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SOME THINGS CAN NEVER BE UNSEEN: THE ROLE OF CONTEXT IN PSYCHOLOGICAL INJURY AT WAR

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Recent wars in Iraq and Afghanistan have reignited debates on how to prevent and manage psychological injury among returning troops. These debates point to the psychological cost of war as a grand challenge whose scale and complexity stretch far beyond the already large and growing number of veterans affected. We use a unique ethnography of a military medical team's tour of duty in Camp Bastion, Afghanistan, to explore the role of institutional context as a contributing factor to psychological injury from war. We find that exposure to war and its consequences invokes sustained experiences of senselessness, futility, and surreality that are partially rooted in cultural expectations, professional role identity, and organizational protocol, and can threaten people's existential grounding in this institutional context. We argue that what makes work at war traumatic for some and not others is likely affected by the specific context through which people filter, frame, and cope with their experience. A contextual understanding of psychological injury at war that is based in organizational research can thus form an important part of better addressing this grand challenge.

War can be deeply traumatizing, even for those not in the firing line, because it tears at the fabric of what it is to be human. Yet there is little indication of war's remission: the 20th century, for all its progress in medicine, technology, and education, was also the most murderous in recorded history. Recent wars in Iraq, Afghanistan, Syria, Yemen, and the Ukraine show no abatement in the trend. Leaving aside the direct cost of war, the psychological costs of deployment are becoming ever more apparent. Of the 2.7 million U.S. troops sent to Iraq or Afghanistan between 2001 and 2011, 20–30% returned with some form of psychological injury (U.S. Department of Veteran Affairs, 2015). While correlation need not imply causation, according to a 2008 Congressional report, military veterans account for 10% of U.S. adults, yet 20% of suicides, with Pentagon figures showing active-duty suicides among U.S. troops exceeding U.S. combat deaths in 2012. Similarly, the U.K. charity Combat Stress (2015) has reported a fourfold increase in ex-service personnel seeking help for mental disorders over the past 20 years, and a 25% increase in referrals for post-traumatic stress disorder (PTSD) during 2014–2015 alone. These estimates do not take into account deployments from the other 42 countries that made up the International Security Assistance Force (ISAF).

The Western media's emphasis on PTSD among veterans risks neglecting the incidence of psychological injury among civilians, estimated by Afghanistan's Ministry of Health to be double that of combat veterans (Canadian Women for Women in Afghanistan, 2015; Cardozo et al., 2004). Moreover, PTSD is only one of several war-related disorders that constitute psychological injury, which also includes depression, anxiety, and substance abuse. In addition, psychological injury is rarely a private affair, with employers and colleagues, friends and family on the receiving end of depressive bouts, violence, and alcohol misuse. Given this scale and complexity, the psychological cost of war is a grand societal challenge that has captured the popular imagination—cinema blockbusters such as *The Hurt Locker, American Sniper,* and *Good Kill* all revolve around psychological injury from war. It has also

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become an acute political issue. In 2015, Barack Obama signed a bill to help prevent suicide among war veterans, and legal experts have suggested that the U.S. criminal justice system should treat veterans suffering from PTSD differently from other criminals, including an exemption from the death penalty.

Yet, despite the prevalence and scale of mental health legacy issues among military personnel, we still know relatively little about their underlying causal mechanisms. This is because most research to date has either exclusively focused on the psychological factors involved in psychological injury from war, or on the effectiveness of different treatment methods. The general attribution in this research of causality to a person's exposure to (the aversive effects of) a traumatic event assumes that the likelihood of psychological injury depends primarily on how well a person can cope with such events psychologically. *Why* and *how* war is experienced as traumatic in the first place are questions that have received much less attention, possibly because the answers may seem obvious given the intrinsically violent nature of combat. Yet, by reducing the problem of psychological injury to a psychological response to (the threat of) violence, we risk losing sight of important contextual factors that can affect how war is experienced, and what makes this experience traumatic for some, and not others.

In this paper, we explore new pathways for better understanding and managing the grand challenge of psychological injury from war through a contextual analysis of the lived experience of deployed personnel. We ask: What role do cultural, professional, and organizational contexts play in the experience of psychological distress at war? This research question aims to broaden the scope of current understanding of psychological injury from war by examining the institutional context in which these injuries are allowed to occur. Seen through the lenses of organizational, occupational, and institutional scholarship, the "context" of psychological injury at war involves more than likely exposure to (the threat of) violence and human suffering. Rather, it includes the cultural, professional, and organizational meaning structures and practices through which people experience, interpret, and cope with such exposure. Thus, the military as an organization is not merely a means by which people become exposed to traumatic events at war; as a workplace it forms a specific context that is likely to be consequential for the way people experience, and cope with, psychological distress. By explicitly considering the role of this context, we may be able to develop better explanations for differential rates of psychological injury in different groups. We may also gain a better appreciation of how particular institutional arrangements can exacerbate, and possibly even create, certain types of psychological injury in organizations more generally.

For this study we draw on an ethnography of a military medical team in Helmand, Afghanistan, in 2011. Our case study is particularly well suited to exploring factors that can play a role in psychological injury at war over and above those typically considered in PTSD research for a number of reasons. We focus on the specific case of damage control surgery (DCS) team members that, as rear located medics (RLM), do not typically have a combat role. Because DCS staff generally have less reason to fear for their lives than frontline troops do, they enable us to explore sources of psychological distress other than the extreme threat of death or injury to self that is widely considered to be a leading cause of psychological injury from war. Moreover, as a group they should be particularly apt at coping with treating severe injuries in others: most are highly experienced and "battle hardened," and their medical training is designed to make them especially resilient (Firth-Cozens, Midgley, & Burges, 1999; Weinberg and Creed, 2000). Yet, despite these factors, PTSD rates among rear located medical military personnel are on par with those of battlefield soldiers (Cawkill et al., 2015). This is particularly surprising, as it is combat exposure specifically that has repeatedly been shown to impact adversely on mental health (Pietrzak, Pullman, Cotea, & Nasveld, 2012, 2013). Thus, how is it that DCS staff are prone to psychological distress, and what may this tell us about the drivers of psychological injury at war more broadly?

Our study shows that the specific cultural, professional, and organizational contexts in which people who work at war are embedded can play a central role in the experience of emotional distress, regardless of whether they are directly exposed to combat. Our findings suggest that this is because these contexts can trigger and amplify repeated experiences of senselessness, futility, and surreality that are known to characterize the experience of war for many who are exposed to it. We argue that when these experiences are sustained, they can dislocate people's institutionalized sense of the meaningful, the good, and the normal to the point where they experience an existential threat to their sense of being in the world (Heidegger, 1962).

We show how institutional context is implicated in this distressing experience in three ways. First, it can produce repeated dissonance between people's institutionalized expectations of the meaningful, the good, and the normal on the one hand, and, on the

other, their experiences on the ground. For example, we show how the heightened sense of purpose and agency of DCS staff, which is rooted in their professional context, can contrast sharply with the care constraints that military protocol places on them, resulting in a profound sense of futility that is particularly distressing for people who have been socialized to "make a difference." Second, we show how this same context can form an impediment to coping with such distressing experiences when it denies people the cultural resources needed to resolve the dissonance they experience. Third, we show that, as a result, doctors and nurses rely on improvised coping strategies to deal with their distress. We argue that these are generally ineffective, and may even exacerbate distress, because they fail to fully address the institutional sources underlying the experience of senselessness, futility, and surreality that, we suggest, lie at the heart of psychological distress at war.

These findings form the basis for two key contributions. First, we develop a contextual explanation for psychological distress at war that is intended to complement and deepen current understanding of the causes of psychological injury. Our focus on *how* context contributes to psychological distress at war enables us to make some tentative suggestions about new possible ways of approaching this grand challenge. Second, we contribute to organizational research by showing how "context theory" (Johns, 2006) may be developed in such a way that it is practically relevant. Specifically, our study shows how and why the very contexts that can look most promising to people who derive a strong sense of purpose and agency from a particular "calling" (Wrzesniewski, 2011) may be inherently prone to produce the opposite: an overwhelming sense of futility and meaninglessness that is difficult to recover from because it can permanently taint the institutional structures that normally ground people in everyday life.

We begin by specifying psychological injury, and what we know about its causes, before presenting the methods and findings of our study. We close with a discussion of the implications for understanding psychological injury at war, highlighting the role a contextual perspective rooted in organizational research may play in addressing this grand challenge.

PSYCHOLOGICAL INJURY AT WAR

The Nature and Prevalence of Psychological Injury at War

Psychological injury refers to a stress-related emotional condition that results from real or imagined threats or injuries. It incorporates disorders such as major depressive episodes, acute stress disorder, substance abuse disorder, a propensity for violence, a myriad of other less-defined anxiety and depressive reactions, and PTSD. The most recent edition of the DSM, used by U.S. clinicians and researchers to identify mental disorders, suggests that PTSD is triggered by "exposure to actual or threatened death, serious injury or sexual violation" (APA, 2013), either in the form of direct experience (e.g., seeing others get killed or injured, being shot at), or indirect experience (e.g., exposure to aversive details of the traumatic event, or learning that the traumatic event occurred to a close family member or friend). Regardless of the specific trigger event, PTSD causes "clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning" (APA, 2013). Symptoms that accompany PTSD include: reexperiencing (dreams or flashbacks of the traumatic event), avoidance (distressing memories or reminders), negative cognitions and mood (feelings that range from a distorted sense of blame to estrangement), and arousal (aggressive, reckless, or self-destructive behaviors). Neither PTSD specifically, nor psychological injury generally, are confined to the military, even if they are popularly associated with it. For example, with its primary interest in veterans, the media has largely ignored the psychological impact of war on civilians, even though they constitute an estimated 90% of all war casualties (Summerfield, 1996).

In the military, related concepts, such as "shell shock" and "irritable heart," have been around since World War I (and "soldier's heart" since the U.S. Civil War), and have had an enduring literary presence (e.g., Conrad's *Heart of Darkness* and Hemingway's *A Farewell to Arms*). Yet, it was not until after Vietnam that veterans were formally diagnosed as suffering chronic, adverse psychological effects from war (Jones & Wessely, 2007). Prior to this—and to some extent still today—psychological injury was looked upon as a form of disgrace (Greenberg, Jones, Jones, Fear, & Wessely, 2011). Such was the stigma that, in the post-1945 period, admissions registers and case notes for officers treated for psychological disorders were systematically destroyed to protect their identity (Greenberg et al., 2011), and their doctors colloquially referred to as "shrinks," "trick-cyclists," or "nut-pickers" (Shepard, 2000).

It is now well established that psychological injury from deployment is a significant problem, with

20–30% of Iraq or Afghanistan veterans showing PTSD symptoms (U.S. Department of Veteran Affairs, 2015).[1] Data on psychological injury in medical personnel at war is harder to come by insofar as this particular group is understudied in relation to psychological injury (Palgi, Ben-Ezra, Langer, & Essar, 2009). One study of U.K. military health professionals estimated 35% to suffer psychological injury (Jones et al., 2008), while Cawkill et al. (2015) found it to be equivalent to other deployed military staff. The latter study also found no significant difference when comparing forward located medics with RLM, despite RLMs being much further removed from combat.

One explanation for the comparatively high incidence of psychological injury among military medics—even taking into account their training, experience, and non-combat role—is that they are typically assembled in groups only weeks before their deployment, as compared to combat units who can spend up to a year training together (Jones et al., 2008). This is relevant in that high team morale and good interpersonal relationships have been found to provide some protection against serious adverse reactions to traumatic experiences (Hatch et al., 2013; Jones et al., 2008). Yet, relatively little is known about the precise nature of the traumatic psychological experiences that team morale can help protect against.

Toward a Contextual Understanding of Psychological Distress at War

One reason why we know relatively little about the experiences that make war psychologically distressing may be that the literature on psychological injury at war predominantly centers around the relative psychological (in)ability to cope with direct or indirect exposure to (threats of) traumatic events. Questions as to *how* and *why* particular events are experienced as traumatic have received limited attention. After all, traumatic event triggers of psychological injury, including PTSD, can seem relatively unproblematic considering the nature of war. Research to date has largely focused on determining the psychological or neurobiological factors that make some people more prone to psychological injury as a result of exposure to traumatic events than others. Yet, without a better understanding of the specific *situated* reasons why and how people experience certain events as traumatic, and not others, it may remain difficult to develop targeted and tailored interventions that can help prevent psychological injury at war for specific groups of people.

In order to better understand these situated reasons, we believe it is important to begin considering the specific contexts in which psychological injury at war occurs. The military is not merely a vehicle through which people become exposed to traumatic events at war; it is also a place of work for millions of people around the world. It thus forms a specific context that may be consequential for the way people experience, and cope with, the violence they inevitably encounter at war. We know that organizations can have a very significant effect on people's psychological well-being, not only in the workplace, but in their lives as a whole (Danna & Griffin, 1999; Warr, 1999). This is not surprising given that people increasingly seek, and expect, meaning and purpose from their work (Wrzesniewski, LoBuglio, Dutton, & Berg, 2013).

Not only can organizations provide a context in which such meaning and purpose may be found, they can also contribute to profound emotional distress, particularly when they deny the fulfillment of a person's calling (e.g., Creed, DeJordy, & Lok, 2010), or compel them to engage with traumatic events while at the same time denying them the means to cope (e.g., Keats, 2010). For this reason, research in the area of disaster management has explicitly included the role of organizational factors in its understanding of the psychological responses of disaster workers to trauma exposure (Paton, Smith, & Violanti, 2000). Research has also shown that the broader institutional context in which organizations are embedded can affect what aspects of their work practices people experience as fulfilling or distressing. This is because the meaning people construct around their experiences at work is directly tied to the institutional context through which they understand this work (Zilber, 2002). Their internalization of the societal values through which different types of work practices are judged can thus affect whether they experience a sense of pride or shame in relation to their work (Ashforth & Kreiner, 1999, 2002).

The question is how this understanding of the role and importance of context in people's well-being at work can be applied to the military context in a way that informs a better understanding of psychological injury. What role does this context

[1] There is literature on veterans inventing narratives of distress, a useful review of which is provided in Jones and Milroy (2016).

play in the lived experience of work at war as psychologically distressing? And what may this tell us about possible contributing causes of psychological injury from war, over and above direct or indirect exposure to the intrinsic violence of war? Below, we address these important questions by analyzing the role of context in the lived experience of work at war by members of a DCS medical team in Camp Bastion.

RESEARCH SITE AND METHODS

Empirical Context

Camp Bastion. Camp Bastion was, from its construction in 2005 until its handover to Afghan forces in October 2014, the largest British overseas military camp since World War II. Four miles long and two miles wide, it accommodated some 30,000 people and incorporated a smaller U.S. base, Fort Leatherneck. It housed a Role 3 field hospital and an airfield that, at its peak, handled 600 flights each day. It was, as then-Prime Minister Tony Blair said in 2006, an "extraordinary piece of desert . . . where the fate of world security in the early 21st century [would] be decided" (Brown, 2006).

Everything in the camp was bought and sold using American dollars. Change came in the form of paper coins, about an inch in diameter, varying in color depending on value. These could be traded for soda pop, food, candy, coffee, toiletries, and knick-knackery in a small market square that featured a Pizza Hut–KFC combo, operating out of a 40-foot shipping container (see Figure 1). There was a coffee shop, a games room, and a general store. Higher ticket items, "near beer" (alcohol free), and electronics were sold in a PX on the U.S. base.

FIGURE 1
The Pizza Hut–KFC Combo

Camp Bastion's field hospital. Camp Bastion's 50-bed field hospital was the most successful of any hospital in any prior war. Of 6,386 admissions between April l, 2006, and July 31, 2013, it achieved a survival rate for U.K. Armed Forces personnel of 99.2%. Led by British forces, Camp Bastion's hospital was staffed by a combination of Americans and Britons in more or less equal proportion, and a handful of Danes and Estonians. Over the years, injury patterns had evolved such that the signature injury of the insurgency during the study period was the double amputation, inflicted by improvised explosive devices (IEDs) (see Figure 2). The study period comprised the hospital's bloodiest and busiest: 174 casualties were admitted during the first week of fieldwork alone, with some requiring upwards of 100 pints of blood each (an adult contains about 10 pints of blood). A record-setting 3,100 pints of blood had been used the previous month. The most serious ISAF casualties would typically arrive in the early morning—victims to IEDs on daily, predawn patrols—or just after evening patrols. About half of the casualties were locals, often members of the Afghan National Army or Afghan National Police. About 20–25% of Afghan casualties were children.

With the outside temperature regularly exceeding 115 degrees Fahrenheit, the DCS doctors spent their "downtime" between the gym and Doctors' Room. The latter featured a leather sofa and plastic desk chairs (one without its metal frame and bolted to an upside-down soda-pop crate instead), long-out-of-date newspapers and magazines, a PC with internet access, an old television, a games console and DVD player, medical journals, a bookshelf full of long-life foodstuffs, a small fridge containing "near beer," and

FIGURE 2
One of Many Double Amputees

a heavily used coffee machine. It might have looked a jumble, but the room was well used, and was the doctors' to do with as they pleased.

Data Sources

Ethnographic data were collected over 16 months, between April 2010 and August 2011, by one of the authors (referred to here as "the ethnographer"), and included predeployment training over the course of several months, as well as a six-week "tour of duty" in Afghanistan. The ethnographer was granted permission to deploy with a DCS team to Camp Bastion for the duration of a typical tour from June 14 to July 29, 2011. He had unrestricted and unsupervised access to all areas of the hospital. The DCS team comprised, at any one time, around 4–5 general surgeons, 6–7 orthopedic surgeons, 1 plastic surgeon, and 5–6 anesthetists, alongside operating department practitioners, theater nurses, and theater coordinators.

Fieldnotes from predeployment training and from the six-week deployment in Camp Bastion comprise the bulk of the empirical data used for this study. The ethnographer's account is composed of thick descriptions of observations, with particularly rich detail on personal reflections on the experience of war, as related by informants before, during, and after their deployment (see de Rond, 2017, for a detailed account). The empirical data also contain reflections in the form of poetry written and shared by DCS staff, a post-tour report by a DCS member of a 12-month embedded tour of duty in an Afghan hospital, a post-tour report by a DCS member covering the study period, data on hospital admissions and triage, data from weekly morbidity and mortality meetings, and some 1,000 useable photographs taken by the ethnographer. Many of these photographs feature the DCS teams at work, and were used to help elicit new data by prompting conversations postprocedure, mostly because it was not usually possible to engage in conversations during emergency procedures (see Harper, 2002).

Predeployment training for surgeons and anesthetists included three core components in addition to weapons handling: a five-day military operational surgical training (MOST) course, a three-day hospital exercise course, and a 10-day operation, test, and evaluation command (OPTEC) course. The ethnographer attended each course (except for weapons handling), as well as OPTEC's civilian counterpart. The informal socialization during predeployment training proved to be a particularly rich source of insight into the private world of DCS staff. Those attending MOST would go to a local pub for drinks (always the George IV on Portugal Street, London), followed by dinner elsewhere. Helped by the alcohol and informality, it was here that they would reflect on their personal experience of war, as per the fieldnotes:

> As The George gives generously, those due to deploy get a chance to socialise, and as the alcohol does the inevitable, stories begin to flow of deployments past, things fair and unfair, surreal but oh so real at the same time. They may hate war but war reminds them of why they went into medicine in the first place . . . It is as Chris Hedges wrote: war is what gives life meaning. Those who choke up take a hike to return a little while later to more merriment, to tales of naked generals and toilet seats and illicit sex on board a ship, all the while working the night into a crescendo more intoxicating and affecting than any drug could. For of course at the end it is the camaraderie that matters . . . the sense of brotherhood that wins small wars.

Those about to deploy had typically been on several previous tours, and were keen to recommend books that they felt best conveyed their own experience of war: *M*A*S*H, Catch-22, My War Gone By I Miss It So, The Bang Bang Club, Emergency Sex, What it is Like to go to War, On Killing, Meditations in Green,* and *Heart of Darkness.* We carefully read these, and others like them, in preparation for this paper. Those who know this literature will be familiar with their explicit raw potency and surrealism, which is reflective of our primary data as well.

To foster reflexivity in data analysis, the ethnographer also kept a personal journal of "headnotes," in which he recorded his own experiences, anxieties, and reflections. While the focus in this paper is squarely on the lived experience of members of the DCS team, we have included occasional references to these headnotes to help locate the researcher in the context of his fieldwork, and to show that the ethnographer was not inoculated from the effect of what he, and the DCS staff, bore witness to daily, as we explain below.

Data Analysis

One of the challenges of writing ethnography is that of drawing inferences from observations such that they stack up to a credible theoretical claim (Ketokivi & Mantere, 2010; Locke & Golden-Biddle, 1997). This inference process necessarily involves

what Langley (1999: 707) refers to as "inspiration:" creating new and plausible connections between formal data, experience, a priori theory, and common sense. For us, this process consisted of systematically and repeatedly interrogating the data, and examining them against the ethnographer's preunderstanding based on his immersion in the setting, as well as against extant theory (Mantere & Ketokivi, 2013). Throughout this cyclical process, we actively and continually called into question our emerging theoretical understanding by exposing it to further data analysis (Alvesson & Kärreman, 2007), until a deeper, empirically grounded explanation of psychological distress at war emerged. Thus, rather than focusing on general empirical tendencies as a basis for inducing new theory (see Gioia, Corley, & Hamilton, 2013), we followed the interpretive research tradition (Mantere & Ketokivi, 2013). This involved actively using the ethnographer's preunderstanding of the setting as an entry point into our data analysis, and focusing on the contextual authenticity of our reasoning in light of the data (Ketokivi & Mantere, 2010). Rather than presuming that the ethnographer's experience was necessarily shared by the DCS team, we used his personal account to sensitize us to plausible themes and theories that may help us structure and interpret the data.

This process began with a series of discussions about the nature of the ethnographer's own experiences, and their possible relation to those of the DCS medics with whom he was embedded. These initial discussions produced a number of themes, including: the dream-like, surreal nature of the ethnographer's deployment experience; the suppressing of emotions during deployment, yet surprise at the absence of guidance on how to cope with distressing events during predeployment training; the flashbacks and anger that followed deployment several weeks later; feelings of powerlessness in the face of suffering; the realization of the brutality, absurdity, and futility of war; the absence of a meaningful narrative; profound existential boredom upon return; and a general lack of zest for life (see de Rond, 2012). Insofar as these themes were also reflected in the fieldnotes, we decided to use them as entry points into our subsequent systematic data analysis. In this way, we sought to get as close as possible to the lived experience of the research subjects, which is a key strength of ethnography (Spradley, 1996; Van Maanen, 2011).

We used two means to verify the extent to, and ways in which the ethnographer's personal experiences were shared by members of the DCS team. First, we systematically compared the content of the ethnographer's headnotes and fieldnotes, noting experiences that appeared unique to the ethnographer. Second, the coauthor played an important reflexive role by actively questioning the validity of emerging insights in ongoing discussions about data interpretation and theory development. This helped us attain the critical distance required for moving from data to general theoretical explanation (Alvesson, Hardy, & Harley, 2008; Cunliffe, 2010).

Analyzing themes in distressing experiences of work at war. In order to establish the main themes that ran across the lived experience of war as distressing, we decided to focus on events—i.e., observations of actual events, or stories of events from current or past deployments—that were associated with direct expressions of distress, or appeared purposely chosen to convey the extremities of war as distressing without necessarily expressing such distress directly. Both authors independently coded the fieldnotes for these events as a basis for discussions on particularly striking examples, and what they might tell us about the lived experience of war across informants. For example, we discussed medics having to unhook a very sick Afghan patient from potentially lifesaving equipment (antibiotics, oxygen, analgesics), and hand him over to a driver with no medical expertise for transfer to a local hospital. "He will die of pneumonia," the doctor in charge of the handover had told the ethnographer, admitting to having resigned himself to the futility implied by these handovers.

In our discussions, we aggregated and connected such examples to five emerging themes in the lived experience of work at war as distressing: horror (associated with [unnecessary] suffering); contradiction (between the obligation to provide the best possible care and the military protocol of handing local Afghan patients over to the local healthcare system as soon as possible); futility (related to the pointlessness of treating patients who would likely die), strangeness (of the contrast between daily routines and the human gravity of the situation); and boredom (medics struggled to deal with the long spells of inactivity when waiting for new patients to come in).[2] In reflecting on these themes, it became

[2] Boredom has also been shown to have a profound, distressing effect on frontline soldiers, some of whom "prayed for contact [with the enemy] as farmers pray for rain" (Hetherington, 2010: 15).

clear that some were closely related. For example, the experience of boredom was intricately related to the experience of futility, with the former exacerbating the latter. For the sake of parsimony, we therefore aggregated the five themes into three overarching ones, going back to the data to identify the most direct expressions of each of these three themes. For reasons outlined below, we also decided to change the heading for our original theme of "horror" into "senselessness." This produced the three themes illustrated in Table 1: senselessness, futility, and surreality.

Analyzing the role of institutional context. In analyzing the role of institutional context in the lived experience of war, we first divided our contextual data into three temporal brackets—predeployment, deployment, and post-deployment (Langley, 1999)—and developed lists of institutionally prescribed practices, rules, norms, and values that were salient during each of these phases. We differentiated between the medical profession and the military as different sources of these institutional prescriptions, creating a third category for where they overlapped.

As a second step, we systematically related these lists to the specific instances of implicit or explicit emotional distress that we coded in our analysis of the three lived experience themes discussed above. We reviewed these for the presence of institutionally prescribed practices, norms, and values, as a basis for building an emerging understanding of the role of context in the lived experience of war. Figure 3 presents an illustration of this analysis.

This process led us to identify specific ways through which the cultural, professional, and organizational contexts played a role in expressions of distressing experiences. During this analysis we also noticed that the role of context was not only marked by its presence in expressions of distress, but also by its absence. This absence was particularly felt in the lack of purpose that the military organization provided other than "doing a job," and in a professional culture that made it extremely difficult to talk about the moral ambiguity and strong emotions that marked the lived experience of work at war. The inability to rely on the organizational and professional context to cope with the distressing nature of work at war was particularly evident in the prevalence of improvised coping strategies in our data, which we discuss next.

Analyzing coping strategies. We used the literature on psychological coping (Bleich, Gelkopf, & Solomon, 2003; Mikulincer, Florian, & Weller, 1993) and normalization (Ashforth & Kreiner, 1999, 2002; Ashforth, Kreiner, Clark, & Fugate, 2007) to sensitize us to the presence of coping strategies in our data.[3] This enabled us to code for the presence of well-known coping strategies (e.g., avoiding, denial, behavioral or mental disengagement, attempts to improve the situation), while leaving room for additional coping strategies that appeared more unique to our setting (e.g., acts of creation, such as baking bread). Both authors coded the fieldnotes independently for the presence of coping strategies, paying particular attention to striking examples as a basis for defining different coping types. Codes and categories were then compared, and differences reconciled in ongoing discussions between the ethnographer and the coauthor.

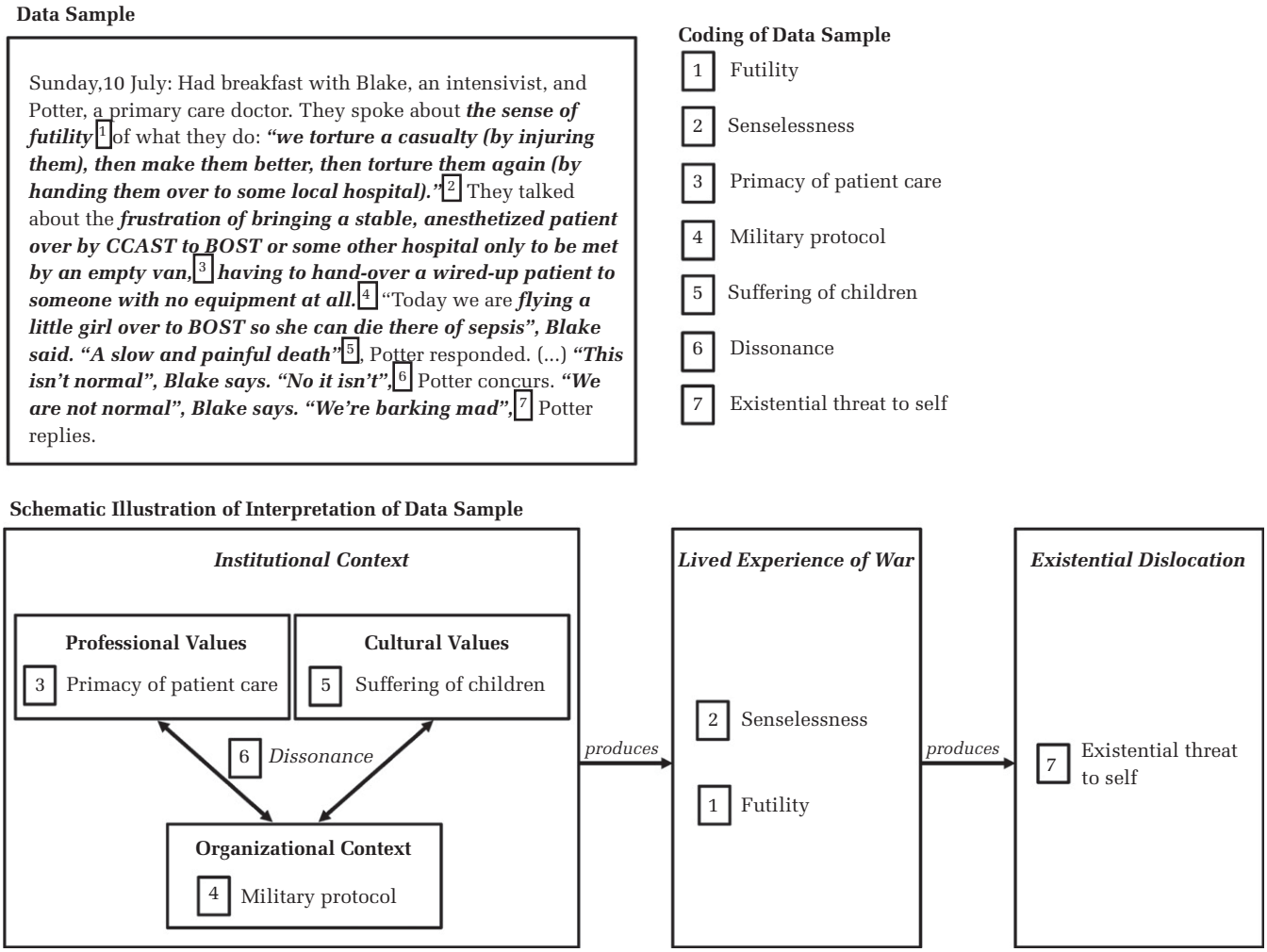
As a basis for judging which of the behaviors identified through this process could plausibly be interpreted as coping responses to the distress of war, we deployed abductive reasoning (Mantere & Ketokivi, 2013) to isolate behaviors that were difficult to explain other than as coping strategies. For example, we observed DCS medics repeatedly using various tricks and excuses to get out of the moral obligation to attend formal repatriation services for troops that had died in battle and had to be flown home. We determined this to be an "avoiding" coping strategy based on the following line of (abductive) reasoning: first, the literature on psychological coping has suggested that escape coping through avoidance is a common way for people to attempt to cope with a stressor (Carver, Scheier, & Weintraub, 1989); second, we have empirically established that the lived experience of work at war is distressing, and explanations provided by those directly involved in avoiding repatriation services provided some confidence that this behavior was specifically aimed at avoiding distressing confrontations with the human cost of war; and third, there was no evidence in the data to suggest that medics were eschewing repatriation services for alternative reasons, suggesting that this was indeed a coping response. Through this process we settled on five distinct coping strategies that were prevalent in the data: avoiding, bracketing, humor, recovering familiarity, and reclaiming control, as illustrated in Table 2.

[3] We consider the normalization strategies that Ashforth and Kreiner (1999, 2002), and Ashforth, Kreiner, Clark and Fugate (2007) identify to be coping strategies in the sense that they are designed to alleviate the stress caused by stigmatization or shame.

TABLE 1
Themes in the Lived Experience of War in Relation to Contextual Expectations

Contextual expectations	Source	Actual lived experience	Experience themes due to dissonance
Children are innocent; symbols of hope	Culture	*The ward nurses talk of the sadness and frustration they feel at the cruelty of the methods employed by the Taliban, and relate the example of them stuffing a donkey full of explosive and letting it be led by a young boy to its target, killing both in the process.*	Senselessness
All patients are created equal; there is only the technical	Profession	*When a U.S. marine dies on the operating table, the effect on the team is palpable. Some of the theater staff are badly affected, such that one broke out in tears and another choked up when realizing that very soon, the man's parents will get a knock on their door to tell them that their most precious possession has just died. As he said at the time: "I really don't know why this case affected me so much, but it did. Maybe it was the culmination of so many cases, I don't know, but it certainly affects me quite badly . . ."*	Senselessness
To provide the best possible care for patients	Profession or military	*In the Doctors' Room they discussed whether pain relief should be continued for this Afghan double amputee and so many others like him? He was on a dose of opiates his local health care system would never in a gazillion years match, and would be discharged within the next few days with nothing stronger than Paracetamol. So why raise his hopes? Southwark suggested they wean him off the most powerful opiate twenty-four hours before discharge to ease his reentry into Afghan care, only for his suggestion to be dismissed by one of the nurses. His pain would be so awful, she said, that he would lie howling on the ward, which would be distressing to all the other patients, and to her staff, and so why not give him a handful of opiates when releasing him to the care of this terrible country just to carry him over for a couple of days?*	Futility
To make a difference	Culture or profession	*When relating the day's experience, he laughed and jokingly replied: "You don't mean to say that our work is futile, do you?" as if they knew something I hadn't caught on to yet.*	Futility
Children's songs are pure; not associated with pain	Culture	*During the evening, a 13-year old arrived with shrapnel wounds from an IED. Small ball bearings penetrated the skin behind his ear, and his arm, while shrapnel entered his neck, buttock and hand. The child sang all the while in rhesus while an older man (perhaps his father?) stood over him with a stuffed, cuddly toy. His voice was high and pitch-perfect, even as he must be in pain.*	Surreality
Taxis are used to transport living people	Culture	*Two badly burned Afghans arrived yesterday afternoon. One died shortly after (with 48% burns), the other was expected to follow suit but, refusing to go to Boost (a local hospital in Lashkar Gah) asked if the hospital could please arrange for a taxi to take him and his dead friend back home.*	Surreality

FIGURE 3
Example of Analysis of the Role of Context in the Lived Experience of War



Theorizing the role of context in psychological distress. As a final step, we proceeded to theorize the interrelations between the main elements of our empirical analysis by engaging the literature on existentialism (e.g., Camus, 1942, 1955; Kafka, 1915). In this literature, themes of surreality and estrangement, as characteristic of lived experience in general, are particularly prevalent, and directly related to context. We were particularly drawn to the concept of "absurdity" as a possible root cause of psychological distress at war: "a sense that one's established social worlds are hopelessly alien from one's conception of the good, the expected, and the 'normal'" (Lyman and Scott, 1970: 192). This concept pointed us to the importance of the *contrast* between (expectations of) the meaningful, the good, and the normal on the one hand—including their institutional sources—and the actual experience of war on the other, as the key to better understanding the role of context in psychological distress. This enabled us to develop the model depicted in Figure 4, around which we structure our interpretive account below.

We begin by describing themes in the lived experience of war, and, in the next section, link these to the cultural, professional, and organizational contexts in which the DCS team were embedded. We then argue why and how the sustained experience of senselessness, futility, and surreality by members of the DCS team posed an existential threat. Finally, we describe their improvised coping responses to this threat, in relation to the (lack of) coping resources on offer in their professional and organizational context. All names used are pseudonyms.

TABLE 2
Types of Coping Strategies Prevalent in the Fieldnotes

Data segments	Coping types
I attended the Wednesday evening vigil for two fallen British soldiers. (. . .) Hawkeye didn't want to come, as did several of the other surgeons, so he had arranged for someone to page him shortly after his departure for the services just so he could make his excuses and return to the hospital.	Avoiding
"But I couldn't work on the wards," she volunteered, as "this is where they become people again."	
Had a chat with one of the operating theater coordinators. He told me that he forces himself to look at—and be shocked by—the injuries coming in: "I still want to be shocked by wounds coming in to remind myself that this is not normal, that there is a normal world out there."	Bracketing
"When I arrived, I was [told] "Take your brain out. I'll show you how to deal with these injuries.""	
Watched new casualties arrive from behind the yellow line. Every conversation was heavy with innuendo. The orthopods, as usual, were engaging in banter. They were taking bets on whether the amputee is a single or double amputee, left or right leg. At stake was a pizza.	Self-distancing through humor
Hunnicutt asked me if I wanted to see a burns casualty. I followed him into the theater where the soldier is sedated and his dead skin is being removed. "Can you smell that?" Hunnicutt asked me, "Oh, I love that smell."	
Tonight is pizza night—like every Friday night, if only to break the monotony of one day seeping into another, and I put in my $10 (and another $10 for Hawkeye).	Recovering the familiar
A U.S. "orthopod" receives a package from home, including glazed pecans, a journal, and an oral hygiene package, including toothpaste, a toothbrush, floss, and bottle of Listerine. Looking at me, he says: "You know what the Listerine secret is? It's vodka with green food colouring (smiling)."	
Kellye is rooting through the drawers of a small desk in the DR, looking for an electric toothbrush. We look at him confused. He needs it, he says, to cross-pollinate his tomato plants since there are no bumblebees.	Reclaiming agentic control
Hawkeye, having closed up two laparotomies this morning was asked to close a shoulder one day early for a Danish soldier who was to be flown home with his dead dog. (. . .) Hawkeye said he had no patience for things like this, and doesn't want to see "someone whining about a dog who is going to be flown home to be put in the burning pit. That's more than we do for our lads."	

THE LIVED EXPERIENCE OF WAR BY THE DCS TEAM

Many of the DCS team had encountered severe trauma on prior tours to Iraq, Bosnia, Kosovo, Macedonia, Sierra Leone, and Northern Ireland. One might reasonably expect such "battle-hardened" medics to have become relatively impervious to war trauma, and yet the data bears out quite a different picture. Many expressed emotional reactions to the nature and extent of the injuries they faced, with the strength of these reactions often depending on the age, gender, and nationality of the victim. Others expressed guilt and confusion about feeling emotionally numb in the face of events that they knew *should* have triggered stronger emotions in them. In both cases, the lived experience of work at war was characterized by a profound and sustained sense of *senselessness*, *futility*, and *surreality*. Below, we discuss each of these in turn, followed, in the next section, by an analysis of the role of context in these experiences.

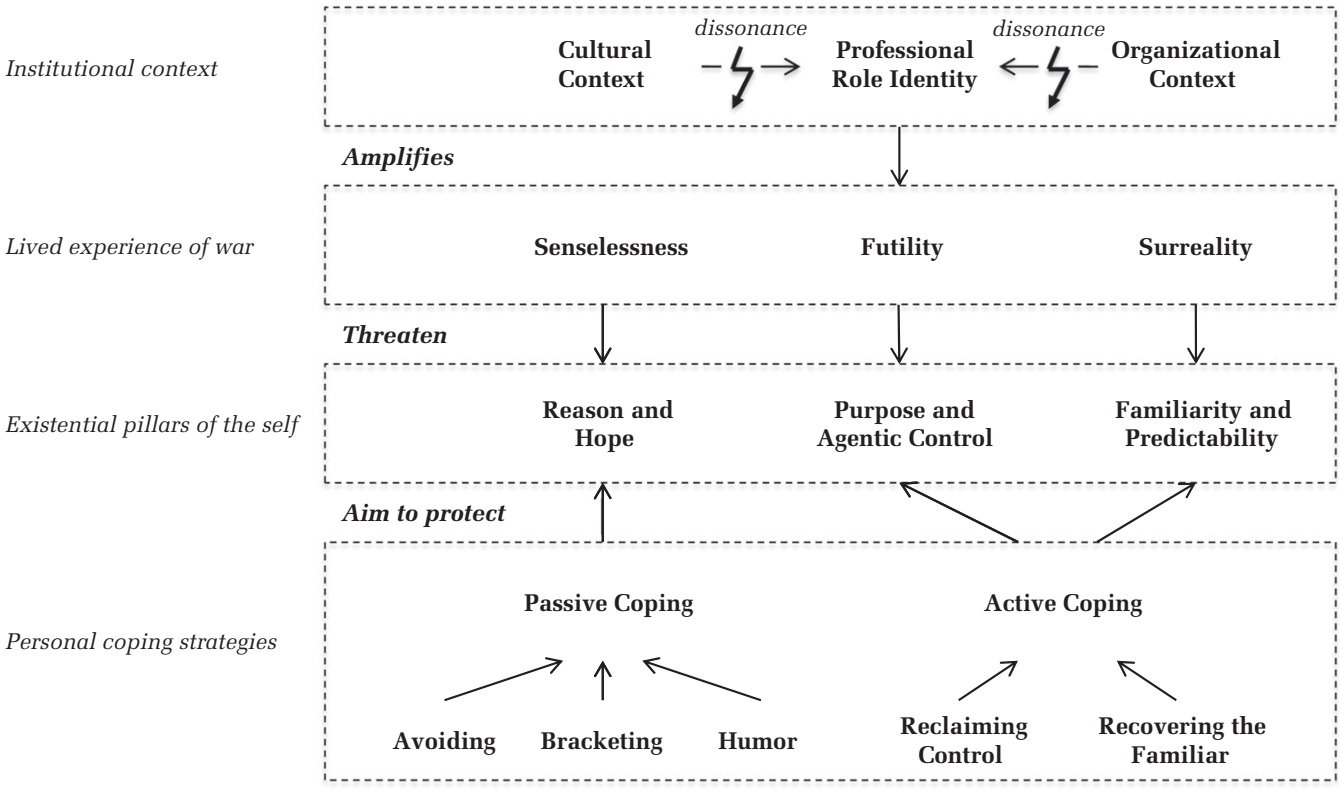
Senselessness

A handwritten poem given to the ethnographer by a member of the DCS team captures widespread feelings of senselessness associated with near-daily encounters with the inhumanity, and, in its more extreme form, the cruelty that characterized this war:

> The loss of your limbs and abuse of your youth / We're left with more questions, no sign of the truth / What kind of father allows his child to lay bombs / Money to feed families to which you belong / The death of these children is nothing but waste / And makes it much harder to cope with this place / Take all my wages for the rest of my days / To stop these kids dying, to allow them to play / I question my loss of humanity out here / That is my worry, that is my fear.

What is particularly notable in our coding of associated experiences of revulsion and moral outrage is how often these involved children: badly burned, drowned, or mutilated by landmines or IEDs stumbled upon while playing. The poem's references to "We're left with more questions, no sign of the truth," and "The death of these children is nothing but waste," suggests that one of the reasons these experiences were so unsettling is the absence of any rational account to make sense of them. Hence, our use of the category of "senselessness" to characterize these experiences is informed by its frequent use in

FIGURE 4
Conceptual Framework of the Lived Experience of Work at War by DCS Staff



the Western media in relation to the killing of women and children as "senseless," as a way of conveying that such killing is considered needless, cruel, without reason, and therefore unjustifiable. The following are three examples from the ethnographer's fieldnotes (see Table 1 for more examples).

1. Hunnicutt, the only plastic surgeon here, and a veteran of many wars, spoke of an experience during his last tour of Afghanistan. A bus full of school children had been targeted in an ambush, and everyone shot and killed. The authorities had wanted to know whether the bullets were "local" or fired by coalition forces. Since Camp Bastion does not have a pathologist, he had been asked to go into the container where the bodies of the school children were laid out, "in a heap," and to go recover the bullets. He described it as a memory that still makes him wake up in cold sweat.
2. At 1730 a Dustoff [helicopter] delivers at 13-year old boy from Forward Operating Base Eddie en route to Kandahar. (. . .) The boy is a double-amputee who has already had a thoracotomy. I take some photos while six surgeons work on him. Hunnicutt works on his right arm before beginning the gruesome job of removing his eye. "I don't mind it so much in adults but I hate it in children. It's just wrong."
3. One of the general surgeons, Hawkeye, talked about a little girl they nursed for six weeks during his last deployment to Afghanistan before discharging her to her family. Having done so, they subsequently learned that she had been starved by her family as she apparently was considered too ugly to ever get married and too handicapped ever to be able to work and provide.

These experiences were deeply distressing, as evidenced by references to "waking up in cold sweat" and "I hate it in children." While treating children can be difficult even in Western hospitals (Marsh, 2014), this difficulty was compounded by the inability to find any sensible place for them in war; their deaths experienced as "nothing but waste."

Futility

As "signatories" to the Geneva conventions and Hippocratic oath, and socialized into a "caring

profession," DCS staff found themselves increasingly unable to live up to their own expectations as they tired of compassion. Circumstances forced them to decide on treatments without the benefit of full information or time, to consign Afghans to a potentially grim spell in local hospitals, and to find themselves complicit in a controversial war. This produced strong feelings of futility, defined here as pointlessness, or the antonym of doing something worthwhile or purposeful. For example, one of the nurses, when asked if she needed anything, replied in exasperation: "a reason to live." The following are empirical vignettes from the fieldnotes that illustrate some of these experiences (see Table 1 for more examples).

1. Spent some time with the nurses in intensive care today. One of them said they are tired of nursing Afghans with no clear explanation of why that is important or even valuable. After all, they came here to treat "their boys." (. . .) So it appears to be the sense of futility associated with having to treat Afghans who will invariably be passed to local hospitals where their chances of successful recovery and/or survival are greatly comprised.
2. In the Doctors' Room this evening, I strike up a conversation with Hawkeye about the (. . .) and when only palliative care should be provided. Hawkeye says that the merciful thing would be to take a pillow and shoot the boy through the head. It is hard to reconcile this statement with the kindness he showed the boy thirty minutes ago, unless one assumes that letting the boy die is actually the kind thing to do.
3. Blake and Potter spoke about the sense of futility of what they do: "we torture a casualty [by injuring them], then make them better, then torture them again" [by handing them over to some local hospital]. They talked about the frustration of bringing a stable, anesthetized patient over to some hospital only to be met by an empty van, having to handover a wired-up patient to someone with no equipment at all. "Today we are flying a little girl over to Boost [a local hospital] so she can die there of sepsis," Blake said. "A slow and painful death," Potter responded. (. . .) "This isn't normal," Blake says. "No it isn't," Potter concurs. "We are not normal," Blake says. "We're barking mad," Potter replies.

This shared sense of futility was amplified by occasional but prolonged spells of boredom, which the vast majority of DCS staff experienced as deeply unpleasant for the unproductivity it implied. As one of the anesthetists explained: "Everyone wants to go home with a sense of pride;" this could only be achieved if they felt they could use their skills to optimum effect. When bored, they expressed feelings of guilt for hoping for new work to come in (for it implied that someone had to get hurt), became critical of each other's clinical decisions or technique, and sought out ways to be assigned more "interesting" casualties. As one of the surgeons said: "I hope they all get wrapped up with those testicles so I can have the next case all for myself."

Surreality

A third category of experience is that of the surreal, defined here as an incongruous juxtaposition between the familiar and the real. Surreal experiences typically have the disorienting, hallucinatory quality of dreams, and, as is evident from Table 1, are often triggered by observations that—because they are so unfamiliar—give one the impression of being bizarre or strange. Daily life within the field hospital had its fair share of surreal experiences.

1. Had a chat with Burns, who coordinates the operating room. He told me about an incident yesterday when a U.S. double amputee, courtesy of an IED, had been brought in. Meanwhile, his fellow soldiers had located his legs. Burns received a call wondering if they could deliver the legs to the hospital, thinking that if they did so within six hours of the explosion, that they might be able to reattach them. Burns knew that would be impossible but didn't have the heart to say so, and the legs were already on their way in any case. When Burns was called to reception a few hours later, a soldier was awaiting him, handing him a cardboard food box with legs inside it. Burns didn't know what to do, he said, and so called the morgue and asked a colleague to walk them over and dispose of them there. He told me he could not get the surreality of the experience out of his mind.
2. An Afghan casualty was returned to Bastion after a short visit to the neurosurgeon in Kandahar. He originally arrived on Thursday with a hole in the head requiring neurosurgery. Problem is that Kandahar forgot to send the relevant piece of skull back with him, and so he lies in bed, looking around wildly. His skull piece was flown back into Bastion at 0100 this morning, upon which one of the orthopedic surgeons (who happened to be asleep on the sofa in the Doctors' Room) stuck it into the small fridge where they keep their near-beer, chocolate, and soft-drinks. It's a good thing the piece survived

as apparently one of the pilots nearly sat on it, not knowing what was in the small plastic bag.

3. One of the theater nurses told me of an experience over Easter weekend, when a double amputee had come in. During the log roll one of his legs had come off, and he was asked to please take it to the mortuary (and from there to the incinerator). As he crossed the ambulance bay carrying a yellow bin liner with a leg, he ran into the Commanding Officer and nurse walking the other way, dressed in bunny ears and carrying Easter eggs.

What characterizes each of these experiences is the *contrast* between the human gravity of the situation on the one hand, and the casual nature of everyday rituals and routines on the other.[4] As Berger and Luckmann (1967) explained, these surreal experiences can have a profoundly disorienting and dislocating effect because they temporarily expose people's inability to "put everything in its right place," suggesting that "all is not right" with the way they normally understand the world. People are shocked by the revelation that the world does not appear to care, as it marches on through its rituals and routines regardless (Camus, 1955).

THE ROLE OF CONTEXT IN THE LIVED EXPERIENCE OF WAR

Several of the first-hand accounts of war recounted by the DCS suggest that this experience of senselessness, futility, and surreality is shared by many of those who bear witness to it (e.g., Hedges, 2003; Loyd, 2000; Marlantes, 2011). Yet, we find that the specific nature of these experiences by DCS staff is directly related to the particular cultural, professional, and organizational contexts in which they were embedded. These contexts caused a number of tensions through which their lived experience of war as psychologically distressing can be better understood. Specifically, DCS staff strongly identified with their role identities as medical professionals, often framing their decision to pursue a career in medicine in terms of "making a difference." They also referred to tours of duty as a positive break from the "lifestyle diseases" they treat in their ordinary work back home. As one of the surgeons explained, to deploy to war reminded them of why they had pursued a medical career in the first place. Hence, the meaning they hoped to find in deployment was closely related to their sense of self as wishing to make a positive difference. As we explain below, this made it difficult for them to come to terms with rules, practices, and experiences on the ground that appeared contradictory to their purpose and values, thus amplifying feelings of senselessness, futility, and surreality.

The Role of Professional Context in Shaping Self-Understanding

The medical profession is broadly seen as "noble," in that it concerns itself squarely with improving the health of mankind, as Wakin (2000: 103) made clear: "It is because we view life to be so precious that we can so readily agree that the profession whose principal function is to preserve life deserves our approbation." As a result, it is not uncommon for medical professionals to experience their profession as a "calling" that serves a higher purpose than careerism. The medical profession channels this higher calling into a number of values and principles that medical professionals are expected to uphold. For example, medical professionals are socialized into prioritizing the patient's interests above all else (Wright, Zammuto, & Liesch, 2015). These values and principles are set out in the United Kingdom's General Medical Council's "Good Medical Practice" guide, and in the United States's "Guide to Good Medical Practice." Among other things "making the care of your patients your first concern," "providing a good standard of practice and care," and "comply with systems to protect patients" are key principles that medical professionals expect to enact (General Medical Council, 2013).

The latter principle refers to a professional culture that takes systems, protocol, and technique very seriously. This was particularly evident in the nature of predeployment training for surgeons and anesthetists, which was exclusively technical in nature. This general technical focus is designed in part to desensitize doctors to emotions that may interfere with their ability to provide the best possible patient care. In medical training, emotions have long been considered potential impairments to decision making and the effective exercising of one's duty. Thus,

[4] A photojournalist who provided extensive coverage of the war in Afghanistan wrote that while he "expected that war would make no sense, [he] was surprised that this madness expressed itself in such an off-balance, weird and at times even comical way" (Bangert, 2016: 1). His recent "Hello, Camel" provides photographic evidence of war's surreality. Many of those who have experienced war first-hand have likewise described its surreality, including soldiers, medics, journalists, and those working for non-governmental organizations (NGOs), typically in first-hand published accounts.

through technical training the medical profession's higher purpose of acting in the interest of patient care becomes embodied in a medical professional's technical ability to heal people. This provides them with a clear sense of purpose and agency that is singularly focused on the patient, and embodied in systems, protocol, and technique.

The medical profession has long shared this impassive approach to problem solving with the military (Becker, Geer, Hughes, & Strauss, 1961; Shem, 1979), producing a culture of silence around emotional distress among both doctors and military personnel (Green, Emslie, O'Neill, Hunt, & Walker, 2010). For example, when, on one occasion, a meeting was called to discuss the death of a young U.S. marine on the operating table, the ensuing discussion was entirely technical, void of any reference to what many had clearly experienced as emotionally upsetting. From the fieldnotes:

> *Trapper:* "How do you think the debrief went?"
>
> *Hawkeye:* "Fine. But it might be worthwhile having a coffee with the lads."
>
> *Trapper:* "You're too soft. There's nothing but technical."
>
> *Hawkeye (to the ethnographer):* "Did you hear that? There's nothing but technical."

Taken together, this context socializes medical professionals at war into understanding their role identities as professionals who pursue a higher, noble purpose; who are there "to make a difference;" who achieve technical mastery through hard work and protocol; and who can maintain composed detachment at all times. This context informed how members of the DCS team viewed themselves and their work, amplifying the dissonance between what they expected and desired as normal practice on the one hand, and, on the other, what they actually experienced on the ground. This was particularly the case in relation to the organizational context that appeared to force them to compromise on patient care, and the cultural context that appeared blind to the inhumanity they encountered.

Dissonance Between Medical Role Identity and Organizational Context

While protocols for triage and treatment were generally similar to those in many emergency rooms, one unique protocol related to the treatment of Afghans beyond damage control surgery. As the hospital had limited capacity (50 beds) and was designed principally to provide support for forward operations, Afghans were expected to be transferred to a local hospital as soon as it was deemed safe to do so, and often within 48 hours. However, given that the local healthcare system was widely considered inferior to Camp Bastion's, and since transferring casualties meant taking them off oxygen, antibiotics, and powerful analgesics not available locally, to do so often jeopardized an Afghan patient's chances of recovery. This caused psychological distress among several of the deployed doctors and nurses responsible for their treatment. Occasionally, administrative procedures would also appear inhumane, as in the case of a severely injured detainee who was kept alive long enough so as to give those in charge sufficient time to declassify him and, in doing so, to ease any further administrative procedures.

Many expressions of senselessness, futility, and surreality explicitly related to this unique organizational context, which formed a stark contrast to their everyday experience of medical practice back home. Specifically, the high levels of distress that often accompanied expressions of futility can be understood in relation to the DCS team's highly agentic role identities, in combination with their professional commitment to good patient care. These required a positive, lasting impact on patient health, making it unpalatable to hand over patients to inferior care that would likely compromise their chances of recovery. The organizational protocol of passing local Afghans on to local hospitals as soon as it was safe to do also amplified the experience of senselessness, as the consequences of this protocol could appear coldhearted. Moreover, the human drama that often unfolded in front of their eyes as a result of this inhumanity contrasted with the often casual nature in which patients appeared to be treated by the local healthcare system, thus exacerbating the sense of surreality that also characterized their lived experience.

Dissonance Between Medical Role Identity and Cultural Context

The humane values of care that are central to the medical profession not only jarred with the organizational context in which they were expected to be practiced, but also contrasted with the broader cultural context, both inside and outside Camp Bastion, fueling the experience of senselessness and surreality in particular. Inside the Camp, the importance of care and respect for patients that is central to the

medical profession played an important role in the many reported experiences of surreality. These often involved a sharp contrast between the human gravity of the situation on the one hand, and the imported, cultural routines and rituals designed to normalize life in the camp on the other, such as consuming "near beer" at the end of the day, or browsing the trivia of Facebook after emergency surgery on a badly injured child.

Outside of the Camp, the cultural context of Afghan society also appeared to jar with the medics' professional and cultural values, particularly in relation to children. In contemporary Western society, childhood is often associated with innocence (Holland, 2004), and the culturally specific idea that childhood innocence should be preserved and protected has been pervasive here since the late 19th century (Gittins, 1998; Kehily, 2004). In the context of armed conflict, the child is also often a societal symbol of peace and hope in many cultures (Greenbaum, 2006). This Western cultural context through which the DCS staff interpreted the suffering of children played an important role in their distressing experience of senselessness.

Thus, the primary way in which cultural, professional, and organizational aspects affected the lived experience of war as distressing was to cause dissonance between professional and cultural values, practices, and expectations on the one hand, and actual organizational practice experience on the ground on the other. This dissonance triggered profound and sustained feelings of senselessness, futility, and surreality that were experienced as highly distressing. Below, we argue that this is because the sustained experience of senselessness, futility, and surreality can dislocate people's institutionalized sense of the meaningful, the good, and the normal to the point at which they experience an existential threat to their sense of being in the world.

THE LIVED EXPERIENCE OF WAR AS EXISTENTIALLY THREATENING

In his review of the construct of meaning in psychology, Baumeister (1991) asserted that people receive their meaning from cultural context, and that the fulfillment of a universal need for such meaning has a stabilizing effect on people. It follows that a threat to such meaning can be destabilizing, and therefore distressing. The field of existential psychology has likewise recognized that a general sense of meaninglessness is a growing psychological problem that has social cultural roots (Yalom, 1980). In his application of this perspective to war trauma, Pitchford (2009) argued that war can shift people's sense of meaning and purpose to the point at which they are no longer able to take part in the feelings and thoughts of others. This can trigger a profound sense of meaninglessness and isolation that can only be healed through helping them reconnect to others, and, through this process, rediscover themselves.

Not only were the DCS team's contextually embedded experiences of senselessness, futility, and surreality profound and sustained, they were also inescapable: the DCS team was confined to life at Camp Bastion without recourse to direct, embodied exposure to more "normal" social realities, such as family life. The lived experience of work at war thus formed a radical, collective disjuncture from the ontological certitudes that normally grounded their everyday existence. Many social theorists have argued that such threats to people's existential grounding in everyday life can "swamp" them with anxiety that, when sustained over time, can lead to a regressive loss of a sense of sanity and agency (e.g., Berger & Luckmann, 1967; Giddens, 1984; Goffman, 1961). Below, we discuss the nature of this existential threat, followed in the next section by an analysis of people's coping strategies in response to it.

Senselessness as a Threat to Reason and Hope

According to Berger and Luckmann (1967), the ability to attribute and provide reasons for the actions of oneself and others is fundamental to our sense of being in the world (see also Giddens, 1984). When those reasons cannot easily be provided, life can quickly begin to feel meaningless, arbitrary, and unjust (Berger & Luckmann, 1967). Camus (1955) argued that when people are confronted with such meaninglessness, their primary recourse tends to be to invest themselves in hope: "everything that makes man work and get excited utilizes hope." We suggest that the sustained experience of senselessness by the DCS team, particularly in relation to the suffering of children, threatened both reason and hope as existential pillars of the self. Not only does first-hand experience of children's suffering violate the symbolic values that society places on them, it can also directly threaten the existential self, insofar as children represent "an extension of the adult self, a symbolic link with one's own childhood" (Kehily, 2004: 2; see also Steedman, 1995). Kehily and Montgomery (2004) pointed out that the idea of "childhood innocence" is an "adult" ideal in that it says more about

adults than children. The "senseless" (or reasonless) destruction and suffering of children therefore not only threatens the hope placed in them by society, but also the deeply personal sense of hope people require to ground themselves existentially. A particularly cruel example of this can be found in historical records of the 1978 Jonestown massacre, where survivors reported that after having been made to kill their own children, many felt that they had no choice but to take their own lives because all hope was lost (Nelson, 2006). It is in this sense that experiences of the senseless destruction and suffering of children can symbolically produce our own existential death through the extinction of the hope and innocence that is symbolically vested in them.

Futility as a Threat to Purpose and Agentic Control

Just as people need reasons to help them understand the death and suffering of others, they also need a narrative to help them make sense of their own experience as "actors" here to enact a "role" (Alvesson & Willmott, 2002; Berger & Luckmann, 1967). Even though such actorhood is a distinctly modern phenomenon (Meyer & Jepperson, 2000), the capacity to exercise control over one's life through a sense of purposeful agency is broadly seen to be central to a sense of meaningful existence. Indeed, Bandura (2001: 1, italics added) claimed that "(t)he capacity to exercise control over the nature and quality of one's life is the *essence* of humanness," and Giddens (1984) considered the ability to maintain some sphere of personal control in daily life essential for human survival. Positive organizational scholarship likewise has pointed to the importance of a sense of purpose and impact for people's well-being at work (Quinn & Wellman, 2011).

It follows that the prolonged sense of futility and boredom that members of the DCS team experienced can profoundly threaten the human desire for purposeful agency that is essential for meaningful existence (Baumeister, 1991). As discussed above, this is especially the case for medical professionals who derive their sense of self largely from their professional roles as people who are there to "make a difference." In our case, the futility and boredom they experienced was not only difficult to reconcile with their expectation of doing something more worthwhile than treating "lifestyle diseases" at home, it challenged their sense of self as highly agentic beings whose positive impact on other people's lives was embodied in their medical skills.

Surreality as a Threat to Familiarity and Predictability

Finally, in addition to reason, hope, and purposeful agency, the familiarity and predictability of routinized everyday life are of existential importance to human beings (Giddens, 1984), because they allow them to suspend doubts of its "realness" (Berger & Luckmann, 1967). Repeated and profound experiences of surreality can threaten this normalcy by endowing it with dream-like qualities: meeting the Easter bunny while walking to the incinerator with a human leg wrapped in yellow plastic; being asked to arrange a taxi for a dead man and his dying friend; or being handed boxed up legs by a marine, who went to the trouble of collecting them from the battlefield in the misplaced hope they might be reattached. Such surreal experiences can be a source of what Berger and Luckmann (1967) call "marginal situations" that can threaten one's sanity by making the routines and rituals that ground people in their everyday lives appear strange and alien. It is this (momentary) realization of the *ab*-normality of institutionalized routines and rituals in the face of human tragedy that can thus be existentially threatening, puncturing them as a "shield against [existential] terror" (Berger & Luckmann, 1967: 119). This terror can pull us into the "horror of aloneness" (1967:119), such that we are no longer able to leverage such everyday contextual means as routines and rituals to sustain a meaningful existence.

COPING WITH THE EMOTIONAL DISTRESS OF EXISTENTIAL THREAT AT WAR

The military organization was aware of the unusually severe nature of injury patterns of war casualties, as well as the possibility of psychological distress in response to them, as evident in its two main support channels for medical staff: predeployment training and on-the-ground mental health support. While the technical predeployment training helped medical staff get to grips with the technical challenges they were likely to face, it did not also help them prepare for the experiences of senselessness, futility, and surrealism. For example, at no point in predeployment training, or during deployment, was the issue of psychological distress, let alone PTSD, ever raised. Moreover, the military never explained, or offered up for discussion, the point of the war effort to attempt to provide a sense of purpose. While, in private, many of the DCS staff

were highly critical of the war, they never expressed this publicly. Questions as to the purpose of their deployment would typically be answered with an "it's my job" reply, leaving the issue of purpose to politicians. As an ex-Royal Air Force officer explained, questions of purpose are not openly discussed for fear of eroding morale, which cannot be put at risk in battle.

The military organization also made available several mental health support resources: a trauma risk management (TRiM) team, designed to provide peer-to-peer support from non-medical colleagues trained in psychological first-aid; a field mental health team (FMHT), comprising three mental health nurses to provide clinical assessment, as well as psychotherapeutic interventions; and a "church" and chaplain (see Figure 5). Yet, the ethnographic data contain just one reference to TRiM, where one of the surgeons suspected an operating theater nurse to have consulted with TRiM after a particularly traumatic death, and none at all as regards FMHT, church services, or clergy. While it is true that people may be reluctant to admit to having sought help onsite, none of these facilities were ever promoted internally. As such, they reflected and reinforced the culture of silence on the psychological impact of work in a warzone. As a result, any admissions to the psychological distress experienced from work at war would always be private. Thus, the very culture of emotional control and focus on the technical that enabled doctors and nurses to be effective in their work at war denied them the resources needed to make sense of, and cope with, the emotional distress involved in this work (see Keats, 2010).

FIGURE 5
Church in Camp Bastion

Instead of being able to rely on cultural, professional, or organizational means to cope with such distress, the doctors and nurses developed a range of improvised coping strategies. These fell into two general categories, namely: (1) passive coping strategies that appeared primarily oriented at coping with senselessness; and (2) active coping strategies that appeared primarily oriented at coping with futility and surreality. We discuss these next.

Passive Coping Strategies: Escaping Senselessness

"Avoidance coping" and "escape coping" are well-known coping strategies through which people avoid dealing with a particular stressor in an attempt to protect themselves from psychological anguish (Zeidner & Endler, 1995). These coping strategies are considered passive in that they generally involve a distancing of the self from potential psychological stressors. This means that, by their very definition, they are unable to help resolve the psychological injury that triggers them, because they can only offer a temporary escape. Yet, passive coping strategies were very apparent in our data, particularly in relation to the experience of senselessness.

Avoiding. Each Wednesday night was marked by a repatriation service that all troops stationed in Camp Bastion, including hospital staff, were expected to attend. It was here that fallen North Atlantic Treaty Organization troops were remembered before being sent home for burial. Many would have arrived at the hospital already dead, meaning that DCS medics would not have been involved. Even so, several of them took pains to avoid attending the service; for example, by asking colleagues to page them while en route to give them an excuse to return to the hospital. And while they might be expected to have a professional interest in checking up on their patients during quiet times, it was rare to see a surgeon on the wards outside of the required twice-daily rounds. These ward rounds were a frequent source of complaint by ward nurses who thought them noisy and unruly, with surgeons and anesthetists paying little attention to patients, other than those they were expected to give an opinion on. Through this lack of engagement with the living and the dead, DCS staff attempted to avoid reconnecting with the sharp end of conflict.

What is of interest here is that these consistent attempts to avoid emotional engagement often coincided with a simultaneously expressed concern about not being more deeply affected emotionally by

what they bore daily witness to, as is evident from the following excerpts.

1. Ran into Mike, one of the American anaesthetists, and struck up a conversation. (. . .) He told me about his worries about feeling callous that he is not affected by deaths. He loses no sleep over it, and worries that this is not normal.
2. Colin, one of the orthopedic surgeons, says what personally affects him more than what he sees here is the recent death of his Staffordshire terrier that had to be put down a couple of weeks ago.
3. Surgeon to ethnographer: "Don't feel any guilt about not feeling emotion. If we got emotional about what we have just done or seen we would never be able to do it again or live with ourselves."

Post-deployment conversations with several members of the DCS, as well as the ethnographer's personal experience, make it clear that they all experienced some psychological distress upon arrival back home, suggesting any emotional numbness experienced in Camp Bastion was temporary, and likely to be a defensive mechanism against the (fear of) being overwhelmed by potentially debilitating emotions related to the lived experience of work at war.

Bracketing. In addition to avoiding potentially painful confrontations with the human side of war, some people engaged in a form of mental escape from the reality of the situation by framing their deployment as a temporary state of affairs, contrasting it with the "normal" to which they soon hoped to return, as in the following excerpt.

> Had a chat with one of the operating theatre coordinators. He told me that he forces himself to look at the injuries coming in: "I still want to be shocked by wounds coming in to remind myself that this is not normal, that there is a normal world out there."

Self-reminders of a more "normal" world out there served to bracket the reality of the Afghanistan experience as something exceptional and temporary, and, as such, not reflective of true, "normal" reality. As such, it can be considered a form of "denial," which is a common passive coping response to distressing events, and was one of Anna Freud's original defense mechanisms (Freud, 1937). This coping response appeared oriented at temporally containing the senselessness, futility, and surreality of the deployment experience sufficiently for it not to bleed into, or otherwise affect, life back home. It may partly be for this desire to compartmentalize that returning medics are often reluctant to speak openly about their experience of war, except with each other. As an operating room coordinator put it: "Sometimes I try telling my family some of these things but they don't understand." It is often not until they meet again post-deployment, usually over drinks, that deployments are remembered and tales told and retold.

Self-distancing through humor. Attempts to create distance between the self and the lived experience of working in a warzone also included the use of humor to deflect or make manageable what might otherwise be experienced as emotionally upsetting or traumatic. Humor is a well-documented response to hospital trauma (Becker et al., 1961; Henman, 2001; Wear, Aultman, Varley, & Zarconi, 2006). For example, Hedges (2003: 3) wrote that "[war] dominates culture, distorts memory, corrupts language, and infects everything around it, even humor, which becomes preoccupied with the grim perversities of smut and death."

Much of DCS's humor was directed at Afghan casualties whose injuries were either self-inflicted (e.g., deliberately shooting themselves in the foot) or the result of incompetence (e.g., accidentally shooting themselves). Targeting these people with black humor as "fair game" served the dual purpose of distancing the self from the human misery of war, and to differentiate "us" from "them." Such "othering" can be experienced as pleasurable in and of itself (Lok & Willmott, 2014), and terror management theorists have shown that derogatory "othering" is a common way to defend the validity of the values on which one's worldview is based, especially in the face of increased death awareness (Greenberg et al., 1990).

Active Coping Strategies: Recovering Agentic Control and the Familiar

In addition to these passive coping strategies, we observed more active coping strategies, known as "approach coping" (Carver et al., 1989). These were primarily aimed at recovering some sense of familiarity to counter experiences of surreality, and some degree of agentic control to counter experiences of futility.

Reclaiming the familiar. What are perhaps most easily observable are the various routines and rituals that appear to have been invented, or imported, by the DCS medics so as to try and establish enclaves of normality, familiarity, and home comfort. Despite every day being like any other (in that there was no real distinction between weekdays and weekends,

workwise), the beginning to every weekend was marked by a "Friday night pizza night," and each Sunday morning by a pancake breakfast. By the same token, theater nurses would organize movie nights, while the Estonian contingent built themselves an authentic sauna in the desert. The "near beer" was always in plentiful supply, and something to look forward to on quieter nights, much like one might relax over beer after work back home. There were poker evenings and sports days. Everyday comforts were valued commodities that were shared, and typically sealed in packages sent from home. Thus, significant effort was expended in trying to generate a sense of normalcy by importing into the hospital the sort of routines and rituals that structure everyday lives back home. Except for the Doctors' Room and Internet, none of the above were formally organized or sponsored by the military organization.

However, even though these active attempts to reclaim the familiar were aimed at staving off the surreal through normalization, they also became constant reminders that this alien environment was *not* like home: e.g., watching the film *Apocalypse Now* on movie night against the background of Apache fighter helicopters taking off on similar missions, tending to a flower garden in a barren desert, or enjoying Pizza Hut in the midst of a war zone. At best, importing home comforts could therefore only offer a temporary *escape* from, instead of a resolution of, the lived experience of war. At worst, this strategy may actually have *contributed to* feelings of surreality by increasing the contrast between the reality of war and reminders of life back home.

Reclaiming a sphere of agentic control. Giddens (1984) argued that the sense of a sphere of agentic control is of fundamental importance for people's ontological security. However, this sense is difficult to sustain at war amid the lack of private spaces, the unpredictability of casualty arrivals, and the experience of futility. In response, members of the DCS team attempted to reclaim agentic control in a number of ways. For example, many made elaborate efforts to construct private spaces inside shared pods, usually by draping linens, towels, or flags over washing lines, to create almost entirely enclosed spaces (see Figure 6). People would turn to these areas for respite so as to maintain some personal space away from work at war, and derive a sense of agentic control from their ability to construct their privacy. Such attempts are consistent with Lyman and Scott's (1970) argument that territorial strategies form an important means of controlling the absurd circumstances of life.

The desire for an increased sense of control in the face of the futility of work at war also found creative expression in the form of an attempt by one of the intensivists to try and grow sunflowers and tomatoes in the desert sands behind the Doctors' Room, tending to his patch religiously (see Figure 6). Others, in a subsequent deployment, baked their own sourdough bread:

> As in the series MASH, the counterpoint to the tales of blood, heroism, and medical miracles was the humour and the humanity that punctuated the bloody routine of daily life; but, instead of a potato distillery brewing alcohol, we made bread. (. . .) In the end, the legacy of this club of five military consultants (. . .) is embodied in their Bastion tour T shirt: "Make bread not war." (Arul, Bree, Sonka, Edwards, and Reavley, 2014: 16–17)

The "Make bread not war" T-shirt symbolizes the sometimes defiant or slightly rebellious nature of attempts to reclaim a sphere of agentic control. For

FIGURE 6
Coping Responses: Acts of Creation and Private Spaces

example, individual attempts at defiant agentic control consisted of refusals to engage with "trivial" cases, such as an Afghan who suffered temporary impotence, and a request to operate on a Danish soldier one day early so that he could accompany his dead sniffer dog on its flight home:

> Hawkeye said he had no patience for things like this, and doesn't want to see "someone whining about a dog who is going to be flown home to be put in the burning pit. That's more than we do for our lads."

As was the case for attempts to reclaim familiarity, it is doubtful that these efforts to reclaim agentic control resolved the sense of futility that often characterized the lived experience of work at war. This is because the attempt to channel a sense of purpose into acts of creation or resistance did not, and could not, address the main source of distress associated with the experience of futility: feeling unable to make a difference to many patients' lives. At best, they therefore offered a temporary escape from the debilitating feeling of being involved in something futile, or brought temporary excitement to punctuate the boring monotony of daily life at war.

DISCUSSION

In this paper, we set out to examine the role of cultural, professional, and organizational contexts in the experience of psychological distress at war in order to broaden the scope of current understanding of psychological injury from war. We took as our subject DCS staff who, as RLMs, are less susceptible to the oft-cited triggers of psychological injury, because they are not usually exposed to the high level of threat to life or limb faced by front-line soldiers, and because they are usually vastly experienced in dealing with catastrophic injury and death, including in war zones. Our analysis showed that repeated experiences of senselessness, futility, and surreality were particularly distressing. Context was directly implicated in this experience through the dissonance it produced between professional and cultural values and practice expectations on the one hand, and actual lived experience on the ground on the other. This same context also made it very difficult for medics to reground themselves existentially, forcing them to rely on largely ineffective improvised coping strategies. These could only offer a temporary escape at best, and may even have further exacerbated the very existential threat they were designed to alleviate by increasing the dissonance between life at war and life back home. Next, we discuss the implications of these findings for both research on psychological injury from war, as well as organization research.

Implications for the Understanding of Psychological Distress and Injury at War

The evidence for the efficacy of interventions to help prevent or treat PTSD is mixed (Mulligan et al., 2010). Recent reviews of the effectiveness of predeployment stress briefings, and the high-profile Comprehensive Soldier and Family Fitness program concluded that their impact is marginal (Sharpley, Fear, Greenberg, Jones, & Wessely, 2008; Wang, 2014). There is also evidence to suggest that debriefs during deployment that are specifically designed to minimize acute emotional distress and the onset of PTSD may actually increase PTSD rates (Wessely, Bisson, & Rose, 2000; Wessely & Deahl, 2003), Evidence of the effectiveness of post-deployment psycho-educational interventions is also mixed. For example, the *Battlemind* program proved beneficial to U.S. armed forces, but showed no improvement in mental health when trialed on their U.K. counterparts (Mulligan et al., 2012). What characterizes most of these interventions is not just their mixed success, but also the universalizing assumptions regarding causes of PTSD that inform them. The general attribution of causality to a person's exposure to (the aversive effects of) a traumatic event appears to assume that the likelihood of psychological injury depends primarily on how well a person can cope with such events psychologically or physically. Research under this rubric includes studies of traumatic brain injury (e.g., Huber et al., 2013), and those into the neurobiological foundations of PTSD (e.g., Sherin & Nemeroff, 2011).

In order to complement this understanding, we have taken a contextual approach as a basis for arguing that psychological distress at war cannot be adequately understood without also taking into consideration the specific, situated context in which it occurs. For example, our findings suggest that it is not exposure to physical trauma in others *per se* that is psychologically distressing to medical doctors. Their technical training has taught them to deploy their skills to optimum effect, and, in our case, surgeons would often compete for the most complex and challenging injury patterns. Rather, we have shown that what was particularly distressing to them was the specific local organizational requirement to hand over local Afghan patients as soon as they were stabilized. This practice tore at the fabric of their sense of professional purpose and responsibility,

which they derived from their ability and obligation to heal and care for their patients. Moreover, our data suggest that even the distress experienced around this particular organizational protocol could differ depending on whether the patients were, for example, Afghan children, or male adults who had injured themselves. Whereas children's cultural association with innocence and hope triggered a profound feeling of senselessness when they were brought in injured, enemy combatants were considered "fair game" in black humor that helped to distance medics from the human tragedy of war.

Hence, we argue that it is not necessarily exposure to aversive details of traumatic events in and of itself that can trigger psychological injury. Rather, our analysis has highlighted some important ways in which institutional context can become implicated in the psychological distress experienced at war. Specifically, we have shown how particular cultural and professional contexts can socialize military personnel into specific values, practices, and expectations that existentially ground their sense of the meaningful, the good, and the normal. We have argued that this grounding can begin to break down through repeated practice experiences on the ground that sharply contrast with these professional and cultural expectations. We also suggest that this existentially dislocating experience can be further amplified by the very coping strategies that are designed to alleviate distress, especially in an environment that leaves little room for alternative ways of coming to terms with the lived experience of war. Our analysis thus highlights the power of shifting research focus from the individual psychological response to war as the primary site of possible improvement, to considering the institutional context, and its unique interactive effects with individual psychology, as a possible additional site of intervention.

We highlight two specific ways in which we believe this contextual perspective may be deployed in future research to help improve both the prevention and treatment of psychological injury from war. First, a contextual perspective can be deployed to enable a more systematic analysis of the differences in the nature and extent of psychological injury between different groups within the military. For example, reservists (or part-timers) and people who leave the military shortly after deployment have been shown to be at increased risk of PTSD as compared to regular troops (Hotopf et al., 2006; Samele, 2013), because they do not have access to the same support networks within the military (Iversen & Greenberg, 2009). However, just what, exactly, the role of the military is in helping to prevent, alleviate, or cause PTSD in different groups of military personnel is still very much an open question. Our research suggests that while PTSD rates between frontline troops and RLM staff (including DCS staff) may be comparable, the specific reasons for this must be different, because the institutional context that helps shape what is considered traumatic for medical personnel is highly specific and situated. This implies that the most effective ways in which psychological injury from war can be treated, or even prevented, are likely to be specific to the particular nature of the cultural, professional, and organizational contexts in which specific groups are embedded.

A second important way our study can act as a basis for future research on psychological injury from war is through an increased focus on the ways in which the very coping strategies people rely on to alleviate psychological distress at war may actually have the opposite effect. Specifically, our study suggests that attempts to normalize the war environment as much as possible through importing home comforts, rituals, and routines may be responsible for amplifying, rather than reducing, the experience of senselessness, futility, and surreality at war by increasing the contrast between life at home and life at war. Existentialist theory has pointed to the fragile nature of the institutional structures through which people ground themselves existentially in everyday life (Camus, 1955; Berger & Luckmann, 1967). We have argued that this fragility can become particularly evident in life at war, because war exposes some of the intrinsic limits of home comforts, routines, and rituals in normalizing lived experience.

Importantly, these limits may not just render people's reliance on them largely ineffective as a coping strategy for psychological distress at war. In addition, we suggest that reliance on them may permanently damage the existential function of home comforts when troops return from war, making it much more difficult for them to adjust back to civilian life. For example, the surreal experience of bumping into the Easter Bunny on the way to the incinerator to dispose of a body part may permanently damage the future ability of Easter rituals to provide a sense of familiarity and existential grounding after returning home. Similarly, consuming chicken wings after a clamshell thoracotomy on a gunshot wound to the chest may forever taint any future experience of KFC by invoking memories of war. Imports are "soiled" by being experienced in a particular context, such that the two may become difficult to subsequently

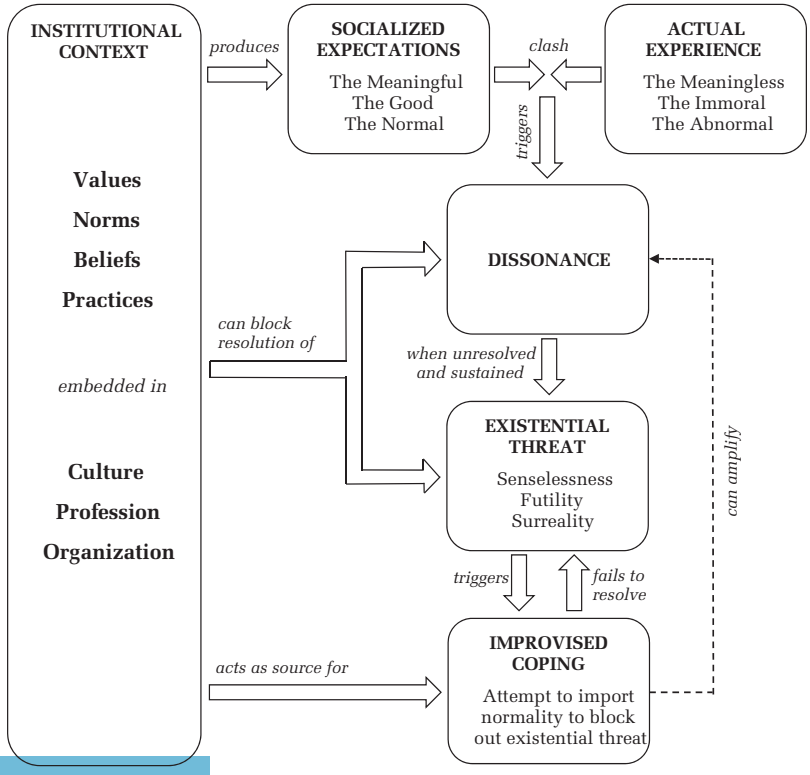
untangle. As a result, people may become estranged from *both* life at war *and* life at home, which may increase the likelihood of permanent psychological injury such as PTSD. Thus, while context may not directly cause psychological injury such as PTSD per se, we suggest that its role in contributing to psychological distress both during and after deployment may be more significant than current theories are able to allow for. We believe future research that further unpacks this role could form the basis for developing new intervention methods that are better tailored to the contextually situated nature of psychological distress at war. Rather than searching for universal triggers and psychological factors that predict the likelihood of psychological injury in general, we draw attention to the situated nature of psychological distress in relation to the specific institutional context through which certain events are experienced as existentially traumatic.

Implications for Organization Research

Institutional theory has been described as one of the most dominant "macro" approaches to understanding organizations (Suddaby, 2010), yet has simultaneously been criticized for lacking practical relevance. For example, Dover & Lawrence (2010: 305) argued that its insights "remain locked within academic circles, (. . .) with attempts to explore practical implications confined to cursory final paragraphs." In parallel, organizational behavior research is seeing a shift toward explicitly incorporating "context" into its theories, following critiques that its impact on micro-level phenomena is not sufficiently appreciated (Johns, 2006). Our research sits at the nexus of these two concerns: the recognized need in organizational research to develop practically relevant context theory through which both "macro" and "micro" approaches can be advanced.

Specifically, our study draws attention to the role context can play in triggering and amplifying existential psychological distress in organizations such as the military. Figure 7 offers a theoretical model that captures this role in three ways. First, through socialization, institutional context *produces* in people expectations of the meaningful, the good, and the normal. These expectations can clash with actual

FIGURE 7
The Role of Context in the Experience of Existential Threat in Organizations



lived experience in organizations—especially in extreme environments such as war—when people encounter meaninglessness, immorality, and/or abnormality in their work. This can produce dissonance, which people attempt to resolve through sensemaking resources that are embedded in their cultural, professional, and organizational contexts (see Lok & de Rond, 2013). However, these contexts may not be conducive to such a resolution, especially when the very cultural resources they offer are part of the reason why dissonance is experienced. Thus, the second way in which context can play a role is by *blocking* the possible resolution of dissonance between contextual expectations and actual experience. Our analysis suggests that this can produce repeated experiences of senselessness, futility, and surreality that can form a threat to people's sense of being in the world. To deal with this threat, people rely on improvised coping strategies through which they try to block out, or cover over, existential distress. In addition to avoidance strategies, we have shown that this can involve attempts to normalize lived experience by superimposing a sense of normality through, for example, importing home comforts and rituals. Hence, the third and final way in which context can play a role in existential distress in organizations is as an important *source* for improvised coping strategies that are aimed at normalization. We suggest that these normalization attempts are likely to fail when they merely cover over the existential threat. They may actually end up amplifying dissonance by increasing the contrast between expectations of normality and actual lived experience. Next, we discuss some of the implications of this theoretical model for both macro and micro approaches to organization research.

Organizational institutionalism. Recent work in organizational institutionalism has begun to focus on emotions as a basis for better understanding "how people experience the institutional arrangements that (. . .) make their lives meaningful and prime how they think and feel" (Voronov & Yorks, 2015: 579). This new research interest is based on the understanding that people derive "high *existential stakes* of life and meaning" from institutions (Creed, Hudson, Okhuysen, & Smith-Crowe, 2014: 281, italics added). Yet, despite this reference to the existentialist dimension of institutions, its significance for both institutional and psychological stability has rarely been discussed (Willmott, 2011). Our study shows that lived experience in extreme environments can threaten the institutional foundations of everyday life through a breakdown of the sense of the meaningful, the good, and the normal. We have shown how this can produce profound emotional distress that can trigger a number of improvised coping responses through which people's practice engagement is significantly altered. Specifically, in our case, practice engagements often became disruptive of normal organizational practice as a result of coping strategies; e.g., unruly patient contact, avoiding repatriation ceremonies, refusing to treat certain patients, denigrating the medical skills of others, etc. Thus, our study builds on, and extends, research that has highlighted the importance of "breakdowns" for the nature of practice engagement in organizations (Lok & de Rond, 2013; Sandberg & Tsoukas, 2011). It shows that in extreme environments, breakdowns may accumulate to the point of posing an existential threat, which can produce coping responses that may disrupt practice. Thus, by highlighting the role of existential desires and anxieties in people's engagement with their organizational lives, our study offers a new possible pathway for future research on the relations between emotions, institutions, and practice engagement.

Normalization research. Our contextual perspective also contributes to micro-level organizational research by pointing to the *limits* of normalization in helping people cope with contextual sources of distress at work. Ashforth and Kreiner (2002: 228) theorized that under extreme circumstances, normalization strategies "may not be able to fully restore a sense of order," and therefore suggest that they are "likely to be most effective in the broad mid-range of emotionality." Our study of a setting in which work experiences were extreme in their emotional charge offers empirical support for this proposition. It also extends this theoretical insight by suggesting that when the distress experienced involves an existential threat, some normalization strategies may not only be ineffective, they may end up amplifying the very distressing experiences they are meant to alleviate.

We believe that the reason we did not observe more typical normalization attempts—such as a reframing of role identity and associated ideology in such a way that it reduces distress—is because this simply was not feasible for DCS medics. Indeed, the very normalization mechanisms through which medical professionals learn to cope with treating severe injuries in their medical training (emotional distance from patients, composure under pressure, and an exclusive focus on technique and protocol in the interest of the patient), prevented them from openly discussing the psychological distress they experienced

and collectively recasting it in a different light. The technocratic culture into which they were socialized denied that there was a problem in the first place, and no alternative ideology was available to help normalize their experience. This produced what could be called a "normalization vacuum:" a context in which it is impossible to normalize existentially dissonant experiences, because the only cultural resources available for normalizing these experiences are those that cause the dissonance. Future research is needed to explore whether and how such normalization vacuums are prevalent in other organizational environments, as a basis for better specifying some of the limits of normalization as a response to contextual sources of dissonance.

The importance of purpose for positive psychology. Finally, rather than exemplifying a source of fulfillment and psychological stability, our study provides an important example of a case in which a heightened sense of purpose was actually an *amplifier* of the psychological distress physicians experienced at work. This suggests that the meaningfulness that is generally associated with a strong sense of purpose and agency in organizations is not necessarily always a source of the types of positive emotions that the field of positive organizational scholarship has pointed to (e.g., Pratt & Ashforth, 2003; Quinn & Wellman, 2011). Instead, we have shown that a strong sense of purpose and agency can be a double-edged sword in situations where there are real contextual constraints on people's ability to fulfill their sense of purpose. Hence, we believe there is a need for future research that develops a more nuanced, contextual understanding of the psychological benefits of a sense of purpose in organizations, particularly in relation to "deeply meaningful work" (Bunderson & Thompson, 2009).

There are many organizations and professions that employ people who experience a sense of purpose so strong that they see their work as a "calling" (Schabram & Maitlis, 2016; Wrzesniewski, 2011). An important subclass of these—such as, for example, disaster relief organizations, aid organizations, the field of medicine, NGOs, and the police—often rely on this sense of calling to attract people to jobs that will likely expose them to pervasive human suffering, or even to the threat of (psychological) injury or death. Indeed, this is an important reason why these jobs can look most promising to people who derive a strong sense of purpose and agency from a particular calling. Yet, these are also the very organizations in which people are likely to face real constraints to their ability to make the kind of purposeful impact they desire, because they face the enormous challenge of turning the never-ending tide of human suffering. We have shown that a profound sense of purpose, and an equally profound sense of futility, may thus become two sides of the same coin. The fact that people in these organizations persist in their work regardless, doing the best they can to care for others in extremely challenging circumstance, deserves nothing but our unreserved admiration. We owe them our support through developing more effective ways to help alleviate, or even prevent, the psychological costs involved in their work.

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