mean it is some of the pain but your anxiety keeps you in the house, it keeps you from doing this and because my life is not living, it's not an existence you know, it's at least not a worthwhile existence you know? You are not having fun, you are not going out meeting people, you're not going out, and [you] sit in your house everyday after work and literally, I don't enjoy anything ... and it's a very shitty existence and I think that's what triggers the depression.

Travis' anxiety is debilitating to an extreme, to the point where he understands his everyday life is not "worthwhile." Playing football, a favorite past time, and running races to fundraise for social causes are no longer part of who Travis is. These social activities are no longer available to him because of his physical injuries but also because of his anxiety surrounding public events. For Travis, the disability compensation is not crucial, but an acknowledgment that the war interrupted his life's trajectory and stole part of his identity. The compensation affords him part of the life he feels he would have had. The monetary part, that is. As he explains it:

I have a decent paying job. I mean it's not amazing [but] it's not horrible ... my house payments are 1200 [dollars] a month. On my salary it would be really tight at the end of every month. If my anxiety didn't suck so bad I would've had a degree by now, doing something. I mean when I joined the military I had a like a 122, whatever the score was, they said I could do anything I wanted ... I could have gone to college and like my sister is a therapist and my brother is an architect. She's making like 60 to 80 [thousand dollars a year] I don't know, he's going to be making 80 to 120 [thousand dollars a year]. It's like I could've done the same thing, get a great degree ... What was I going to say? Crap, I lost my train of thought again ...

It kind of makes up for what I could've been making had I not had, you know,

issues in life from being blown up so many times.

According to Travis, he had the “smarts” but now after the war he “can’t handle” college because of his traumatic brain injuries. These injuries affect his prospects for a high-paying professional career but compensation makes his life “a lot easier” because he does not have to “penny pinch” in order to pay his bills.

When Travis returned from war he went to college but explains that he had no aspiration nor did he care about his education and goals, “the depression and anxiety kills all that.” He also had difficulty concentrating and he often loses his focus in our discussions. I asked him what aspirations he had after the military:

Well, I always wanted to be a cop or a firefighter but then there was always an electrician, a specialized person in the trades, an electrical engineer. I was always good with my hands and problem solving and that kind of stuff. Before I went into the service that was the path I thought I would've gotten out and done.

Travis is in his mid-20s and while he views his life as “not worthwhile” he does offer a glimmer of pride when he speaks about helping other veterans as a claims officer. He advocates strongly for his clients (I witnessed this and also heard it secondhand from other veterans) and while he feels that compensation cannot make up for lost futures, he does his best to help those “get what they deserve.”

Arguably, Travis has found his place as a trauma broker but it is at a great sacrifice to what he had envisioned his life to be. He struggles daily with interpersonal interactions at his job and his life outside of work is painfully lacking in happiness or optimism. But he tries to be a productive member of society and his personhood is enabled, not through compensation but through his own will, despite his debilitating anxiety. His therapy he explains, keeps him from “going

down the tubes” too fast, but he is not convinced it is stabilizing his condition. It is possible that Travis will be 100 percent disabled in the near future. He has been waiting over 16 months for the claim for his hip to be processed:

My hip claim? Its month 16 now. It’s a clusterfuck. It’s actually kind of funny. My hips are messed up and I filed for the nerve impingement—so I have numbness in my legs and shooting pains because the nerves are getting screwed up because of my hips—so I go into comp and pen and they say “So we are doing a claim for your hips and knees?” [Laughs]. I was like you idiots, no. I was like “No, not the knees guys.” So whoever in the VA ordered the exam ordered the wrong thing so its like more delay. Actually, the funny thing is, even though I didn't want to file for my knees yet—since I walk funny because of my hips—my knees hurt more. So when I was in, he [the evaluator] said “Let me look at your knees anyway, since your knees are affected by your hips I'll grant you your knees too” even though I didn't file for it or want it.

Perhaps it was the obvious physical disability that made this compensation and pension evaluation (what VA assessors utilize to determine disability benefits) oddly generous and even caring, or maybe the doctor himself sustained injuries from a war. But for the majority of veterans I spoke with and worked with, especially those applying for service connections related to PTSD, the process was experienced as demeaning and alienating.

At this point I would like to highlight that Kurt and Travis’ narratives point out that PTSD as an “invisible wound of war” is an injury that crosses many intangible aspects of life including spiritual health, social belonging, leisure, recreation, personal safety and the existential.

THE “AWARD”

Suffering, symbolized in the form of these disability ratings, is an item of exchange that creates conflicted feelings and divergent meanings for veterans.

Even the small gesture of the evaluator putting her hand over her mouth in Kurt's evaluation can be interpreted as either a personal validation of the horror he experienced or, as another veteran pointed out to me in a similar circumstance, a demonstration that evaluators have no idea "what we went through" (and by extension proof that society as a whole has no concept of what war does to a veteran). As a result, there exists a desire for many veterans to have their suffering validated in other ways and, arguably, being "awarded" (VBA speak) a disability rating fulfills this function.

Although the implication of an award is that it has been earned, this validation does not imply that veterans—labeled as victims by others—defined themselves by their disability. Disability status was hidden from the public in almost all situations. Veterans adjusted to the label and passed through a laborious and painful process of recognition to win financial reparation (Fassin and Rechtman 2009; James 2010). Some, like Kurt, did so because it was necessary for survival and others, like Travis, did so for consolation for the robbing of their personhood. Like the *viktim* of Haiti's organized political violence during and after the coup years (James 2004) and the *victim*es of torture and repression seeking asylum in France (Fassin and Rechtman 2009), proving the psychological effects of violence was necessary to "authenticate" veterans' disability status.

A grueling and abhorred part of this authentication process is the compensation and pension evaluation ("comp and pen exam"). This is the actual

face-to-face evaluation (and re-evaluation) of a veteran's traumatic experiences and the impact of these experiences on that veteran's ability to function in daily life.

For the veterans I interviewed and the few I followed through claims processing and disability appeals, the comp and pen exam further demeaned the trauma of war and military service through attaching a price tag to loss and sacrifice. Objectifying the intimate experiences of war in this manner estranged veterans from their personal and professional efforts as soldiers. In other words, having their sacrifices "judged" and rated by people "who never served in a war" disconnected veterans from their work and in particular, to their "selfless service." Partly, this is related to the training for war that, by necessity, instills a sense of collective identity and purpose (that prepares troops for killing). This collective identity does not foster a sense of personal injury or individualized suffering and is part of the sacrifice that soldiers make, essentially to survive as a unit. The rating process forces an individualized form of suffering that alienates veterans from this collective self-understanding of "we are all in the shit together." (I detail this more in chapter 5).

It is also important to acknowledge that war is work but that for many veterans, signing up for the military is more than just signing up for a job: for some it was a civil responsibility and for others a family legacy. As one veteran put it:

They're taking your life purpose and saying, "Um, I think that's worth \$400 a month". How can you take a person's life and really tear it apart like that?

This veteran's disbelief and disgust at reconfiguring his self-understanding and purpose into a monetary wage can be understood as a form of alienation. In Karl Marx's conceptualization of alienated labor the worker becomes detached from the product of his work through the commodification of his labor (Marx 1927). In this framework, labor (i.e., military service and sacrifice) is reduced to an exchange value (i.e., disability compensation) and the lack of command over the exchange value contributes to alienation. The philosophical significance of alienation is that it interrupts one's progress to self-actualization, or the realizing of one's full potential. More specifically, this alienation contributes to a lack of self-worth and absence of meaning in one's life (Honderich 2005) that, I argue, describes veterans experience in the disability rating process. In the disability evaluation process the veteran loses control over the exchange value of their service and sacrifice gets turned into ratings and percentages.

This evaluation, and the waiting for the results, was an anxiety-ridden and stigmatizing experience. First, veterans felt like they had to "prove" their trauma and defend their reactions to those traumas and second, they felt they were morally judged by the examiners who themselves were often not veterans (sometimes even medical interns). To add salt to these wounds, the reliving of trauma through multiple assessments agitated veterans and made them feel worse, triggering or exacerbating their PTSD. This is what I conceptualize as "bureaugenic" effects. Similar to iatrogenic effects, the bureaugenic generates illness symptoms through administrative processes that are intended to create

opportunities to lessen those very symptoms they end up producing. The compensation and pension evaluation is a major cause of bureaugenic effects that exacerbate not only PTSD symptoms, but also the sense of alienation that estranges veterans from their military service.

Day of Reckoning

You are being judged on all sorts of different levels – not only for disability but for your character in a sense. You have a John Wayne-type guy sit across from you and start crying. Well you either feel sorry for him or have some disbelief.

–Dan, OIF Marine Vet, VA Claims Officer

The comp and pen exam is dreaded by every veteran. It is a test of “how messed up you are” and “how much money that is worth in the eyes of the government.” William, who deployed to Iraq in 2004, received a 30 percent disability rating four years after returning from war (concurrent with seeking therapy at the VA). He described his evaluation in this manner:

It's the day of reckoning where you know you have to relive your trauma to people who have no concept of the experience itself or the context, all they know are percentages and algorithms to see how much money you do or don't get.

This reliving of trauma is required for processing veterans because the VBA (benefits) and VHA (healthcare) are separate entities with separate administrative functions. The PTSD diagnosis is necessary in order to begin the rating process but before a disability rating is “awarded” (VBA speak) veterans must go through more assessments. Veterans perceived multiple assessments as a VA strategy to mitigate fraud but also as a way for the VA to save money through denying veterans their benefits. It is important to mention that earlier VA scandals of doctors under-diagnosing PTSD to deny veterans disability

compensation and “save tax payer money” are part of the collective cultural memory for veterans of the Iraq and Afghanistan wars.¹¹ It is easy to see then, the logic behind veterans’ suspicions that the VA does not want to compensate them and that the bureaucracy is in place to frustrate and obstruct disability awards.

To compound this, built into the claims process is the need to produce evidence of trauma, or a “verifiable stressor.” Before 2010 this required the veteran to prove the location and time that their trauma occurred, along with verifiable names. Undeniably, this “stressor” was very difficult to produce, months or years after traumas occurred and specifically for Vietnam veterans but especially for combat veterans like Kurt, Armando and William, where events were often not documented in the chaos of battle. So for example, William had to contact the other members of his squad:

So it's like, you know imagine my friends getting a call from me saying “Can you write down what happened?” You know? That's gotta be a weird phone call.

Not only is this a weird phone call, but also a call that requires an extended network of supporters to relive events that were possibly traumatic for them as well. In an effort to provide improved care and reduce this burden of proof, the “evidentiary standard” was “liberalized” in July of 2010. If veterans could prove they served in a war zone and experienced fear for their life, this was enough to start a claim. Of course veterans still need to go through multiple appointments to evaluate these claims but it is no longer necessary to provide evidence that the

traumatic event occurred through letters from witnesses or military medical records.

Not surprisingly, all the veterans who served and were processed through the VA pre-2010 felt they had to “prove” they experienced trauma and that the effects of that trauma were real. In other words, there was a feeling of judgment before the process even started. As a result of having to produce this evidence repeatedly, veterans felt that the VA did not believe them, care about them, or want to compensate them. Armando describes his frustration with VA

bureaucracy:

I'm trying to justify the way I'm feeling the way I do. I have to justify why I have an issue. It makes me feel bad. Things get brought up and get stuck in my head and I have to think about it over and over again. It's too hard. In the comp and pen process you talk to the psych [evaluator]—“Did you ever see anyone die? Give me the details.” Well, I went over that with my therapist already AND when I was put into the system, AND with the claims officer. I didn't even know why I was doing this again. They don't tell you anything. It seems redundant. It gets fucking annoying. You keep having to justify. Look at your record!

“That's all they Care About, Paperwork”

This discord between the chaos of war and the chaos of institutional paperwork points to a conflict of values and priorities between veterans and VA staff. The role of the soldier is to fight and protect to the end and the role of the bureaucrat is to remain objective and provide equal assessment for all. In other words, in the soldier's world nothing is fair and in the bureaucrat's world everything is fair. In general there is a lack of common ground that gets transformed into a devaluation of personal trauma. It is the job of the bureaucrat to not cloud assessment with empathy and emotion but it is this very human

response and recognition that veterans are seeking. Because they do not find it through the compensation process, the experience is categorized as insensitive and incompetent care. To negotiate this, some veterans adopt bureaucratic strategies of their own.

Nikki's medical file is almost two inches thick. She carries it around with her as she goes from one VA appointment to another, like an attorney carries their trial notebook. The file is a symbolic index of social capital and sacrifice and very similar to what Erica James (2004) calls the "trauma portfolio." James conceptualizes these portfolios as material and symbolic signs of victimhood, resembling financial portfolios of investments in that they were "exchanged in the local, national, and global humanitarian markets as commodities or currencies" (2004:33). In the Haitian context, a "pooling" of trauma portfolios operated on a community level to help Haitian *viktim* access bureaucratized care. Portfolios were aggregated to increase a *viktim's* chance of receiving monetary aid and a local community agency's chance of receiving global humanitarian funding to distribute this aid.

Nikki's medical file, like the trauma portfolio of Haitian *viktim*, included documents, letters, medical records and psychological evaluations that authenticated her trauma in order to receive care and reparation. In contrast, Nikki already had access to care via her military benefits. Her trauma portfolio merely operated on an individual level as a "back-up" in a system where "things get lost" in transit, even when the transit is internal and electronic. (The

aggregate of portfolios at the VA might assist on an institutional level to receive more government funding for staff and services but that is beyond the scope of this project.)

Nikki, an Army Reservist, served in the Iraq War in 2004 and was denied service connections for her PTSD, back injury, migraines and asthma, all due to lack of evidence that the injuries were service related (she made a claim in 2005, before the verifiable stressor for PTSD was liberalized). She explains the importance of her file:

It is your responsibility to prove why you deserve compensation. If you don't get those records to them, even if they (VA) have them, they won't compensate you. They don't help you. They don't want to pay ... You get so frustrated you just give up.

Nikki's medical file holds documents from multiple appointments she has had at the VHA with multiple doctors, providers outside of the VA and correspondence with the regional VBA. It also holds the denial form of her previous application, copies of the letters her Sergeant wrote to provide "evidence of traumatic events" while deployed and a statement from her ex-husband.

Nikki is re-applying for a disability rating after all these years because her conditions are getting worse. Namely, her depression is so intense that sometimes she has problems getting out of bed in the morning. As a single mom, with PTSD, she has difficulty taking part in all those things that 10 year-old kids like to do: go to the movies, skate parks and other social events that involve crowds of people. Because her PTSD affects her relationship with her son,

something she values more than anything else, and because her PTSD was caused by her military service, Nikki feels she deserves to be compensated.

This recognition process is especially exhausting for Nikki because she has been through it before, she knows how brutal all the assessments can be and the additional toll they will take on her wellbeing. What is especially salient is that Nikki's PTSD creates severe insomnia which affects her ability to "control her emotions" and "express" herself. This is a problem when assessments are based on self-report and another reason to keep a backup file—for reference. For her and many other vets, "keeping your story straight" was very important, as not to attract any suspicion of lying and malingering. Referencing her file helped Nikki keep her details in order over the course of all her appointments

The need to prove, through a paper trail, that their traumas affected them, and pre-2010, that they in fact occurred, was exhausting and morally defeating for veterans. The constant interrogation was experienced as an assault on their character and a test of their integrity (and their patience). Kurt found it especially "nerve-racking" that very personal questions were asked from doctors who he had no rapport with. He explained, "It's not *your* doctors that actually might care about you." In a heated outburst he described his first comp and pen exam that took place in 2009:

[I] remember one HUGE thing with me was there was a part where I had to sit in front of like three doctors and I had to stand up and stuff and they kept quizzing me, grilling me on my medical record because a big thing when you go to get compensation is they want stuff that is documented in your medical record.

So like in Iraq, "Well this isn't documented" and again I was infantry I didn't have the luxury of living on base ... One doctor, she would not even look me in the

face and she was reading my file: “Knocked out by IEDs, mortars.” I had numerous concussions and she said there was not enough evidence. That’s because I was infantry! Your corpsman [medic] would push out with 40 Marines and I couldn’t walk for three days because I had a parasite. That wasn’t documented because we were not on base! We were getting shot at! She did not understand that. Then I almost had a panic attack because she did not know what an IED was. Here she is, totally ignorant of my injuries.

The lady who is in charge of my disability has no idea what’s going on ... I got really frustrated and started yelling at the doctor, “Are you telling me you guys don’t believe me? I was infantry! Do you know what infantry does?”

I’m like “I did not live on base!” ... And they are just looking at me and I remember thinking at that point of my disability compensation rating, I was thinking, I’m not going to get anything because these people don’t have documentation and that’s all they care about, paperwork.

They don’t care what your job was or your experience and I was SO WORRIED. So worried. It was very nerve-racking. And then I had to wait six months to wait and see what it [rating] was. It’s not like they tell you at the end. Oh, like “We believe you.” You just walk out and they don’t say anything to you and its like, FUCK.

The fact that these physicians, who work in Veterans Affairs, did not understand Kurt’s job is part of the alienation and identity loss that Kurt feels more generally. As William so blatantly explained it, “In the military you are treated and respected at a certain level, as if you are valuable and indispensable, and then you get to the civilian world and you’re not even recognized.”

This is what was so agonizing for Kurt, there was no established common ground between himself and the comp and pen evaluators. These physicians had no understanding of what his military operational specialty required of him, the risks his work environment posed or even the everyday circumstances of the war theater. In general, the process of having soldiers’ work undermined through rendering their job invisible is reflective of a wider condition: society’s ignorance of the professional work of war.

In terms of VA processing, the chaos of war versus the chaos of institutional paperwork starkly illustrates gaps in reality that not only frustrate veterans but also threaten their selfhood. A good soldier is fighting, sacrificing, persevering—not taking medical notes to claim future disability compensation. The conflict of values between veterans and VA staff that emerges in the comp and pen exam, of good soldier versus good bureaucrat, is experienced by veterans as insensitive care. (I would like to note that the physicians who were interviewed expressed that they hated the comp and pen process “as much as veterans” did but were constrained by VA mandates to follow process.)

Veterans experience the conflict of priorities, fighting for survival and “getting shot at” versus reporting medical conditions, as VA incompetence. This ignorance, I will illustrate, is further exemplified in the “unplanned exposure therapy” the disability rating process generates. Conforming to the bureaucratic requirements of this process veterans (consciously or not) end up pitching their trauma and participating in the devaluation of their own suffering.

THE TRAUMA PITCH

It's like a performance. You act out everything except the event. I feel it detaches you from your memories. They lose meaning...

—William, OIF Army Vet

How is it that you can measure my trauma and categorize me on a scale of one to seven when your one is my seven?

—Nikki, OIF Army Vet

When William went to the VA for the first time, seeking mental health care, he ended up performing (and reliving) his trauma multiple times in what he

sarcastically calls “unplanned exposure therapy.” It was unplanned because he was not prepared to discuss his war experience with so many different providers and VA staff, nor was he prepared for the effect this would have on his memories. For William and every veteran I worked with, the disability determination process was more coldly clinical and demeaning than the diagnostic procedure. In part this was due to a conflict of expectations: the disability rating process was handled as an administrative interaction when a therapeutic interaction was desired (and expected)¹² but also, there was something corrupt about putting a price on lost opportunities and lost lives. This was especially true when the veteran was dealing with the lost life of a loved one or the loss of ones’ pre-military imagined self.

What makes this exchange of goods (trauma for disability ratings via diagnosis) so painful is the bureaucracy of care that transforms personal memories into criteria that quantifies suffering. As a commodified exchange of memories for monthly checks, compensation is a well-intended practice to provide reparation to veterans. Still, there is ambivalence in this form of recognition.

As Armando explains it, the pain is measured and the “VA matrix spits out a number” and “you get a check in the mail.” Although this seems straightforward, veterans’ ambivalence lies in the process to ascertain disability status and the perpetual need to recite trauma experiences to total strangers. The veterans I interviewed recounted their traumas four to seven times in the disability claims

process, depending on where they started. Since disability determination relies on diagnosis, these processes (therapeutic and administrative) are often intertwined, unbeknownst to the veteran, as I have already explained in the previous chapter.

William, for example, who was in the Army infantry in Iraq in 2004 first sought out counseling in 2008 at a Vet Center (a satellite of the VA). It was here where he was advised to go to the VA to “get into the system” and to have his physical injuries assessed for future health services. In a barrage of appointments, William (like Armando) was not aware that he was simultaneously being evaluated for a disability rating and thought he was going to the VA for health care.

At the VA he was connected with a service officer, whom he had to recount his trauma to. This officer filed for a service connection (for William to receive a disability rating) and set up his medical appointments. William told his story for the third time to a primary care provider who made an assessment and referred him for a traumatic brain injury (TBI) evaluation (with medical students observing). After the TBI evaluation he was referred to a psychologist for a diagnosis. Then, he saw a psychiatrist for medication. This veteran gave his trauma account six times to six different people. He explains how this made him feel:

William: I mean part of you gets sick and tired of telling your own story, and its like not really an easy thing to talk about, it's like a business pitch you know? You have to get it down, right? I just get tired, really tired of it you know?

Ethnographer: You say it's like a business pitch and you have to get it down, why

is that?

W: Well you don't have to. I mean it just happens. Because you have so many doctors appointments and so many people you have to talk to and explain to them why you're there you know, it's just you get it down. You're like ok, this, this and this, and I know all the information you want from me. And you just come with a, you know, like the easiest way to explain.

To reiterate, from a bureaucratic point of view, diagnostics (scales and measures) and disability determinations (claims application and comp and pen interview) are separate processes carried out by separate departments, but for veterans this is all characterized as “VA appointments” and VA paperwork. These “technologies of trauma” (James 2004) are the scientific and rational (and necessarily bureaucratic) practices that authenticate suffering.

The more memories were shared, the less personal they became and the more detached vets felt from their service. In a similar manner, Sarah equated the trauma pitch as:

Kind of like getting desensitized to violence when you see it over and over. I don't want that to happen. I don't want to devalue the situation. I don't want to share those stories with just anyone.

What is so extraordinary about her explanation is that the therapeutic technologies that the VHA mandates for trauma, specifically Prolonged Exposure, are based on desensitizing veterans to feared memories. The problem is that these memories are experienced, in an intricate manner, as both traumatic and sacred. As illustrated in the previous chapter, they are sacred in that remembering is part of being a good soldier (and veteran) and traumatic in that the details of the memories are often vile. For Sarah and William, these memories are an expression of their identity, part of their strategy to perform and

maintain their veteranhood. Sacrifice and honor are values instilled in their training and even though veterans are well aware that a disability rating is based on “how bad” these memories are and how they impact everyday life, sharing them with strangers (at least in a manner that is somehow not in reverence) feels dishonorable. But it is also painful, turning a deeply emotional social interaction into a clerical task, devoid of “humanity”:

William: You are sharing it [trauma] with someone who has no frame of reference, and that is hard to do because you know there is no emotional connection there and there is no give back to it [the sharing]. When you tell someone something usually you receive an emotional response, whether it is empathy or some, something in return. With this it's just “Ok, click, click, click” on the key board.

So first of all it's someone who you have no idea who they are and you have no idea what they are doing with your story because it's so personal and it's so raw and sometimes it's like the deepest cut you have, you know, in your life. And you're telling this person because supposedly you could get a disability rating, and in my case, someone signed me up for a battery of appointments where I didn't really know what I was doing or what I was going for and all of a sudden I'm telling my story for the third time feeling like I want to blow my head off.

Because it's so new and so fresh, even though I have been out for 10 years, its still like yesterday. All those emotions, I can access those very easily ... it's like you're going to an appointment and then you're fucked up for a week after because inadvertently, they are asking you [questions] and “Oh yeah, these are just questions about your experience” but to me you're just tearing open wounds and making me, forcing me, to address these things when I'm not [ready to] and then they [feelings] come up and then you stuff them back down. Whether that's with alcohol or drugs or whatever your vice is, that just brings it right back and that's why it's is so traumatizing.

I want to point out that what was “so traumatizing” for William was that he was required to recall events he was not ready to deal with, forced to transform his memories into an articulate story. He did not know how his “story was being used” or interpreted. He had no control over the value or the meaning the evaluator was attaching to it. Did it “hold up” in comparison to the other notes in

his file? Was he faking it? Is he viewed as a monster? Is he a criminal? Is he mentally disordered? Is he a victim? Was he doing his job to the best of his ability? Was he following orders? Was he a good soldier? This social process of being judged by someone who has no “experience serving his country” is alienating for William. The judgment creates a situation where military work and service become objectified into rating matrixes, far removed from the real labor and sacrifice of war. Another veteran can only understand this sacrifice. William describes the difference in sharing his experience with another veteran versus

VA staff:

William: [I]t's like a safety net. It's being confident that you can share your emotions with this person without being judged, without that kind of judgment and with the VA that's gone. There's nothing to support that [safety] so you are just hucking these stories out to people who are assessing you whose job it is to just to listen to people talk about why they are fucked-up all day.

Ethnographer: What's that like?

W: It's unsettling to have no reaction [to your trauma] and know that your experience is just typing on a piece of paper. There's no humanity to it so it's really a strange situation to be put in. One, if you are not expecting it and two because it's your memories and those are important to you. They are important to me so sharing with someone who has no interest in them is difficult to do.

William expected that his interactions with VA staff would be reciprocal, involve some reaction. It is this lack of mutual social dynamic in the sharing of his intimate memories that he experienced as moral judgment and lack of empathy. But again from a bureaucratic viewpoint, this is necessary to maintain objectivity in providing equal opportunity for all. This silencing of trauma, through the negation of an empathetic response, is the opposite of what veterans are seeking: acknowledgement and validation of their service and its sequelae. Also,

the consequence of the disability determination process, an exacerbation of PTSD symptoms, occurs through forcing vets to address deep wounds that are “fresh” and “raw” without any continuity of care.

While honoring service members is explicit in the VA’s mission statement, its bureaucratic structure strangles this through the dogma of contained objectivity and administrative excess. The clinicians and veteran service providers are victim to this as much as the veterans are and limited in the “holistic” care they can provide within the confines of mandated technologies of trauma.

Warrior Ethos and the Request for Aid

These early nonreciprocal social interactions with VA staff, combined with military values surrounding sacrifice and group loyalty, led veterans to protect their personal meanings of trauma and war. In some cases it even led to treatment avoidance, as was the case with William. For others it resulted in lower disability ratings because they would not share their experiences in full. Even in our multiple discussions over three years, my lead participants guarded the details of traumatic events despite our growing rapport:

You train for it [death] not to happen and train to avoid it at all costs and until you have been through that training process, it doesn’t mean the same thing [to a nonveteran]. This understanding is not something to brag about. These are Army core values, selfless service and personal honor. The values are a direct representation of who they [the fallen] were and we take that very seriously. They [the values] are instilled in you and I can’t emphasize that enough. It’s part of the process of reprogramming. Personal courage, telling people that stuff [trauma] goes against that. It’s not courageous to have those emotions in front of other people who view you as a warrior.

Part of this reprogramming is moving from being an individual to being the collective. Talking about individual suffering inherently goes against this training that tears down the individual to rebuild the group. This training against death, “to avoid it at all costs” ensures cooperation among people “who come from different places” and normally “would fight amongst each other.” The military strips recruits of their individuality, all the way down to “same haircut, same clothes, same glasses, same punishment” to promote this group cohesion. If one person makes an error or breaks a rule, the entire group suffers push-ups. In return for the loss of individuality soldiers are able to rely on the group unconditionally for their needs and protection. This is what is referred to as the soldierly bond, brothers in arms or the brotherhood.

But after separation from the military this protection and support disintegrates. No longer are soldiers able to rely on the unconditional support of the brotherhood and the military. Many vets are forced to rely on disability compensation as they once relied on the military and their brothers in arms. As soldiers they view themselves as strong, reverent and self-reliant but the role of government aid supplicant requires the opposite. The trauma pitch is a request for support in a place of insecurity and uncertainty—the civilian world. This insecurity is experienced both materially and psychically.

Materially, employers have difficulty translating military skills to the workplace, contributing to a high unemployment rate for young veterans (21 percent compared to 7 percent for civilians).¹³ Stigma might also play a role with

the media continuing to promote stereotypes of veterans as dangerous and unpredictable; veteran news stories focus on linking violent crime, PTSD and military service.¹⁴ Psychically, combat veterans move from a professional context where they have to work under constant pressure, with intense responsibility, and are respected and valued, to a world where, as Armando put it, “We are only viewed capable of being security guards, truck drivers and warehouse stockers.” Often, these war memories are the only link veterans have to their previous (professional) selves.

Many veterans felt that these memories were losing meaning through the trauma pitch but the real assault on veteranhood was how the process insinuated that their service and sacrifice were fabricated. The experience was that they had to “defend” their reactions to war. As Armando explains:

I think they are looking for inconsistencies in the story. Like here is my impression: I go in one day and tell them I saw five IEDs. Next time they ask, it's three. You feel like you are giving a testimony. I have to tell you this. It's on record. It's the same story. Why do I have to do that for level two and three? It's intruding ... I betray my own convictions entering that building [the hospital] because I don't think the VA is in the business of helping veterans at the expense of these providers who are there to help.

In this way, the trauma pitch created a general feeling of moral judgment for veterans and emerged as a stigmatizing experience and a defamation of character. The respect that was once honored them as soldiers, is now questioned as they take on the role of supplicant and possible malingerer.

William, when he went for his traumatic brain injury (TBI) test was angered that

[T]here were four med students in there, their trainer and my doctor. They were asking me questions and I felt like they were cross-examining me to see if my statement was the same [as previous assessments] and my story held up.

(TBI and PTSD have many of the same symptoms so often veterans will go through screening for both if they have had a head injury or were exposed to a concussive blast).

The perceived moral judgment that began in the diagnostic process was exacerbated during the compensation process. Veterans unanimously expressed anger at the depersonalized bureaucratic process that was required for them to receive a service connection and disability rating. They became angry both when they needed to tell everything in detail in order to get a high rating (with the assumption that the VA already had all this evidence in a medical file) and when the VA awarded them a lower rating than they thought they merited. Telling everything in detail to get a high rating risked betraying core values of personal honor and courage and receiving a low rating punished that betrayal.

The trauma pitch played into a feeling of abandonment that veterans conveyed to me: an overall feeling that the VA was not looking out for their interests, trying to “catch them in a lie” and “refuse them a service connection.” The tragic irony of the trauma pitch and veterans’ perceptions that they needed to keep their facts straight is that memories are fleeting and cognitive processing wanes under stress. Memories come and go. As Crystal, a VA psychologist explained to me, the physiological process of memory is such that the details of traumatic memories can change over weeks, months or years. Indeed, these details can vary in the time gaps between diagnostic assessments and comp and

pen evaluations. In other words, memories can change in the time it takes to process through the VA system.

Unplanned Exposure Therapy

It's like you're going to an appointment and then you're fucked up for a week after because inadvertently, they are asking you... 'Oh yeah, these are just questions about your experience' but to me you're just tearing open wounds and making me, forcing me, to address these things when I'm not (ready to).

—William, OIF Army Vet

When you talk to the comp and pen don't talk about that rape incident... You don't want to give them a reason to connect PTSD to something that's not covered. Fear of getting raped does not qualify.

—Travis, OIF/OEF Vet, VA Claims Officer

The following excerpt is taken from my field notes of observing the claims process at the VA:

As I walk through the narrow main hall of the VA hospital to meet Nikki, trying to make sense of the way-finding colored lines on the floor that lead to corresponding elevators and clinics, I get agitated with the lack of personal space. It is crowded and difficult to navigate the bowels of this old building with all the additions that have been built on over the years. A couple of old timers from the Korean War are being pushed in their wheel chairs, connected to IV drips, while the proud insignia wearing Vietnam vets stop each other in the hall to chat. It is as if I crashed a miniature reunion, but as I eavesdrop I realized this is a common meeting place and hospital visits are part of these veterans' weekly routine. Despite the friendly banter and patriotic framed posters of yesteryear on the walls, the painted cinderblock walls vibrate a dismal institutional hum of beige. I witness only three young veterans tactically dodging in between the overweight, underweight and incapacitated.

I met Nikki at the end of this long hall, in front of the "commissary" where veterans can buy tax-free items from this scaled down department store. There was a sale and Nikki had bought some toys for her son and a book of daily affirmations for herself, "365 days worth" of good words to live by. As usual she was carrying her overflowing medical file. She catches me glance at it: "I know I have more paperwork but I'm disorganized because there is so much of it and it's everywhere," she explains. She goes on, in an

exhausted tone:

I was looking at my records and I found stuff that wasn't true. I didn't notice at the time because I was disconnected. They denied me my claim on my back because in 2004, for my annual reserve exam they said I did not complain about it but I did. They also said the asthma was a known clinical diagnosis but there was no way to prove it was caused by living in the desert. BUT I didn't have it prior to the military.

We walk to the VBA regional office together and it is much like going through security at an airport. We have to dump all our belongings on a small conveyor belt so the armed VA police¹⁵ can search our bags via their x-ray machine. We walk through a metal detector and then provide photo identification and our names are taken down along with offices we are visiting. Multiple advocacy groups have their offices located in this building and the claims are processed here as well.

Nikki and I find her service organization, a large room with multiple cubicles. The business cards of the staff on the front desk indicate which service officers are veterans. As we wait Nikki tells me she collected the evidence of her PTSD diagnosis and also had her clinical social worker (from another VA hospital in 2006-2007) write a letter of acknowledgment of her "reason for PTSD and the service connection." Nikki relates the conversation she had with her social worker:

She was looking up my records while we were on the phone and said "Oh, I can see you have been going to the doctor." It's really funny because then here people act like these records don't exist and they can't access them. She even said "I don't know why the VA plays these games with people. They have it. It's all there." You get so frustrated you just give up. In the process they do not tell you what they have and what they don't have. It is your responsibility to prove why you deserve compensation.

We get called in after 15 minutes and meet with a service officer, Travis, who is a young Iraq vet. The cubicle is small and sterile with a desk, computer and phone. Nikki explains to Travis that she filed a claim in 2005 and never appealed it but would like to reopen it. As he looks through her stack of paper work he asks her what she wants to file so he is not looking at things that are irrelevant:

Nikki: PTSD, low back pain, asthma

Travis: Is that the only three?

N: Probably migraines. My denial refers to an assessment for an annual exam in 2004 that says I did not complain of any of these things and that is not true. They wanted more info from my original claim and that is when I was diagnosed with

PTSD. The diagnosis came from a military doctor at the VA and she wrote a statement about that and put me on anti-depressants.

(Nikki later handed me this “statement in support of claim” where the doctor wrote down all Nikki’s symptoms and “depression.” Further down on the statement, dated the very next day for a follow-up appointment, was a medical note diagnosing Nikki with PTSD and a recommendation: “I do not recommend that she remain in the Reserves.”)

Travis begins to look up “the law” in a three-inch book entitled “Federal Veterans’ Laws, Rules and Regulations” and starts clicking away, putting in codes in his computer. He explains how some things have changed since her last claim:

T: As of two years ago you’d have to have proof that said you saw Jimmy so-and-so get his head blown off. Now it is enough that just a fear of a hostile enemy attack is good enough. We just need to get a diagnosis ... so with the records we have 3 options: one, hope VA has it—

N: They have to have it.

T: I’m just saying, did they scan it? Did they lose it? You can get the records [from outside providers] yourself or you can contact VA and have them contact your doctor for records. As long as you have a diagnosis we can put in a claim. Your low back pain got denied because you did not have a diagnosis.

N: They are trying to put me out now because of my back so I know I have a diagnosis [we are going through her two inch stack of papers] I must have another huge folder somewhere else.

After more discussion on how and where to get evidence for the low back pain we begin the PTSD statement. (Nikki is visibly agitated, sighing often and her eye is twitching.) Travis, possibly noticing her discomfort, explains that for the statement “We have to give a brief description of the trauma. Was it a general fear or specific event?”

N: It was constant stress. Friends got hurt, people were dying and getting severely injured. I saw someone get raped when there was a skid¹⁶ dropped and we all ran out of the showers naked looking for our gas masks ... I don’t know I guess that’s the first thing you think of when you think you’re going to die ... I was put on escort and had to escort Iraqi men and I was the only woman in a truck of men. Even though I was armed it was stressful because from the time we got there we were told not to be alone ever around these men because they had different cultural ideas about women. And if anything happened there would be no recourse except to fire them from their job.

T: When you talk to the comp and pen don't talk about that rape incident. Don't talk about the shower incident. You don't want to give them a reason to connect PTSD to something that's not covered. Fear of getting raped does not qualify, if you say you had trauma due to running out of showers naked and witnessing rape you're not going to get it ... Stick straight to I feared for my life, I saw friends get killed and injured.

In private conversations Nikki expressed to me that the rape incident was a point in her deployment where she no longer trusted her own team, people who she was supposed to rely on to fight the enemy. Now the enemy was everywhere, even in her own ranks. This caused immense stress for Nikki, and is a major contributor of her PTSD symptoms—insomnia, fear of crowds and hyper-vigilance. But this does not fit with the dominant narrative of combat PTSD.

Travis goes on to explain to Nikki the importance of being clear and simple with her trauma narrative, (he obviously wants her to get a high rating and firmly tells her, “Don't give them an excuse to not grant you”). But still, he also is very matter-of-fact:

T: What is the approximate date the PTSD started?

N: Oh, I'm not sure, the whole time?

T: Just give me a date of, hey, your friend's got blown up.

N: May 2003, her name was Alison—

T: You don't have to worry about that.

What Travis meant is that Nikki did not have to worry about the specific details of the event, but Nikki clearly was trying to recount the incident with reverence. During the whole application she kept saying how she hates talking about “this stuff” and how tiring it was. Travis kept pressing her with questions but at the same time offered the language and possible events to help her with her statement, making the process less exhausting and painful for everyone:

T: Where [did event occur]?

N: [Provides name of city]

T: Was she injured or killed?

N: I don't know. We never heard back about her. [Nikki grows quiet.]

T: [Pausing] What about sirens? Incoming mortars? Did you have to go into a bunker?

N: No, a warehouse maybe. In 2003 there wasn't a lot of protection for people. We had plastic doors on our vehicles and were doing convoys outside of the wire.

T: We have to give a brief description, is there anything else?

N: It was just constant stress [she is getting tired of talking, her agitation is manifesting again through her eye twitching].

T: I want to give as much info as possible, but if this is all that is totally fine. [He reads back a three-sentence statement and she agrees.]

As Travis goes to get a print off of the claim for Nikki she tells me the next steps:

Then they'll send me a letter that says we have no medical evidence and then they'll say you have to go in for an appointment and then you go in and they'll say "How are you today?" And you say "fine" and they say "There's nothing wrong with you." I don't like talking about this stuff. I don't want to talk to him. I seriously want to go to sleep now.

Travis provides one last bit of advice for Nikki for her comp and pen exam:

T: The big thing is that you have to make sure you get a diagnosis. When you go to comp and pen you take it on yourself to tell them what your problem is. The big thing is the current symptoms. They base it on current symptoms now. Tell them "I don't sleep now." That's how they pay you. With your back they base it on pain and range of motion. Make sure you don't take Motrin or Tylenol that morning or else you'll be cheating yourself out of—

N: Pain?

T: Yeah. And make sure as soon as you feel pain you say it. If in constant pain be sure to tell them.

Benevolent bureaucraft is the concept Erica James (2010:88) uses to describe

this claims officer's approach to assisting Nikki in applying for a disability award:

Bureaucrats, like ritual experts, employ ideologies and practices to achieve concrete goals, whether those of their client or those of their own ... Thus the bureaucraft concept refers to a spectrum of interventions that are perceived as benevolent or malevolent depending on the political position of the actor.

The process at work here is a form of benevolent bureaucraft but inadvertently it ends up silencing the details of Nikki's trauma. This claims narrative exposes how bureaucratized care, specifically the criteria that comp and pen evaluators are mandated to use to "qualify" trauma for a service connection, can end up silencing the very traumas those criteria are intended to acknowledge: in this case, witnessing a rape and the fear of a similar assault from colleagues. Travis' coaching to not talk about "the shower incident" in order to secure her disability qualification (certainly a form of bureaucraft) subtly robs Nikki of her experience and is a consequence of the universalizing and equalizing process of VA bureaucracy.

Travis' instruction was based on his experience with the rules and regulations of disability determination and his intention is to help her receive the highest rating. Certainly, it came across that he was trying to be as efficient and effective as possible. But, like Kurt's experience in his comp and pen re-evaluation, this universalizing process inadvertently erases the complex relationship between "specific events" (and very personal events) and "general fear." As she described it to me, but did not detail in the claims interview, Nikki's PTSD was rooted in a constant fear of being assaulted by those she was trained to rely on. Finally, her experience is further suppressed through the necessarily

sterile process of Travis collecting “relevant” facts and decontextualizing her memories. But there is no time for full recollection in this environment and it is not the role of the claims officer to bear witness.

Nikki’s appointment took about forty-five minutes, her PTSD statement about fifteen minutes. But that fifteen minutes was enough to put Nikki in a place that only sleep could help her escape from. In our quick debrief in the parking lot all she has to say is: “They make you work for it. I understand why. They just don’t want to pay you.”

This view that the VA does not want to provide disability compensation to veterans is, as I have thus far mapped out, a consequence of the trauma pitch and bureaucratized care. According to Michael, a retired Marine, ex-VA staffer and current director of a veteran service organization:

There is common misconception that VA is trying to ditch veterans and not give them their benefits. There is a law out there “Duty to Assist.” Our duty is to tell veterans exactly what’s there and what is needed [in claim/benefits]. We ask for all evidence, we don’t know what’s out there.

Michael does not perceive the VA as practicing malevolent bureaucraft, he just acknowledges the complex “paper life” (Bullon et al. 2011) of veterans and all their injuries. He explains:

The reason why the claims process takes so long is that on average vets have 14 issues compared to WW II vets who had two issues per claim. And Vietnam, they had four to five per claim. With this war it is eight to 15 per claim. Why? One, survivability in battlefield, two, advancement in medicine and technology and different diagnosis and symptoms like TBI and three, advancement in weaponry. 65 percent that would have died have survived. In [Viet] Nam we didn’t travel in vehicles we stepped in a landmine. Now in vehicles you have multiple injuries from IEDs blowing up: tinnitus, TBI, PTSD, back injuries ... The reason the process takes so long is that 15 issues are the norm. They (VA) need to make sure the evidence is there for each one.

This supplying of evidence is burdensome but if veterans supply it themselves, the wait time is less and there is less chance that the claim will be denied.

Sarah has just supplied the evidence for a newly acquired health condition and applied for an increase in an existing one. She filed for hearing loss and a back injury after her first deployment in 2004 and has a ten percent disability rating for each. After her second deployment in 2009 to Afghanistan her hearing loss has progressively gotten worse. She also has developed asthma and esophageal issues from the burning pits and exposure to chemical spills. But Sarah is vehement about not claiming her PTSD. As I already mentioned there are many reasons for her choice: losing her current military status, “devaluing” the sacrifices of war, and sharing classified memories. There is however, one other reason why she refuses to go through the comp and pen for her trauma:

[A] lot of times with PTSD you don't have enough information to back it up you know? That's the other thing I am afraid of. Why should I make a claim, go through all of that and relive those moments that I am trying to work past only for them to tell me there isn't enough documentation for us to prove that you actually got PTSD from the Army?! And I have seen that happen to guys too, so I am not—that is a chance that I have to be in the right mind in order to do because if you do it wrong it is just going to stir up all those emotions again.

Sarah’s reasoning echoes William’s experience of being forced to face issues he was not ready to address, and without therapeutic follow-up. In order to be recognized in the claims setting veterans had to perform their suffering and sometimes, had to reframe their trauma in a manner that reduced reverence and challenged their military values. Even when veterans thought they were ready, they felt the trauma pitch exacerbated their PTSD. A few days after Nikki’s claims

appointment I followed up with her and she told me that the interview with Travis stressed her out:

The stress alone triggers my PTSD. I have to live it all over again ... My blood pressure goes up. I start to sweat. I can't focus. I start thinking about that stuff. I can't sleep...

Undeniably, the trauma pitch placed veteran's pride and identity at stake but in their view, it also aggravated symptoms of PTSD. After VHA/VBA appointments veterans expressed to me feelings of becoming "withdrawn and want(ing) to be away from the world", of "feeling bad about myself", and "retreating to the basement and not talking to my wife or daughter." As Armando put it, "It would ruin my whole week, that one bad interaction. You feel vulnerable after that ... I'd go back into my hole." These feelings that veterans experienced are consistent with the Diagnostic and Statistical Manual of Mental Disorders Five (DSM-V) PTSD symptom criterion B4/5, C2, D2/6, E1/5/6 (VA, 2013):

- B4. Intense or prolonged distress after exposure to traumatic reminders
- B5. Marked physiologic reactivity after exposure to trauma-related stimuli
- C2. Avoidance of trauma-related external reminders
- D2. Persistent negative beliefs and expectations about oneself or the world
- D6. Feeling alienated from others (e.g., detachment or estrangement)
- E1. Irritable or aggressive behavior
- E5. Problems in concentration
- E6. Sleep disturbance

The Worthiness of Wounds

One further consequence of the trauma pitch and rating suffering through this disability determination process deals with self-worth. The rating system created an environment where veterans felt a need to compare their disability award: either reflectively or with each other. Inevitably for combat vets worthy

suffering was reduced to the physical and mostly visible injuries and the secondary effects of having to adjust one's life to a new body. These visible bodily injuries transcended the invisible injuries of the mind and spirit. How did this competition for just validation and reparation via rating currencies affect selfhood? The following is excerpted from a conversation with Armando:

Ethnographer: You said that it [diagnosis and rating] validated your experience?

Armando: It's mixed. It's like, I feel like I said, I feel okay, good. So I wasn't just like losing my mind, like there was something going on that I don't understand that professionals deem appropriate to compensate me (for) or that I need to go and talk to them about, okay, awesome. But at the same time I feel like really shitty about it because I have both my legs I have both my arms, I have all my faculties.

I don't have—there are people, like I met a dude who lost part of his leg. And I get more disability than he does. I'm just like, phhfff, that's fucked up. And I don't think like, that's fucked up on the system. I think that's fucked up on me. Like, almost like, I should be like, how much do you get paid in disability? And then take what I get, and like make sure he gets at least a dollar more you know what I'm saying? Like why am I getting more than he's getting? So yeah, there's the validation of, I guess, there must be something wrong with me. But there's this kind of like, well, there's people that are way worse off than I am, like why am I getting this?

While the professional acknowledgment validated Armando's trauma and its sequelae, in a very insidious manner it produced self-stigmatizing feelings that his injuries were not as worthy of a high rating as someone who was missing a leg. Like the desire to keep memories classified in the trauma pitch, these feelings are rooted in what it means to be a good soldier: group loyalty and sacrifice. Armando blames himself, not the system, because he has all his "faculties" and body parts and does not perceive his loss as great as the amputee veteran. In comparison, Armando does not feel he is worthy of his disability award. He receives a 70 percent disability rating, 50 percent is for PTSD.

In the previous chapter I illustrated how military values of accountability and reverence and the connected expressions of shame and guilt kept veterans from sharing their trauma with clinicians. These values transfer almost seamlessly to the disability award, where guilt about the authenticity of their war injuries denies veterans the full experience of having that trauma validated. In other words, the trauma gets acknowledged but the side effect is feeling “shitty” or “guilty” about it:

William: I get 30 percent for PTSD and I know a veteran who is missing a leg and he gets 30 percent and then you start feeling guilty because I didn't lose a limb ... but I'm whole, at least physically. And I know people say “Well, you have wounds on the inside” but at the same time I really don't think wounds on the inside amount to missing a leg because that's a whole new thing you have to learn to deal with in your life and I just think the rating system itself is fucked. The math to figure out how much disability you get for what is fucked.

So what they should do is, amputees should be on a percentage scale and if you are showing symptoms of post traumatic stress, PTSD or whatever, it should be a set (amount) this is what you are getting: “Thank you for your service, sorry this experience has affected you so much. Thank you for fighting for your country but we are going to try and take care of you for the service that you did do, here's a thousand bucks a month for the rest of your life. Thank you.” That, I think veterans would appreciate more than this fuck around of “Ok, you lost your leg and you have PTSD and you have a TBI and you get 40 percent.” How the fuck did they get that?! You asked me to join and volunteer I did my service I earned my benefits and I got fucked up in the process. You need to take care of me because I answered your call for this country.

William's underlying critique is that to be recognized and materially compensated for moral suffering is impossible according to current (subjective) measures of chronic pain (more discussion of this topic in chapter 5). It is immeasurable precisely because it is invisible and no amount of math can do the conversion. His suggestion of a standard “thank you for your service” reparation for war veterans with PTSD speaks to how the current recognition, almost solely

experienced through a language of biomedicine and disability, alienates veterans specifically by not recognizing the moral decisions that had to be made in that service to country.

This bureaucratized recognition is offensive and alienating to William specifically because he “answered your call.” In his mind, still 11 years after signing his contract to join the US Army,¹⁷ he did something only one half a percent of the population volunteers to do: “protect the country and spread democracy.” That call, the disappointment of a failed mission and the losses it incurred, (including 350 thousand lives due to direct violence and the knowledge that those losses did not democratize Iraq and Afghanistan or liberate women in those countries)¹⁸ is now reduced to a monthly stipend and a diagnosis. The words of Travis, a claims officer and Iraq vet, whose quote I open the chapter with, are worth repeating: “So watching my friend’s head blow up gives me 400 dollars a month for the rest of my life? Great. Thanks a lot.”

While some veterans I spoke with internalized the flaws of the disability determination process as a reflection of their own unworthiness, others, especially those working within the VA, viewed the system flawed. Jim, who works full-time in the VBA rating office and checks the evidence in claims, explained the limitations and unjustness of pricing out injuries:

Jim: I’m rated at 70 percent: 30 percent for mental health and 40 percent for physical injuries, shoulder and back stuff. I have a buddy who deployed with me, he has got 23 pieces of shrapnel in his body, he cannot have an MRI ever again in his life. So okay, that’s pretty shitty. That sucks for him. Why is he only rated at 10 percent?

Ethnographer: Oh my god.

J: With 23 pieces of shrapnel that's absolutely absurd you know? You go through all sorts of crap—go to the airport, okay, hey now you are picked out because what the hell, you are beeping all over the place. You know? The inconvenience.

E: The inconvenience let alone, but it must be painful. Is it painful?

J: Well bores wear out, or shrapnel you know, it will eventually work its way out depending on location. Alright, then at that point, yeah, it can be painful but it is also continuing to do additional damage as it grows out of your body you know, so is that a fair [assessment]?

E: You can't remove it?

J: The amount of compensation, normally with removing shrapnel, depending on the location and stuff, like it actually does more damage to remove it than it does to leave it in ... but yeah to have something like that, that is just, it is a slap in the face. It is like oh hey, you have got blown up shit. Nice.

E: Do you think it is because it is not on the rating scale ... or is there, maybe, there is inaccuracy? Or maybe there is just unfairness in some of the rating?

J: That's, yes you know, well it doesn't affect his range of motion so that's fine. He is good, well yeah, you will verify that that is shrapnel in there but if it doesn't affect his range of motion then we are not going to call it anything you know. We are going to give him the low rating you know.

E: Right because it is kind of like an immediate, the immediacy of what it is causing [pain] not like in the future. So in the future he could go back and get it bumped up?

J: He could get an increase.

E: Bumped up because now a piece is coming out of his arm or whatever, but still you would think that they would have dealt with that enough—

J: And what about all the secondary effects you know? If he has some physical ailment that he can't you know be treated for because he can't have an MRI now you know?

E: Oh my god, what if he like falls off his bike and he can't have an MRI?

J: Right, or what if for some reason the shrapnel that was in him prevented the treatment that he needed in order to survive, you know? Okay, now what? Is his death going to be service connected and will his surviving spouse receive the dependency and indemnity compensation? Probably not. He was rated at 10 percent for shrapnel. [A veteran needs a 30 percent rating to receive these benefits.]

This narrative suggests that moral injuries are not the only invisible wounds that become erased through bureaucratized care. Jim so clearly explains that secondary effects are uncertain and more importantly, go unacknowledged. In order for this injury to be worthy it must have an immediate measurable consequence on a vet's life (i.e., range of motion). Like mental anguish, physical pain is quantified and given a rating and monetary value, but it has to fit in certain objective criteria. As Jim explains, if the veteran can move his arms and legs fully, "we are not going to call it anything" and "give him a low rating." In the narrative above, Jim views this low rating as an insult to his friend's sacrifice. What I want to point out is how tenuous the meaning of a disability rating becomes when the lines between material need and validation become blurred. The questioning of self-worth emerges as a consequence for many veterans as they compare sacrifice, types of injuries and disability awards.

THE MEANING OF DISABILITY RATINGS

They gave me a PTSD rating at that point and it was weird because when I saw that, it was almost like validation of how I felt. Like, 'Oh, so there is something wrong.' But at the same time I thought, well what does that mean? Because I hold down a job, I'm not getting in trouble...

—Armando, OIF Army Vet

You know I think the whole compensation thing is like a sensitive subject with vets because a lot of people look at it like welfare.

—Kurt, OIF Marine Vet

Vets clam up in the compensation and pension exam and as a result get a ten percent rating when they deserve a 50 percent rating.

—Travis, Claims Officer, OIF Army Vet

Validation

Thus far I have illustrated how the dynamic between military selfhood (reverence, group loyalty, sacrifice, strength) and bureaucratized care can put veterans' pride and identity at stake. As many claims officers described to me, the consequence of this dynamic is that vets "receive less than they deserve." The underlying implication is that compensation is linked to merit, rather than tangible need. This difference in meaning points to contested understandings between veterans and the VA of what a disability rating is. This is an important topic to broach when some of the narratives that I have presented, of Armando (70 percent disabled), Travis (90 percent disabled) and Jim (70 percent disabled) challenge my own ideas, and by extension that of civilian society, of what disability is—especially when these young men have full-time jobs, own cars and homes, and by global material standards are "living the dream."

A significant difference surrounding the meaning of disability ratings existed between veterans, VA service providers and institutional definitions. For the veterans in this study, a disability rating was in part a validation of their war trauma and sacrifice. The rating provided a stamp of truth in a system, they believed, was designed to catch frauds. It also created some questioning around the ability to fulfill one's social role:

Armando: When I came back and I started going to the VA the first time, there was nothing on paper saying like you have PTSD. I was going to the PTSD clinic, I was in the office, but there was nothing in black and white until I came home the second time. When that became a quote unquote official, and they sent me my packet from the VA saying here we're rating you at this that or whatever, they rated me at 30 percent. I don't know what that means at all, I have no idea. But so they gave me a PTSD rating at that point and it was weird because when I

saw that, it was almost like validation of how I felt. Like oh, so there is something wrong. But at the same time I thought, well what does that mean? Because I hold down a job, I'm not getting in trouble, all these different things you know ... I'm still married, can work, you know? Was going to school.

So the way that it was being presented to me was like I have this debilitating disorder. And then I see 30 percent. So am I like 30 percent of the way to like full blown PTSD? Like what does that mean? It affects 30 percent of my life? And so really, I went on this kind of multi-year journey of not knowing what that meant.

The concept of a rating did not fit in Armando's framing of disability, which was a condition that was essentially debilitating. In addition to creating questions around personhood, the rating as a validation of a mental health condition, created questions surrounding selfhood and recovery. Six months after I accompanied Nikki to her appointment to reopen her disability claim she was awarded a 30 percent rating for her PTSD and was denied (again) her back injury due lack of evidence. She texted me the following after we had met for coffee to catch up on things:

I was thinking about our convo the other day. You asked what is different now that I have a rating for PTSD? B 4 I felt like they denied my claim cuz what was happening should be something I would recover from. Now I know from the rating I won't get over this. I will have to deal with these feelings, thoughts, my changes for the worst, forever. And the government has finally acknowledged that fact.

The meaning of a rating for Nikki and Armando was a validation of the effects of war but while this was perceived as positive the new classification of "disabled" hinted to that of being a different, and broken, person now. For Nikki, it meant she was forever damaged, something that she earlier did not consider. In our previous conversations trauma recovery was something she felt she could attain through her faith in God and her service to her community and other veterans. This new understanding of herself as permanently disabled is what lan

Hacking (2006) refers to as “making up people”: the process where science (i.e. psychiatry and psychology) creates types of persons that did not exist before, either to control or help them.

In Nikki’s case it helps her because the diagnosis and service connection of 30 percent provides her with lifelong therapy and a small financial compensation (that she admits does not matter to her because she works full-time). Significantly, the rating has enabled her to remove self-blame: “I know now I’m not going crazy and this is has to do with my brain.” For Nikki, the government acknowledgment and financial reparation authenticated her suffering from war in a way that a clinical diagnosis did not. The rating means that she is now officially mentally ill due to the war and that there is something very permanent about her condition if the government is willing to compensate her for the rest of her life.

This was a sentiment expressed by many veterans: the permanence and severity of an injury if the VA was going to “pay” for it, especially within an administrative process that felt very disingenuous. For Nikki and Armando the rating functioned as a validation but also labeled them as damaged goods. The rating was not about a material tangible need, in the financial sense at least.

Social Safety Net

For me, I don't feel too bad about it [claiming disability] because I'm fucked up because of shit I had to go through and the way I pushed my body. And I don't look at it as a bad thing because in my mind it is acknowledging all that sacrifice and all that time I did that I got fucked up and they are giving me money to try and help take care of me and help me get on my feet.

—Kurt, OIF Marine Vet

Unlike Armando and Nikki, both Kurt and William sought out monetary compensation because they needed help realizing their place in society. The following is excerpted from a discussion I had with William regarding his decision to file for disability:

William: I was just like, I knew I needed to file for that [disability] because a lot of the shit that I was going through like affected my life. And I really felt that it's directly related to war.

Ethnographer: ... So you have a disability rating of 30 percent, I mean how does that help you?

W: Yeah, yeah, I mean it really has helped me try to, I guess, do better with what I have, because that's coming in, I know that's coming in and that makes me, I guess able to make better decisions about spending money and stuff I need to do.

E: Can you give me an example?

W: Well, if I have bills to pay or whatever, it helps me, and by having that taken, that extra money to help take care of some of my bills, it frees me up to the point where I think I'm able to function better. If that makes sense. Just generally.

E: You figure that's like an extra four hundred bucks you get a month, and you said it frees up your time to function better, what do you mean by function better?

W: Well, I feel that if I'm in a work environment that I either don't like or just doing something that I don't enjoy really, that really brings out a lot more of, I guess you could say, symptoms of PTSD. So—

E: What symptoms? Like if you were in an unhealthy work environment?

W: I feel like my nightmares are worse if I'm in, if I have a lot of stresses, like coming in on me like from outside sources and that's kinda where that disability helps. [It] kinda takes a layer of pressure off of what I need to get done. But I feel like there's a lot of outer pressures and then the more that (they) are pressing in on me is when symptoms and stuff flare up. So stress levels are up, I get hyper awareness, I get, I feel like when my stress levels rise it just kinda tips over into military mode. Where that's like if your stress levels reach this bar [gestures high] it just kinda spills over into resorting back to like survival stuff.

“Survival stuff” for William and many other veterans involves making split second decisions that are so reactionary and lodged in the present moment that

they end up sabotaging personhood. When in “military mode”, if decisions are not life threatening they are often considered unimportant. These decisions or neglect of them (i.e. the mundane responsibilities of everyday life like paying bills or going to work or school) interrupt futures and relationships and can end up displacing vets.

So for example, when a veteran like William is stressed, he isolates or makes quick decisions that end up disrupting his long-term plans and the time invested in those plans. The compensation assists in maintaining these plans and relationships through maintaining stress levels, particularly in a manner that allows William to do the community service work that he so enjoys and makes him feel part of a “larger mission.” In much the same way, the opening narrative of this chapter illustrates that for Kurt, the compensation allowed him to go to school and spend the extra time he needed to do well in his classes so he could professionally develop his career goals.

This social stress that William and other veterans refer to, as it is linked to the meaning making of disability ratings, was mired in the number and types of war experiences veterans endured. The quantity, versus the quality, of those experiences was what veterans felt they were being assessed for. Veterans felt that they were being rated for how many deployments, how many times they were blown up, how many people they shot and how many friends died. This is understandable considering the tools used to screen for PTSD such as the Combat Exposure Scale (see Appendix).

The rating matrix and the institutional definition of a disability rating are not about the quantity of war experiences but the effects of these experiences, or “occupational and social impairment.” This is what the VBA bases a rating off of (according to the VA General Rating Formula for Mental Disorders). Certainly veterans talked about social and occupational impairment in terms of no longer being able to engage in certain activities but this was more often in relation to physical injuries. When it came to mental injuries, a disability rating was most often viewed as an acknowledgment of “being messed up by war” and a way for the government to “take care of you.”

What I have thus far illustrated is how suffering, symbolized in a disability rating, becomes an item of exchange that creates conflicted feelings and meanings for veteranhood. While the disease category is not a valid form of suffering for this subset of combat veterans, the recognition gained through financial reparation can be.

What are the consequences of commodifying suffering in this manner? In order to be recognized in the claims setting veterans have to reframe their trauma in a way that reduces reverence and challenges their sense of self. This social process alienates veterans from their military experiences in that it objectifies their work as soldiers in service to their country. Some are proud of this service and others are not, but regardless, veterans want the sacrifice of this work acknowledged. The reframing of trauma that reduces reverence

compromises veteranhood but is necessary to find one's civilian personhood on the road to "normal." These compensation stories show that there are aspects of life that are difficult to measure and commodifying them can threaten veterans' self-understanding and connection to their past.

The theory behind disability compensation posits a transformation of war trauma into something positive—therapy to promote healing and financial support to open up possibilities to pursue one's vocation. But from the veteran perspective, the commodification process turns deeply emotional and autobiographical social interactions into clerical tasks devoid of compassion and reverence. Disability ratings become an ambiguous form of validation in a world where the warrior is no longer publicly revered or understood. While veterans adjusted to the PTSD label in order to pass through the compensation process, values of selfless service, pride and personal honor were challenged. Putting a price tag on trauma often times demeaned their war "work" and even made veterans ambivalent about seeking a disability determination.

What these narratives also suggest is that the conversion of suffering into monetary reparation can become a denial of peoples' experience of violence (Argenti-Pillen 2003; James 2012; Petryna 2002). For these combat veterans in particular, the bureaucratic need to supply a trauma pitch erases the significance of suffering in an undignified manner. This occurs through further challenging military values and diluting meaningful experiences through rote performance. These bureaugenic effects of demeaning experience and pricing out suffering,

juxtaposed with veterans' desire for validation, covertly denies selfhood by creating inner conflict. The unintended consequence is that the process creates morally self-evaluating experiences for veterans and, in their view, contributes to a worsening of symptoms in an administrative context without clinical follow-up.

Commodification can also threaten personhood unintentionally in a manner I have not mentioned yet: secondary gain and abuse of monetary rewards. The issue of secondary gain points to the elusive quality of the "psychological effects" of war, chronic suffering and "fixing" the sequelae of systematic violence through disability ratings. This will be addressed in the next chapter.

Chapter 4

From Victim to Malingerer Being Paid to Stay Ill?

The institutional perception of VA is that they (veterans) are coming to the treatment setting with ulterior motives.

—Dr. Luhrson, VA psychologist

Our lane is clinical. Our lane is not benefits. Do not cross out of that lane and begin to make statements, write letters, tell people 'you need to be 100 percent certified'. Do not do that. If you do that you are not helping the veteran.

—Dr. Argosy, VA psychiatrist

It would be a huge disservice to say that the majority of individuals are as worried about their benefits as they are about feeling better.

—Dr. Jameson, VA psychologist

A check doesn't fix anything. At least it didn't when I first got back. It just supported my drinking and provided a steady flow of numbing. Looking back, that was the last thing I needed. It kept me from having to look inside myself... It stunted me.

—William, Iraq Veteran

In the last chapter I illustrated how a disability rating functions as a form of validation for veterans, albeit an ambivalent one. I suggest that many veterans desire this validation because they cannot find recognition publicly in a society that is so far removed from the personal costs of war. Even though the disability determination process threatens military values tied to self-identity, compensation can enable opportunities for “getting back to normal” in the civilian world. From a

clinicians' perspective though, disability compensation can promote malingering and obstruct personhood through secondary gains, specifically through "being paid to stay ill."

This issue of secondary gain is at odds with recent anthropological and sociological readings of trauma that posit a social shift from the assumption of malingering to victimhood (Fassin and Rechtman 2009). Fassin and Rechtman, in their genealogy of trauma illustrate how this shift transpired through a change in moral climate from suspicion to authenticity. The authors mark the unfolding of war atrocities committed by United States soldiers during the Vietnam War, along with the work of anti-war protesters and the reactions of the military, as a major source of this shift. In particular, it was the push to publicly reveal the terror of war without morally condemning all the individual soldiers who were following orders or responding to horrific circumstances. The medical result was the inclusion of "self-traumatized perpetrators" (a term used by Alan Young referring to the soldier traumatized by their own actions) into the trauma category (combining perpetrators and victims into a single classification). This moved the attention away from the moral conditions to the environmental circumstances that could make any healthy individual engage in trauma-inducing atrocities. To illustrate the gravity of this shift, symptoms of trauma expressed in soldiers during World War I were seen as cowardice, while those of Vietnam War veterans were seen as normal reactions to abnormal situations (essentially a human response).

Fassin and Rechtman deliberately point out that it was social history and the actions of the people not connected to the mental health field that influenced the medical history of trauma. The point in history where a person suffering from trauma was no longer viewed as a faker or profiteer was marked with the publication of the third edition of the American Psychiatric Association's classification of mental disorders (DSM-III). It was in this edition that a new term, PTSD was added. The major difference between the criteria of PTSD and its earlier version, traumatic neurosis, was the first criterion that asserted that any normal individual exposed to an event deemed traumatic could suffer.

This new criterion made the sufferer a priori credible and removed the question of secondary gains (Fassin and Rechtman 2009:77). In other words, with a PTSD diagnosis the victim is trusted, legitimized and has a right to reparation. Fassin and Rechtman argue that the political uses of trauma, framed in victimhood, are illustrated through the practical ways in which trauma is applied to claim reparation, testimony and proof. In all these instances the focus is not so much on eliciting empathy but on claiming rights: trauma is theorized as a tool to demand justice. But at the VA this is not the case, the sufferer is not a priori credible, despite institutional mandates that have relaxed requirements to authenticate trauma. Why has this ideology of victimhood not caught on at the VA despite over 30 years of possible adaptation?

I suggest that the socio-moral considerations of victimhood that Fassin and Rechtman posit are at odds with the trauma narratives of OIF/OEF veterans

and their clinicians because of three interrelated issues: (1) the professional ethos and pride of clinical staff; (2) the invisibility of PTSD and the ambiguity of policy terms and; (3) disability and impairment.

First, from a clinician's perspective claims and therapy have distinctly different purposes: "claims is not about validation, treatment is" and disability compensation is about "what you can and cannot do" in relation to occupational tasks. Disability compensation creates a fundamental conflict for clinicians whose professional responsibility and goals revolve around helping the veteran get better: a disability check, viewed as a form of secondary gain, can hinder this healing process. Veterans experience this therapeutic ethos as branding them with the stigma of malingering while clinicians view this ethos as their duty. To compound the ethical dilemmas that compensation creates, therapists are often requested by veterans to authenticate their trauma through filling out medical forms. Also, on the institutional side, therapists are required by this particular VA medical center to do a quota of comp and pen exams. This crosses professional "lanes" for therapists and "muddies the water" of therapeutic relationships.

Second, the nature of chronic pain and the "invisible wounds of war" are subjective and therefore also suspicious. Similar to other chronic pain patients who cannot "show" their pain (Delvecchio-Good, Brodwin, Good and Kleinman 1992) this hiddenness amplifies the production of malingering. There are no objective physiological markers to certify that someone has PTSD. Much like the personal experiences of war, the pain that emerges and is categorized as PTSD

is something that lacks words. It is, as Elaine Scarry (1985) advances in her work on violence and torture, the invisibility and unsharability of pain that defies language. For Scarry, pain destroys language and silences in a way that is beyond one's control. But what is distinct for these combat veterans is that often times this silence is a choice. The "invisibility" of wounds can be subjective and suspicious but also, often be produced by the veteran. This is especially true of the moral and spiritual wounds. Chronic physical pain, on the other hand, is a domain where veterans more often experienced stigma from VA staff through feeling the judgment of malingering and ageism.

Third, overlapping the professional ethos of clinicians and the invisibility of chronic pain is the ambiguity between the language of compensation, specifically "disability and impairment, and contradictions between the institutional function of financial reparation and its actual application. The function of disability compensation, according to VA staff, is to augment veterans' income in situations where their earning potential has been reduced by injuries connected to military service. But some veterans, who work full-time, are awarded a 90 percent disability rating. This begs the question, what is impairment? In this chapter, hiding beneath these issues of clinician ethos, chronic pain and institutional contradictions is, once again, the tension between military values and civilian futures.

A CULTURE OF COMPENSATION AND THERAPEUTIC ETHOS

Many veterans view the symbolic and monetary reparation of disability compensation as a form of validation in a world that is far removed from the personal costs of war. In contrast, mental health providers view their work and the therapeutic relationship as form of validation and a disability rating as a marker of occupational impairment. Diagnosing for a disability rating and the linked compensation creates ethical and moral conflicts for therapists. From their perspective the disability system, set up to help veterans, can obstruct healing and reintegration into civilian society. But from the veterans' point of view, a rating is necessary either to survive or to make up for who and what they could have become. When veterans do not receive the rating and compensation they feel they deserve, they experience this as stigma and poor care—not a necessary step in the therapeutic process.

Recall from the last chapter, Nikki, Armando and Kurt's trauma pitches: for them the compensation process and required diagnostics insinuated that their service and suffering was fabricated. The general feeling was that the VA viewed them as malingers, "trying to catch them in a lie" and viewed their trauma as inauthentic. This perspective of veterans is in stark contrast to the therapists in this study. As Crystal, a VA psychologist put it, "Everyone I work with gives the vet the benefit of the doubt. We all hate the comp and pen process. We care about the vets and hate to put them through this." All of the providers I interviewed concurred with this disdain for the compensation process. The

following is excerpted from my field note journal and the transcription of an interview with VA psychologist, Dr. Jameson at his office:

Lost once again in the bowels of the VA I am all at once struck with the hopelessness of these aging injured souls and the contrasting friendly directions they are giving me. I'm holding the card in my hand that a veteran volunteer "greeter" has given me upon entering the hospital. It says "Thank you for smiling." I recognize him from the weekly PTSD group I bring my therapy dog to. I'm reminded that small recognitions matter in such environments as this. I finally make it to Dr. Jameson's floor and he is waiting for me at the elevator like all the docs do when meeting their patients for the first time.

His small office is crammed with two comfy chairs, an institutional computer and a personal laptop with some biofeedback device, lots of books and manuals, a teapot, granola bars, candy, affirmation posters and scenic paintings on the wall and small stuffed animals that look like thank-you presents from the VA commissary. It is cozy. He offers me tea. This is quite the opposite of the sterile cubicle of the claims officer, Travis, with only a computer and phone as his singular tools of his trade.

These opposite work environments, in a small way, reflect the interactions these VA staff will have with veterans: Travis meeting once or twice to hash out details of injuries and to advise on the straightforward claims process and Dr. Jameson, perhaps sustaining a relationship from eight weeks to many years, however long it takes to build trust and work out the messiness of trauma symptoms. Dr. Jameson described to me the goal of the therapist and how "benefits" challenges the "imperfections" of his profession:

Dr. Jameson: Regardless of what they are related to, our goal is to treat the symptoms to improve quality of life. It (compensation) gets very confusing and I don't pretend to be an expert on the Veterans Benefits Administration side of it but from the healthcare side of it we treat the symptoms. I mean if someone has adjustment disorder and their primary presentation is PTSD symptoms without a PTSD diagnosis we would treat the same way we would treat somebody who had PTSD because we are treating the symptoms. There's an underreporting that happens for people and so sometimes the ways that we try to use measures to diagnose is imperfect.

Ethnographer: So when they underreport you mean the person is underreporting their symptoms?

Dr. J: Yeah, underreporting how much these symptoms affect their life so we can't just go by a number on the scale so to speak and a lot of times it is not until you talk to somebody and get through the initial sort of resistance or initial impression management that sometimes happens with people ... that you really get into the detail of what it is that somebody's been through.

The point that Dr. Jameson makes so clear is that therapists are not so concerned about diagnostic labels; their concern is alleviating suffering. If anything, a diagnosis is a “communication tool” for clinicians (and they admit, a poor one at that) but not required for therapy. The problem is that claims processors require a diagnosis to provide a rating and veterans who are seeking validation through that disability rating desire a diagnosis. The implication is that a diagnosis is more of a tool for benefits or insurance purposes. From Dr. Jameson’s standpoint the problem of underreporting and the murkiness of diagnostic measures adds to complications for disability rating. Due to veterans’ self-censorship of symptoms, this imperfect science of diagnosis highlights the therapist’s priority with alleviating pain rather than labeling it. For Dr. Jameson, it is an “infinitesimal minority” of people he sees who are consciously seeking out secondary gain through a diagnosis and disability check:

It is a huge majority of people who want to feel better and don't care what their benefits are. They would rather feel better and that's it you know. And for the small subset of individuals who are focused mostly on their benefits those are the individuals where the benefits themselves create that feedback loop of disability.

Yet almost as if it is a disclaimer to his professional point of view, he goes on to explain that there is also that possibility that the system can “foster a sense that one has to be disabled in order to maintain their benefits.”

I don't know how you resolve this, I really don't know ... but like, how do you balance those two things if a lot of it really is, you know, if somebody has the insight or not into their symptom presentation?

This is a nice way of saying, “How do you know if a patient knows enough about the disorder that they know how to fake it?” in order to keep the money flowing in.

And that is a huge dilemma for clinicians, how do they know if a patient knows “how to present” and how do they know what the motivations for seeking treatment are?

Downstream, this underrepresenting and over-representing of symptoms has ramifications for compensation and poses conflicts for therapeutic interventions. Many providers felt that, at some level, compensation hindered treatment through the possibility of incentivizing illness. This is part of the balancing act Dr. Jameson refers to: how to help veterans get back on their feet through monetary aid but not deter the therapeutic process? Notably, the clinicians who had a stronger opinion surrounding secondary gain had a longer history working at the VA, were also in the military and veterans of the Iraq and Afghanistan wars. As Dr. Argosy, a psychiatrist put it:

Here’s our problem as VA providers ... we are training as mental health providers to help someone who is distressed and sick. I want to help you get better, that’s easy. The problem is we have people coming in with different motivations—they need to have me writing in their chart, in a certain way, that they have these symptoms and ‘it is affecting my life in this particular way because I am going to take that to regional office where I am now going ... to convince them that I am sick so I can get my paycheck and you are a tool that is going to help me with that.’ And so VA providers, wanting to help out, we are helpers right, so you come and say “I need a letter.” I need a letter from Dr. L telling me that I am really sick and I can't work anymore ... that would be counter-therapeutic for me to do that ... I have been used sometimes and it bothers me to this day.

For Argosy, using professional expertise to testify for disability can derail veterans from seeking therapy. Underlying these “counter-therapeutic” aspects of authenticating disability is the threat to their professionalism. Dr. Argosy felt strongly, as other therapists did, that their “lane” was “clinical” and not “benefits.” Straying out of the clinical lane undermined clinicians’ goals of healing but also

threatened their professional standing: losing veterans to the compensation system means the possibility of losing them as patients. More importantly, therapists are trained as medical professionals, “not bureaucrats” and resented having to fill such a role that felt deliberately un-therapeutic.

To complicate matters further, clinicians at this VA worked as both evaluators and therapists. At this VA medical center doctors were required to do a quota of compensation and pension exams per month. Should they have to evaluate one of their patients, providers would trade comp and pen exams with another provider. Still, this mandated administrative role left most clinicians unsettled since compensation in general was met with ambivalence and skepticism, at least from a therapeutic point of view. So both the VA and veteran patients push therapists out of their “lane.”

As an “accomplice” to thwarting the healing process through possible secondary gains, most clinicians resented being used “as a tool” for something other than their trained expertise, both by the VA and by the veterans themselves. When patients begin to go to therapy for administrative reasons not healing, clinicians experience this as an assault on their profession ethos. To illustrate, as of writing this chapter, therapists have recently been mandated to abstain from filling out “Disability Benefits Questionnaires” (DBQs) for their patients. DBQs are medical examination forms used to capture essential information for evaluating disability compensation or pension claims—most

definitely outside of the “clinical lane” (the form for PTSD is over one hundred questions and six pages long).

Veterans like Nikki experience this denial as a form of betrayal, as the VA “not wanting to help veterans” and “not wanting to pay.” The clinicians’ logic is that this form of helping stunts the healing process (and is not in line with their job description). According to Travis, the claims officer who filed Nikki’s paperwork, the backlog of disability claims would be reduced drastically if doctors, who are familiar with their patients’ injuries and mental history, would agree to fill this out. In his view, the clinicians do not want to help their patients “get what they deserve.” He believes clinicians should be mandated to fill out these forms. Recall Kurt, who was so anxious about his comp and pen exam because of evaluating doctors who did not understand his military work and history: “It’s not YOUR doctors that actually might care about you...” Veterans in general viewed clinicians’ lack of support in benefits matters as a lack of caring; their trauma not fully recognized.

But providers want what is best for their veterans and many feel conflicted in encouraging support through disability compensation. In some sense, it is a case of tough love. This was especially true of seasoned therapists. Stories of the compensation system gone wrong circulate in clinician team meetings and among staff:

Dr. Lührson: It (disability compensation) was, that for those that couldn't keep a job, it gives them money to sustain housing and to live and so you know in that respect (is important). I know that one of the veterans said to me you know Dr. L, I wish I had never had the compensation because—and I remember him telling

me—he said, “Because I think I would have had a more fulfilling life but I relied on that.”

Ethnographer: That is very interesting. What do you think he meant by that? I mean, do you know what he meant by a more fulfilling life?

Dr. L: And he received his compensation at a fairly young age.

E: Is he a Vietnam vet or Iraq vet?

Dr. L: He was Vietnam, yeah, and he said you know I was getting this money and felt like I was—he said it was money coming in—and I sometimes feel that it wasn't, you know, the life that I wanted. So in his case he was looking back and he said, “I should have went to college or I should have did this kind of work” or I think he was thinking counseling or teaching. But that compensation, “I just felt like it was easy money at the time.” So for him it wasn't such a good thing but that is only one particular person and you know there are others and it's, you know, it is keeping them going.

So it is a double-bind that clinicians find themselves in. Compensation can enable personhood by giving veterans the means to live and find their place in society, as is the case with William who uses his disability compensation to pursue the kind of jobs that fit his values of service (but do not pay well). But it can also obstruct personhood by creating a situation of dependence and apathy that does not challenge the veteran to be their best self but instead rely on “easy money.” This is particularly the dilemma for therapists seeing this new era of veterans who have a “full life” ahead of them. As Leslie, a VA clinical nurse and captain in the Army confided:

I will be really honest with you, that's [compensation] a huge struggle for me and for my team and for people who work in this area. We want to do everything we can to help you get the benefits, and certainly if you are having a lot of issues PTSD or physical injuries or whatever, we want to get you through the comp and pen process and get you service connected through the VA so you can be compensated because there are, there IS, going to be a period of time when you may not be able to work ...

But you don't have a 22 or 23 year-old sitting in your chair and then you are kind of like giving them all these things—it is a weird thing—that you know sometimes

they may or may not get better. And you know it goes both ways but it is almost like I feel that people are paying them to stay sick. They get into that comfort zone or like “Okay, I am getting all this tax-free money every month, like why should I work you know, because people are stupid and I can't deal with stupid people so I am not going to work.”

Listen, we are talking about 20 year-olds, 25 year-olds, so it doesn't matter the age, young people who haven't even lived life yet who are put into these horrific situations in a combat zone—seeing and being in charge of troops and losing people and all those crazy responsibilities that they have—and then they come back and they can't even get a job at McDonalds or they can't even [at a loss for words] you know what I mean? They can't even get out into public.

I want to highlight Leslie's recognition of trauma and the difficulties of post-deployment reintegration. This validation, in both the privacy of a counseling session and a public statement, is a form of bearing witness. Fassin and Rechtman (2009), in their historical analysis of humanitarian psychiatry, show how bearing witness becomes the central activity for aid workers in situations where “actual conditions in the field often limit the possibility of giving material assistance” (Fassin and Rechtman 2009:162). They highlight how aid volunteers arriving in post-earthquake Iran in 2003 had to redirect their efforts from medical assistance to clinical psychological support for survivors. This transpired because there was no chance of actually rescuing any more survivors by the time medical teams could be deployed. In a similar manner, Leslie, and other VA clinicians, utilize therapy to bear witness in order to aid veterans in situations where they cannot materially intervene. In fact, clinicians vehemently argued that validation is the role of therapy, not of disability compensation.

Returning to the above narrative, Leslie recognizes that this validation may not be enough. The situation of the veteran can be dire and a job at McDonald's does not build morale or utilize the skills of persons who have been responsible

for the lives of other human beings. Sometimes financial aid is necessary. She knows this, as do other clinicians, but is still ambivalent about the long-term benefits of compensation and is torn between the need and the lack of motivation it can create in young veterans. Her major concern is that these young people have not “lived life yet” but in a twisted way have seen and been responsible for a life’s worth suffering. She contradicts herself often in our conversation: compensation is at once necessary for those periods of adjustment where unemployment is inevitable but paying veterans to stay ill can keep them from trying to work and *be* in civilian society. She struggles with the best way to assist veterans and the paradox of “helping” through monetary reparation:

With all of my heart I want to get people into the system and I want to get them connected with every benefit they deserve, however ... [you] have a 22 or 23 year-old sitting in your chair ... up front the need is there, believe me, I have worked with plenty of people who come home broken, have a mortgage payment, they have a family, they can't get a job due to symptoms and ... so of course we get them compensated to the highest level possible that we can to help them in that area, but yet then ... where is the incentive to get them into a different mind set? Again, when I have people sitting there in my office and I am working with them and I develop that relationship, I always find myself asking them out loud you know, “What were your dreams when you were a kid?”

Leslie went on to explain that “getting them into the system” via disability is a strategy to get veterans into the VA for assistance. Leslie works on a team that goes to the demobilization sights (the bases where veterans fly into when they begin their discharge from service). She explains to me:

The VA is there, we have representatives, we want to get your claims started right away. So that is another thing, that is like here we are, you haven't even hardly gotten off the plane and I want you to sign up for disability. It is a message that, again, we want to get them through the process because we don't know if we can capture them again you know, and get them in (to the VA).

This is what VA clinical staff refers to as a “culture of compensation.” It is the carrot that can bring veterans in for treatment. It is also the nemesis of therapeutic intervention: it brings veterans to treatment settings for the wrong reasons and “wastes everyone’s time.” Despite this, therapists believed that most veterans were not exaggerating symptoms. As Dr. Jameson summed it up: “You know there is a much smaller subset I think of people who have that as their primary concern—their benefits—they just want to feel better.” So while veterans experienced the diagnostic and compensation process as a judgment of malingering, clinicians generally did not view the veterans as faking symptoms. I suggest that this perception is product of the bureaucratic process (delineated in chapters 3 and 4) but the other piece involves the therapeutic intentions and goals of clinicians who view disability compensation as a barrier to achieving personhood.

The above interview excerpts illustrate how the compensation system creates ethical and moral conflicts for clinicians. It is the clash in roles between healer and bureaucrat that threatens therapeutic goals and professional ethos and creates constant tension between determining when compensation enables and when it obstructs veteran reintegration and personhood.

INVISIBLE WOUNDS OF WAR

You want to be able to give them hope you know? And PTSD is still an area that, you know it is like depression, there isn't a lab test or there isn't an x-ray which says “Okay, this is what you have.” We are going by their symptoms and you know, wanting to bring them hope and resolution, we tell them there are some medications out there that can help with the symptoms. There is therapy, you

know, that combination is right now [at] this date and time, is [the] most helpful. And helping them work through problem solving, relationship building. But it is not easy. I don't think right now there is an easy solution...

—Dr. Luhrson, VA psychiatrist

Clinicians want to help, to give patients “hope.” But doing so is difficult when you are not certain what exactly it is that your patient is dealing with. Allan Young’s (1995) historical account of the origins of traumatic memory illustrates that PTSD is not a “found object” but a “man-made object” made real through psychiatric practice. Despite this assumed “thingness” of mental illness, disease and expertise vary according to socio-political environment and require a specific epistemological lens. To illustrate how this can affect people, Lakoff (2005), in his account of a Buenos Aires mental hospital shows how the social revolution and resistance to authoritarian regimes contribute to the absence of the bipolar diagnosis. He further argues that neither science nor pharmacogenetics can answer questions of disease etiology. Other researchers have illustrated how psychiatry has been swayed by social and political influences in the development and utilization of diagnostic categories (Kutchins and Kirk 1997; Applbaum 2009; Oldani 2009; Watters 2010).

The often taken-for-granted reason that this category creation can occur is the invisibility and lack of tangibility that characterizes chronic pain (Delveccio-Good, Brodwin, Good and Kleinman 1992). For veterans, like other chronic pain patients, the physical and mental intertwine creating a chicken or the egg scenario: as anger, anxiety and cognitive problems are both the cause and result of physiological pain. While PTSD is invisible in the sense that the “wounds are in

the inside” so is the chronic pain of damaged knees and backs from carrying artillery and heavy gear. But there is a distinct difference between these types of pain and how they are expressed and the role of stigma.

Stigma

To provide some background on stigma theory, historically, the term was understood as a symbolic mark or discrediting physical attribute that branded someone as different. It was the work of American sociologist Erving Goffman (1963) that reconceptualized stigma from a symbol to a process of exclusionary social practices. Goffman theorized stigma as a process of stereotyping where negative labels (i.e. unpredictable, dangerous) are attached to a category (i.e. PTSD), distinguishing people as dissimilar or unacceptable and thereby tarnishing their reputation. The “spoiling” of identity in this manner results in discrimination, loss of status and social exclusion.

Developing stigma theory further, sociologists Link and Phelan (2006) view stigma as the result of the interaction of five interrelated components. In the first, differences are identified and labeled. The second component involves stereotyping where the labeled person is associated with undesirable characteristics. In the third component, the group doing the labeling separate themselves from those with the undesirable characteristics. In the fourth component, the labeled group experiences discrimination and loss of status as a result of this separation. Link and Phelan hypothesize that the labeling,

association with negative traits, and separation of “us” from “them” creates the rationale for rejection and exclusion. The fifth component of stigma involves the exercise of power. Stigmatization cannot take place without the social power necessary to translate all these components into negative consequences for the stigmatized. The negative consequences for veterans involve loss of status through being denied a disability rating and its social consequences.

In this model doctors have the political power, through diagnoses, to stigmatize. For example, recent ethnographies (Gutmann and Lutz 2010; Caplan 2011) illustrate that the military has been controversially discharging troops under the claims of “preexisting conditions” (such as personality disorder and anxiety disorder) that predate military service in order to deny benefits. From 2001 to 2007, 22,500 individuals were discharged without benefits in this manner (Gutmann and Lutz 2010:159). Some suggest that this was a strategy to save on funding while Glantz (2009) points out that the pressures put on military therapists to assign personality disorder over PTSD was a way to discharge “undesirables” (Caplan 2011:143). These stories circulate among vets and contribute to an atmosphere where they feel vulnerable to stigma even before they start the evaluation process.

Stigma of Pain and Age

For the veteran participants in this study, the stigma of malingering unfolds through multiple layers of appointments and is one of the bureaugenic effects of

the claims process (chapter 4), but it also trickles down through interactions with individual providers. Travis explained it this way:

My big thing is, all these doctors—like with me, I mean I feel I get a little shafted when I go to the medical center because they look at me like a 25 year-old kid that should be healthy. And I will complain about, “Oh my back is screwed up” (and) this and that and if an 80 year-old says that they are jumping through hoops trying to get braces, trying to do this, this, and this. When they hear someone like me bitch, I think they think “Oh yeah, he is just being a whiner or a complainer. He is just trying to get money.” No, no, no, I have really bad health problems because of what I have been through so please give me the same amount of respect in treatment that I deserve because yes, I am not that old but I have the body of a 45 to 50 year-old right now at 25 years-old you know?

Certainly the invisibility of Travis’ pain is compounded by his age, how he looks and the social expectation of health that goes along with his appearance.

Veterans and VA staff, when I asked about malingering, mentioned that physicians were “not used” to this new young generation of veterans and are accustomed to working with older veterans from different wars. VA clinicians, used to treating the aging veterans of Vietnam and Korea are not habituated to such levels of chronic pain and complaint from such young people. With humor, Kurt looks back at his initial visit to the VA after his first deployment in 2004:

I must’ve looked crazy ‘cause I was a 19 year-old kid. They’re like “Who’s this kid? He looks like he is in high school or middle school.” And I walk into the VA like that [laughs]: “Hey, guys I need help” and they are like “Who the fuck is this? You need to be a veteran to be in here” [laughs]. That is what THEY SAID. And I said “I was in Iraq” [laughs]. I was a little kid.

But these twenty-something Iraq and Afghanistan veterans have been coming into the VA for a decade now. Why do they perceive that they are not experiencing the “same amount of respect in treatment”?

The cultural norms and expectations surrounding aging certainly could be a factor. Many young veterans commented on “living in an old body” and “being

an old soul” after returning home from war. These metaphors speak to the physical, spiritual and psychological wear and tear of deployment and military life but it also reflects how the body is a situational object that is constantly reinterpreted in social interactions (Gubrium and Holstein 2003). These interactions are heavily affected by ageist cultural norms that connect youthful appearance to social currency (Clarke 2011). Ageism, as Robert Butler, the first director of the National Institute on Aging coined the term, is defined as the systematic discrimination against elderly persons on the grounds of their being old (Palmore 1999:5). More recent definitions have expanded the definition to discrimination based on one’s age but I would argue that our cultural tendencies direct ageist practices more towards the elderly: regarding older persons as debilitated, unfit for work and a burden on society.

I am suggesting that ageism might lie at the root of the interactions that OIF/OEF veterans are experiencing with their providers: these vets look younger and healthier than their Vietnam counterparts even though their hidden symptoms are similar, yet more fresh and more raw. This reverse ageism conceivably explains why, as one VA clinical psychologist explained to me, “The institutional perception of VA is that they (young veterans) are coming to the treatment setting with ulterior motives.” Often veterans experienced this subtly in their appointments, as Kurt told me:

I went to the VA last week and they kept making comments of how much I work out because I am a bigger guy and I don't look like I'm overweight or something. Yeah, I try and take care of my body, I was Marine infantry and that was pretty implemented into my life. But I am fucked-up. I am jacked. I mean this weekend I could not even turn my head. And it bothers me so much because I feel

vulnerable ... well, if I have to fight right now, I can't do anything because I can't move my head and it hurts and it scares me.

Many veterans felt that they were being viewed as frauds in their PTSD evaluations due to the repetitive nature of the bureaucratic process but some even outright experienced this in their physical exams. Jim, a veteran and employee in the VA disability rating office recounted his last comp and pen exam for his damaged knees:

My comp and pen nurse made the comment "Who is telling you what to say when coming in for your exam?" She's not following the "benefit of the doubt" requirement in the 38 CFR [the VA Schedule for Rating Disabilities].

Thus far I have provided narratives that exemplify how the stigma of malingering plays out through clinician expectations of what a youthful body and mind should be capable of. Partly, this is connected to professional ethos and its counter-therapeutic view of disability compensation but also, I suggest, veterans' experience of stigma is linked to cultural norms and habituation. The difference between injuries of the body and injuries of the psyche is that the former are more easily confirmed: as Dr. Luhson's opening statement infers, there is no "lab test" or "x-ray" that establishes "this is what you have" when it comes to the hidden pain of PTSD.

This "invisibility" of "psychological wounds" can be subjective and suspicious but also, often be produced by the veteran. Sharing the mental anguish of war creates a clash of moral obligation and self-evaluation as I have illustrated in the previous chapters. Recall Sarah not wanting to share "dying moments" because they were sacred, Travis keeping the "deep rooted feeling" of

killing to himself because “that’s part of who you are” and “embarrassing to yourself” or William, afraid that sharing his trauma with an unempathetic listener would “dilute” the “honor and respect” for those he deployed with. The veterans are intentionally hiding their wounds. In this way, these combat veterans challenge universalizing assertions of pain as controlling and they maintain some agency in claiming their historical and cultural subjectivity.

This is similar to the active practice of "pain-taking" by Vietnamese women who participated in the Communist Front and were tortured during the French and United States wars in Vietnam. While in prison, these women performed socialist songs and skits (to keep up morale) that they now rehearse and stage to sustain their community and educate the public. Eisner (2012) shows how these political prisoners’ refusal of language to express their pain is an “active expression of resistance” and their performance is a core set of rituals that connect them to their national heritage of heroic struggle. Like these women, United States combat veterans embody pain as a core set of rituals linked to success, strength and loyalty they learned in basic training. In their military world, pain was not even a reasonable expression of distress and now, in the civilian context, it is a requirement. This creates a clash of moral obligation and questioning of self for many.

But when these veterans do not receive the rating they feel they deserve, they believe they are being stigmatized. They believe they are not taken seriously because their age and bodies do not reflect their pain and impairment. The

importance of this is two-fold: specific to mental illness not only can stigmas exacerbate symptoms through treatment avoidance but they often create more suffering than the disease itself through a “cycle of stigmatization” (Sartorius & Schultz, 2005). This cycle involves a “marker” (behavior or label), which is loaded with negative content (from media, community members and personal experiences). The marker becomes the “stigma” (in this case that of a malingerer) and can lead to discrimination that leads to disadvantages in housing, employment, social networks, and healthcare.

These setbacks can create a sense of social defeatism and damage a person’s self-worth. In this case, malingering goes against all the values of integrity, selfless service and strength that the military world upholds and engrains in its members. The added stress of a stigma may intensify the person’s condition, leading to greater disability and thereby strengthen the marker, creating a cycle of stigma.

While most veterans I interviewed and worked with felt stigmatized at some point in their interactions with the VA, many understood the logic behind the claims system and recognized that some veterans were indeed faking it.

Those veterans that faked their symptoms for compensation were condemned.

As one veteran at the VA coffee shop told me in passing conversation:

He [comp and pen examiner] said “expect 10 percent, we’ll see you later.” [He thought I was] more or less just looking for a handout and unfortunately there are a lot of people in the VA system looking for a handout, which screws everything up for the people who actually need it.

Perhaps it was mere bureaucratic efficiency on the part of the doctor but this veteran was still slighted by the comment and offended at the idea that he was “looking for a handout.”

The Stigma of Being a Blue Falcon

Faking symptoms for a handout is dishonorable and is contrary to the moral obligations of being a good veteran, namely upholding values of group loyalty. With limited VA resources, collecting money via disability compensation or even seeking health services at the VA means that some other veteran, who is in more dire circumstances, might miss out. Any indication of malingering is taken as an insult not only because it renders a veterans’ experience as imaginary but also it threatens their military identity by insinuating self-interest. William described those who are fraudulently gaming the system:

There’s a military name for them, Blue Falcons, they just care about themselves and don’t think about how their actions affect everyone else. They are the ones who sneak a candy bar in [during training] and the rest of us have to do push-ups while he eats it.

Blue falcon is the more socially acceptable term for the acronym “bf” that stands for “buddy-fuck” (as in “fucking over your battle buddy”). When these Blue falcons are caught they are publicly shamed. One famous video recording of a congressional hearing for IRS contractor Braulio Castillo (who sought disabled status for a sprained ankle injury sustained in military prep school) went viral in 2013. He sought disabled status because disabled veteran owned businesses receive preferential treatment for government bids. Representative Tammy

Duckworth (who incidentally is a Purple Heart Iraq veteran who lost both legs in her military service) accused Castillo of fraudulently gaming the system in a Government Reform Committee¹⁹ hearing:

Does your foot hurt? My feet hurt too. In fact, the balls of my feet burn continuously, and I feel like there's a nail being hammered into my heel right now. So I can understand pain and suffering, and how service connection can actually cause long-term, unremitting, unyielding, unstoppable pain. So I'm sorry that twisting your ankle in high school has now come back to hurt you in such a painful if also opportune way for you to gain this status for your business as you were trying to compete for contracts.

Representative Duckworth went on to publicly shame Braulio, pointing out that there were thousands of veterans in need, waiting on their disability claim to be processed—veterans who had been deployed to protect the country not who hurt themselves playing football—and that he was robbing these fellow service members of time and money.

I received a flood of text messages from veterans sending me a link to this video when it was Tweeted in June of 2013. The popularity of this video (I doubt Government Reform Committee hearings are a hot social media commodity) speaks to the vehemence of such behavior in the military community. This incident occurred at a time when veterans had to wait on average 237 days for an initial disability claim. Fraudulent claims like Castillo's are extreme but add to the backlog and break veteran and public trust in the system. These situations also create distrust among VA staff, adding to the doubt that already surrounds the invisibility of chronic pain. Travis states:

Yeah, there are fakers and there are people trying to get money, but for people like me it is like dude, I can show you. Do I need to bring you my Purple Heart

every time for you to take me serious? Should I bring in all of my pictures of my vehicles blown apart? I was blown apart and I am still alive!

The point is, there are veterans who are gaming the system but this label of malingering is in direct opposition to military values, especially for those young veterans who still feel a strong affiliation to their branch and service. Interpreted as blue falconing, the faking of symptoms for individual benefit is an affront to group loyalty and the marker of a bad soldier.

In light of these cultural nuances, the expectation of malingering among the clinicians interviewed for this study was low. Providers felt that a majority of their patients were authentic about their symptom presentation. If anything, because of strong military values of psychological resilience, impression management and the culturally normative concealment of emotions, clinicians believe that symptoms are more underreported than exaggerated. This view is in line with institutional perspectives on malingering and PTSD policy. The following is excerpted from a policy memo for the Army Medical Command (*MedCom* 2012:5)

f. Although there has been debate on the role of symptom exaggeration or malingering for secondary gain in DoD [Department of Defense] and VA PTSD Disability Evaluation System (DES) processes, there is considerable evidence that this is rare and unlikely to be a major factor in the vast majority of disability determinations. Strong evidence comes from an internal 2005 study of the VA Office of the Inspector General showing that of 2,100 VA disability cases rated at 50% or higher, only 13 (0.6%) had evidence that they were potentially fraudulent (Marx, 2011). These findings were later corroborated in a study by Dohwenrend, who found virtually no evidence of attempts by veterans to inflate disability claims (Marx, 2011). Several other studies have shown that compensation seeking and disability benefits are associated with improved treatment outcomes (Marx, 2011). As a result of these and other studies, the VA recently relaxed policies that required veterans to provide proof of specific combat-related traumatic stressors, essentially accepting that deployment to a war-zone is sufficient to meet the A1 criterion.

STIGMA INTERRUPTIONS: AMBIGUOUS IMPAIRMENTS

Linked to malingering is an ambiguity between the meanings of impairment and disability and their relationship to a rating. The Post Traumatic Stress Disorder General Rating Formula for Mental Disorders²⁰ used at the VBA rates for “occupational and social impairment that affects the performance of occupational tasks.” Certainly, someone can be severely impaired but not disabled: in other words, still able to work. This was evidenced by veterans like Travis, Jim and Armando who have 70 to 90 percent ratings (moderate to highly impaired) and work full-time jobs.

As one provider put it, “The reason for compensation got lost somewhere because the idea is that if you are 30 percent service connected, 30 percent of your earning potential has been eaten away.” Earning potential is also ambiguous. Theoretically it might be reduced through no longer being able to live out one’s dream of working as an engineer, and as a result of war injuries, one ends up working as a full-time security guard. Importantly, all the employed veterans in this study with 50 to 90 percent ratings were working for veteran-owned businesses or veteran organizations (i.e. the VA). This suggests a therapeutic relevance of work and purpose for disabled veterans, as well as the need to have employers who understand the nature of war’s effects.

To push the question of impairment and disability further, I observed that reduced reliability and productivity could mainly lie in the social realm, with certain types of employment still manageable. That is, work was possible but

social lives were severely impaired. As a case in point, recall Travis who goes straight home from work every day and closes all his blinds and locks himself in his house until work the next morning. Public misperceptions of this ambiguity between being disabled, but able to work, contribute to stigma surrounding veterans who are service connected. It was these gaps in understanding of how a disability rating functioned where stigma emerged.

For example, I personally observed within my social circles when I discussed my research project, that military service, as voluntary, was viewed as a choice of employment that veterans already had been compensated for. Veterans viewed the public unsupportive and as Jim says, “They figure you signed up for it, what did you expect?” The implication is that any issues derived from the war were knowingly self-induced by choice and not worthy of monetary compensation. Kurt defends:

Like I've had friends straight up tell me, “That's where our tax dollars go to? Giving people money to (makes gesture of disbelief)?” And they don't know I receive disability but its like, whew, holy shit. I'm pretty jacked up compared to you and I sacrificed a lot of my time and like, my LIFE. And I'm never going to be normal I feel like.

At first glance this stigma process is grounded in an unsupportive and apathetic public. Looking deeper it has everything to do with a majority of society being completely detached from the effects of war and a general lack of public understanding and emotional investment. A *Time* magazine cover story addressing the widening military-civilian gap labels the U.S. military as “The Other 1%” highlighting the seclusion of an all-voluntary force where fewer and

fewer Americans know someone who has served (Thompson 2011). The result is the alienation of veterans as they return home. As William describes it:

People don't understand what I went through, what happened at war. They don't know anyone who has been through it. The fact that I collect money from the government, they don't truly understand [why] no matter how much I explain that. They look at me and automatically make the connection that you look fine. I don't mention my compensation because I don't want to have that fight.

Refusing the Service Connection

There were instances where veterans refused a service connection or told stories of friends who refused their disability benefit. The reasons had mainly to do with stigma but were also linked to distrust of and frustration with the government. For Sarah, who is still in the military, there is no tangible need for a rating. In fact, it could threaten her future. For war veterans who are not separated from the military (Army Reserves, National Guard and those on inactive duty) a disability rating could mean the end of their career through being "medically boarded out" (being discharged from the service on medical grounds because one is unfit to perform their job). This is the case for Sarah. She is concerned that she will be medically discharged for her asthma (possibly caused from the burn pits and inhaling debris like asbestos from blown out buildings) since she has trouble running and for the same fear of discharge does not claim PTSD:

I don't want it [a rating] to cause me to get kicked out or barred from reenlistment because as it stands right now I am not ready to give up the Army. I enjoy it too much. I don't know what I would do without it, really. I mean I would probably be fine but I don't know what I would do without it. I don't know how to – it's everything I have done since I was 17. I don't know what I am supposed to do

without it. So it's kind of like who I am and I feel like if I get out part of me would be missing.

Sarah's personhood is so intricately tied to her military work, training and unit that a medical discharge would be devastating. Notably, she has not filed for PTSD because she does not want this on record (military units have access to VBA records), "there is too much stigma around it" she explains and she is afraid she could lose her rank as an officer "over a few hundred dollars a month." Avoiding stigma, for Sarah, is an option because the tangible need is not there.

The experience of stigma not only surrounds mental illness, as it is linked to dangerous and unpredictable behavior (e.g. Hinshaw 2006), but also around claiming disability in general. Compensation was not something that veterans brought up in conversation. After two years of formal and informal discussions, Kurt opened up on the topic of disability status:

You know I think the whole compensation thing is like a sensitive subject with vets because a lot of people look at it like welfare. Like I have friends who are willing to do it like me ... but I have some friends who refuse to get it who say, "No, I don't want anything from the government." Like "I did what I did because wanted to" and I have other guys that just don't do it because they just don't want anything to do with the government and they don't want to be involved with that stuff anymore. I think also guys are scared to get it because if you do it then you get that label of PTSD or whatever.

Soldierly pride was the reason for some not to seek a disability rating and the stigma of welfare was what interrupted this pride. Sayer, Parker, Hintz & Rosenheck (2011), in their research on veterans' reasons for seeking VA disability benefits for PTSD offer a glimpse into the connection between stigma and disability compensation. Their results showed that veterans who did seek disability benefits did so for tangible needs, to help clarify their health issue, as a

form of recognition, and through the encouragement of trusted friends or professionals. Veterans who were deterred from applying for a service connection were concerned with negative public perceptions associated with disability and also with receiving government aid. This corroborates partly with earlier research done by Rank (1996) on welfare recipients from diverse ethnic backgrounds participating in various public assistance programs. He found that lack of privacy and social stigma associated with government aid partly drove recipients to exit from welfare.

While vets do not typically exit from disability their ratings may decrease—especially with a mental health service connection. Re-evaluations are part of the bureaucratic process and slated to occur every two years, although with the backlog this rarely occurs, according to the clinicians and veterans I interviewed. In part, this may be due to veterans voluntarily going in for a rating increase. Out of all the vets in this study only Kurt has been called back for a re-evaluation. Some of the veterans I worked with had been service connected for six years and had not been called in for a re-evaluation of their PTSD. The possibility of these follow-ups creates concern in vets, especially those who rely on their service connection for healthcare (Nikki) or who need that added financial aid (Kurt and William) to pursue their careers.

In summary, refusing a service connection is linked to avoiding stigma surrounding a disability rating when the rating functions as a symbol of individual dependency or social instability. In these situations a rating threatens

personhood in that it is viewed as a barrier to a life trajectory (in the case of Sarah) or an affront to one's integrity and civil service (Kurt's friends).

The Social-Moral Considerations of Victimhood and Veteranhood

Summerfield (2001) suggests that the right to reparation and the rise of victimhood is linked to changes in concepts of personhood and its relationship to modern life. For example, the concept of personhood that is held by a culture at a certain point in time affects how much adversity one can handle while remaining "normal" (i.e. what a reasonable expression of distress looks like, acceptable behavior and how help is sought). Certainly this is the case for OIF/OEF veterans, where the warrior ethos demands group responsibility and support for brothers in arms and then separation from that collective culture pushes veterans to seek disability compensation (see *Warrior Ethos and Request for Aid* in chapter 4). Summerfield illustrates how an individualistic, rights-centered culture can foster a sense of personal injury and need for restitution in everyday events that previously were viewed as part of life. Veterans, coming from a collective culture, move from a world where pain is not a reasonable expression of distress to a context of care where they are required to talk about it. The sharing of pain, as I have previously illustrated, creates a clash of moral obligation for veterans. A good soldier honors the fallen and pays reverence to the families' loss, not complain about how that feels and request restitution.

I began this chapter with a discussion of the social shift in trauma from malingering to victimhood (Fassin and Rechtman 2009) and suggested that the socio-moral considerations that are the basis of this shift are at odds with the trauma narratives of veterans and their clinicians. First, I have illustrated that clinicians do not view disability compensation as a form of validation, rather that is the purpose of therapy—to bear witness. Compensation, on the other hand, can hinder treatment through the possibility of incentivizing illness. This creates ethical conflict for clinicians and challenges their professional responsibility to help veterans heal. While a disability rating can assist veterans in need, clinicians feel it can also obstruct healing and reintegration through reducing veterans' motivation and confidence to become their best selves. In clinical terms, compensation is counter-therapeutic. Veterans however, experience this concern for their future as uncaring and stigmatizing, insinuating malingering rather than professional responsibility.

Second, the invisibility of chronic pain and ambiguity of psychiatric diagnoses further complicates clinicians' determination of disability as enabling or obstructing personhood. However, I suggest that this "invisibility" is also produced by the veteran as an expression of psychological resilience. It functions as a strategy to claim historical and cultural subjectivity in a world that is far removed from war. Nowhere is this stoic "pain-taking" so stark than when veterans communicate the time, place and operational specialty of a deployment.

Just those three words operate as a code for suffering among veterans and their providers; they require no clarification and suspend suspicion.

In conclusion, the social utility of victimhood and malingering is limited in the veteran context where veterans' identity is tied up in military cultural values of selfless service, physical and psychological strength and group loyalty. This is especially salient considering: (1) the public shaming of "blue falcons" that are gaming the system at the expense of veterans who need VA assistance and (2) the underreporting of symptoms in order to maintain soldierly pride and selfhood.

These last two chapters have developed the idea that disability ratings function as a paradoxical and ambiguous form of validation in a world where the warrior is no longer publicly revered or understood. This is due not only to a clash in moral values but also to the intensely incommensurate internal and external worlds of war and peace. The experiences that veterans are exposed to in their military service, of training for war, the culture shock of working in foreign countries, the spiritual shock of witnessing the intense human deprivation of war-torn communities, and physical shock of new natural environments in which they work, all contribute to an intense change in worldview. The fallout, as the next chapter will address, is a cultural dissonance and a secrecy that creates obstacles for personhood.

Chapter 5

From Soldier to Civilian: Severing the Finger from the Hand

In the military you have a roommate with the same schedule as you ... you go out on missions with them, form bonds with people and then you come home and that's all gone.

— William, OIF Army Vet

I never felt so much love, being part of something, where people literally would sacrifice their life for you. I never experienced that in civilian life.

— Kurt, OIF/OEF Marine Vet

I'm proud of my service but there are situations where I just don't tell people because being a vet is equal to having PTSD in most civilian eyes.

— Sarah, OIF/OEF Army Reserves Vet

As I have systematically illustrated in the previous chapters, the military values of sacrifice and group loyalty that veterans so strongly identify with often conflict with the trauma technologies and bureaucratic interventions intended to ease civilian reintegration. Beyond the context of the VA, the tension veterans' perceived between their military past and civilian present is expressed in everyday life as "living two lives" or "having a split personality" and most revealing, "hiding the real me." Who veterans disclose to and why, whether it is their military status, war experiences or PTSD diagnosis, provides a window into the trajectory of personhood. These discussions, introducing the values of a

collective military culture that inform veterans' self-understanding, lay the groundwork for a more nuanced understanding of social difference and stigma.

Social stigma certainly is related to how veterans experience diagnostic labeling and feel discrimination, but I will argue that to get a grasp on these processes, cultural consonance (what I have heretofore hinted to as common ground) is a crucial consideration. Cultural consonance is a theoretical construct that describes the degree to which individuals, in their own beliefs and actions, fit in the broader shared cultural models in which they are part (Dressler 2007). This concept, able to address both the internal and external worlds of the veteran, helps to describe the contradictions that arise when vets intersect warfront and homefront. The construct further offers a deeper investigation into social exclusion than stigma alone does, opening up new spaces for theoretical discussion and public health interventions. Cultural consonance also allows a shift in focus from victimization, in the context of stigma, to agency as veterans choose not to engage with people that do not share similar cultural models.

I suggest that veterans' disclosure is related to a lack of cultural consonance with civilian peers, not necessarily or entirely to fear of stigma or self-stigma, as dominant narratives of military mental health research suggest. Through the following narratives of wartime and peacetime, I argue that the veterans' place in society has been fundamentally disrupted through an abrupt breakage in cultural consonance. To illustrate, I will trace (1) how social difference becomes embodied in the veteran and (2) how this difference affects disclosure and sense

of self. The embodied social difference brought on by war plays out in a number of ways that both enable and obstruct personhood, but it is the lack of fit, of essentially feeling like strangers in their own land, which emerged as the locus of turmoil for veterans, not stigma per se. It is as one veteran put it, moving from a “highly organized machine where you know where you fit in the hierarchy... to complete chaos.”

This social difference that veterans experience is psychological and physical: first, through military training and the building of a collective identity and second, through the environment of war. These two factors necessarily impose an outward looking approach to one’s self-understanding that follows veterans to the homefront. As a brief example, when veterans meet for the first time the initial question is “Who were you with?” not “What did you do?” Veterans identify through their military company—the descriptor of where they were located, their mission and even their sacrifice.

This collective identity, shaped by training for war and punctuated by the “psychological inoculation” that prepares troops for killing, does not foster a sense of personal injury or individualized suffering. In fact, the strategy of the collective and “strength in numbers” is even reflected in sharing painful experiences. It is significant that some painful moments are not exclusively remembered as moments of suffering precisely because they were shared. Only when the psychological inoculation training fails, does this create issues for the

individual and their military selfhood. But when training succeeds, it creates problems for civilian selfhood.

The lack of common ground I presented in the previous chapters, between veterans, their clinicians, and the VA bureaucracy, is here interrogated further as veterans try and return to what they perceive and expect to be their “normal” pre-deployment lives. The following memories and experiences illustrate how incommensurate the military and civilian worlds are from the point of view of a returning veteran and elucidate the impact this has on constructing self and threatening personhood.

MILITARY TRAINING: SHARING PAIN AND REFRAMING MISERY

For veterans, the daily experience and practice of “structured violence” is possibly the most distinguishing factor that separates the military from mainstream American society. Performed as “combat readiness”, preparation for direct violence is an essential part of the soldier’s job and is something that all recruits share: it is the misery, pain and accomplishment that is known as basic training.

Strategies utilized to attain this level of preparedness include “violence of action” and “psychological inoculation”; both manifest as conditioned reflexes. By design, this form of training allows for split-second decisions and precise applications of assault that, according to military psychology, necessarily bypass the soldier’s moral compass and overcomes resistance to killing. This is, as Armando once explained to me, crucial because “The minute you start thinking

about what you are doing you put everyone in danger.” Violence of action and psychological inoculation allows the group to think and act as one for the benefit (survival) of all—except the enemy.

This learned behavior becomes embodied in the veteran in basic training, something that all service members go through as a general preparation for war. Many scholars have addressed the social function of basic training as part of their ethnographic analysis: as a rite of passage where recruits learn obedience, respect for authority, mission first and to never accept defeat (Holyfield 2011); as a strategy to bypass individual moral autonomy, absorb hostility and exert dominance through targeted aggression (Caplan 2011) and; to instill teamwork and the ability to endure intense hardship (Gutmann and Lutz 2010). The consensus of these readings, and of my interviews with veterans, is that no amount of simulated training can prepare one for the military and medical situations that war presents.

While the following narratives parallel these analyses in some respects, my intention is to highlight how basic training erases the individual and is the beginning of a form of a collective “pain-sharing.” Much of the misery that soldiers experience, in “basic” and then in deployment, is a shared form of suffering that counters the individual expressions of distress that are normative and expected in civilian culture. Significantly and paradoxically, these memories become reframed as happy moments. This form of suffering and happiness is linked to the selfless service that is instilled in service members and, I argue, contributes

to the embodied social difference that creates a lack of cultural consonance for veterans on the homefront.

Building the Biggest Gang in the World

Ty, an Army infantryman and Iraq veteran, described his basic training as being a process where recruits were “broken down to nothing” in order to be built up again as a cohesive group. Coming from Chicago gang culture and growing up in Cabrini Green, one of the city’s most notorious public housing projects, Ty was very insightful regarding the different ways in which group violence differed between civilian and military contexts. He was well versed in both.

Ty began selling drugs and carrying a pistol by age 14. A self-proclaimed retired “thug” Ty credits the military for his departure from the streets: the army was his escape from gang violence and its inevitable consequences, death or jail. He decided to join the military at 17, after being shot over some drug money near his house. And he chose “human resources” as his specialty not only because he enjoyed helping people but also he felt it was a safe choice, being a “paper-pusher” behind a desk. Still, all recruits are required to do basic combat training, a challenge for Ty who was used to being “his own boss.” Ty refers to basic training as a process that rips apart one’s self-confidence, but is necessary to build group cohesion among very different people. These rituals of degradation are a key feature in what Goffman (1961) describes as the “total institution”, where activities are designed to uphold the goals of the institution at the expense

of demoralizing individuals. Soldiers become institutionalized into the military through basic training. Ty described it in the following way:

So it's like, the whole thing in basic training is (that) it is a process ... they break every new soldier down. And I found out the reason for this: it's because you ... got people in basic training coming from all these different walks of life and everybody thinking, [I] don't like this group and they have to figure out a way to bring everybody together without a bunch of violence. So they have a process where every new soldier, they literally break them down and I mean break them down to their lowest point ... once you get to that point, that's when they build everyone back up at the same time ...

[P]eople just kinda start encouraging each other little by little, literally, little by little. Once the drill sergeant sees that, that's when they bring everybody together and that's when they build you up as a soldier.

You are all now part of the United States Army which means ... it's not about where you from no more it, its not about the fact that you was a Blood and you was a Crip [rivaling gangs found throughout US cities]. It ain't about none of that no more because once you put on this uniform, you belong to the biggest gang in the world.

What Ty so distinctly exposes, is the power of basic training to instill an awareness of and dependence on others who are very different from one another: family background, ethnicity, socio-economic status and geography. This is achieved through stripping people of their individuality and creating physical and psychological environments where the individual is rendered useless but also helpless without the others. Ty's example of Crips and Bloods coming together to put on the same uniform, to fight for the same territory, is a fitting example for the power of military training to promote a group consciousness that overrides personal affiliations. (Crips and Bloods have been engaged in turf wars in major United States cities since the early 1970s.)

The "breaking down" of civilian markers begins before basic training in "30th AG." This is the in-processing where recruits are issued their uniforms and

military gear. It involves weeks of physical training exams, medical exams and immunizations. It is where service members learn to “hurry up and wait” and stand in line for hours at “parade rest.” Not exactly resting, this involves standing at formal position, in complete silence, where the feet must be 12 inches apart, hands are clasped behind the back and the head is held facing forward motionless: this is the first group “torture” that recruits experience and the beginning of developing discipline.

Beginning in 30th AG, beliefs of self-importance, self-worth, self in general, are systematically eroded. In our image-conscious culture, this starts with one’s face. One veteran writes in his memoirs that the first discernible moment of this “identity-stripping” is the military issue haircut and glasses:

[T]here are a lot of people who identify with their hair, or had long hair in the civilian world. You are stripped of your identity and they do this by giving everyone a buzz cut. Now the dude rocking a ponytail when he came in is a totally different person to you after seeing him with a shaved head, it’s a pretty amazing transformation for everyone. Also, there are the infamous general issue glasses. You have to wear them if you have a prescription of any kind, and they immediately make you look like a dork ... that’s why they are referred to as “birth control glasses,” or BCs. I feel very fortunate that I don’t, or never have worn glasses because those things are hideous. They are thick brown plastic square framed glasses ... [It] brings dudes who aren’t with the program yet down to earth, crashing down to earth.

Beyond the clean cut, uniforms and matching glasses²¹ the self becomes eroded through overt interpersonal hostility from the drill sergeants. What Ty refers to as “breaking you down” is intended as a form of “psychological inoculation” against the stress of combat. According to military psychologist Lieutenant Colonel Dave Grossman (2009), it is not danger that causes psychiatric stress; rather it is facing the hostile aggression and hatred of others.

The fake contempt and sadistic actions of the drill sergeants specifically prepare soldiers for this personal aggression experienced in combat.

Drill sergeants are very adept at interpersonal aggression, picking out those recruits who are not good at dealing with pressure situations. These recruits are “blood in the water” for drill sergeants who, three at a time would gang up on one “poor bastard” and simultaneously scream in that person’s face. These training procedures are appropriately named “shark attacks.” Ty remembers his first shark attack, it happened the minute he got off the bus for basic training and set the tone for the rest of his time on base. A drill sergeant told him to stop walking like a gangster, screaming “You’re not in the hood anymore! You are nothing here!” and “Stand up straight!” and was screaming so hard “dude was spitting in my face.” So Ty pushed him. For Ty this was a normal reaction—someone was taking up his personal space and insulting where he came from and who he was. All the other officers within earshot descended upon him in a “triangle of death.” That was the last time Ty was overtly insubordinate. He explains that he learned his lesson quick, “real quick.”

The drill sergeants were testing Ty’s composure and ability to absorb aggression. Also, it taught everyone else who witnessed this to not stand out in the crowd. Other veterans have explained that blending in is the best strategy: do not be the best, do not be the worst and do not volunteer for anything. In short, do not attract attention to yourself. This is another key feature of the total

institution, the constant conscious effort required to blend in in order to avoid unintentionally breaking any rules (Goffman 1961).

Civilians may find it hard to believe that the staged and vulgar personal affronts can have such an impact. But it is the constant and direct public humiliation and hostility from a complete stranger, who has no insight into that individual's character that makes seemingly ridiculous insults quite painful. While this interpersonal verbal abuse is often individualized, everyone endures it at some point in training. Some "favorites" that were shared with me include:

The beatings will continue until morale improves.

Pain is only weakness leaving the body.

Your dad should have just jerked off in the shower.

The verbal abuse was always accompanied by "corrective action" or physical training (push-ups) and punishment meted out for breaking regulations or insubordination was overtly a form of group pain-sharing. If one person in a company did something stupid, like sneak off to have a cigarette, the whole company is punished (upwards of two hundred people) and the platoon even more so for not stopping that person (see Figure 4). One person lacks discipline? Everyone pays. And those closest in structural organization to that person are the most responsible.

To provide some context, a company in the Army can be comprised of upwards to two hundred people. That is a lot of soldiers woken up in the middle of the night to do two hours of corrective action after watching one guy smoke a cigarette. Then the platoon, maybe twenty soldiers, is further punished and must

“pull watch” over the smoker to make sure he does not try and escape. What I want to point out is that soldiers learn to organize the self and their social role around everyone surrounding them: their battalion, company, platoon, and finally the smallest unit, the squad, as well as rank and command (see Figure 4).

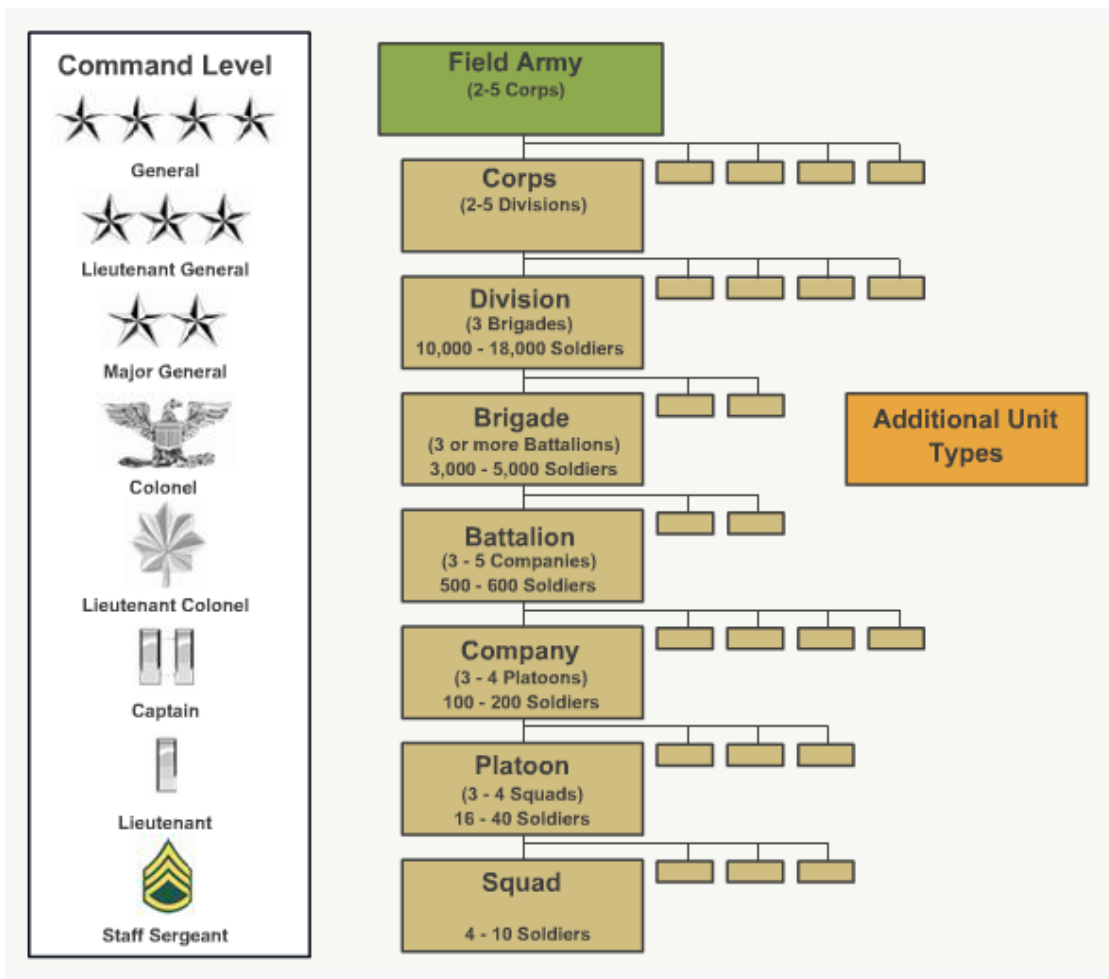


Figure 4. Operational Unit Diagram (2014 Homepage of United States Military)

All soldiers know where they fit in the structure and function of military culture. The individual self is nothing without their squad, platoon, company and leadership. Furthermore, the individual does nothing without everyone else

knowing or being involved. As so many veterans stated, there are no secrets in the military: “You eat, sleep, and shit together.”

In addition to the psychological preparation for hatred, physical repetition of such activities as reflexive shooting and clearing a building of its inhabitants trains soldiers for close quarters combat. “Violence of action” is an integral part of this training and is described as an unexpected and volatile force that eliminates the threat with the least chance of reconciliation (*Army Field Manual*, 1992).

The key goal of violence of action is to train soldiers to do the morally unnatural: to kill other humans. Specialized drills create muscle memory that allows for automatic reactions and reflexes. Violence of action is rehearsed to the point that soldiers become comfortable moving through a building and “engaging targets” with speed and surprise. To ensure overcoming the resistance to killing that first-time soldiers experience, recruits are conditioned to shoot at “targets” shaped as human silhouettes (see Figure 5). This assists in dehumanizing the enemy. In a discussion about the morality of war, Armando vividly remembers this part of his training and describes it in a rote manner that parallels the rhythmic nature of the shooting exercise:

It’s easy not to be moral.
You’re trained from the beginning that your target is a human silhouette.
Trained from the beginning to kill the enemy, it’s not human.

There should be no human objection to kill the enemy.
Because they are not human.
They’re a silhouette.

You’re conditioned from the first day to do what a soldier does.
Destroy the enemy.
You start seeing faces and hearing voices.

The silhouettes don't exist.
But the enemy is so engrained.



Figure 5. Human target practice

The reverberations in his description are so striking because they so lucidly reflect the physical repetition of muscle memory training.

The monotony of this training is part of what makes it work, that response that does not leave room for moral consideration, but the monotony is what also makes it so painfully boring. William described his training as often droning but was well aware of the intention of practicing specific maneuvers until they were automatic:

We just practiced man-down drills over and over again. When your partner is down, just kick him quickly out of the way. Take over his spot and keep shooting.

Keep shooting and don't think twice that he might be dead or other people will die.

The message the new recruit gets is that individual expressions of distress can be lethal. Any moment of personal pain or moral regret needs to be relinquished for the sake of group survival.

It is the combination of psychological inoculation and the violence of action that prepare soldiers to kill but also develop selfless service for the survival of the group. Physically they are prepared through the muscle memory of repetitive drills and emotionally through the build up of their defenses against interpersonal hatred. But an underlying theme is group misery and pain-sharing. As William put it:

The thing about it is, everyone is sucking together, pulling over watch in the rain, doing push-ups, sleeping in a hole on the side of a hill in freezing temperatures. We're all tired, cold and shitty together.

Somehow this makes horrendous circumstances easier.

Returning to the opening narrative on training for the “biggest gang in the world”, it is the encouragement recruits provide each other to pull through the misery of basic training that helps to build group loyalty. Ty, in drawing contrasts between the military and civilian worlds of violence, explains this loyalty is not so strong in urban gangs. In his hood “it is chaos” and people are vying for dominance and respect, “brothers will stab you in the back” if they can benefit and push their own agenda. In the military, “you know they got your back” and “you know who your brothers in arms are.” This is what is known as “I got your six” in military terms. Knowing whom one can rely on and who has one’s “six”

was important to a number of veterans I interviewed. It helped to explain why some veterans wanted to go back to Iraq and why they felt more safe at war than at home: “You have the protection of your squad, of your platoon. At home you are alone, you really don’t know who to trust.”

Slowly and uncomfortably, military training replaces self-understandings of the individual as autonomous with ideals of selfless service, group loyalty and collective strength. But it is war, not practicing for it, that really demands and engrains these values.

The Happiness in Shared Misery

So many veterans recounted deployment stories of hardship with pride, happiness and love in a manner that the overt misery of it all transformed into a happy memory. Beyond illustrating the shared suffering of war, the following narratives of Louis and Kurt point to how individual expressions of distress are absorbed by the collective unit. It is the connection, the common ground that deflects the pain. As Armando tries to describe it for non-veterans:

Part of what I said earlier about the appeal of the military was, you know, carrying a rifle and a heavy pack and marching and, what I've kind of discovered in my time out of the military was, one of the things that appealed to me was, you were always miserable. But so was the person next to you. And so that shared misery was actually what made it fun.

So like, being in an OP [observation post] and sitting in like a dirty mud hole, or an old Iraqi fighting position, and it was cold at night, it was like January, February, it would get cold at night and you're just miserable and tired. But then you look over and you see the person next to you is feeling the exact same thing. That was always fun for me ...

There's like so many people now who are aware of all the negative that goes with it [military service]. So the idea that I try to put in peoples' mind is, when you are

miserable and you're like sitting in this hole and it's muddy and you're cold and it's raining and you're just like, fuck my life, why am I doing this, and you start to pity yourself and you look over, and your battle buddy is standing there or sitting there or whatever next to you, and they're cold and they're wet and they're cranky and they're all the things that you are, and you look at one another, and you just kinda like laugh you know? And like that's what makes it fun.

A paradoxical form of nostalgia this happiness is and it specifically relates to the group of guys who were “in the shit” together. This sharing of wretched circumstances is intimately linked to the loyalty and “love” that soldiers feel for one another. Kurt, with so much reverence recalls his first deployment and how the “older” guys in his platoon looked out for him. He reads to me from the personal journal he kept while in Iraq, the passages spark memories that, to the privileged listener, feel happy. He is laughing and smiling as he reads amidst all the death and destruction:

I was the little guy, 19, they are 21,22, 23. All our sergeants and corps kept getting blown up so we kept getting smaller and smaller. So the younger guys had to pick up rank and pick up the roles of the leaders. They really tried to protect me. I remember Briggs, we were going into a building that was just bombed and all these people were killed, and I remember Briggs telling me “Oh, no, don't go in there Kurt. Stay out here for a second.” And I was like “Oh, okay.” You know he was trying to protect me of the visuals of war, [he] didn't want me to be exposed to that.

I remember we ran out of food for a couple of days and we had a Chef Boyardee can and it was me, Briggs, Sam and Mason, and we opened the can and we sat in a little circle and we all had a spoon and we all took a bite and passed it [around] until it was gone. And that was like, *that's how it was*. If no one had food except one, it wasn't one person got full—it was everyone got a bite and spread it around. We always looked out for each other. I never experienced that in the civilian world. I had friends from first grade and if I ever were to get in a fight I can't confidently think they would back me up.

The following reflections further interrogate the possibility of happy memories linked to traumatic histories and emerged when I asked Kurt if he could describe a certain event that summed up what it meant to be a Marine:

[W]hat I remember and what I take from the Marine Corps are my friends and that loyalty which is something I have never experienced with any other kind of people in my life.

The Marines I served with, I know they would die for me and I would die for them without question or hesitation because I would be in situations where I was about to run up and Briggs would push me to the floor and he would run instead. [They would] do things like that, and if I would've seen one of them get killed I woulda lost it. I probably would have lost my mind. I don't think I would have been able to handle that. And like Briggs, to me, I love him very much. He's a big guy, you saw the picture of me sleeping next to him ... He really protected me and loved me.

Obviously it was not just one event that summed up being a Marine for Kurt. It was the process of sharing and witnessing war but also the love that grew out of adversity. The path I am carving out here is one where shared misery (not just the training strategies that create interdependence for survival) develops an interpersonal loyalty that is experienced as happiness. I provide one more vignette, that of Louis, before I discuss the implications of this for embodied social difference and victimhood.

Louis, a Marine infantry gunner who deployed three times to Iraq between the years 2004—07, was taking part in the inpatient treatment at the VA for his substance abuse. He had been picked up for disorderly conduct (being passed-out drunk in a park) and agreed to do treatment in exchange for keeping his police record clean. Louis, diagnosed with PTSD and traumatic brain injury, typically responded to my questions vaguely, with one-sentence answers imbued with indifference. When, for the first time, he spoke for more than ten seconds I was stunned. I was under the impression this man was completely damaged from his time at war (or maybe he was bored with my questions) so the fact that

he smiled and laughed in recounting the following battle surprised me but also made me conclude that it is, in fact, a happy memory.

He spoke of his 45-day wait in Fallujah during the Bush and Kerry election race with a combination of disbelief, bravado and pride. At this time the offensive in Fallujah was stalled, according to Louis, so there would be “no bad media” coverage to affect Bush’s ratings. As a consequence, troops were sitting ducks and running out of food because the “supply and mail trucks kept getting blown up.” Louis and his battle buddies were reduced to shooting pigeons and eating them to stay alive when no more food could be found. He also recounts that they would sometimes find food in the homes of Iraq citizens that were forced out before Marine troops invaded the city. The “cool” part for Louis and the part he recounts fondly of this time period, despite the hunger and imminent chance of being killed, was the morale boosting and intimidation tactics of “PSYOPS” (psychological operations):

[T]hey [enemy forces] were doing this call to arms ... they all have these sound systems that go through to tell you when it is prayer time and what not. The mosques are hooked up to it so they can do their prayers over the loud speakers. And they were doing this call to arms, like “Stand up against the Americans, fight them!” and they were doing it from the mosques. They were calling everybody into the city like come out and fight against the Americans.

Well, like our psyops team ... rerouted it so we could talk back to them and let them know like “We understand that this is your holy place, however if you continue doing call to arms from this then we are going to bomb it” and it was on my 19th birthday, I remember this huge mosque, we would just bomb the shit out of it.

And they [mosques] like all fell down and then on the loud speakers afterwards they [PSYOPS] played like all these little kids laughing, we did [that] to the Iraqi people, like these kids [laughing] hahahahaha, like all these kids laughing through the city back at them ... and then like a big fire fight broke out and I remember it was like something in a movie and then after the fire fight they ...

played the Drowning Pool song, like “let the bodies hit the floor” like through the loud speaker thing ...

And like in the morning if we would go on patrol ... it would be like 5, 5:30 in the morning, because you know you want to do it right before it is light out and they [PSYOPS] would play like AC/DC Highway to Hell and stuff through the whole city [by loudspeaker] ... like let them know, “Hey, we are out here” kind of thing and stuff, so, it was kind of cool, I thought. I was like 18, 19. I thought it was like really awesome ... and then PSYOPS would be like “Anybody have any requests?” and then you could go give them CDs ... so they would play that through the city obviously to piss them [Iraqi insurgents] off. So that was pretty funny.

PSYOPS job, of enticing the enemy to “come out and play today” is a happy moment because “you get to utilize your skillsets” and “do your job” with everyone you trained with, instead of sitting around doing nothing. Bored. This is something “civilians don’t get”, it is the misfortune that is fun precisely because it is not experienced alone and everyone is “hyper-focused on a common goal.” It is also a type of memory that is counter to any socially normative “happy” moments and for veterans, is the memory that gets translated as “bad” in biomedical and even public contexts. Louis lost a lot of people in the battle of Fallujah, so this happy memory certainly does not exclude pain and survivor’s guilt. But it does challenge the idea of victimhood in that Louis chooses how he feels and represents his past.

Philosopher Carrie Hamilton (2007) writes that the strong influence of trauma models on memory studies has led to an emphasis on suffering and victimization that tends to disguise other forms of memory. Hamilton refers to “happy memories” not as “unmediated reflections of past ‘true feelings’ but to retrospectively constructed representations of the past” (p. 66). She suggests that if we understand people to remember their past with mixed emotions that

they can then be positioned as agents in the construction of their own cultural histories. The recounting of happy memories in a seemingly miserable situation of pigeon eating and fire-fight waiting can suggest that for Louis, these memories do not have to be framed exclusively by pain and suffering.²²

This does not make the events less disturbing or remove accountability but it proposes an alternative reading of traumatic memory that makes remembering also an active, rather than exclusively passive and victimizing, event. This theoretical framing mirrors the military values and practices of remembrance (recall chapter 3) as a point of honor and an activity of responsibility to carry on the legacy of the fallen.

I had to reflect on these unexpected “happy memories” like Louis’ and try not to write them off as the sequelae of trauma, indoctrination or a disordered state of mind—some twisted glorification of “badass” team America. These differences in our perspective, of victimhood (read: bad memories) from a civilian, and survivorhood (read: good memories) from a veteran’s point of view is mirrored in the vet’s everyday mundane interactions with family, friends and the general public. It keeps veterans from sharing their happy moments, their experiences and what makes them who they are (addressed later in the chapter).

To summarize, I argue that a veteran’s collective understanding of self is developed through “shared misery” and “shared sacrifice.” Personal suffering is not an accepted form of distress for soldiers, as the drill sergeants so clearly remind recruits, and when it comes down to the reality of war, the collective is

there to help absorb that distress. In part, it is the pain-sharing, whether commiserating in the punishing environs of training exercises or starving for days waiting for the enemy to engage, that manifests as social difference when veterans return home. But also, it is the animalistic, irrational and nonsensical aspects of war that transform soldiers' worldviews, and bodies, making it difficult to relate to civilians "who have no context for life."

THE ANIMAL WORLD OF WAR VS THE CIVIL WORLD OF HOME

Yeah it feels like I was never really in the Marines or never really went anywhere or I don't even know—it feels like combat, like the whole thing, like almost a decade of my life feels like a movie kind of.

—Louis, OIF/OEF Marine Vet

It is so un-human, so out of our scope that you have to be trained to do it.

—William, OIF Army Vet

In all my interviews there came a point where veterans were unable to make sense of the "craziness" of their deployments. These experiences marked by "being hunted" and having "no control" over one's destiny in the "shitty backdrop" of poverty, were so irrational that they often completely transformed veterans' bodies and minds. In this section of the chapter I present an assemblage of narratives to illustrate the range of these types of war experiences that challenge the natural order of things and the stress this caused. I then illustrate how these experiences contribute to an embodied social difference and,

from the veteran's point of view, how this plays out in civilian life, challenging dominant narratives of stigma and PTSD.

*Hunter and Hunted:
Armando*

We're not fighting [in a manner where] you're in a uniform, I'm in a uniform, you're over there, I'm over there, the drummer stops, we volley back and forth. Nothing like that. You're watching me 24 hours a day, you're learning my habits, you're finding when I'm most vulnerable. That's the same thing animals do. So I can't approach this with any sort of logic. I can't think about it. This is more ... is more primal.

Then one day I just learned, don't even give a shit. It doesn't do you any good. Like I said, you learn to cut off empathy and compassion and love and kindness and consideration because they serve no purpose.

Dr. Argosy

The insurgents realized that Americans would never hurt children. Children were used to stop convoys. They would hold hands and cross in front of the road to get them to stop and then the insurgents would ambush the vehicles and shoot RPGs (rocket propelled grenades). There are soldiers with conversion disorders, who have their legs but can not walk, this is directly related to them running over children ... they were following their orders.

Ty

I didn't think I had PTSD or anything like that I was just, I felt my reaction was normal ... I killed a kid and then I didn't go to jail ... Why would you put a goddam weapon in a kid's hand and put him up against full-grown American soldiers who is trying to fucking kill? It's ridiculous. And then nobody understand it. Nobody *want* to understand it. Even the goddam psychiatrist I was talking to. This guy throws some goddam medication at me and tells me I did the right thing.

Kurt

So we would put up signs [on the road] that said "DO NOT BLOW THROUGH HERE OR YOU WILL BE SHOT AT" and people would still blow through us [in their cars]. So what would we think? ... again, a lot of these people are probes. The terrorist groups are trying to see what our protocol was or how we work, how we do things and they would do stuff like this just to see what our reaction would be, how long it takes us to do it, things like that. Do we let him go? Do we put him in prison? Do we interrogate them? And this is all things people don't think about in the States because they're all like "Ugh, you kill these people?"

These experiences of being hunter and hunted, and the extremes that the enemy would go to, were outside of the realm of these soldiers' understanding of how the world operates. These extremes that were in complete opposition to US soldiers' cultural rules of combat, created conflicted feelings of accountability. Soldiers are ordered to "win hearts and minds" through passing out soccer balls in villages or giving out candy while on patrol, but once in a while one of those children, in order to secure his or her own survival, followed enemy orders. These abrupt changes in professional intentions and expectations, from bringing medical supplies to a village for example, to the "gory war stuff" created intense stress for soldiers. As Louis explained, there are two ends of the spectrum and soldiers have to work both of them, "It's hard to comprehend it all."

At some point the lines between good and evil were no longer drawn and there was only, as Armando put it, necessity. This necessity is harsh, as it systematically betrayed soldiers' own cultural ideals, of empathy and compassion and love and the good fight. But there was also the feeling of being betrayed by others because "you are there to help these people but they can turn against you." Not only did this affect the ability to trust others but it also impacted one's self-esteem. This is illustrated in Armando's quiet and unspecified confession that he is not necessarily proud of his actions.

In addition to issues of trust, the culture of urban warfare in Iraq and Afghanistan had physiological effects on the body and behavior. Not being able to identify the enemy, of being on constant guard, of intense boredom punctuated

by dramatic life-threatening disruptions, created biological stress that followed veterans home. While a neuroanthropological analysis is out of the scope of this dissertation, the effects of perceived threat on the brain are relevant to a discussion of embodied difference.

Finley (2012) in her analysis of the neurocultural processes of PTSD suggests that the “dislocations” that veterans felt upon returning home often arose from the changes in a veterans’ emotional life that were a direct result of combat. As a result, veterans in the civilian world are over-reactive and have anger issues. These changes are both related to the brain, or “stress-related neuroplasticity”, and an individual’s personal history and their own cultural expectations. Finley (2012:274) refers to recent animal and human imaging studies to illustrate the neurological processes behind uncontrolled emotions:

Rochstroh and Elbert have observed that repeatedly stressed brains appear to use what they call a “low road” for sensory processing that speeds up the ability to configure a threat response by bypassing the prefrontal cortex. In other words, instead of using a “high road” pathway that privileges the prefrontal cortex’s ability to analyze complex data and regulate emotion accordingly, these brains have developed pathways that privilege a more rapid response, changing from “a careful analyzer of the environment to a rapid threat detector” (Rochstroh & Elbert, 2010, p. 14).

In terms of these neurological processes and the narratives above, I want to point out the gap between what actually happens in war (“high-threat”) situations and how veterans and civilians interpret these events. Veterans interpret their actions as following orders and, in line with the above neurological explanation, an inability “to think about it” or “to approach it with any sort of logic.” This is what many veterans described as going from “zero to ten” without

stopping in between. Civilians (as perceived by veterans) interpret the actions as random and unnecessary killing, specifically in the case of civilian casualties.

Veterans' perceptions of civilian interpretations are limited to a cultural model of rational action that assumes autonomy. For the veteran, these gaps in knowing are what contribute to self-identified social difference and why civilians will never "get it."

*No Control of Destiny:
Nikki*

We went on convoys and got lost and this was like the most ridiculous shit, there are no streets, you are driving through the desert from one place to the next. Not on the road, just driving and you get lost and you are looking at dead camels around you because that is their road kill, camels, and it's like ridiculous. You are trying to pay attention to something that doesn't make sense. I don't know how a bunch of road kill, a bunch of dead camels on the side of the road is not something that makes sense, like why did they die?²³ While we are driving like this it's really hot and I'm really tired and looking out this window for something to shoot and kill. Like, I don't understand this. I don't understand why I had to give up pieces of my life to be here and you don't know what the hell is going on.

Kurt

We had an officer we didn't like. It was like the movie Platoon. We actually used to talk about shooting him in a firefight because he was going to get us killed ... so it's October 8th [reads from his journal]:

Every time we take gunfire or are being mortared he's the first one running away or taking cover. For instance, once at a checkpoint, checkpoint 9, we were getting mortared really bad and taking small arms fire and he's yelling at us to get a POO [point of origin of the mortar fire]. So he's yelling at us ... get a POO, while he's hiding under the fucking Humvee [laughs].

[A]nd he's telling me to stand up and like look around and I just turned my head like "Idiot, I'm not going to do this." He's not like some officer you respected, he was the officer in my Marine Corps experience that was the typical movie officer where he's an idiot and fucks everything up. That was our officer in our first tour, which was very dangerous because he came very close to killing more of us or getting more people hurt.

And he just acted in an unprofessional way. Like he was mean to the Iraqis and stuff and [we] hated him. We're all out there fighting our ass off trying to get these people to like us and he's treating them like shit.

What Nikki and Kurt have in common, although in very different situations, is a lack of control over their fate and the anger and frustration these circumstances elicited. Social epidemiologist Leonard Syme (2004) defines the concept of “control of destiny” as the ability to influence the events that impose on one’s life. This lack of control of destiny is also related to multiple health risks (Marmot et al. 2006) and low control over work in high demand situations, as reflected in both Nikki and Kurt’s subordinate status in the military hierarchy, is normally accompanied by feelings of anger (Williams et al. 1997).

For Nikki, the limitations on her personal autonomy were reflected in the mundane common workflow of doing convoys, getting lost looking for “something to shoot and kill.” The surreal quality of the desert was completely nonsensical for Nikki—of being in a natural environment that was so different than any she had ever experienced, with massive dead animals littering the landscape, blistering temperatures that kept soldiers from using the toilet (“people would pass out in the Port-o-potties from the heat”) and being lost with no way to orient herself. She describes it in other conversations as a point where “you realize how small you are.”

For Kurt, the dramatic situation of having to choose between getting shot or disobeying the orders of an “idiot” seem much more severe than that of Nikki and yet Kurt has some power, he was able to disobey and in that moment of

doing so he had control over his fate. What Kurt did not have control over was his officer's behaviors towards the Iraqi people and that had a direct impact on him and his platoon. Another way to interpret the lack of autonomy on health is through what Marmot et al. (2006:103) conceptualize as the effort-reward imbalance. This imbalance results from a lack of social reciprocity and incongruities between costs and gains.

Underlying Kurt's anger is not just a fear of retribution from the Iraqi people but also the fear that his officer's actions will get people killed. Kurt followed his obligations as a soldier and expected certain duties to be performed by his lieutenant in exchange, namely leading the troops in an honorable and competent manner that would not put them in danger. The dedication to mission directives is not mutual when his officer is hiding under the Humvee while ordering Kurt to reveal himself during an attack. This failed reciprocity of "mutual co-operative investments" produces negative emotions and sustained stress responses (i.e. autonomic and neuroendocrine activation that can affect coping skills). While these interpersonal situations certainly can be found in a civilian work environment, the ramifications typically are not lethal.

The point I would like to stress is that the lack of control of destiny is not just relegated to acute life or death situations, it is commonplace and arguably, may be worse in noncombat situations where soldiers have less autonomy and the effort-reward-balance might be lower. Stating the obvious, control of destiny is put to the limit when the stakes are life or death.

Third World: The Shitty Backdrop
Louis

I was in Heet providing security (for the elections) it was end of 05 beginning of 06 ... and that was a real strange town in general like because it was apparently like one of the towns or areas that Saddam may have used different chemicals and stuff on the people. So there was a lot of handicapped people and stuff like that. So you would see, I would see people who couldn't like walk so, with their arms crawling down the street and stuff.

And I remember clearing a house once and I came out and I kicked the door open and this younger type kid came out and was like on all fours. And he must have had some kind of back disorder because he walked kind of like a gorilla with his hands like on the ground. And it was really just a weird area cause there weren't very many normal people there. And then like talking to their interpreter they said like basically like that area had like [pauses] Saddam had done a bunch of stuff to it. I think it was along the lines of punishment and all that.²⁴ I didn't quite take it all in at the time. I don't know ... it's two ends of the spectrum, humanitarian aid and what not and then war.

William

It's a shitty backdrop to chaos. Eventually you get used to it but it's hard to find beauty in such a shithole. There is just sewage flowing in the streets, there's no infrastructure whatsoever, and it smells and it's muddy everywhere. You are doing patrols in that everyday and then you are stepping in shit. And for some reason it amplifies the anger. Like what the fuck am I doing?

Sarah

There are kids running around with no shoes, they are hungry, people have no food, there's no clean water, they are forced to work for the terrorists even though they believe in our mission. What's going to happen to them when we leave? And here we are supposed to save them?

Going to a different country for the first time can create shock and awe: the different physical environment and new cultural practices one must acclimate to and make sense of can be frustrating and anxiety provoking. For Louis, William and Sarah, war was their first international experience and the poverty and social injustice that they witnessed was part of their culture shock. Culture shock is

experienced when an individual enters a foreign culture where all the familiar signs and cues of social interaction are missing. The loss of these familiar orientations to everyday life can create difficulty adjusting to new surroundings and cause individuals to reject the new culture (Oberg 1960). For Louis, William and Sarah, this rejection was inextricably linked to the social injustices they experienced in a third-world country ravaged by civil war.

What stands out in their narratives is that these are situations that North Americans typically experience from afar via media news outlets. They are situations not overtly representative of a First World nation such as the United States, and definitely not representative of the cities Louis, William and Sarah grew up in. Witnessing such social crimes can be horrific to young people who have never been exposed to such injustices in person. Finley (2012:272) writes, “Horror connotes an emotion so powerful as to overwhelm the individual’s capacity for immediate sense-making or cognitive processing.” It is a term that includes a broad array of distressing emotions including shame, disgust, terror, helplessness, anger and hopelessness.

Sarah, William and Louis, in remembering their deployments, expose an understated form of horror—a form of horror that often gets glossed over in trauma narratives—the abject poverty of the locations they operated in. These were poverties of failed social policies and racism and everyday realities that these US soldiers had never experienced in their lower and middle class lives. Less immediately tangible as the death of a battle buddy or the killing of an

innocent civilian, the horror of poverty and all the deprivation that accompanied this created a socio-ecological stress for soldiers. Those who did not live on a base occupied the same villages and lived in the same material and aesthetic deprivation as the locals. We might consider that this was experienced as a situational poverty.

Arguably, these veterans were privileged in their First World I-witnessing. To even consider the deprivation of beauty for the occupying US troops seems ridiculous in itself, if not blatantly conceited. And yet my rationale for doing this is to focus an awareness of the cumulative experiences and stressors that make veterans different—socially, culturally and neurologically. I also would argue that many veterans, upon returning home, if and when the “unraveling process” (the remembering and self-reflection of traumatic events) begins, critically reflect on their I-witnessing and the impact they had on the lives of civilians. Certainly this is a factor in some of their suffering. As one Iraq veteran in a meditation workshop I participated in testified, it is difficult to enjoy your own family when you are living with the guilt that you robbed so many innocent people of that very joy.

Related to this guilt, beauty is a topic difficult to broach, especially considering veteran accounts of the “necessity” of poor Iraqi children, paid by the wealthy, to booby-trap American troops of “trained killers” with their million dollar arsenals. Having to shoot and kill young boys around the ages of 13, 14 and 15-years old, boys with no training in using the outdated weapons they carried was a necessity

for American soldiers. As Armando remembers with disbelief and disgust, these were not exactly worthy opponents, but a threat nonetheless: “Are these children our enemies? Really? Or just fallout of a fucked up situation?” The very dissonance of his reaction points to the manner in which the poverty of others flowed into the emotional landscape of some soldiers. Beyond the culture shock of experiencing and witnessing the structural human deprivation in a foreign land, there is a deeper moral reaction linked to this soldier’s actions and role in perpetuating that deprivation.

Above, William alludes to how the deprivation of beauty in the physical environment—the smells, the color, the texture, the visuals—compromised his mental state. Sensory stimulation (what we see, hear, smell, touch and taste) is a significant factor contributing to mental capital, including cognitive capability, emotional intelligence and resilience to stress (Cooper et al. 2009). These types of exposures I present in this section, to routine ugliness and also the witnessing of poverty, are underrepresented in the trauma literature that focuses on the more dramatic “event.” For some veterans, pinpointing that one event that spurred their PTSD was difficult and as Nikki said: “The thing that caused it? How about the whole war? How about putting your life in other peoples’ hands who don’t have your best interests in mind? *Every day.*”

Embodied Social Difference and Cultural Consonance

You see what is really going on in the world and you see these different parts of the world and you see the way that children don't have shoes, they don't even

know what a shoe is, they have never seen a shoe, and here we are eating our McDonalds and talking about how broke we are.

— Sarah, OIF/OEF Army Reserve Vet

Trying to relate to someone who has had everything given to them and hasn't had to sacrifice yet in their life makes it hard to have deep meaningful conversations.

— William, OIF Army Vet

PTSD is what war does to the brain ... it changes your reactions with everyone.

— Jim, OIF Marine Vet

Many scholars and veterans (e.g. Caputo 1997; Marlantes, 2011; Seahorn and Seahorn 2008) have written about how war changes people, the cumulative wear and tear of trauma and how soldiers come home different. There are psychological (e.g. van der Kolk 1987), biological (e.g. Pizarro et al. 2006), spiritual (e.g. Tick 2005) and cultural (e.g. Finely 2011; Gutman and Lutz 2010; Kleinman 2006) explanations for these changes.

My concern here is to expand on this body of work and show how veterans' embodied difference relates to cultural consonance and stigma. In trying to get a pulse on stigma experiences in my research, I never mentioned stigma per se but discussed with veterans how they perceived themselves to be different, how they experienced friends and family treating them as different and how they reacted to this. Veterans consistently talked about how they perceived themselves as changed by their experiences, as more "mature" or "wiser" while their civilian peers were still the same. It was their irritation with civilians "who

don't get it" that emerged as the main script for social exclusion, as opposed to fear of stigma. Significantly, this was a self-selected exclusion and was informed by feelings of hostility and lack of empathy towards peers.

To provide some theoretical structure, I suggest that the "it" in "civilians don't get it" are those cultural domains that are important to veterans and that veterans perceive civilians are not able to identify with. A cultural domain is any "organized focus of discussion in a society" (Dressler 2012:391) such as education, family or life purpose. When people have sufficient agreement in a domain, let's say higher education, then those people share a cultural model. The cultural models are made up of culturally derived ideas and practices that inform everyday life and provide information about how to be a decent person, how and when to do the right thing and importantly, how to avoid doing the wrong thing (Fryberg and Markus 2007). The degree to which individuals share cultural models correlates to levels of cultural consonance and the higher one's cultural consonance (with the people in their community) the better one's health (Dressler 2012).

"They Just Don't Get it": Contested Cultural Models

For the sake of this analysis, I am adopting the concept of cultural consonance as a lens to view nondisclosure and social-exclusion. I am suggesting that lack of cultural consonance, brought about by new cultural models resulting from military training and travel in foreign countries, is a

counternarrative to stigma. The following narratives illustrate, from a veterans' perspective, how much the veterans' cultural models have changed in contrast to their peers, and that those domains important to their peers are no longer relevant to veterans. The reasons for this are both cultural and biological. The following interview transcripts from Sarah, Armando, Kurt and William typify veterans' frustrations reconnecting in the civilian world and provide insight into how the theoretical term social stigma is limited in certain disclosure contexts:

Sarah: Well, coming home from my first deployment, I was 20-years-old when I came home, so I came back and tried to go to college and it was like people just didn't get it. They were just like, their views of the world, their own little world, was all that matters and they don't see the bigger picture and you see what is really going on in the world and you see these different parts of the world and you see the way that children don't have shoes, they don't even know what a shoe is, they have never seen a shoe, and here we are eating our McDonalds and talking about how broke we are yet we are driving a car and all these things and it really is all relative.

While ... people in Africa, people in Afghanistan, people in Iraq, could live for years on what 'under the poverty level' lives on here. And yes, I know it is a different cost of living and things like that but I feel like sometimes people take things for granted—cell phones and cars and all these things. You know there are places in this world where they don't even ever know what one is.

Ethnographer: And you realized that at age 19?

S: Right. And here I am with all these college kids who were like "I am so broke, I am so broke" and it is like no you are really not. You are going to college. You have the opportunity to go to college, that alone puts you in the upper class of the world. To be able to go to college in America? That's an awesome advantage. You have an advantage over the entire world and people don't see it that way. They see it in their little world.

E: And how did you feel about that?

S: You know a lot of times it would aggravate me. So I would try and brush it off and be like they just don't know. They don't know. So I would try and explain to them what I had been through and they would be like "Well yeah, but that is just over there." But it's not just "over there", it is real. It is really what is going on. It is just not a fictional story like "Oh, it's just over in another part of the world."

These are human beings who are living at this type of level with this type of terror in their everyday life. And these are the people who are being tortured. Women are being stoned to death because they were raped, you know? Like you have no idea how good you have it here. So that is kind of like how people would really get under my skin. So a lot of time I would just walk away and eventually lose friends that way, because they are like, "Well she kind of got crazy when she came home and all of a sudden she is on this kick where, where we just can't complain about every day things." But I couldn't, I couldn't take it, you know?

What is so piercing about Sarah's narrative is that when she shares her deployment experiences with her friends, her peers just write it off as "fictional" and from another world. In this way, part of Sarah's biography of suffering becomes very blatantly erased, as is revealed in her anger that what is happening to the Iraqi people, "it is real." For Sarah, her sense of purpose is wrapped up in where she was and what she learned in her deployments, this extends to her "outcome oriented" nature that the military instilled her and her goals for earning her degree and working in social services. Her experience in college is frustrating because the relevancies of the world, for her, include women being stoned to death for being raped and children living without everyday material necessities, not looking attractive for class or "scoring booze" for some weekend partying.

What is so interesting is that Sarah still experiences herself in relation to a social collective and it is the taken-for-granted conceit of her friends and classmates that pushes her to "walk away." Sarah's cultural model of how to be a good student, classmate, friend and citizen are contested in this new civilian space.

It is these small details of life that define and connect people. For veterans, their details are located in a far away place and so very different from their civilian counterparts that they often have stopped trying to connect. Sarah could not “take” those inconsequential details of civilian life that she interpreted as ignorance and ungratefulness. She could not be open and talk about herself freely, not because of fear of stigma, but because of fear of getting pissed off at her peers, of wasting time trying to connect to people that wrote off her experiences as irrelevant. So as a result she spends time with people who “get it”, mostly other veterans.

For Armando, conflicting cultural models led to more serious social exclusion. Armando describes the general public ignorance and ingratitude, not only for military service but also surrounding the privilege of being a US citizen, as a contributing cause to his “disgust” with humanity. Armando’s contempt for people who are not veterans stemmed from an almost humble self-understanding that his own cultural models had changed drastically. The following interview segment illustrates Armando’s self-induced isolation:

Armando: I don't know how you can go, you're 21 and you go and you see people that are dead, or you see people that are like in really bad circumstances, you see all this negativity, how it's not gonna affect you? And how, when you come back, you don't forget that stuff. And so now, have you ever heard someone use the expression like you have American problems?

Ethnographer: American problems? First-world problems?

A: Yeah. Have you ever heard that? Okay same thing, right? Like someone bitches that like their Internet's not working, and you're like you have American problems or you have First World problems, okay? I come home and I hear people bitch about this, that or whatever, and it's like what context do you have? Like what experience do you have to relate that as, “This is like the worst thing ever?”

So I didn't feel as though I ... could see [how to be grateful]. It was nothing like that. But it certainly was like, *you* definitely can't. Like I didn't feel enlightened. But I certainly felt like don't bog me down with your nonsense. Like you have no—

E: You weren't enlightened, but everyone else was still ignorant?

A: Well I wasn't enlightened. I'm not gonna be so bold as to claim that like, you know, but yeah, you have at least no context for life or anything. And I think I held that against people ... I would just disregard people left and right. Very easily.

The point I would like to argue is that Armando's disregard for people was related to a lack of cultural consonance. I am suggesting that self-isolation, as a proxy to social exclusion and a consequence of social stigma is a very limited interpretation. Underlying Armando's disdain for civilian "nonsense" is again, the value of selfless service and the perceived lack of this mutual experience in the civilian context. William articulates this embodied social difference of veterans in a profound way when he states:

People do not understand that there is such a connection to selfless service and duty that you don't understand until you do it: giving up family, weekends, giving up your clothes, your socks, everything you like, sitting in a manured field for 72 hours doing recon [reconnaissance]. Trying to relate to someone who has had everything given to them and hasn't had to sacrifice yet in their life makes it hard to have deep meaningful conversations. Plus we [military] had to do it together, we had to suck together, lose all that together, it's an understood feeling. I don't have words to explain it, except that here is a bigger purpose and mission that's a point of pride that civilians don't understand and don't do.

The social connection William describes is an understood collective feeling. Csordas (1999) defines embodiment as an existential condition where the body is an intersubjective location for experience. The experience of selfless service William describes above is not really about the self per se but is embodied collectively precisely because the memories are sensory and defy conscious

explanation, yet still accessible by other veterans. In this way they will never be accessible to nonveterans. I want to reiterate that despite the misery of sacrifice, it is a happy feeling, collective in nature (relating to accomplishment and pride) that cannot be shared with civilians. The significance of sharing and connecting with others in happiness cannot be understated. It explains how so many veterans described being happier deployed, under fire, living in aesthetic and material deprivation. It explains why veterans continue to choose to leave their families to go fight, even after multiple deployments.

Alternately, veterans were able to adapt to civilian social contexts, it was just not as “meaningful.” William explained the difference between himself and veterans that isolated, such as Armando:

The thing is you can connect with them [civilians], bring yourself down to their level and pretend. But you know your worldview is exploded and that naiveté is blasted out of you, so the connection is all fake. So to have some semblance of a relationship you have to have a connection, but you know you're not. Some people fake it and some people withdraw because they can't.

This insincere connection is not only superficial but also compromises the veterans' emotional and intellectual growth and sense of self. It also undermines personal experiences in a manner that, as I illustrated in earlier chapters, pushes veterans to search for validation in more private and less satisfying ways, such as disability compensation. This is not to say veterans cannot have meaningful relationships with civilians, it is just critical that civilians respect that vets tell their stories as they wish to tell it and then to listen without judgment. This at least provides veterans an opportunity to connect.

Kurt, unlike Armando has many civilian friends, an active social life and also attends the university. But he also opts to keep quiet about his deployment and veteran status around civilians, not because he has internalized his trauma and diagnosis as a form of weakness, but mainly because he cannot be bothered with people “who don’t get it.” Our discussion on disclosure points further to the contesting cultural models that exist between veterans and their civilian peers:

Kurt: I'll tell people I'm a vet, if it comes up in conversation. I won't go out of my way to tell people that, but if people ask me I'll say I was in the military for a while and now I'm going to school

Me: Where there examples of when you didn't express status?

K: To people? In school many times I specifically don't say anything. Like in class, I've only ever been called out once. That someone questioned my like answer and it was a military question and I made a high distinction compared to everyone else. And the professor called me out and I said I did two tours, I was infantry in the Marines, and everybody was like “Okay, oh shit. Okay.” Other than that I really try not to.

Me: Why didn't you disclose in class?

K: I think I get really weary because I think a lot of kids are closed-minded. I don't want to say closed-minded but they are so open-minded that they are just like so anti-everything. Anti-government , anti-military and anti-occupation, anti-Israel, that I don't want to, again, cause any weird vibes in my class or I don't want take the risk of getting upset because some 19-fucking-year-old says “Oh well, that was wrong, blah, blah” and I would just be like “Okay 19-yr-old kid, shut your face. Like, don't talk to me right now.” So I don't ever try and put myself in that kind of position ... so like with girls I date I don't really even tell them stuff because it's just they don't care really or they don't understand and I'm not going to waste my time really. You know?

Kurt very clearly illustrates how the cerebral interpretations of his classmates clash with his more visceral understanding of the not-so-black-and-white politics of war. As he once explained to me, people do not understand that “[A]t war you are not thinking about oil or politics or money, you are just trying to save you and

your buddy from being killed.” Kurt’s reasoning for nondisclosure is tied up in “not wasting his time” but also in avoiding “weird vibes” in class.

He is not worried about being stigmatized by his classmates because they lack the cultural, social and political power to translate negative beliefs into consequences (Link and Phelan 2006). Rather, the immediate consequence Kurt is avoiding is the negative emotional energy and possible verbal confrontation that disclosure may elicit. This is significant especially since the main goal in reintegrating is getting “back to normal” and fitting in. But this is difficult when one’s cultural models have evolved at a varying rate than peers. Keeping veteran status under wraps may be a strategy in fitting in but also creates tension for those who identify strongly with their military selves.

Like Sarah, Kurt does not like to put himself in a position where he will become angry or waste his energy on trying to connect with people. For so many veterans this anger revolves around values of sacrifice and honor that is not reciprocated in the civilian world, values that are intricately tied to veterans’ identity. For example, a lack of understanding from civilians of the “legacy” of military service is a significant point of contention that kept some veterans from disclosing. William describes a situation where someone did not give proper respect to their grandfather who served in World War II:

How living through these situations is a point of pride you think about the people who came before you and how bad they had it – the equipment and the technology, and Vietnam and WWII and the real hardcore suffering they had to go through to fight in a different time and you respect that. We are trained to have a deep appreciation for those who came before us and then some guy says “Oh yeah, my grandpa was in WWII” and you are like, “Do you have any idea the

situations he was in? The conditions he survived?" You just have to be in awe, thinking about how bad we have it versus what they had to go through.

Many veterans described their hostility and lack of empathy towards civilians as something that was frustrating and difficult to deal with, but not inherently a problem with themselves. This lack of emotional affect had a huge impact on family dynamics, social interactions and "fitting in." Fitting in referred to a continuum of social circumstances where veterans could not relate or did not want to adapt to expected behaviors and sensibilities. For Kurt, this included the ability to console his good friend when her dog died, a feeling he could just not muster up. For Sarah, she no longer cared to spend time on "superficial" things, like fashionable clothes and other material objects, finding it hard to connect with her old friends. Armando, Kurt and Sarah, all did not want to "waste their time" trying to connect with non-veterans who did not hold the same values and priorities in life.

Importantly, the above cases do not fit with the theoretical models of self-stigma where the person with mental illness (e.g. PTSD) adopts stereotypical understandings of themselves through their membership in society (Link and Phelan 2001). In other words, the individual begins to believe that something is flawed with their character. In this model, these stereotypes may lead persons to believe they will be devalued or excluded by others, thereby creating low self-esteem and causing them to withdraw. With veterans like Sarah, Kurt, Armando and William, while they may be stereotyping civilians, they do not have the power

to stigmatize and create negative social consequences. For this reason, the theoretical framework of cultural consonance offers a more fitting lens to interpret difference and exclusion.

Cultural Consonance or Stigma?

In Euro-American traditions we have been raised to experience ourselves as “isolated centers of awareness and action” (Watts 1995:17). I began this chapter illustrating how this self-understanding becomes reversed through military training and deployment experiences and is at the core of cultural dissonance for veterans reintegrating into civilian life. I delineate that this happens mainly through the understated experience of group misery of pain-sharing and the sometimes paradoxical happiness this provides. These experiences impart values of sacrifice, selfless service and group loyalty that inform veterans’ cultural models and are in tension with the veterans’ perceptions of civilian life, especially the idea of individualized suffering.

I suggest that this lack in cultural consonance is what creates issues for personhood and reintegration for these veterans with PTSD diagnoses, more so than that of stigma. Interfering with achieving cultural consonance is empathy, both on the side of civilians who find it challenging to relate to veterans’ selflessness and veterans who find it difficult to deal with civilian self-centeredness. Critically, this embodied difference of veterans, as expressed through a lack of empathy towards civilian “First World problems” is informed both biologically (neuro-endocrine effects of war’s backdrop) and culturally

(changes in mental models). According to the veteran, the civilian never “gets it” and never will, in part because the trauma body is different, in part because the veterans’ military-induced worldview is different.

Proposing that lack of cultural consonance contributes to obstructing personhood also suggests a shift in focus from victimization in the context of stigma, to agency as veterans choose not to engage with civilians that by default do not share similar cultural models and similar values. Using this alternate lens of cultural consonance to interpret disclosure and veteran personhood by no means disregards social stigma. Apart from disparate values and cultural models leading to exclusion, stigma played a role in veterans’ disclosure on levels of structural and individual discrimination. These variations in experience will be delineated in the next chapter.

Chapter 6

Stigma Interruptions: The Subjective Possibilities of PTSD

I'm a veteran that then understands that my service didn't end when I took my uniform off. And so my service to my community or this subset of community is still important to me.

—Armando, OIF Army Vet

They're seeing more than they should have seen and you know that's when they need to talk to someone about things ... having that PTSD diagnosis gives you that street cred I guess you could say. Like yes, it is legitimate.

—Sarah, OIF/OEF Army Reserve Vet

I don't feel like most people who go to Iraq who are in combat and I find myself in a very small group ... only 20—30 thousand were outside of the bases in combat ... Everyone else lives on a base but everyone else who lives on a base, gets the same credit we did and they get the same labels...

—Kurt, OIF Marine Vet

In the previous chapter I argued that it is a lack of cultural consonance that prevents veterans from forging meaningful connections in civilian society, suggesting that resistance to mental illness labeling is not totally captured by the theoretical term stigma. This lack of common ground however, also creates gaps in understanding and missteps in social interactions that feed into social stigmas.

The narratives thus far have provided a glimpse into stigma experiences for veterans along a continuum: from overt to covert and from individual to institutional. Stigma may be discreet, like the perceived stigma veterans felt in the pathologizing of their military skills and “normal” emotional responses to war (chapter 3). Stigma may also be more overt, as portrayed through the stereotypes of malingering and the bureaugenic effects of VA processing (chapters 4 and 5). In these more obvious instances the social power of those persons who can create negative consequences for the stigmatized is very clear.

But often this power is more tenuous, even fragile, as is the case with relationships with loved ones, peers and the general public. These social contexts are very relevant to disclosure strategies and stigma experiences are contingent upon how social identities are constructed within these contexts (e.g. responsible soldier, loyal veteran, strong parent or stable employee). More explicitly, how veterans inevitably differentiated their own PTSD from other veterans shows how these individuals maintained a sense of self even within the socially stratified context of veteranhood.

Unlike the embodied social difference that military service and deployment produces, stigma is not embodied in the person but embedded in social interactions (Goffman 1963; Hebl and Dovidio 2005). In this manner stigmas are mutable, appearing and disappearing depending on the context. For a veteran serving in a particular war theater in a specific capacity, let's say Iraq, 2004, infantry, this experiential marker (or stigma) can create fear and ambivalence in

civilians or respect and admiration in fellow veterans. I want to emphasize that the social contexts determine how veterans experience stigma, disclose their PTSD status and risk placing themselves in stigmatizing situations. I found that veterans were not victims of a label in the sense that this label was internalized as a deviant condition. Many of the veterans I worked with and interviewed were able to strategically utilize the PTSD diagnosis or the assumption of it in order to maintain a sense of self and place in the world. In this chapter I will illustrate these main points through three case studies detailed below.

While there were many veterans who resisted labeling in institutional contexts where the consequences were quite devastating, they were the same vets who then adopted the label in situations where it was meaningful and upheld their self-worth or collective-worth of the group. This I will illustrate through the narrative of Sarah and her contrasting experiences as a mother and a staff sergeant. As a mother she contended with stigmas of being a violent parent but as an officer in the Army Reserves was able to use her PTSD status as “street cred” to lead and mentor her soldiers.

Second, I will argue that veterans themselves even reproduce stigmas within the group in order to differentiate their trauma and maintain personhood, as illustrated through a vignette of Kurt and his experiences in college classrooms. This case study shows how individuals are not just passive recipients of public stigmas, but can actively engage in the perpetuation of the stereotypes they themselves are managing.

Third, through a case study of Armando, I will show how nondisclosure in domestic contexts may operate as a form of protecting group identity in specific military communities, as opposed to internalized self-stigma. In contrast to intimate non-disclosure, Armando deliberately shares his story in public to help dispel public stigmas of veterans as victims, malingerers and violent people. In this manner disclosure contexts and strategies mirror veteran values of self-discipline, self-sacrifice and even survival. This case conceptually challenges the highly individualistic readings of stigma posited by theorists in social-psychology and sociology.

In a subtle way, these strategies I map out of disclosure contexts and within group stigma reproduction, suggest a shift in focus from victimization to subjective possibilities for agency (Jenkins and Carpenter-Song 2008). These vets were skilled in deflecting assaults on their personhood despite the deep cuts that stigmatization made.

To summarize, the major claims I make in this chapter are: (1) that social context is relevant to how a veteran experiences stigma and uses disclosure as a strategy to enable personhood; (2) that these subjective experiences change as veterans move through their social space and; (2) that a major strategy in achieving personhood and validating suffering involves disclosure of PTSD in public spaces, in contrast to domestic and intimate spaces. These public disclosures mirror veterans' values of service, group loyalty and the "bigger mission" and allow for a validation of suffering that fits with their ethos.

These findings corroborate with theoretical models that posit stigma to be a social process with multiple dimensions, as opposed to a psychological process located mainly within the individual. To provide some background for my analysis I will offer a brief overview of leading stigma conceptualizations, along with the framework I adopt.

STIGMA

Since Goffman's pioneering work *Stigma: Notes on the Management of Spoiled Identity*, stigma models have developed in a wide-range of perspectives including sociology, social psychology, evolutionary psychology and anthropology. While Goffman (1963) viewed stigma as intersubjective, operating not as a "thing" but a perspective that changes depending on the context of social interactions, many contemporary readings have diverted from his original conceptualization. These reformulations retain Goffman's ideas of "spoiled identity" and social exclusion but are more focused on health-related stigma with wider implications for identifying areas for intervention. A full review of models and their components is too complex to include here but I would like to introduce two main distinctions in stigma modeling from sociological and social-psychological theory, and then comment with an anthropological approach. In the most general sense, sociological frameworks consider stigma as an intersubjective process occurring outside of the individual in the social sphere and social-psychological perspectives view stigma as a cognitive process focused within the individual.

In social psychology, stigma has been theorized as: a situational threat that influences how an individual is treated (Jones et al. 1984); a threat to identity (Crocker et al. 1998); and a psychological process of stereotyping, prejudice and discrimination (Corrigan et al. 2000). In these models, the focus on the psychological processes of individuals allows for an analysis of various stigmatizing attitudes and behaviors. This is particularly attractive to public health interventionists seeking points of contact to change behavior. One critique of these models is that the social aspects of stigma are limited to those environmental components of stigma that intrude on the individual (e.g. interactions with stigmatizers in various contexts like home or work). In this way the person is viewed as the primary location where stigma processes occur (Yang et al. 2007:1526). In other words, stigma is a cognitive behavioral set of events coming from inside the individual.

Sociological models that adopt a symbolic interactionist perspective have maintained Goffman's theoretical assertion that stigma is intersubjective and operates mainly outside of the individual in the social sphere. The leading model in this area is Thomas Scheff's (1975) "Labeling Theory" which asserts that stigma is a thing symbolized by a label that influences one's self-perception and response to others. This application of deviant labels (e.g. mental illness diagnosis) and the stereotypes attached to them have been learned and reinforced daily, thereby creating a master status where the individual becomes

the label. Scheff proposed that the labeling process is the major cause of symptomatic behavior.

Developing this model further, the “Modified Labeling Theory” put forward by Link et al. (1989) posits that anticipated devaluation and social exclusion caused by labeling might exacerbate pre-existing illness symptoms. Further negative psychosocial outcomes could develop through an individual’s reaction to stigma (e.g. avoiding treatment), making them susceptible to psychiatric relapse. These symbolic interactionist models postulate that objects in the social world gain meaning through social interactions and social responses to behavior are contingent upon the relevant contexts that shape those meanings.

Notably, more recent work by Corrigan et al. (2004) in social-psychology considers the structural determinants that lie outside of the individual, such as the political, economic and historical roots of structural discrimination. In this case stigmatizing behaviors do not stem from the individual but from societal policies or bureaucratic procedures. Anthropological readings of stigma, although few compared to psychology and sociology, focus on structural discrimination and the stigmatization that emerges at the intersections of culture, power and difference.

Central to the mission of anthropology is to make connections between the macro-world of political economics and the micro-world of patient beliefs and experience. For example, Das and Adlakha (2001) suggest a notion of “domestic citizenship” as a useful tool for moving the focus away from individual agency to the broader social sphere (kinship or community). Domestic citizenship

relates to how the family, embedded in the broader kinship or community, ends up confronting the stigma, making it difficult to assume stability between the two in the case of a stigmatizing illness. Relations between those persons with stigmas and their immediate family can be broken as a result of the family trying to fit in with the norms of the wider community. What this reveals is that stigma associated with disease and disability "...is located not in (or only in) individual bodies but rather as "off" the body of the individual within a network of family and kin relations" (Das 2001:2). In this manner one is able to think about the different types of stigmas that exist in relation to one's domestic citizenship.

For example, in Weiss's (1998) study of "appearance impaired" newborn infants in Israel, she found that children with facial defects were abandoned to the state or hidden to "protect" other siblings from stigma processes. The rationale behind this is to save face in the social lives of families and as a result, these infants lose their domestic citizenship due to a "tyranny of norms of appearance" (Das 2001:2). In another example of "off" the body readings of stigma, Paul Farmer (1999) has illustrated that the overriding propensity in medical discourses of tuberculosis is to blame the patient and their "beliefs" for not complying to treatment. He found that patients often fail to follow medical regimes or seek help due to inadequate supplies, inability to reach providers, and severe time and money constraints. In making links between the micro-level experiences of patients and the macro-world of politics and economics, Farmer exposes the "structural violences" that influence peoples' behaviors.

In sum, using an anthropological lens, stigma is theorized as also located outside of the body. Most recently stigma is understood as occurring beyond the individual to include social networks and threaten family ties, thereby creating a “social death” for the devalued person (Das 2001) or shaped by moral experience and threatening what matters most to people (Yang et al. 2007). For the sake of my analysis I adopt the view that stigma cannot be reduced to individual psychology and is intersubjective in nature, with the anthropological understanding that stigma exerts its “core effects by threatening the loss of what really matters” (Yang et al. 2007:1524).

Explicit in the stigma interruptions presented in previous chapters, what really matters for veterans are their values of group loyalty, sacrifice and selfless service that are in conflict with their desire to return to their “normal” civilian lives. The contrasting cases of disclosure in public spaces and nondisclosure in domestic (intimate) spaces in the following vignettes, reflects this tension. These narratives from Sarah, Kurt and Armando provide variations on stigma experience and the intersubjective aspects of how these stigmas threaten personhood. I will further illustrate the importance of this intersubjectivity through veterans’ use of the diagnostic label to mitigate these threats and maintain a sense of self and purpose.

CONTEXT AND STIGMA

Sarah: Civilian Motherhood versus Military Motherhood

Public stigma, rooted in stereotypes of veterans as damaged and violent, can affect how individuals on a structural level perceive of veterans in their civilian roles. Vets I interviewed often remarked that they had been treated in a discriminatory manner because an institution or individual “know I am a veteran.” While this treatment was experienced as a threat to those particular roles (e.g. employee or parent) vets were able to counter these threats to their selfhood by using PTSD status in ways that opened up opportunities to maintain their place in the world.

In one of my morning interviews with Sarah she arrived visibly worn out and agitated. She attributed her stress to the situation with her eight year-old daughter who was recently diagnosed with attention deficit disorder, oppositional defiance disorder and delayed separation anxiety related to Sarah’s deployment to Afghanistan. Sarah describes her daughter, Celia, as “super-intense” and explains to me how “exhausting” her child can be:

Mornings I dread. The hour getting her ready for school is absolutely just, I don’t—I dread it everyday. Everyday I go to sleep I dread it because I know I have to wake up dealing with that ... She doesn’t listen. She doesn’t do what she is told. She just stomps around and screams, kick, yell, whatever it may be.

This behavior, the doctors say, is related to Celia’s perception that if she acts out her mother will not leave again. In addition to the behavior issues, Sarah has to contend with the medical system. She seems exasperated with the medications, speaking fast and loud without pause:

So two years after everything happened [deployment] and struggling to figure out what meds to put her on is exhausting. General side effects of them, weight loss, irritability ... they put her on anxiety medication and she is in behavior modification therapy, so it is exhausting. It is a lot of hard work. They have her on Zoloft and Focalin for ADHD so um, but so there's only that window of time where the meds are actually working and like for the ADHD meds the anxiety seems to be more 24-hour acting but the Focalin is basically only while she's at school so anything before and after I pretty much get ultimate craziness.

We never have a good day, ever. So it's just a battle of trying to maintain so that she doesn't get overly upset so it's really exhausting. We do a lot of extra activities to keep her active cause she has so much energy she just go go goes til she finally drops.

She does not really know how to do well in social aspects anymore, like she doesn't know how to act when she's in public. She will try and show off for anybody even if she doesn't know them so she'll be like doing cartwheels in the middle of the grocery store, things like that and you can tell her to stop but she doesn't listen. So it's exhausting.

This snapshot of Sarah's everyday life with her daughter provides the backdrop for the public stigma Sarah deals with in trying to provide the best care for Celia.

Sarah explained that as a mother she is very "leery" about telling people that she has a diagnosis of PTSD and is a veteran. Sarah recounts the critical event, where she realized she had to "be careful" who she discloses to. The following is excerpted from our interview:

Sarah: My daughter is very dramatic, she said my mom tried to kill me because I tried to put my hand over her mouth cause she was screaming. So the social worker calls me and goes "I am a mandated to report [this]. I have to report you to CPS [child protective services]" blah, blah, blah. But you know I know you are a veteran and I know you are dealing with PTSD, blah, blah, blah and I am like, don't make this something it is not.

Ethnographer: How did she know you were dealing with PTSD?

S: Because I had told her that previously ... I had had some difficulties bonding with her when I first got home, trying to figure out where the ADD—how to deal with the ADD. My daughter comes home from school that day, says "Well the social worker told me to tell you that you should have a counselor"... mind you, I almost got called into child protective services because apparently I am a violent [becoming upset], because I am violent and have PTSD.

When it honestly was my daughter, she exaggerates as most seven year- olds do and you know, we deal with some difficult times but to me that was like, you [the social worker] just used what I told you like in order for us to try and come to a good consensus on how to better parent, to make sure my child has a good environment at school and you totally used that against me and tried to make that an issue because you see in the media PTSD means everybody is violent and in the movies you know everybody is, you have that violent stigma attached to PTSD and you know I saw that first hand in dealing with my daughter. And it is like that is not what this is about. Like my child? We are dealing with the diagnosis of ADD.

E: Her ADD, not your PTSD?

S: Right, right, exactly, so can we try and figure out what we are doing here. So like that to me was like the biggest thing that I was just like, I can't just tell people these things because they are going to use it in however they see fit because when they hear PTSD, they don't think of it the way I do, which is something that I deal with everyday and certain things that trigger or don't trigger it. They think of it as what the media portrays about the soldier who committed suicide because they had PTSD or killed their wife and then killed themselves or you know the soldiers who went crazy and killed a whole bunch of Afghanis you know? That is what they think of when they hear PTSD so I guess that was really a huge key for me to like be careful who you who you tell this to.

What is most at stake here for Sarah her role as a mother and the stigma of being a “crazy” and “violent” vet threatens this. But in trying to be a good mother, through disclosing her PTSD and deployment status in order to work with professionals to figure out what is behind her daughter’s problems, Sarah is blindsided.

The problematic adjustments that Sarah encountered with her daughter upon returning home from deployment cannot be understated. Some of these issues related to her daughter’s deference to her grandparents (Sarah’s parents) over Sarah herself. Celia lived with her grandparents when Sarah was deployed and according to Sarah, “relates to them as parents and to me as a sister.” This involves family dynamics where Celia “tells on” Sarah in order to get the to

manipulate situations and in a sense blackmail her mother. For example, Celia will threaten her mother by saying she will tell grandma that Sarah is texting while driving or engaging in other bad behaviors. In response, Sarah's parents berate her for these behaviors in front of her daughter, which is not only uncomfortable but according to Sarah, "undermines my parenting skills totally, like who is the parent here?"

Sarah describes this behavior as disrespectful and finds it outrageous that her daughter does not defer to her as the parent in their relationship. At the same time, Sarah feels responsible for her daughter's "disorders" because she feels these conditions would not have developed had she remained home with her. Being a good parent for Sarah means disclosing those life experiences that may have had an impact on her daughter's development and could help professionals work with the family to find the best therapy.

Returning to the above narrative, the public stigma expressed by the social worker could be influenced by the fact that Celia's ADD drugs are at their most effective during school hours, so the school staff does not experience Celia in her "ultimate craziness." But the fact remains that the assumption was made that the incident was a result of Sarah's PTSD—not her daughter's defiant behavior.

This hegemonic use of diagnostic labels does a disservice to this family by creating barriers for care and healing. Not only is Sarah's professional commitment to her job and military service to blame for Celia's diagnostic label of

oppositional defiance disorder, the very symptoms of her daughter's disorder become construed as Sarah's psychological issues. This creates a double whammy of parental guilt and culpability that, in the end, punish Sarah's parental responsibility and actions. This geography of blame contributes to interpersonal conflicts that obstruct the social networks and family support that is so detrimental in the reintegration process. This use of diagnostic labels further promotes the dominant position of the "mentally well" (e.g. teachers and grandparents) to parent. For Sarah and Celia, the consequence is Sarah's nondisclosure to those professionals that might be able to help Celia.

This stigma of being a violent parent obstructs Sarah's personhood in that she feels she must hide her status at the risk of her daughter. In other words, Sarah can no longer do everything possible to be the best mom she can be. Significantly, this involves being transparent about her own emotional issues in order to assist in her daughter's healthy development and recovery. As it stands, she already blames herself for her daughter's issues and asserts that Celia was a good kid before the second deployment to Afghanistan.

At this juncture I would like to make a critical distinction between stigma and prejudice. In examining the research literature, Bos et al. (2013:5) conclude that there is much overlap in the two concepts but that stigma is distinct because it "involves reactions to perceived *negative deviance*" (author's italics). Prejudice does not necessarily involve deviance since it can be expressed between groups that are similar and have no differentiating deviant traits (e.g. football teams or

military branches). This distinction between prejudice and stigma is important because it allows for analyses of where the negative perceptions stem from, what they are, and eventually public health interventions. As Sarah herself concludes, the reaction of the social worker was likely rooted in media representations of veterans and over-exaggerated equations of PTSD to violence.

The Military Mom

While Sarah's PTSD threatened her role as a mother, she was still able to maintain this self-understanding in other areas of her life in different relationships, and without having to hide her status. To recap, Sarah does not claim a service connection for PTSD to receive a disability compensation for fear that she will be demoted or viewed as unfit for deployment. But she uses her PTSD status as a form of credibility with the soldiers she leads. As a staff sergeant she is responsible for the physical and psychological development of her team—much like a parent. And as the only woman in her platoon during her deployment, she took care of her soldiers in a self-identified motherly role:

[T]he stigma of being a female is definitely always there in the military but it works, it works in a good way too because a lot of guys feel they can come to you because they know that you are going to more than likely have all the extras that guys don't carry, Band Aids and all those things ... I always had my backpack full of goodies, snacks, like "Oh, I am starving" you know or "I feel like my blood sugar is dropping, I need something" and I was like "Here you go. I got a fruit snack or granola bar." That is just kind of how you kind of play that role and they trust you.

Taking care of these types of small needs was part of Sarah's socialization as a female in civilian society and she used this to her benefit to

build her integrity in a male dominant workplace. Interestingly, playing within the boundaries of her gender role actually allowed Sarah to transcend traditional gender limitations and become a leader among men. To be this successful in her career, Sarah obviously fielded much more difficult situations than “low blood sugar.” She was personally responsible for the physical preparation for war and the psychological maturation of her soldiers to deal with interpersonal conflict and hatred that war generates. In these situations she also used, what she identified as “emotional” feminine sensibilities, to counsel her soldiers and help them through difficult times. This is distinct from peer mentoring since Sarah is older, more experienced and in a leadership position, but her leading was softer in the manner in which she related her style to that of a “den mother.” Here she discusses how being a woman, a stigmatized status in itself, is beneficial in the military:

I definitely think that being a female in a leadership position is a very different thing. Some guys will say they don't like it. They prefer guys because guys understand and girls are emotional but ... when it comes to this kind of thing I definitely think it's more beneficial because as girls, as a woman, I can tell when one of my soldiers, who I have known for a long time, is off. I can tell better than the guys could tell.

I could say there is something going on with him, I don't really know what it is but I am going to pull him. I am going to pull him aside and I will ask him and then he will tell me, “Oh my girlfriend broke up with me” or “I found out my girlfriend is cheating on me” and those things are huge triggers ...

I have soldier who goes to school here who I did not deploy with but he is with my unit now. I don't know him all that well but [he] started posting some questionable things on Facebook and I was like you know, I have to figure out what is going on. So I message him and I say “Hey let's meet up for coffee and chat.” You know he told me he is dealing with some major PTSD ...

First, this vignette continues to illustrate the values of group loyalty and how veterans look out for each other in civilian contexts. Sarah expressed concern and responsibility for this other soldier, a stranger she did not deploy with, picking up on clues from Facebook. What made her sensitive to these “questionable things” this soldier posted was her own experience with PTSD and deployment. Second, while being a female in the Army was difficult, paired with her PTSD, it allowed Sarah to mentor and intervene in ways that men could not. Sarah attributes her intuitive nature to being more “emotional” than male leaders but she also understands what triggers a PTSD episode based on her subjectivity. In other words, her PTSD diagnosis allowed her opportunities to develop her own personhood, as a strong leader and nurturing “den mother” through assisting others. As a woman, Sarah felt soldiers trusted her with their problems but it was her PTSD status and experience in combat that gave her the real integrity:

I can talk about it [my PTSD] all day long ... soldiers who haven't been deployed, you can see the fresh mind where they just want to deploy and see what it's like and you know, then you see the same soldier after [pause] after they get back and you can see that it's not—their brain is not like that [fresh] anymore. They're seeing more than they should have seen and you know that's when they need to talk to someone about things ... having that PTSD diagnosis gives you that street cred I guess you could say. Like *yes, it is legitimate.*

Arguably, Sarah is in a social context where PTSD is considered a positive trait. PTSD is heavily stigmatized in the military as a condition of psychological weakness, unreliability and instability (Finley 2011; Hoge et al. 2004; Caplan 2011). The symptoms of PTSD are problematic in a warzone, not only severely unhealthy for the individual but also a “liability” for the team where everyone’s actions are so integrated and lives are at stake. But Sarah’s immediate context is

one of training, outside of a warzone, as an experienced leader preparing her troops. It is also a context where she is battling other stigmas, namely that of being a female in a male dominant profession. In a very counter-intuitive manner, Sarah uses her PTSD status to counter her status as female in the training context.

This is different than the war context where she has to maintain the psychological strength to build confidence in her soldiers. Here she maintains her troops as opposed to preparing them. These contrasting contexts are very relevant for disclosing PTSD because the latter, of maintaining troops during war, requires a certain amount of bravado to maintain moral in the ranks.

In conclusion, social context is very relevant to stigma experience. While this situation of PTSD disclosure obviously threatens Sarah's motherhood in the civilian world, she is still able to express this role and utilize her experience with PTSD to develop her personhood as a citizen soldier in the Army Reserves. More specifically, this disclosure of PTSD occurs in the immediate context of training for, as opposed to being in war. While reserves are one weekend a month and there generally are training missions for a couple of months a year, Sarah extends her care of her soldiers beyond the spatial and temporal boundaries of military work. I would argue that it is due to an unconditional love, much like that found between parents and children. In this military family, PTSD can be discussed as an asset, a form of experience that lends to mentoring.

Again, this challenges the dominant discourse of PTSD and victimhood: Sarah (paradoxically) uses her PTSD diagnosis as a symbol of reliability through capitalizing on female gender norms as a vehicle to counsel other soldiers. PTSD is a notch on her belt and provides her with the credibility to express a military version of motherhood. But also, counseling her soldiers about trauma through her own lived experience offers an opportunity to validate her sacrifices in a manner that does not undermine her values or beliefs (or parenting skills). Notably, this is in contrast to the validation sought through disability rating and compensation.

Kurt: Reproducing Public Stigmas

Sometimes public stigma is experienced on a more even leveled playing field, as with friends and peers. This type of stigma is bit more tenuous in that the power dynamics are not as explicit as in structural stigmas where social hierarchies are more transparent and the consequences are more tangible. It is in these situations where complex coping strategies take place, namely that of reproducing public stigma (Jenkins and Carpenter-Song 2008). The following narrative illustrates how public stigmas can obstruct personhood, but also how stigmatizing can be adopted by veterans themselves to challenge such threats. It is crucial to point out that in these circumstances public stereotypes are not internalized as self-stigma, but reproduced and directed towards others within the group. I am calling this “insider stigma” to add to the typology presented earlier

and provide a type that is in parallel with the strategy of reproducing stigma. This strategy allows for an agency that differentiates the stigmatizing veteran from others within the social group (e.g. malingering or homicidal veterans).

Whenever I met with Kurt the one thing he was consistently excited about was anything having to do with acquiring or finishing the renovation of a firing arm. He would show me photographs on his phone and go into detail regarding all the modifications and restorations he made on his guns, much like a father shows photos of his kids, recounting play by play the goal that was made at the last soccer game. Kurt's hobby is not unreasonable, considering the training he went through in the Marines as a rifleman. He describes going to the shooting range to practice shooting as "meditative" and "calming" since it requires intense concentration. This focus, and the breathing control involved in mastering marksmanship, Kurt describes as "therapeutic." But Kurt cannot share his hobby without the judgment of friends and peers. In the following discussion he expresses his concern about the new anti-gun legislation that requires background checks for veterans:

So there are these laws being implanted and people have this whole crazy thing like "Oh, you like guns?" Even my friends and colleagues even say shit to me you know?

One of the only things that makes me happy in this world is shooting [at a shooting range] ... But I get really weary of the government because now I am like even scared to go to therapy because I, you know, I'm really worried about this mental back-ground check with guns and stuff ... a bunch of my friends are like, I can tell you at least five vets I know, stopped going to therapy because of it.

In line with Pryor and Rechter's (2011) model, we can see how public stigmas might inform legislation and policies related to gun control and operate in a bi-directional manner to contribute to structural stigmas. Veterans like Kurt who are fearful of losing their gun rights do not want to be labeled unfit to own a firearm. Unquestionably, taking away this one happiness could derail Kurt's reintegration in that shooting operates as a stress reliever for him. Depriving him of this outlet, "one of the only things that makes me happy in this world", could potentially contribute to a downward spiral of symptoms that could interrupt his school, work and personal relationships, and contribute to a cycle of stigma.

Also, shooting is something Kurt is good at. It is way he evaluates himself in comparison to others and informs his self-concept. For example, when he goes shooting with his friend, who is an instructor and veteran, he tells me that he is working towards competing in marksmanship. Kurt wants to achieve the level of expertise and skill where he can also become an instructor.

Certainly our skills help to define who we are and contribute to our self-understanding. Being a marksman and arms aficionado is inherently tied to Kurt's identity: his passion for the history, craftsmanship and engineering of a weapon is no different than any other person who is a collector of things. That said, Kurt takes public stigmas equating veterans and guns with suicide and homicide as a threat to his identity. Gun laws are something Kurt is very concerned with as the following interview excerpt illustrates:

Again, I'm just weary about the whole PTSD label because I think its abused in our system, especially now with the media and guns, and vets killing themselves. I don't know if you have heard this now but they are thinking about maybe like

taking away rights, gun rights, if you have a PTSD label. It's like I think about myself, I've been medically diagnosed with PTSD because of crazy events I've been through because I've volunteered my time for this country. I only have this stuff because I went to war for this country.

But you're gonna tell me you are going to take away my guns because I'm a risk to myself or killing someone else? I have NO CRIMINAL history, literally. Literally. I have no criminal history. I go to school. I work [in social justice and advocacy]. I look like a fucking angel on paper. And I would be labeled just like one of THOSE people just because I got labeled with PTSD. I look better than probably most people who haven't been labeled with PTSD. You know?

I want to point out a stigma coping mechanism related to maintaining personhood that is buried in the end of this interaction. This strategy is what Jenkins and Carpenter-Song (2008:390) term "reproduction of stigma" and is "perhaps the most complex (of strategies) and highlights the difficulty of managing stigma." According to their analysis of people living with schizophrenia and their coping strategies in the face of stigma, differentiating oneself from the category of "mentally ill" allows individuals to define themselves in a positive light. This self-defining is in opposition to negative stereotypes of other people with a diagnosis. In Kurt's case, the comparison of being "an angel on paper" with no criminal record and going to war in service to his country offers a marker of his own stability, responsibility and social service in contrast to "THOSE people." In Kurt's view, he is not shooting weapons because he is "crazy" or depressed or suicidal but because it is part of his personal development: he is training to become an instructor and he uses shooting as a form of therapy.

There were other instances where Kurt adopted this strategy of stigma reproduction in order to maintain his personhood. He often compared himself to

other veterans to define himself in light of his PTSD diagnosis and his deployment experiences:

There were 150 thousand troops over there. Out of 150 thousand troops, how many were combat troops? 20—30 thousand. Which means only 20—30 thousand were outside of the bases in combat ... everyone else lives on a base. But everyone else who lives on a base gets the same credit we did and they get the same labels and they get PTSD for living on a base because they were away from their family or some bullshit and that pisses me off you know.

I was in class the other day and there are these two military kids that sit in the front of me in Korean War class. I have never told anyone in my class I was in the military, nor am I going to unless I have to ...

And the other day in class we were having a discussion about the Korean War and she was like “Well, that’s just not how it would be” and the professor was like “Well, how would you know that?” [She responds] “Because I was in the war” and I remember her making that comment and I literally went “pffhh” ...

So I hate having that [PTSD] label because that girl probably has the same label I do ...

There was an article about this woman who got PTSD because she's so stressed out because she was away from her family. She got PTSD for that. Like I legitimately was in combat. I did, saw, crazy shit and I get pissed off about other kids that went over there and what [missed their family]?

In chapter 3 I argued that Kurt’s reaction to “other veterans” is linked to his professional pride as a Marine rifleman. But here I want to add that in order to maintain this identity and differentiate himself he ends up reproducing public stigmas of malingering, in the case above specifically.

In his perspective, claiming PTSD and receiving disability compensation because one has been traumatized from being separated from their family is a form of malingering. It is not true PTSD because it did not involve the losses and sacrifice that the combat troops experienced. Importantly, combat PTSD is the form of PTSD distinguishing military trauma from forms of civilian trauma, such as domestic violence or natural disasters. In fact the diagnostic scales used to

assess civilian PTSD is different than that of combat PTSD and according to VA clinicians, more holistic in terms of life consequences.

Kurt's frustration with a female veteran claiming PTSD because of the trauma of family separation, insinuates that her PTSD is superficial and not worthy of a diagnosis or subsequent disability compensation. Her trauma is different than Kurt's because it is linked to her individual pain—separation anxiety from being removed from her family—not the collective sacrifice of engaging in the pain-sharing of combat. This is not to say that her suffering is false, but in the framework of military values she is not exhibiting the traits of selfless service, honor and group sacrifice in her suffering.

Understandably, Kurt does not want to be grouped with this female veteran relative to the sacrifices and losses he experienced on the warfront. I am suggesting that although public stigmas can obstruct personhood, these stigmas can be adopted by veterans themselves to enable their own personhood. It is critical that these stereotypes are not internalized as self-stigma, but reproduced as insider stigma and directed towards others within the group. Other veterans I interviewed and worked with would drop hints to this insider stigma also, especially in relation to combat PTSD as different, almost more authentic, than the PTSD from “being on base.”

Paradoxically, Kurt utilizes “othering” as a buffer for stigma (Jenkins and Carpenter-Song 2008). The social power he holds is tenuous, but it is possible that Kurt could create negative consequences for the veterans he “others.” For

example in the classroom, delegitimizing other veterans' experiences could negatively influence their social status among peers, (e.g. through gossip or influencing group assignments), but also create low self-worth through publicly "calling out" and damaging their image. The social context of the classroom affects the way Kurt experiences stigma in that here he is the stigmatizer, as opposed to his work environment where he is stigmatized for being dangerous.

Kurt's case reminds me of a story Nikki (an Army veteran who deployed to Kuwait at the same time Kurt was in Iraq) recounted about someone in a college class of hers. One of the students asked (in an accusing tone) a veteran classmate if he killed anyone in Iraq and if he thought that war really helped to alleviate political conflicts. This veteran became upset and left class, did not return in the following weeks and then finally showed up to class drunk. According to Nikki, the "ignorance and insensitivity" of the students, influenced by this public "calling out", led them to openly stigmatize this veteran as a violent killer, pushing him into a "downward spiral" of depression, substance abuse and isolation. This is the overt manner in which stigma operates to create negative consequences among peers, though creating an "us" and "them" scenario that contributes to social exclusion, internalized stigma and low self-worth and spoiled identities (Goffman 1963; Link and Phelan 2006; Sartorius and Schultz 2005).

As one veteran whom I worked with always reminded me, "Everyone has a story" and how one deals with trauma depends on that individual's personal history, social support and spiritual and psychological reserves. In other words, it

is not the amount of trauma or the kind of trauma that makes it different for everyone, but the subjective response that is influenced by that persons' biography and body (Finley 2011).

While acknowledging that everyone responds to trauma differently is a politically correct response to all veteran suffering, and in line with group loyalty, those combat vets who acknowledged aggregate forms of PTSD as valid inevitably differentiated their own PTSD (and by extension that of their battle buddies) from those who were not in "killing" roles. This differentiation also suggests how vets maintained a sense of self within the socially stratified context of veteranhood and reinforces my larger point about the relevance of social context to stigma experience. Critically, this sense of self was still connected to the collective, as Kurt asserted when he so often declared that everything he and his peers sacrificed gets undermined when all trauma is collapsed under one diagnostic label.

In sum, Kurt experienced a public and institutional stigma attached to his hobby of guns and shooting that insulted his character and obstructed his personhood, specifically through the potential of thwarting his goal of becoming a marksmanship instructor. To enable his own personhood in other areas of his life, he adopted stigmatizing efforts of his own that involved othering non-combat veterans. He achieved this mainly through his nondisclosure of being a vet, implying non-affiliation, and more active expressions of insider stigma.

As a counter-narrative to theoretical confluences of nondisclosure and internalized self-stigma, Kurt reproduced and directed public stigmas of malingering towards others within the group in order to maintain and enable his own personhood. In a complex manner this illustrates that it is possible that veterans are not passive recipients of public stigmas that then become internalized, but can be actively engaged in reproducing the very stereotypes they themselves are managing (e.g. malingering, violent or unstable).

Armando: Public Disclosures and Personal Secrets

Goffman's work on stigma was informed by his interest in micro-social processes and how the self is created and maintained. From an anthropological perspective, his analysis was loaded as highly individualistic (Das 2001). Following this critique, I will suggest that the collective level of social response to stigma between veterans, of not disclosing PTSD, might operate not as self-stigma but as a way to protect the group identity of specific military communities (e.g. Marines or Army infantry). In this reframing, nondisclosure fits more securely in the value system of veterans, operating as a form of self-discipline, self-sacrifice, and even survival. I would argue that this reading better reflects how the self is understood, created and maintained in relation to the collective of the Marines and Army infantry. I will illustrate this through the experiences of Armando.

Armando is a veteran advocate. In addition to helping veterans on an individual level he is interested in politics and hopes his work will contribute to

changing the public's views of veterans and government policies. This work includes public speaking engagements, student lectures and blogging. In this capacity Armando is very frank about his experiences with the military, PTSD, therapy, the VA and the issues he had reintegrating into civilian society. Like Sarah he uses his PTSD as a form of credibility—although he often makes the disclaimer that “everyone’s experience is different” and “everyone deals with PTSD differently.” He uses this platform as a way to enable his own personhood but also that of the veteran community through deliberately sharing his story in order to dispel public stigmas of victimhood, malingering and violence. This contrasts Kurt’s strategy of stigma reproduction to differentiate himself from other vets.

In the two lectures I attended, his testimonials were quite personal considering the audience of strangers. He talked about his reasons for joining the military, what war was like, his disillusionment with the government, his experience returning home and what the community can do to help vets reintegrate. The following excerpt is from a discussion I had with Armando after one of these lectures regarding his public disclosures:

I didn't get drafted, I didn't get in trouble with the cops and the judge say military or jail. I did it for whatever reason whether it was patriotism or college money or family legacy or whatever. I did it. I don't want to be criticized for it. And I'm not saying you have to agree with it. Just don't judge me for it ... I'm trying to do things. I'm a minority of a minority of a minority. And then I'm a veteran, and I'm a veteran that then understands that my service didn't end when I took my uniform off. And so my service to my community or this subset of community is still important to me.

I came to learn that it is the judgment that Armando experiences that pushes him to do the work he does to educate the public. Armando discloses his PTSD in his public practice of advocacy to illustrate that veterans with PTSD are not “crazy”, “broken”, or “damaged goods”. I understood Armando to utilize his PTSD status not as a point of pride or sympathy but as a trustworthy source for what does and does not work with “military people.”

His personhood is clearly tied to his continued work in the veteran community. But in more intimate, one on one situations, he generally does not disclose because he does not want to be viewed as unstable or incompetent, especially in circumstances where he is counseling other veterans or among family:

I try to be open with my wife. But even then, I don't like, like my wife knows that I've got PTSD diagnosis and stuff like that. But I don't talk to her about how I feel. I talk to her more about my experiences.

I don't want people to view me as weak. I don't want people to view me as like, he can handle all this shit [war] but he can't handle lay up. I don't want people to pity me, I don't want people to question me and by that I mean I don't want them to wonder about me. I don't want people to feel like I have a breaking point. I don't want people to think that I can't handle whatever it is that's in front of me, and be able to be successful at it.

Armando's experience is in contrast to Sarah, in relation to disclosure and counseling other vets, and illustrates the hold that hyper-masculine gender norms have and how they follow vets into the civilian world (Finley 2011; Holyfield 2011).

A hesitancy to disclose is especially true for Armando, and other male combat vets, when they are in the presence of other military folks:

I don't talk about that stuff with certain people. Like my grandfather, so my dad's dad, he was a Marine so he would have served in the 50s, and like my grandfather I respect him probably more than anyone else. He worked for the

same job, he was a machinist for like 55 years, he did all the, I mean he's like your old school guy and he was a Marine. I would never talk to him about this. When I go and I visit or when I go hunt and I stay at their house or whatever he'll ask me about work and I talk about stuff, I never ever talk about myself. Ever. I do not want, I don't want there to be a question about me. Like if he would ever ask me, like "So you're dealing with all these veterans that are having you know whatever this is called. You got that?" I don't even think I could tell him.

What is at stake for Armando is the judgment of those he respects, provides for, and depends on. The consequences of coming across as "having a breaking point" could threaten his role as a provider for his family and his responsibility as trusted counsel for other veterans. These roles are equally important to Armando's personhood, in terms of interpersonal relationships. I would argue that for Armando and most veterans, their Brothers in Arms are a form of extended family and most often (as illustrated in earlier chapters) have closer bonds than kin. But is it Armando's identity or the identity of combat veterans as a group that is at stake?

At face value, Armando's fear of sharing his PTSD with his grandfather and other veterans is a form of self-stigma, according to the model above where self-stigma includes the fear of being exposed to stigmatization and the potential to internalize those stigmas. This response is also understood in other ethnographies as an expression of the hyper-masculine social norms that these men are following (e.g. Caplan 2011; Finley 2011; Holyfield 2011). This contemporary view that is highly individualized is also part of military perspectives on stigma (e.g. Hoge et al. 2004). According to the military report, entitled *Army 2020: Generating Health and Discipline in the Force* (2012:69),

“Acknowledging a problem, particularly anything associated with an individual’s mental health, is frequently perceived as admitting weakness or failure.”

In considering the counter-individual culture of the military, I am suggesting the possibility for an alternate reading to self-stigma that places nondisclosure in a collective framework of “domestic citizenship” (Das and Adlakha 2001). To address the collective level of social response, i.e. how families and social groups respond to stigmatized illness within kinship or neighborhood, Das and Adlakha refer to domestic citizenship as a way to provide insight into how stigma is located not in individuals but “off” the body. In other words, stigma associated with disability and impairment is located in a “domestic space of family and kinship networks”, not just within the person. In this way, the concept of domestic citizenship is a useful tool for moving the focus away from the individual (e.g., self-stigma) to the broader social sphere.

The concept relates to how the family, embedded in the broader kinship or community, ends up confronting stigma, making it difficult to assume stability between the two in the case of a stigmatizing illness. Relations between those persons with stigmas and their immediate family can be broken as a result of the family trying to fit in with the norms of the wider community. In this manner, we can think about the different types of stigmas that exist in relation to one’s domestic citizenship.

According to this model public stigmas do not only threaten the individual but entire networks. I would argue that this is especially true in the domestic

space of the military (and to a double extent military families like Armando's). The manner in which many male combat veterans respond to the stigma of PTSD within their military network is, according to Armando, "not talk about it because there is already that understanding." There is also the need to exude strength and reliability in supporting one another. Part of this is related to the necessity to maintain morale and confidence in a military context, but this transfers into the civilian setting, especially for those who are working in the veteran community or maintain close relations with those they deployed with.

When Armando is having a hard time he does not explain it as PTSD, even with the vets he deployed with. He merely states he is "having a bad day." In response, his battle buddy provides seemingly vague support like "It will get better." This support however, goes a long way since there is so much common ground between these men. They both live the emotional roller coaster ride that is the result of PTSD's cyclic nature.

Extending Das' concept of domestic citizenship in synthesis with moral experience, it is possible that Armando's nondisclosure is not related to fear of losing social status among peers, as military reports suggest, (e.g. *Army 2020:69*) but a way to express and maintain the values of self-discipline, sacrifice and group loyalty. This social context is one of understanding, pride and reverence: in other words, a place of common ground where peers have shared loss and trauma, commiserated in training exercises, and experienced all those life-changing experiences in foreign lands that have changed their perspectives

and matured them beyond their civilian peers. This context is one of comradery and shared world-views where veterans connect through the silence of knowing. It is not the same social milieu where vets feel defensive and secretive, deflecting stigma through nondisclosure as a strategy to get back to “normal civilian life” or, as I argued in the last chapter, where vets feel such a sense of cultural dissonance that they do not even try and share experiences with their civilian counterparts or those vets who have not experienced combat. The overriding propensity of stigma discourses is to frame these nondisclosures as fear of being stigmatized and identity threat.

This ambiguous speech and nondisclosure between vets functions as a local technique to deflect stigma and maintain veteranhood, as opposed to functioning as a form of self-stigma. As one Marine explained it, “You don’t dump your purse for everyone” to see, and for fellow veterans, experientially they already know what is in that purse. Sharing its contents with civilians reveals secrets that could damage the cultural and historical subjectivity of the veteran community. And disclosing PTSD can threaten domestic citizenship and the collective identity that veterans hold dear.

In summary, what is at stake is not just Armando’s individual identity; it is also family legacy and his veteran community, as his paradoxical biography of disclosure suggests. In utilizing his PTSD status in contexts that are distinctly public, his credibility enabled Armando to find his place in the community as an

advocate. In this capacity he attempts to protect the domestic citizenship of veterans and their values through his own selfless service of selective disclosure. While Armando's nondisclosure of PTSD in more personal settings implies self-stigma, an alternate possibility is that this common secrecy among veterans is more than machismo and operates as a way to protect group identity. In this reframing, nondisclosure is not a result of fear or victimization, but functions as a form of self-discipline, pride and self-sacrifice.

The Subjective Possibilities of PTSD

The variation of stigma experiences and coping mechanisms of these veterans illustrate how the PTSD label simultaneously operates to enable and obstruct personhood. These biographies of disclosure point to the complex pathways in which veterans actively challenged or succumbed to stigma in order to maintain sense of self and place in the world. For Sarah her PTSD operated as a form of "street cred" that gave her the credibility to lead a team of men but also marked her as a violent and irresponsible mother. Kurt, through reproducing stigmas of malingering, differentiated his trauma from other non-combat veterans to maintain his veteranhood and group honor, but also simultaneously contended with stigmatization from his own colleagues for being aggressive and violent. In contrast, Armando paradoxically used his PTSD as a form of authority and a tool for stigma reduction in the public, but on a personal level did not disclose in order to maintain his, and the military's, identity of strength and resilience.

Importantly, these various ways of expressing suffering outside of the pathology allows veterans a validation that mirrors their value system, as opposed to disability ratings and compensation that creates moral and ethical tension. A major strategy in maintaining self-worth and social place, as illustrated through Armando and Sarah's narrative, was being part of a "bigger mission." Using the pain they experienced towards something positive, that other veterans or soldiers could benefit from, fit their values of service. In many cases, this involved disclosing PTSD status in public contexts with the intention of changing peoples' perceptions. It is significant, and a topic for further research, that public disclosure in these contexts was less threatening than disclosing to family, friends or co-workers. In a subtle way, these strategies suggest a shift in focus from victimization and self-stigma to subjective possibilities for agency. These vets were skilled in finding validation for their suffering in creative ways and deflecting assaults on their personhood.

Chapter 7

Conclusion

The Double Binding Path to Personhood

Some injuries are worse than others, and while they may heal over time, they may cause you to be labeled. Often, having the label changes how injured people are treated, so many of them lie about themselves. This lie consumes them as well as those around them ...

I ignore the label of PTSD and go about my days as normal now. When anyone new asks me about what I have been through, I lie because I don't want to be treated differently after they find out I have PTSD. Now I feel as if I am living a lie by cutting out one truth from my life, but I have realized I am not living a lie, I am actually living in fear. This fear was created by the very people who said they cared about me.

— Richard, OIF/OEF Marine Vet, A “Life Lesson Essay” entitled “Two Lies But One

SUMMARY OF DATA

The intent of the PTSD label, created in the 1980s post-Vietnam political milieu, was to alleviate the suffering of veterans. Its formal recognition was partly the result of many years of advocating and collaborating between groups representing the traumatized and psychiatrists. As a communication tool to interpret, measure and categorize traumatic experiences, the goal of the PTSD label was to provide public acknowledgment, grant financial compensation and ultimately, reduce stigma (Young 1995).

The fieldwork for this ethnography began with the question: how does the PTSD diagnosis function today, 35 years later, for a new generation of war veterans? Who does it liberate? Who does it constrain? And how does the process of being labeled affect veterans in their reintegration back into civilian life?

In exploring these questions ethnographically, I found that the experience of PTSD, or the preferred wording “how vets respond to trauma”, varied widely. But the well-intended bureaucratization of care and commodification of trauma brought about similar experiences of conflict for personhood and perceptions of stigma. Whether the diagnosis threatened or enabled personhood depended on veterans’ socially constructed selves, e.g. Kurt viewing the diagnosis as an insult to his professional service and the collective sacrifices of his battle buddies, or Sarah, embracing her PTSD as a form of “street cred” to lead, nurture and prepare her male soldiers for deployment.

What emerged so compellingly was that the skills, personal characteristics and ethos that make a good soldier became transformed into a mental disorder in the civilian context. This was a particularly difficult transformation in self-understanding for first-generation Iraq combat vets to make.²⁵ Some pieces of this story we have known for some time—that many of the symptoms associated with PTSD are normal and functional in dangerous situations (e.g., Cannon 1932; Hoge 2010). But looking deeper into the pathologizing of soldier’s work and the “battlemind”, I found that the moral values of veterans were constantly challenged

in both the biomedical technologies (diagnostic scales and measures, Prolonged Exposure Therapy and Cognitive Processing Therapy) and bureaucratic processes (being “put into the [VA] system” and VBA disability rating) associated with a PTSD diagnosis. Clinicians emphatically experienced the failures of these technologies and VA processes also, as illustrated by their professional resistance to mandatory diagnostic scales and evidence-based therapies and their anti-bureaucratic ethos.

For every vet in this study, having their trauma authenticated was stigmatizing, whether as a patient, government aid supplicant or “malingerer.” The bureaucratization and commodification of suffering generally threatened veterans’ identity through “cheapening the sacrifice” and objectifying autobiographical memories. These social processes associated with authentication distorted traumatic memories in ways that diluted the meaning of veterans’ experiences and created conflict for civilian personhood.

I have illustrated that this distortion and its consequences—treatment avoidance, non-disclosure, moral self-judgment, and general difficulties connecting with non-veterans—are informed more by a lack of cultural consonance, than self-stigma surrounding being labeled with PTSD. In fact, this lack of “fit” emerged as the locus of turmoil for veterans, not stigma per se. Like immigrants in a new country, veterans essentially feel like strangers in their own land, experiencing home as a clash of beliefs, morals and expectations. Their

self-understanding and new world view, informed by military training, war, and exposure to foreign lands and people, conflict with their civilian peers and family.

As a result, veterans find themselves at odds with an American civilian culture they once were a member of, a culture that puts a high value on individualism and choice. Enculturated into a military world where they are “a member of a team ... serving the people of the United States ... always placing mission first”²⁶ vets felt disconnected from civilians who they perceived as naïve and “ungrateful” in their preoccupations with “First World problems.” It was the irritation with civilians “who don’t get it” that emerged as the main script for social exclusion, as opposed to fear of stigma. Significantly, this was a self-selected exclusion and was informed by feelings of hostility and lack of empathy for “civvies” and their problems.

The common thread throughout these chapters is the existence of a lack of common ground, or lack of *cultural consonance*, between civilians and military service members. Cultural consonance describes the degree to which individuals, in their own beliefs and actions, fit in the broader shared cultural models in which they are a part of (Dressler 2007). This lack of cultural consonance, I argue, is a common pathway to the complicated outcomes of PTSD experience and perceived stigmas.

The one deep fault line is the lack of public support and recognition stemming from a society far removed from war and its effects. This communal detachment pushes these combat vets to seek a depersonalized bureaucratic form of

acknowledgment through diagnosis and financial reparation. Vets described this form of validation and its bureaucratic process as an experience that made them feel ashamed, judged and undermined their professional service and commitment. Paradoxically these negative emotions enabled personhood but at the expense of questioning one's own moral grounding.

Enabling personhood, the transactions of the diagnostic and disability compensation process were able to transform war trauma into something positive—therapy to promote healing, validation of sacrifice and financial support to open up possibilities to pursue one's vocation. But at the same time, as a threat to their personhood the reification and commodification of trauma turned deeply emotional and autobiographical social interactions into clerical tasks devoid of compassion and reverence. The unintended effect is that the process created stigmatizing experiences for veterans and contributed to a worsening of symptoms.

These unintended effects generated through the bureaucratic process (designed to universalize and provide just and equal care) forced veterans to recount traumatic memories to apathetic listeners over and over again through the *trauma pitch*. As a result veterans felt stigmatized for malingering through this repeated questioning that was experienced as an assault on their integrity and service. The *trauma pitch* also required an articulation of individual suffering that was difficult for veterans coming from war, where individual expressions of distress were lethal and endangered the group. Talking about one's personal

pain and traumatic memories also risked betraying core values of personal honor, group loyalty and reverence. In summary, in order to be recognized in the VA setting veterans had to reframe their trauma in a way that challenged their military values and training.

It is worth mentioning that the exacerbation of symptoms brought on by the *trauma pitch* is not just a consequence of VA bureaucratization but rooted in the core value of collective selfless service that the military instills. Many veterans did not share their “classified memories” out of a sense of personal honor to fallen soldiers and military code. Sharing these memories with uninterested civilians diluted their meaning and undermined their significance. These memories were symbolic in that they functioned as an expression of suffering outside of a diagnosis and in a manner that fit with veteran ethos. In this way, when veterans did recount these memories to civilians it was in the context of intentional reverence, such as a death anniversary, public commemoration like Memorial Day events or teaching moments linked to advocacy.

What I have illustrated through my analysis of a bureaucratization of care is how suffering, symbolized first in the form of a diagnosis and then a disability rating, becomes an item of exchange that creates conflicted feelings and meanings for veteranhood. While the disease category is not a valid form of suffering for this subset of combat veterans, the acknowledgment gained through financial reparation can be.

As Fassin and Rechtman (2009) theorized in their social genealogy of trauma, the obligatory label is accepted because trauma victims have to pass through that process of recognition to receive reparation. This does not imply that a person is defined by that experience. What the narratives of Kurt, Travis, Armando, William, Nikki, and Jim suggest is that the new label of disabled veteran and the financial compensation attached to it, is at once enabling but also threatening to personhood. It is enabling in that it provides validation that something is wrong and outside of the control of the individual or “makes up for” the pre-military selves that might never be realized.

Financial compensation provides a hopeful path to that realization by assisting veterans, in a very tangible way, to finding their place in society through achieving desirable social norms such as vocation, homeownership and family. This is what veterans call “getting back to normal” and a “normal life.” But the more intangible aspects, what we might tag Quality of Life, that includes a sense of social belonging, safety, and the existential, are more tenuous and difficult to measure let alone address via a disability rating that is based on measuring social and occupational impairment.

Part of what these PTSD compensation narratives suggest is that the conversion of suffering, through disability ratings and related diagnostic procedures, into a monetary reparation can become a denial of peoples’ experience of violence (Argenti-Pillen 2003; James 2012; Petryna 2002). The bureaucratized recognition, in the form of a PTSD label and disability checks, can

be offensive and alienating to vets who “answered the call” to protect and promote the freedoms that civilians “take for granted everyday.” This very hidden recognition is a poor substitute for community validation of veterans’ suffering, but the only option in a country so far removed from the effects of war.

The bureaucratic process and its trauma technologies also deny selfhood in that the *bureaugenic effects* of pricing out suffering, combined with veterans desire for validation, creates interpersonal conflict through a deeper questioning of one’s own mental resilience, purpose and moral worthiness. In other words, those ideals that are intricately tied up in their identity as military veterans. The chipping away of selfhood through the bureaucratic quantifying and comparing of soldierly “service and sacrifice for country”, operates in a manner that puts veterans’ warrior ethos at stake.

This observation echoes Erin Finley’s (2010) careful articulation of how PTSD diagnoses can humiliate and undermine combat soldiers’ sense of self and duty in the context of American male ideals. But I suggest it moves beyond machismo. Sacrifice and honor are values instilled in training for all soldiers, regardless of gender. Even though vets are aware that a rating is based on the severity and impact war memories have on everyday life, sharing them with strangers through the impersonal transaction of the *trauma pitch* feels dishonorable. As I have illustrated, it is painful disclosing these experiences to a non-responsive listener or a listener that, despite any benevolent bureaucraft, often ends up silencing the veteran’s need to recount trauma with reverence.

To reiterate the consequences of commodifying traumatic memories, veterans have to reframe their trauma in a way that reduces reverence and challenges their military sense of self in order to be recognized in the VBA claims setting. This creates a double bind that demands a compromise of military selfhood but is needed to find one's civilian personhood on the road to "normal." Veterans' disability compensation stories remind us that there are aspects of life that are difficult to measure. Commodifying them can be a "slap in the face" and threaten those things that matter most, whether that is pride in service or reverence for those who died.

Commodification of suffering can also threaten personhood unintentionally through secondary gain and abuse of monetary rewards. It is a serious issue that only a couple of veterans admitted to but many service providers expressed concern over. The topic of secondary gain points to the elusive quality of "psychological effects" of war and what is needed to ground and "fix" them. As William explained to me:

A check, it doesn't fix things because we have seen the extent to how far humanity can fall. It's kind of like knowing how bad sugar is and having someone coming up to you and giving you a donut because they want to do something nice for you ...

What William is alluding to is that the VA's "culture of compensation" (a term used by clinicians at the VA) is much like a dentist giving a child a lollipop after drilling out a couple of cavities. William used the money from his disability check and the stipend from his GI Bill to cope with his trauma—he spent it at the corner bar and drank away his pain. He did this for four years until his student benefits

ran out. He admits receiving a monthly check of 1500 dollars was not the best thing for him at that time. Still, he feels that financial compensation can help in certain circumstances depending on where in the process of reintegration a veteran is, "It doesn't fix things but it can help." William is now using his disability benefits for mental health counseling, to help support himself in starting his own business and for vocational rehabilitation to receive additional training. But the underlying question is, when does compensation operate as a form of secondary gain and function to obstruct and when does it enable personhood?

This is the double bind clinicians often find themselves in and a topic for further research. For clinicians, a disability check is viewed as a barrier to the healing process through creating situations where a veteran may become dependent or apathetic, no longer challenged to become their best self and instead "relying on easy money." Disability compensation is particularly conflicting for clinicians who are seeing this new generation of young vets who have a "full life" ahead of them but also need help in the adjustment period. The need for financial support early on is especially critical in a cultural and economic context where vets have difficulty finding work, let alone a job that allows them to use their skills. From the clinician's perspective, disability compensation can promote malingering and obstruct personhood through "being paid to stay ill."

Disability compensation or "diagnosis for a rating" creates a fundamental conflict for clinicians whose professional ethos and goals focus on helping the

veteran get better. While clinicians view this ethos as their duty, veterans experience this therapeutic ethos as an expression of the stigma of malingering.

MAIN CONTRIBUTIONS TO TRAUMA AND STIGMA LITERATURE

There are four major findings that this ethnographic research has produced that add knowledge to stigma and trauma studies:

- (1) The concept of self-stigma is an inaccurate interpretation of veterans' resistance to PTSD and associated trauma technologies.
- (2) Cultural consonance is what creates issues for personhood and reintegration and is the main script for difference and social exclusion, not stigma.
- (3) Victimization is an inaccurate framing of war experience and traumatic memory that misrecognizes the significance of military values. It mislabels the active form of reverence and self-construction in remembering.
- (4) The bureaucratization of care yields unintended and tragic results.

While social stigma is related to how veterans experience diagnostic labeling and feel discrimination, this ethnographic data suggests that this concept is limited in its applicability to this population. Self-stigma in particular misapprehends the life experiences and self-understanding of veterans. My data suggests that PTSD is an unacceptable expression of distress (to this subset of first-generation combat veterans) because honor and sacrifice, expressed through remembering and intentional reverence, are representative of being a good veteran. This is a counter-narrative to contemporary mental health readings and military psychiatric explanations that highlight self-stigma and public stigma

as the main barrier to mental health care (according to the most recent review of studies between 2001 and 2014) (Schreiber and McEnany 2015).

Even though these links between stigma, PTSD and help-seeking are highly understudied (Blais and Renshaw 2013) and there exist many gaps in the literature regarding veterans' mental health beliefs (Vogt 2011), public stigma and self-stigma continue to dominate the literature.

A lack of cultural consonance lies behind the social processes that contribute to nondisclosure of veteran status or trauma experiences and ultimately overdetermines stigma as a barrier to care (and by extension, reintegration). This lack of cultural consonance, I argue, is a common pathway to the complicated outcomes of PTSD experience and perceived stigmas. The contradictions that arise when warfront and homefront intersect and the secrets and isolation that result, are not necessarily or entirely related to fear of stigma or self-stigma. It is the incommensurate military and civilian worlds and subsequent clash of cultural models that destroy this notion of self-stigma as a main barrier to care and "getting back to normal."

The data presented here also dismantle concepts of self-stigma through shifting a focus from victimization to agency, as veterans chose not to engage with people that did not share similar cultural models—whether that included clinicians, bureaucrats, family and friends, or the public. For those who chose to share their stories, they did so to deliberately break stereotypes and because it was an expression of their values of honor and selfless service.

One other finding that deserves to be highlighted here is the construction of traumatic memory that makes remembering an active, as opposed to exclusively passive and victimizing, event. The collective pain-sharing in war deployments and the construction of these misfortunes as good memories, e.g. waiting in 100 degree heat for the enemy “to come out and play” or shooting pigeons for dinner, or even firefights, are “happy” precisely because veterans shared the misery in the attainment of a common goal. Certainly this is counter to any socially normative happy moments but PTSD frames all memories as traumatic. As Carrie Hamilton writes (2007), it is the strong emphasis of trauma models on memory studies that has led to an emphasis on suffering and victimization that tends to disguise other forms of memory. The rather unconventional suggestion I am making is that these memories of war do not have to be framed exclusively by pain and suffering. They can be an active form of reverence and reminiscing and position veterans as agents in the construction of their own cultural histories.

GENERAL RELEVANCE TO ANTHROPOLOGY AND PUBLIC HEALTH

Medicalization of Daily Life

This study has relevance to researchers interested in the medicalization of daily life and how biomedical technologies control social lives. It provides a specific regional example of how the pathologization of human experience can destabilize local strategies through labeling life situations as a mental disorder.

Considering the nature of recent wars in Iraq and Afghanistan and the experience of constant daily violence brought on by civilian insurgency, this project raises questions about war trauma and remembering as an event or everyday life situation, as well as the consequences of pathologizing this everyday experience on personhood.

In a global humanitarian context, this analysis of first generation Iraq and Afghanistan US war veterans' idioms of distress (culturally sanctioned ways of expressing suffering) suggests that nondisclosure of individualized trauma and collective remembering is just representative of the violence and trauma of everyday life as a veteran. Pathologizing local customs and values that deal with violence undermines a peoples' biography of suffering.

This dissertation further adds to the case studies detailing how medicalization depoliticizes illness, detracting attention from broader social issues by individualizing disorder and placing the blame on that individual (e.g., Castro and Farmer 2005; Coker 2005; Kleinman 2007; Scheper-Hughes 1988). The distinction I make, however, is that these veterans are not entirely victims of their sociopolitical environment, nor does the framework of victimization mirror their self-understanding.

Bureaucratization of Care

This study contributes to the body of work on the bureaucratization of care and the modern bureaucratic institution through detailing the consequences of

universalizing, equalizing and commodifying the subjective experience of trauma. Perhaps the main contribution here is the *trauma pitch* and the conceptualization of *bureaugenic effects* as a negative outcome of institutional approaches to validating one's experience. In ethnographically addressing how veterans were "processed" through the VA system, the organizational causes behind stigmatizing experiences emerged. These findings offer alternatives for misinformed stigma interventions, alternatives that focus on institutional practices as opposed to changing an individual's beliefs (see policy recommendations below).

Trauma and Memory Studies

The relevance to memory studies and the anthropology of trauma is threefold. First, the compensation stories presented here add to the literature on the political uses of trauma and how traumatic memory is used in very practical ways to survive (e.g. financial reparation). Corroborating with other studies (e.g. Fassin and Rechtman 2009; James 2010; Summerfield 2001) these narratives show how trauma is utilized not to elicit empathy but as a tool to claim one's rights. Second, in contrast to dominant understandings of trauma as an expression of victimhood, this study suggests a counter-narrative where traumatic memory can be a deliberate expression of socially constructed selves. Individuals can in part be considered agents in the making of their own cultural histories. Finally, the suggestion that some of the memories linked to trauma can

be happy and function as positive recollections that build selfhood, imply that individuals have some choice in the remembering. Not all memories are intrusive and negative. As one veteran articulated so poignantly:

It made me who I am and tells me who I am not. The memories link you to true friendship, true compassion and true suffering, and suffering is what strengthens the other two.

These sentiments echoed all those who took part in this study.

Cultural Appropriateness in Health Promotion

The topic of veterans and PTSD is relevant to mental health researchers interested in tailored interventions. This field of research and practice highlights the dimensions of cultural core values of specific populations and the role these values play in the use of healthcare. This qualitative dissertation points out the pitfalls of assuming a universal experience of core values through illustrating variations in how a PTSD diagnosis enables or threatens personhood.

The current approach to PTSD care, detailed in the chapters on diagnostic technologies and disability compensation, illustrate how these strategies fail both clinicians and patients. These case studies imply that when cultural concepts are taken out of context for easy measuring they lose their meaning. As a result, beliefs become misconceptions. For example, when military concepts of mental toughness and psychological resilience are taken out of the context of broader values of group loyalty, sacrifice and selfless service, treatment avoidance becomes framed as “not wanting to be viewed as weak” or self-stigma.

Reinserting these constructs into a broader value system of veteranhood, the

data here shows that for some veterans, psychological resilience is an expression of suffering rooted in reverence and collective memory linked to legacy.

POLICY RECOMMENDATIONS

This formative study has the potential to impact public health through government reintegration programs and disability determination policy and VA practice, specifically in regards to PTSD screening tools and procedures. The cyclical model of stigma (Sartorius and Schultz 2005) implies that there are points of intervention in those bureaucratic processes that are experienced as stigmatizing. The marker may not be able to be removed (i.e. “PTSD” or “veteran”) but there is an opportunity to reduce stigma-producing experiences at various touch-points.²⁷ Using a community based participatory research approach (Themba-Nixon, Winkler and Freudenberg 2008) I engaged veterans and VA staff in discussions on how to improve the VA process. We generated suggestions, organized below using a socioecological model for health promotion (McLeroy et al. 1988). This model addresses the importance of intervention on multiple levels that impact healthy behavior: the individual, interpersonal, organizational, community, and public policy. This model assumes that changes in the social environment will produce changes in individuals and that social support of individuals is critical in bringing about changes in the environment (McLeroy et al. 1988:351).

Organizational Level Recommendations

- (1) Mandatory “Decompression Training” after “the honeymoon period.” To allow veterans some time to come down from deployment, reflect on and ground their experiences, and begin to acculturate to civilian life, the Department of Defense could require a mandatory decompression time. Veterans pointed out that in WW II soldiers came home together, on a boat, and had three months to think, remember and discuss what happened. In the fast-paced-high-tech society we live in today, vets are home in a couple of days and military outprocessing begins: a sea of paperwork, Powerpoint presentations and health exams. Many veterans are in a hurry to get back to family and start their lives over. They rush through the bureaucratic process as fast as possible to enjoy a month or two of homecoming. And then the cultural dissonance begins. Providing vets with a mandatory decompression period, with no bureaucratic commitments, might ease transition and allow for important reflection in a safe context. Having veterans meet a few months after coming home, post “honeymoon period”, for an extended amount of time, would allow for peer support and collective remembering.
- (2) OIF/OEF Veterans Grand Rounds. To combat stigma in the clinical context, VA could develop VBA training or VHA Grand Rounds that include a panel of Iraq and Afghanistan veterans speaking about the impact of PTSD on their daily lives. The intention would be to dismantle notions of what PTSD looks like in younger veterans (this addresses the issue of being treated for one’s symptoms, not one’s age or appearance) and provide an understanding of how PTSD and physical injuries interact (the need for holistic care).
- (3) New Screening Protocol. VA could eliminate the use of the Combat Exposure Scale and develop a screening protocol for PTSD, in addition to training in how to most effectively use it, that allows clinicians a maximum amount of flexibility in interviewing veterans while still providing some measure of PTSD.
- (4) Claims Fact Sheet. VBA could provide a letter or fact sheet, when a claim is initiated, that describes in detail what the institutional definition of a rating is, the process (who, what, where, why and approximately how long) and be clear that “these appointments are not a treatment initiation”.
- (5) Claims Status Alerts. VBA could send emails or texts explaining the status of a claim, specifically describing at what step in the process the claim is at (i.e. Veteran Service Officer [evidence collection], Rating Veteran Service Representative [rating] or Veteran Claims Examiner [authorization])

– “...so they (claimants) could see the progression rather than always think they are ignored.”

- (6) Contact-based Training for Medical Students. To combat stigma at the structural level contact-based training and education for medical students is suggested and have proven to be effective.

Community Level Recommendations

- (1) Peer Navigator Program. To assist individuals with PTSD in the VA claims process, a “peer navigator program” could be developed in partnership with local veteran service organizations. Ideally, peer navigators would be persons with PTSD who have a similar Military Operational Specialty (service background) as the veteran, and who have been through PTSD screening and the disability determination process. This would be a peer support person, not a VA social worker or patient advocate, who would be able to accommodate veterans to their appointments. To reduce the need to recount their trauma, a peer navigator could operate as a representative for the veteran in need.
- (2) Trauma Statement. To further reduce the *bureaugenic effects* of the *trauma pitch* for veterans with PTSD, the veteran (and peer navigator) could create a written statement that holds all the pertinent information regarding traumatic events and exposures. The veteran in need could provide this statement to VBA and VHA staff during appointments should verbalizing these details prove to be too difficult. This statement might also be used by the peer navigator as a reference.

Public Policy Level Recommendations

- (1) Reintegration Fund. This employee benefit would provide financial support for veterans for daily living upon separating from the military. This fund would allocate a certain percentage of soldiers’ paychecks, matched by the government, that would supply rent and living expenses for the first six months veterans return home. Not a “hand-out”, this financial aid would take the stress off of being “homeless and unemployed” upon returning from war and allow vets to make more informed decisions about their civilian futures, e.g. mitigate “starting school just to get the monthly stipend.”

- (2) Third-Party Evaluations. Compensation and pension evaluations could be performed by a third party separate from the VA hospital and at a different location (concern was raised that contract staff “not working with combat vets all day” would be insensitive to war trauma and combat PTSD, training for these contractors would be necessary).

CLOSING THOUGHTS

Moral Injury, Ritual and Community

If we don't come to terms with the fact that political validation for our friends' deaths is never coming and that each other is all we've got, then I don't know how we, as a generation of returning veterans will collectively be able to get out of bed in the morning.

–Thomas Gibbons-Neff, Marine OEF vet

If we understand PTSD as an issue of cultural dissonance, rather than a mental disorder, and we consider the veteran as a displaced person as opposed to a traumatized victim, then the answer lies in the community to provide therapeutic care. Cultural dissonance is at the root of veterans' incapacity to share their experiences—and the ability to share experience, ideas and thoughts is what fundamentally connects us as humans. When this connection is blocked a very deep form of alienation occurs and personhood is shattered. Certainly this alienation from self and others is what is leading so many veterans down the path of substance abuse, violence and suicide. This is especially critical considering so much of the problem is moral and not biological. The recent growth in empirical research (Maguen and Litz 2012) and popular discussion of “moral injury” as a manifestation of war trauma separate from PTSD (e.g. Tic

2005; Wood 2014; Nakashima-Brock and Lettini 2013) suggests a hope for a non-clinical community based care.

Moral injury is not a clinically defined diagnosis but has been defined as the feelings veterans experience when their actions, or the actions of peer and leaders, conflict with deeply held moral beliefs (Drescher et al. 2011).²⁸ When soldiers see and do horrible things and have guilt and remorse over it, and these feelings are not addressed, then the theory is that these unattended emotions may result in PTSD. Moral injury is different from PTSD in that symptoms are more closely rooted in guilt, creating feelings of shame and grief (see Figure 6). These are the deep pains that PTSD diagnostic and therapeutic technologies do not capture.

Standard mental health approaches fail because they do not address the cultural dissonance vets experience on a moral level. PTSD drugs and therapies are more specifically directed at removing those symptoms associated with fear (e.g., flashbacks, hyper-vigilance, “startle” reflex). Evidenced-based approaches such as Prolonged Exposure Therapy focus on reliving experiences over and over again in order to subdue the fear associated with particular memories and situations (e.g., being in the same sensory environment in which a traumatic event occurred, like being stuck in a crowded public place or smelling diesel fumes). This repeated recall of events has the opposite effect of healing when veterans are reliving moral choices. Coupled with the continuous assault on

veterans' moral values that the bureaucratization of care creates (e.g. *trauma pitch*), it is no wonder PTSD treatments are ineffective for many combat veterans.

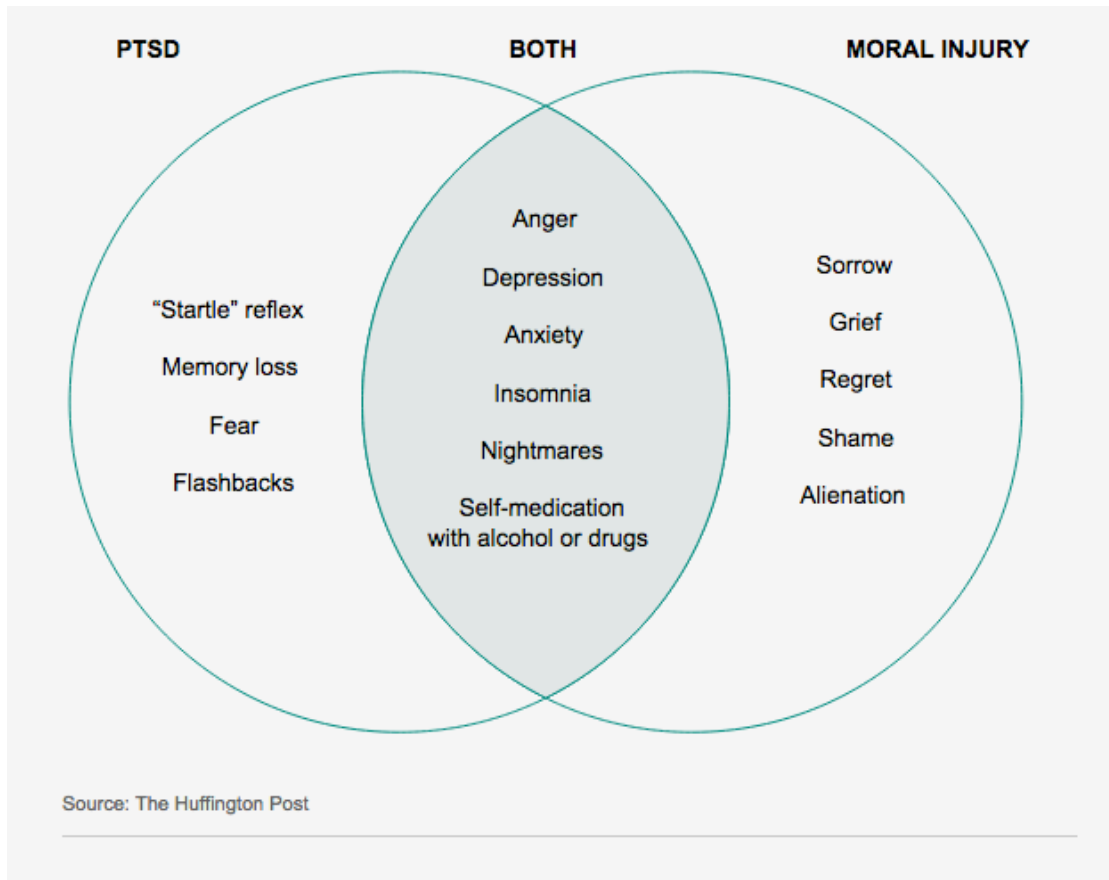


Figure 6. Symptoms of PTSD versus Moral injury (Wood, 2014)

This distinction between moral injury and mental disorder is important, not only for veterans but also for the public, clinicians and bureaucrats they interact with. If we consider the seat of morality to be the heart, as opposed to the brain, then the healing of moral injury lies within the realm of the soul or spirit. Healing the soul requires forgiveness and empathy, rather than pharmaceutical or cognitive therapies that blunt or reframe autobiographical memories. This

forgiveness can come from oneself, one's peers, a higher spiritual force, or society. The idea of a moral injury links the disproportionate worlds veterans experience, between soldier and civilian, because it represents that exact point where these two worlds collide: where right becomes wrong.

In this manner, moral injury is a type of internalized cultural dissonance that occurs on an intrapersonal level, as opposed to PTSD that is an expression of external dissonance. If cultural dissonance describes the degree to which individuals, in their own beliefs and actions, do not fit in the broader shared cultural models of the communities they live, then moral injury is that space where an individual's previously held beliefs and actions (at war) conflict with their current (civilian) cultural model they are rediscovering. As an intrapersonal phenomenon, moral injury can be more painful in that individuals blame themselves, rather than the broader society for their suffering. What distinguishes moral injury is that it is an evolved expression of cultural dissonance—it is a sign that the displaced person is returning home. In other words, it is a sign of moral health and healing.

Many of these veterans killed unnecessarily, stood by and witnessed atrocities and treated people in ways they would never want to be treated. At the time this seemed to be the right thing to do. But when they return home and have time to reflect, digest new information that comes forth via media outlets, they feel shame and disgrace. This is normal and a sign of moral health, a sign that the human being—the friend, the mother, the father, the daughter, the son, the

sibling, the civic member, inside of them—is returning, displacing the trained expert of violence. The transition is very painful and confusing for selfhood. In many societies this transition is marked with rituals of forgiveness and purification (Nakashima-Brock and Lettini 2012).

Some military leaders have already begun to incorporate “makeshift rituals of cleansing and forgiveness.” One battalion chaplain, after a 12-month combat tour in Iraq, had his troops write down everything they were ashamed, angry or regretful for, on a piece of paper. As the soldiers stood silently in a circle, the chaplain laid these papers in a symbolic baptismal font and burned them. The hope was to help the soldiers leave behind their moral injuries in the place where they occurred (Wood 2014).

At the close of the Global War on Terrorism, this forgiveness is especially necessary to heal in a society where veterans feel that “political validation for our friends deaths is never coming.” With the continued horror in Iraq and Afghanistan, brought about by al Qaeda splinter group ISIS, “it is as if everything we did, all the lives lost, the security provided for voting, the aid, the rebuilding, didn’t even matter.”

The military is full of rituals developing and commemorating a recruit’s transformation from civilian to soldier. But there are no community rituals to assist in the transformation from soldier to civilian. We need more public practices to acknowledge and help vets accept their memories and losses in a manner that fits with their values of group loyalty, reverence and selfless service. Forgiveness

is the first step to make meaning out of the moral transgressions that war necessitates. We need to come up with an alternate form of validation, not mental illness diagnosis, not disability compensation checks, that acknowledges the losses and sacrifices of all those affected by the War on Terrorism. Rituals are something we as a community can design.

Moral injury *is not* a mental disorder and creating a formal clinical category with all its scales and measures will do veterans a huge injustice. With respect to the efforts of theologians, therapists, chaplains and veterans associated with the Brite Divinity School, the term moral injury gained recognition in 2009. Their testimony was taken to the Truth Commission on Conscience in War in an effort to acknowledge moral injury alongside PTSD as a category for treatment and funding. Currently, the construct of moral injury is being “validated” for its viability and usefulness in traumatology research. But how will pathologizing morality, far outside the social context in which the questionable moral actions occurred, help veterans? Will it provide a clinical solution? A cure?

Morality is not something that can be measured and medicalizing it will only continue to corrupt the experiences that make veterans who they are. Morality is not something to be “treated”—it is something that is nurtured and developed through the community and society as a whole. This is where the healing will happen.

NOTES

¹ You can view this collection of books at <http://www.veteransbookproject.com/the-books/>

² With a 30 percent disability rating veterans receive free care for life. Some veterans would argue that healthcare is not “free” and part of the contract they signed with the government was that the VA would take care of them should they obtain any injuries during service. Part of the VA’s mission is to “serve those who served their country.”

³ At the time of data collection the PCL-5, based on the new DSM-V criteria was not out yet. At the VA the PCL-IV was used for screening, monitoring symptom change and provisional diagnosis. There were three subtypes: a PCL-Military and PCL-Civilian and a PCL-Specific. Many VA providers I spoke with used the PCL-Civilian because it was more holistic and ‘encompassing’ of the sequelae of trauma.

⁴ As an example, new changes to the DSM include splitting DSM-IV criteria into two criteria in DSM-V. This means that a PTSD diagnosis must now include at least one avoidance symptom. As Crystal explains, a veteran can be very disabled but still not be avoiding anything because they are making every effort to address their issues.

⁵ Crystal’s clinical team actually administers the civilian version of this scale, (rather than the military version) because it is more ‘inclusive’ of life experience.

⁶ Kurt’s interpretation is certainly linked to broader stereotypes of mental illness as threatening and also to how the popular media focuses on PTSD as a causal link in any story covering a veteran who committed a violent crime.

⁷ Source: <http://lightbox.time.com/2011/11/11/the-art-of-war-honoring-the-fallen-for-a-lifetime/#1> (accessed June 30, 2014)

⁸ Creeds are oaths that set the tone for life in the service and promote a warrior ethos. Every branch of the military has their own creed. Source: <http://www.hood.army.mil/ncoa/SoldiersCreed.aspx> (accessed June 30, 2014)

⁹ My use of commodification in this analysis is informed by Karl Marx’s critique of political economy where commodification relates to the transformation of relationships formerly uninvolved with commerce. Commodity in Marxist terms is understood as any good or service that is for sale on the market (Capital: Volume I, p. 36).

¹⁰ The Veterans Benefits Administration will rate injuries at ‘0%’ to acknowledge that an injury was sustained during military service but not disabling. The benefit of this is that in the future, if this injury becomes worse with age or causes ancillary conditions (i.e. arthritis, fusing of vertebrae or chronic pain) the veteran can re-apply for a disability.

¹¹ See <http://disabledveterans.org/2012/03/05/is-army-ptsd-misdiagnosis-scandal-also-fraud/> (accessed July 28, 2014)

¹² This, as described in the previous chapter, is due to an unawareness of bureaucratic process where diagnostic procedures blend with the administrative (benefits assessments). This also is an issue at this particular VA campus where the benefits administration and the health administration are located on the same campus and comp and pen evaluations are done within the hospital where veterans also see their doctors.

¹³ According to PBS News Hour, the Bureau of Labor Statistics posted an “ultra-high jobless rate” of 21.4 percent and stated in its annual review that despite training and job skills acquired in the military young veterans have more difficulty finding work than their civilian counterparts. See <http://www.pbs.org/newshour/rundown/unemployment-rate-among-veterans-drops-remains-high/> (accessed August 12, 2014)

¹⁴ See <http://vets.syr.edu/as-attitudes-shift-on-p-t-s-d-media-slow-to-remove-stigma/> (accessed August 12, 2014)

¹⁵ Veterans do not look at these police with much respect, as William puts it “They are there to arrest veterans for loitering when their appointments have been scheduled eight hours apart.”

¹⁶ A skid is similar to a very large pallet and used when airplanes deliver supplies. When accidentally dropped they make a massive sound and in this instance the sound resembled a loud hollow pop, similar to that of a chemical weapon.

¹⁷ A contract he and so many others remind me includes health and disability benefits.

¹⁸ As of writing, these are the numbers provided by the *Cost of War*. This project involves a team of anthropologists (namely Catherine Lutz), economists, physicians and legal experts who are tasked to analyze the social and economic consequences of war. See <http://costsofwar.org/> (accessed August 16, 2014)

¹⁹ See http://www.vva.org/ptsd_levels.html

²⁰ See <http://www.msnbc.com/the-last-word/tammy-duckworth-rips-irs-contractor-seeki>

²¹ Military issue glasses are no longer these ugly, sex-partner-repelling artifacts and since 2012 have been replaced with a hipster version that is more in line with the thin rectangular black rimmed versions reminiscent of beat poets. Still, everyone wears the same style.

²² These memories are divergent from the intrusive memories that are part of the PTSD diagnostic criteria. These bad memories are typically uncontrolled and triggered by something sensual—a sound, smell, the weather, a type of car, a bridge and so forth.

²³ Dead animals often incited fear in soldiers because improvised explosive devices were embedded in them.

²⁴ This chemical warfare on the Kurds was part of Saddam Hussein's ethnic cleansing program.

²⁵ I attribute this to the uncertainty and unpreparedness of the military early on in the Iraq and Afghanistan wars and the kind of urban, close combat, insurgent warfare that was to culminate. Veterans of this time period (2004-2005) did not have the proper equipment and protective gear to deal this and horrendous, repetitive losses were incurred as a result.

²⁶ This is verbatim from The United States Army Soldier's Creed. Soldiers are required to memorize this in basic training and first generation Iraq Infantrymen were required to carry this on their body at all times.

²⁷ For other innovative ways of reducing stigma experiences see Schreiber and McEnany's review of services and programs to improve veteran care at <http://www.ncbi.nlm.nih.gov/pubmed/25587819> Accessed January 19, 2015.

²⁸ The viability and usefulness of this construct has not yet been validated in traumatology, according to these authors, although it has been used in scientific and popular writing since the 1800s. In my research, moral injury resonates more with veterans in explaining their suffering than PTSD does.

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Weeks, and Matthew J. Friedman

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APPENDIX

PTSD Checklist – Military Version (PCL-M)

Name: _____ Unit: _____
 Best contact number and/or email: _____
 Deployed location: _____

Instructions: Below is a list of problems and complaints that veterans sometimes have in response to a stressful military experience. Please read each one carefully, put an "X" in the box.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful military experience?					
2.	Repeated, disturbing <i>dreams</i> of a stressful military experience?					
3.	Suddenly <i>acting or feeling</i> as if a stressful military experience <i>were happening again</i> (as if you were reliving it)?					
4.	Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful military experience?					
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful military experience?					
6.	Avoid <i>thinking about or talking about</i> a stressful military experience or avoid <i>having feelings</i> related to it?					
7.	Avoid <i>activities or talking about</i> a stressful military experience or avoid <i>having feelings</i> related to it?					
8.	Trouble <i>remembering important parts</i> of a stressful military experience?					
9.	Loss of <i>interest</i> in things that you used to enjoy?					
10.	Feeling <i>distant or cut off</i> from other people?					
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					
12.	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?					
13.	Trouble <i>falling or staying asleep</i> ?					
14.	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?					
15.	Having <i>difficulty</i> concentrating?					
16.	Being " <i>super alert</i> " or watchful on guard?					
17.	Feeling <i>jumpy</i> or easily startled?					

Has anyone indicated that you've changed since the stressful military experience? Yes ___ No ___

Description

The Combat Exposure Scale (CES) is a 7-item self-report measure that assesses wartime stressors experienced by combatants. Items are rated on a 5-point frequency (1 = “no” or “never” to 5 = “more than 50 times”), 5-point duration (1 = “never” to 5 = “more than 6 months”), 4-point frequency (1 = “no” to 4 = “more than 12 times”) or 4-point degree of loss (1 = “no one” to 4 = “more than 50%”) scale.

Respondents are asked to respond based on their exposure to various combat situations, such as firing rounds at the enemy and being on dangerous duty. The total CES score (ranging from 0 to 41) is calculated by using a sum of weighted scores, which can be classified into 1 of 5 categories of combat exposure ranging from “light” to “heavy.” The CES was developed to be easily administered and scored and is useful in both research and clinical settings.

Source: United States Department of Veterans Affairs website

CES

Please circle the number above the answer that best describes your experience

1) Did you ever go on combat patrols or have other dangerous duty?

1	2	3	4	5
No	1-3X	4-12x	13-50x	51+times

2) Were you ever under enemy fire?

1	2	3	4	5
Never	<1 month	1-3 months	4-6 months	7 mos or more

3) Were you ever surrounded by the enemy?

1	2	3	4	5
No	1-2X	3-12x	13-25x	26+times

4) What percentage of the soldiers in your unit were killed (KIA), wounded or missing in action (MIA)?

1	2	3	4	5
None	1-25%	26-50%	51-75%	76% or more

5) How often did you fire rounds at the enemy?

1	2	3	4	5
Never	1-2X	3-12x	13-50x	51 or more

6) How often did you see someone hit by incoming or outgoing rounds?

1	2	3	4	5
Never	1-2X	3-12x	13-50x	51 or more

7) How often were you in danger of being injured or killed (i.e., being pinned down, overrun, ambushed, near miss, etc.)?

1	2	3	4	5
Never	1-2X	3-12x	13-50x	51 or more

Keane, T.M., Fairbank, J.A., Caddell, J.M., Zimering, R.T., Taylor, K.L. & Mora, C.A. (1989)

DSM-5 Criteria for PTSD

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (1). The diagnostic criteria are specified below.

Criterion A: stressor

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: intrusion symptoms

The traumatic event is persistently re-experienced in the following way(s): (one required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Criterion D: negative alterations in cognitions and mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

Criterion E: alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

Criterion F: duration

Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

Criterion G: functional significance

Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criterion H: exclusion

Disturbance is not due to medication, substance use, or other illness.

KATINKA HOOYER CURICULUM VITAE

EDUCATION

2015	PhD, Sociocultural Anthropology, Medical Anthropology focus, Public Health minor, University of Wisconsin-Milwaukee
1996	MS, Cultural Anthropology, University of Wisconsin-Milwaukee
1991	BA, Ethnic Studies, University of Wisconsin-Milwaukee

POSITIONS

2012-present	Community Research Consultant , Healthier Wisconsin Partnership Program, <i>Dryhootch iPeer</i> : Medical College of Wisconsin with Clement Zablocki VA Medical Center, Milwaukee, WI
2012-2014	Lecturer , Concordia University, School of Pharmacy
2011-2012	Instructor , University of Wisconsin-Milwaukee, Anthropology
2006-2008	Lecturer , University of Wisconsin-Milwaukee, Women's Studies
2005-2008	Corporate and Community Marketing Researcher Caffeine Communications, Murphy Marketing, Milwaukee, WI
1999-2005	Lecturer , University of Wisconsin-Milwaukee, Ethnic Studies

GRANTS/PRE-DOCTORAL AWARDS

2012-2014	Research Assistantship , University of Wisconsin-Milwaukee, Center for Applied Behavioral Health Research, stipend
2013	Writer's Residency , Veterans Book Project and Milwaukee Art Museum, Wisconsin
2012	Disability Determination Program Grant , Dissertation research, Social Security Administration and Policy Research, Inc., \$10,000
2011-2012	Teaching Assistantship , University of Wisconsin-Milwaukee, Anthropology Department, stipend
2009-2011	Project Assistantship , University of Wisconsin-Milwaukee, Medical Anthropology Lab, stipend
1993-1995	Teaching Assistantship , University of Wisconsin-Milwaukee, Anthropology Department, stipend

RESEARCH INTEREST

My research centers on alternative therapies to improve military veterans' health. Methodologically, I use collaborative ethnography to understand the cultural factors that influence behavior and shape experience. This involves engaging with the community in all phases of research and dissemination. My goal is to develop interdisciplinary projects that design and test culturally tailored health services.

PUBLICATIONS: Peer Reviewed

Hooyer, K. (2014). The “User-generated Classroom”: Co-designing the Learning Space for Novice Anthropologists. *Anthropology News* 55(5-6), 13-14.

Policy Research, Inc. and US Social Security Administration (2013). *“The Trauma Pitch”: How Stigma Emerges for Iraq and Afghanistan Veterans in the PTSD Disability Claims Process*. Washington, DC: **Hooyer, K.**

Hooyer, K. (2012). Going AWOL: Alternative Responses to PTSD Stigma in the Military. *Field Notes* 4(1), 106-127.

Hooyer, K. (2010, April 21). Ethan Watters’ Crazy Like Us: The Globalization of the Human Psyche [Review of the book *Crazy Like Us: The Globalization of the Human Psyche*, written by Ethan Watters, 2010]. *Somatosphere: Science, Medicine and Anthropology*. <http://somatosphere.net/author/katinka-hooyer>

CONFERENCE PRESENTATIONS: Refereed

- 2014 **Hooyer, K.** *Objects for Deployment: Creating New Observers and Spreading the Burden of War*. Paper presented at the Art in Response to Violence Fifth Annual International Conference, Chicago, IL.
- 2014 Rizia, R., Franco, Z., **Hooyer, K.**, Patwary, A.B.M.K., Ahsan, G.M.T., Curry, B., Flower, M. and Ahamed, S.I. *Mobile Peer-Mentoring: An Approach to Make Veterans Seek Mental Health-Care a Normality*. Short paper, 10th IEEE International Conference on Collaborative Computing: Networking, Applications and Worksharing, Miami, FL.
- 2014 Rizia, R., Franco, Z., **Hooyer, K.**, Patwary, A.B.M.K., Ahsan, G.M.T., Curry, B., Flower, M. and Ahamed, S.I., *eVeteran Community: A Sociotechnical Approach for Improving the Quality of Life of Veterans Reintegrating into the Civilian World, Mobile Peer-Mentoring: An Approach to Make Veterans Seek Mental Health-Care a Normality*. Poster, Anita Borg Institute Grace Hopper Celebration of Women in Computing, Phoenix, AZ.
- 2013 **Hooyer, K.** *Tracing Trauma: Creating New Observers*. Participatory theater facilitated and paper presented at the American Anthropology Association Annual Meeting, Chicago, IL.
- 2013 **Hooyer, K.** *Killing Innocence: Indirect Violence and the Combat Veteran*. Paper presented at the Central States Anthropological Society Annual Meeting, St. Louis, MO.

- 2012 **Hooyer, K.** *PTSD: From Warfront to Homefront*. Paper presented at University of Wisconsin-Milwaukee Graduate Student Conference, Milwaukee, WI.

INVITED PRESENTATIONS

- 2014 **Hooyer, K.** *Making Sure Your Audience Gets Your Findings: Community Forms of Research Dissemination*. Invited speaker. Anthropology Student Union, University of Wisconsin-Milwaukee, Milwaukee, WI.
- 2013 **Hooyer, K.** *Qualitative Methods in Program Evaluation*. Guest Lecturer. Evaluation Research, Helen Bader School of Social Welfare, Graduate School, University of Wisconsin-Milwaukee, Milwaukee, WI.
- 2012 **Hooyer, K.** *Design Anthropology for Social Change*. Workshop facilitator. Student and Faculty Research Workshop, Milwaukee Institute of Art and Design, Industrial Design and Engineering, Milwaukee, WI.

COMMUNITY-BASED RESEARCH and DISSEMINATION

- 2013-present **Dryhootch iPeer: A Social and Technology Support Program for Veteran Mental Health**. Medical College of Wisconsin, Healthier Wisconsin Partnership Program (HWPP) with Clement Zablocki VA Medical Center and Dryhootch of America. PI: Zeno Franco. Award: \$750,000 over 5 years. Role: Consultant, qualitative design research and development of iPeer mobile phone application and curriculum development of peer mentor training program.
- 2013-present **Tracing Resilience: Spreading the Burden of War**. dissemination of research findings on veterans' experience with deployment and posttraumatic stress into the community via participatory theater performance
- 2012-present **Objects for Deployment: Surplus Data**. *The Veterans Book Project*, travelling archive. Primary Facilitator: Monica Haller. The Guggenheim Memorial Foundation and National Endowment for the Arts. Role: Book author and presenter. <http://www.veteransbookproject.com/the-veterans-book-project/>
- 2012-2014 **Community Pharmacists' Response to an Emerging Prescription Drug Monitoring Program**. State of Wisconsin

and Concordia University, Distinguished Professorship. Awardee and PI: Michael Fendrich. Award: \$180,000 over 3 years. Role: Qualitative research, focus group facilitation, survey development, grant writing, manuscript preparation (graduate research assistant).

- 2012 **Designing Desire: The Cultural Effects of Marketing:** Milwaukee Institute of Art and Design, Brook Stevens Gallery. Role: guest curator, exhibit research and design examining marketing's influence on consumer culture and impact on specific groups of people.

ACADEMIC RESEARCH and DISSEMINATION

- 2011-2015 **Mentally Disordered or Culturally Displaced?: How the PTSD Label Transforms Personhood in US Military Veterans,** University of Wisconsin-Milwaukee Department of Anthropology and Helen Bader School of Social Welfare. Award: graduate stipend \$55,000 over 3 years. Role: PI, doctoral fieldwork on the impact of diagnosis and trauma technologies on social stigma, personhood and veteran reintegration.
- 2012-2013 **PTSD Disability Claims Process: How Stigma Emerges for Iraq and Afghanistan Veterans,** Social Security Administration and Policy Research, Inc. Disability Determination Program Small Grant. Award: \$10,000 over 1 year. Role: PI, research design, implementation, and final report
- 2009-2011 **A Clinical Ethnography of Mental Health Services in Wisconsin,** University of Wisconsin-Milwaukee Research Growth Initiative (RGI) Grant # 101X144. PI: Kalman Applbaum. Award: \$112,599 over two years. Role: PA, secondary research on injectable anti-psychotics and physician decision-making
- 2011 **Going AWOL: Alternative Responses to Mental Health Stigma in the US Military,** preliminary dissertation research analyzing treatment barriers and government responses to PTSD, published.

COMMERCIAL PUBLIC HEALTH-RELATED RESEARCH

- 2008 *"Rider's Edge" Motorcycle Safety Course and Injury Prevention for Women Riders.* Harley-Davidson Motor Company, PI: Katinka Hooyer. Role: marketing research and communications recommendations targeted at female risky behavior.

- 2008 *Eco-Certification Program for Nonprofits: Improving the Physical Work Environment for Better Health.* Wisconsin Green Building Alliance and Pragmatic Construction. Role: community needs assessment of nonprofit employees, program design and proposal writing for funding.
- 2008 *"Loud Pipes Risk Rights" Voluntary Noise Regulation and Injury Prevention Campaign.* American Motorcycle Association and Harley-Davidson Motor Company. PI: Katinka Hooyer. Role: behavioral research and communications design to improve environmental health in motorcycle-dense communities.
- 2007 *Affordable Green Housing Alternatives to Improve Environmental Health and Early Childhood Development.* Milwaukee City Housing Catalogue and Urban Infill Project. Eppstein Uhen Architects and Milwaukee Department of City Development. Role: consumer research and evidence-based design, co-authored proposal for housing catalogue.

TEACHING/CURRICULUM DEVELOPMENT

- 2012-2013 Social and Behavioral Medicine in Pharmacy Practice (2 classes)
 -co-developed curriculum and taught a total of 164 students
 -gave 1-hour weekly lectures
 -designed, facilitated and graded bi-monthly group activities
- 2011-2012 Introduction to Cultural Anthropology: Understanding and Appreciating Human Diversity (2 classes)
 -designed blended curriculum with new teaching material
 -facilitated weekly 3-hour lectures for a total of 72 students
 -supervised and evaluated 18 group projects
- 2006-2008 Media Literacy and Feminism: Representations of Women and Sex in Pop Culture (5 classes, blended undergraduate and graduate)
 -designed and taught new curriculum
 -supervised three graduate students
 -facilitated weekly 3-hour lectures
 -enrollment at capacity with a waiting list every semester
 -taught a total of 165 students
- 1999-2006 Shamans, Mystics and Medicine Hunters: Tribal Healing Systems and Ethics in Pharmaceutical Research (8 classes)
 -designed and taught new curriculum
 -gave one 50 minute lecture twice a week
 -taught 20 students per class, total of 160 students

ACADEMIC SERVICE

- 2014-present *Field Notes: A Journal of Collegiate Anthropology*. Ad Hoc Reviewer
- 2013-2014 Graduate Student Anthropology Union, University of Wisconsin-Milwaukee, Milwaukee, WI: Representative (appointed). Role: organized and promoted professional development workshops
- 2012-2013 Veterans Advisory Council: Department Representative. University of Wisconsin-Milwaukee, reported to Chancellor. Role: survey research and needs assessment for student veterans, consulted on marketing communications for veteran campus center
- 2011 Community Advocates: Public Policy Institute Report "Making Parity Real." Role: consulted on and edited stigma section for final report to State of Wisconsin

COMMUNITY SERVICE

- 2013-present Veterans Health Coalition: Co-facilitator (appointed). Healthier Wisconsin Partnership Program, Medical College of Wisconsin. Role: facilitate meetings and coalition building
- 2013 Wisconsin Initiative to Eliminate Stigma (WISE). Rogers Memorial Hospital, program director: Sue McKenzie. Role: conceptual and organizational development, marketing for statewide coalition building
- 2011-12 PTSD Support Group for Veterans. Dryhooch of America, facilitator: Art Soto. Role: weekly therapy dog visitation
- 2010 National Association of Mental Illness-Milwaukee, director: Peter Hoeffel. Role: project proposal for anti-stigma campaign development
- 2008 Wastecap Wisconsin, director: Jenna Kunde. Role: facilitated focus groups for professional construction waste recycling training and certification program

ONLINE TEACHING PROFICIENCY

Blackboard
Desire2Learn
ANGEL

MEMBERSHIPS AND PROFESSIONAL ASSOCIATIONS

American Anthropological Association
 Society for Applied Anthropology
 Society for Medical Anthropology
 Graduate Student Union, UW-Milwaukee 2011-2015
 Anthropology Student Union, UW-Milwaukee 2012-2015

REFERENCES

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