FEMALE VETERANS WITH SELF-IDENTIFIED PTSD:

HOW MILITARY CULTURE INFORMS UNDERSTANDING OF THE CONDITION OF PTSD AND THE DECISION-MAKING PROCESS OF SEEKING TREATMENT

by
Christine Elizabeth Zerr

A thesis submitted to the Department of Comparative Cultural Studies,
College of Liberal Arts and Social Sciences
in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

in Anthropology

Chair of Committee: Andrew J. Gordon, Ph.D.

Committee Member: Rebecca Storey, Ph.D.

Committee Member: Matthew W. Gallagher, Ph.D.

University of Houston
August 2020

DEDICATION

To all the people in my life whose support made the completion of this thesis possible, I dedicate this work to you. To my husband, Zachary Zerr, who inspired me to be the best version of myself and kept me going when I felt disheartened. To my parents, Poppy and William Derosia III, who have always encouraged me to do everything to the best of my ability. To my brother, Aaron Derosia, who would always lend an ear when it was needed and who reminded me when I needed to step back and to his beautiful fiancée, Liliana Villanueva, who makes my brother very happy. To my grandparents Bettye and Nathan Grimes, who have always encouraged me in my studies. To my grandparents, Nadine and Tony Guetti and Lisa and William Derosia II, for their love and support. To my in-laws, Dawn and John Zerr, for their encouragement and consideration. To the friends who have supported my husband and myself in the final stages of graduate school, Lisa and Justin Cole, and my best friend who is more like a sister, Brittanie Rising.

To my professors and the teachers in my life who have ignited a passion for learning and for anthropology, I extend my deepest gratitude. To Dr. Jennifer Trunzo and Dr. Angela Bratton of Augusta University, who introduced me to the field of anthropology. To Dr. Andrew Gordon, Dr. Rebecca Storey, Dr. Randolph Widmer, Dr. Susan Rasmussen and all the faculty and staff of the Department of Comparative Cultural Studies at the University of Houston, without whom I could not have succeeded.

And finally, to all my peers, extended family, friends, and co-workers for your support and help. Your patience with my curiosity, encouragement to pursue higher education, and guidance to become the best version of myself has made me who I am today.

ACKNOWLEDGEMENTS

I wish to thank those whose contribution made this thesis possible. To my thesis committee chair, Dr. Andrew J. Gordon, I express my sincere appreciation for his guidance in not only the process of creating my thesis, but in the application and instruction of anthropology as well. I would also like to extend my gratitude to the other members of my thesis committee, Dr. Rebecca Storey and Dr. Matthew Gallagher, for providing support and feedback in the course of writing this thesis and navigating the hardships of graduate school during the COVID-19 pandemic. Of course, I also greatly appreciate the help of the University of Houston's Comparative Cultural Studies faculty and staff. I especially thank the interviewees, without whom this thesis would not be possible.

ABSTRACT

This thesis explores how female veterans with Post-Traumatic Stress Disorder (PTSD) adapt to the condition of PTSD, its diagnosis, and subsequent labelling as informed by military culture. The work for this thesis was conducted by interviewing six female veterans from the Houston area regarding the unique challenges they face, the condition of PTSD, how daily life changes after PTSD, the process and challenges of treating the condition of PTSD, and the process of reintegration into civilian life as a PTSD sufferer. By exploring the interviews and extracting beliefs, values, and behaviors informed by military culture, this thesis illustrates the particular challenges faced by female veterans and elucidates the reasoning behind their choices throughout the process of obtaining a diagnosis and seeking treatment as they navigate civilian life.

TABLE OF CONTENTS

DEDICATION ..... **iii**
ACKNOWLEDGEMENTS ..... **iv**
ABSTRACT ..... **v**
TABLE OF CONTENTS ..... **vi**
LIST OF TABLES ..... **ix**
LIST OF FIGURES ..... **x**
CHAPTER 1: INTRODUCTION **1**
CHAPTER 2: TOPIC REVIEW **12**
Post-Traumatic Stress Disorder 12
The DSM-5 and PTSD 12
PTSD Introduction 12
PTSD Overview 14
Brain Changes with PTSD 15
Anthropology and Veteran PTSD 16
Military Culture 18
Principles 20
Language 25
Daily Life in the Military 29
The Importance of Military Culture in Healthcare 32
Veteran Cohorts and Veteran Culture 37
The Gulf War-Era I/Desert Storm Cohort 37
The Post-9/11/OEF/OIF Cohort 39
Veteran Culture 42
Female Veterans 43
Medicalization, Labeling Theory, and the "Sick Role 51
The "Sick Role" 51
Labeling Theory 52
Medicalization 54
Analysis Methodology 56
Data-Driven Analysis 56
Grounded Theory 57
Summary 60
CHAPTER 3: RESEARCH METHODS **61**
Selecting Interviewees 61
The Interview Process 62
Analysis 63

CHAPTER 4: FINDINGS 66
The Interviewees 66
Maya 67
Amy 71
Charlotte 73
Deanne 76
Jane 78
Sara 80
Analysis of the Interviews 82
Childhood Trauma 87
Military Sexual Trauma (MST) 91
MST Overview 91
MSTs by Strangers or Acquaintances 93
Domestic Abuse MSTs 97
The Role of Military Culture in the Decision to Report the MST 101
Combat Trauma 106
The Experience of Having PTSD 113
Symptoms 114
Triggers 119
PTSD Episodes 121
The Progression of the Condition 121
Medicalization and Labelling 125
Diagnosis 125
Disability Rating System 127
Perception of the VA 132
Methods of Dealing with the Condition 137
Self-medication 138
Coping mechanisms 142
Professional Medical Treatment: Medicine 147
Professional Medical Treatment: Therapy 148
Military 149
Before the Military and Reasons for Joining 149
Reasons for Exiting the Military 151
Rejoining the Military 152
Time in the Military 153
Reintegration into Civilian Life 160
College 160
Work 163

Society....165
Interactions with other Veterans....168
Stereotypes....169
Representing Veterans....171
CHAPTER 5: CONCLUSION....173
The Role of Anthropology....173
The Gendered Experience....176
Labelling, the "Sick Role," and Medicalization....181
Labelling....181
Medicalization and the "Sick Role"....185
Demedicalization....190
PTSD as a Cumulative Condition....191
This Study and the Concept of the Wall of Resilience....191
Other Studies with the Same Conclusion....194
The Role of Military Culture in Decision-Making....196
Final Remarks....198
Reflection for Successive Studies....199
REFERENCES....201
Appendix....207
Excerpt from the DSM-5....207
Survey on the Perception of PTSD....228
Research Methods....228
Findings for the Survey on PTSD....229
Utilization of Prior Research-Survey on PTSD....238

LIST OF TABLES

Table 1: All themes as determined through qualitative coding 86
Table 2: Survey-Response Means per Individual 232
Table 3: Survey-Correlation Matrix of Top Variables by Respondent.....234
Table 4: Survey-Correlation Matrix of Top Variables by Symptom.....236
Table 5: Survey-Correlation Matrix of Symptoms by Respondent 237

LIST OF FIGURES

Figure 1: Maya's Interview Topic Frequencies-Sunburst Chart.....67
Figure 2: Amy's Interview Topic Frequencies-Sunburst Chart.....71
Figure 3: Charlotte's Interview Topic Frequencies-Sunburst Chart.....73
Figure 4: Deanne's Interview Topic Frequencies-Sunburst Chart 76
Figure 5: Jane's Interview Topic Frequencies-Sunburst Chart.....78
Figure 6: Sara's Interview Topic Frequencies-Sunburst Chart.....80
Figure 7: Summary of Themes-Sunburst Chart 83
Figure 8: Symptoms-Pie Chart.....114
Figure 9: Triggers-Pie Chart 119
Figure 10: Perception of the VA-Sunburst Chart 132
Figure 11: Treatment Strategies-Pie Chart 137
Figure 12: Self-Medication by Type-Pie Chart 138
Figure 13: Coping Mechanisms-Sunburst Chart.....142
Figure 14: Severity of Trauma Type-Illustration.....192
Figure 15: General Perception of PTSD Survey-Pie Chart 230

CHAPTER 1: INTRODUCTION

From the moment I decided to go to graduate school, I knew exactly what I wanted to study for my thesis topic: how veterans navigate the condition of PTSD. However, I lacked a clear direction in what exactly I wanted to contribute towards the body of knowledge on the subject. My adviser, Dr. Andrew Gordon, motivated me to find the answer by looking inwards through autobiographical examination. After much discussion and support from him as well as other faculty at the University of Houston-such as Dr. Rebecca Storey, Dr. Randolph Widmer, and Dr. Susan Rasmussen-it became clear to me that what I needed to contribute was an understanding of how female veterans with PTSD, such as myself, recognize their condition and the culturally-informed decision-making process which makes them seek (or not seek) treatment for the condition.

For the sake of reflexivity, it is important to understand my relationship to the source material and how that may or may not have contributed towards my conclusions. Coming from a military family, I'd always had a fascination with the military life and structure and wanted to understand it more. It had been a topic which interested me as a child, seeing evidence of my father, grandfather, and several uncles' service to the United States Army, but it was the events of 9/11 while I was in Middle School which sparked the desire to go in myself. I followed the stories of soldiers who deployed, felt for those whose family and friends went overseas in response to 9/11, and came to understand that PTSD was a common condition for those who returned. As a driven student, my path seemed to be taking me to college instead of the military, so I scratched the itch in other ways. In High School, I took part in the marching band and its competitions each year,

eventually becoming Drum Major my Junior and Senior year. However, the reality of the cost of education and impending massive debt for a large part of my youth became increasingly daunting as I approached graduation. Since my father had contracted in Iraq and Afghanistan for several years preceding this decision, I leaned on his experiences as a soldier as well as a contractor to make an informed decision about whether I wanted to join the military. Although his time overseas ended with a slipped disc in his back which eventually ruptured and perforated his spinal cord, he had considered that time to be an influential part of his life. After much consideration and debate, I chose to go into the United States Army.

What I encountered was a microcosm of American culture comprised of the myriad of experiences and individuals from the vastly culturally diverse subcultures found in the United States. State sizes and populations seemed to be represented by the composition of those who made up the unit. Some would seem to overdo their cultural stereotypes for the sake of reclaiming individual identity, others took on new identities as enabled by newfound anonymity, and still others remained the same as they had been before joining, but what became clear was that the common thread between all of us was our shared military culture and experience. I'd always been a people-watcher, but my exposure to military culture and the variety yet similarity found within sparked an interest in studying anthropology. However, entry into a new culture is not without some growing pains and the evidence of PTSD was seen even in those still in the service.

I had been aware of the process of deconstruction of individual identity and reconstruction into a unit before I went into the military, and in retrospect, now understand that the process of Basic Training was in fact the way the military

enculturates new recruits into its ranks and maintains a unified, overarching sociocultural structure. When someone enters the military, the first phase they take part in is Basic Training, where they learn basic marksmanship skills, build up physical capability via physical training (PT), take classes which cover necessary skills, such as combat life-saving techniques, and learn what it is to be part of the U.S. Military. Phrases, acronyms, songs, and stories told by the drill sergeants and Cadre solidified concepts and normalized the feelings of isolation and dislocation alongside the newfound sense of camaraderie between the trainees. The drill sergeant most hard on us was the one with PTSD, both by his own admission and clearly evident in his eyes and actions. This was my most in-depth, personal experience with someone with the condition. He seemed volatile, usually quick to punishment and threats, but this only made the rewards from him mean even more to us. Although we had all initially feared the drill sergeants, we came to respect and care for them as part of our newfound military family.

However, early on in Basic Training, I suffered an injury during a training accident. I fell roughly two and a half stories off of Warrior Tower and injured myself. At the time, my adrenaline was high, so I didn't realize how bad the damage was and the fear of being "recycled" into another Basic Training unit over and over again until my injuries healed prevented me from seeking treatment for it until after I graduated. I had also wanted to impress the drill sergeants and prove to my male battle-buddies that I wasn't weak or incapable, so I pushed through the pain and suffered in silence. Over time, I came to realize that something was seriously wrong because the sheer amount of pain I was in became a constant static in the back of my mind, making it difficult for me to retain instructions or comprehend what people were saying to me. Despite the pain,

after the graduation ceremony from Basic Training, I truly felt like I was part of something greater and embraced the culture wholeheartedly. I surprised my family by wolfing down my food within a minute or so of receiving it, being jokingly told I should at least try to taste it first. I fell asleep instantly when I was in the backseat in a vehicle, much to their delight, because I'd been trained to get sleep where I could, even if it was the five minutes between being picked up by the cattle truck and dropped off at the range.

It was only after I reached Advanced Individual Training (AIT), the specialized training for my Military Occupational Specialty (MOS), did I finally go and get the injury checked out. Due to the perception by Sick Call (or the local clinic on base) that anyone there was most likely trying to avoid PT by faking or overblowing a minor health issue, called "malingering" in the military, as well as the prevalence of soldiers doing exactly what I had done-waiting until after Basic to get checked out-it took five months after I had injured myself to finally get it looked at. I was sent to physical therapy for an unknown problem and after an initial appointment, the physical therapist determined I needed X-rays. Just before heading to my unit, I was given my results: I'd shattered two parts of the saddle part of my hip bone and had been running and training on a broken hip, even nearly maxing out my PT test score despite the serious injury. Because I was so close to graduating AIT, they decided to send me along to my unit instead of medically discharging me right there, which would have happened had I gotten it checked out sooner.

I was stoked to be sent to my unit, finally part of the "real Army" and no longer in training, dogged by constant, debilitating pain and a still-broken hip. After I handed my Platoon Sergeant my physical profile, or the sheet which indicates what a military

physician says I should not physically do or risk injuring myself further, usually referred to as a "profile," he joked, "What, did they wheel you in on an ambulance?" Still a fresh trainee, my serious demeanor melted away as he pulled my 200 pounds worth of bags out of the van that brought me to the unit, shouting in dismay, "Oh no! A woman who knows how to pack!" I was simply glad to be there, feeling vindicated for my suffering for having made it to the unit and the capability to be considered a veteran even if I became medically discharged due to my injuries. Over time, the constant pain and severity of my injury and my developing pre-PTSD meant a drop in my memory capabilities. In order to carry out new tasks, I had to write and follow a bulleted list, a task which frustrated my Non-Commissioned Officers (NCOs) at times. My experiences in the unit were very different from what I had experienced in training, and I found it to be a more relaxed environment yet a source of stress and danger, especially for a young female.

Since it was overseas and isolated from other unit command structures, my unit had some unusual practices. Some practices involved the blending of local law as well as American law, making the rules on Post more fluid and less rigid than I had grown accustomed to in a military setting. But what really stood out to me was the social treatment of females there. I'd had many male soldiers proposition me or try to tell me that my only job was to sexually entertain them. I'd been put in several compromising positions but managed to wiggle my way out of it. I met my now husband in this environment, and he was the only one who truly made me feel safe there. When I had a near-sexual assault, he was the first person I thought of and went to for safety and comfort. We were together for less than a year when we got engaged, despite the fact that we had been trying to take it slow. This may seem like a short period of time, but there is

a certain sense of urgency when soldiers consider marriage since each wants to ensure the other is taken care of while on deployment-which is both dangerous and a frequent inevitability for those on Active Duty. It was during this time that I was given the news that my condition would not only worsen but would cause several serious comorbid conditions and I was advised to consider a medical discharge. Considering the fact that I was going to get married soon and harsh military life would only exacerbate my condition, I made the difficult decision to allow myself to be medically discharged for my hip injury. At the same time, whilst in the required meeting with a recruiter, my fiancée was coerced into renewing his military contract when the recruiter used the idea of supporting me while I exited the military as a way to convince him to stay in. What this meant is that he was sent to another duty station soon after, and I was on my own in this predatory unit while going through the Medical Evaluation Board (MEB or MedBoard) process.

After having a difficult, botched dental surgery to remove five of my healthy teeth (simply because some were wisdom teeth and the other had a tendency to move) which left permanent numbness in parts of my face, and an even more difficult recovery, I was put into Rear-Detachment (Rear-D). Another soldier from my previous unit was also in Rear-D, and since he'd been close with my fiancée and we trusted him, I would sometimes hang out with him. On one of those occasions, he attempted to sexually assault me. We struggled for a while as I repeatedly told him no, but I managed to wear him out (despite the broken hip) and he eventually seemed to come to his senses and quickly left. However, that event left deep psychological scars. My outlook instantly changed, and I was booby-trapping my room and avoiding others as much as possible,

especially while I was still in Rear-D. I didn't seek an official report because it seemed that there wouldn't be enough proof to support my claims and I didn't want to get embroiled in the military law process, potentially having to stay at this unit longer, far from my fiancée and also delaying my wedding for an indeterminate amount of time. I sought care immediately through the informal channels provided for unofficial reports of Military Sexual Trauma (MST) and was informed I likely had PTSD and would need to get checked out once I exited the military. While my representative, the psychologist, and the chaplain were good, I was stunned at the way the MST counselor responded to my attack. She told me, a female Active-duty soldier who had fought off her attacker, that I should "take self-defense courses," in order to prevent it from happening again. Certainly, I couldn't have been the only female she said that to and the clear disregard for the fact that I had in fact fought him off seemed insulting and unhelpful-almost dismissive.

I left the military, finally feeling free but with the heavy cloud of PTSD and depression settling over me. After the initial elation of the freedom to sleep past 5:00 am and do as I pleased throughout the day, I noticed that I wouldn't be able to rest unless I checked the locks on all the doors and windows at least once, maybe twice, because my memory wasn't as good as it had been. I was afraid of driving, even to the grocery store. I felt panicked when I went to large stores, seeing too many people, none of which seemed to be paying attention. I changed my habits so that I did my grocery shopping late at night when there were less people around, but still watched for predators in the dark parking lot. After some prompting by my husband, I sought treatment as a military spouse, getting a mixed bag of results from the military physicians on Post, one of which treated

every condition I came in for as potential pregnancy-including the flu. After my husband left the military, he worked as a contractor but ended up losing his contract and we had to move suddenly to my parents' place. We decided to go through college and get our degrees before trying to establish ourselves in a career again. In the meantime, we also went in and applied for our disability ratings. Although we had been told to do this immediately, I had waited several years because I was too depressed to manage it on my own and instead did it at the same time as my husband. We both got our ratings and he and I both were service-connected for PTSD, meaning we were both diagnosed by the independent doctor contracted to evaluate us and that a U.S. Department of Veterans Affairs (VA) rater had determined that each of us had PTSD from something that happened in military service. This is important because that meant that we were eligible for VA healthcare, medication, treatment, and other services provided to veterans.

Because of our service-connections, we have both utilized the VA as our primary source of healthcare for a little over six years now. I have struggled to get treatment for my chronic hip injury and the comorbid injuries it has caused, and have utilized the mental healthcare services of the VA extensively. One thing I had noticed before starting this project is that the VA tends to switch doctors fairly frequently. It seemed every couple of years or less, I had a different doctor, an observation my husband had as well. Some were more amenable than others, but one of the first things I noted was the sheer amount of medication I was put on. I had often felt that my doctors just wanted to medicate my symptoms rather than treat the root problem, but diligently did as I was told. After having some severe side effects from a few medications, my trust in the absolute authority of the doctors diminished and I was more careful about what I did or did not

agree to take and took more agency when it came to arguing for my health and what I would or would not do. My experiences with mental health have been largely positive, barring some serious side effects of medications I had been put on, and they were quick to switch me as needed. In the case where I was left without a provider, a VA official helped me get my medication and a new provider. In speaking with other veterans, I found aspects of my experience echoed by every veteran I spoke to, both in regard to the military and within the VA healthcare system.

As I entered graduate school, I considered my options regarding what I should study for my thesis. Since so many other veterans expressed the same experiences and perceptions I had noticed yet few outside of the system seemed to understand it, I knew I wanted to study the veteran's experience and shed light on it from an anthropological point of view-to make the unfamiliar familiar and the familiar unfamiliar. Around the same time, my husband's condition of PTSD rapidly worsened, prompting the need to understand the condition so I could support him as best as I could. His condition was further exacerbated when, in practicing the common symptom of avoidance, the VA decided that he didn't have PTSD because he hadn't been coming in regularly enough. In the subsequent review of his disability rating, one report which didn't even ask him anything about his military service somehow came to the conclusion that it was "clearly not military-related," and attempted to reduce him to 0%. His condition quickly deteriorated after this, making him largely home bound and prone to frequent debilitating episodes. Through my own intervention and the support of friends who were willing to write character reports on him, we were able to prevent his disability from being taken away by the VA disability rating system. I had feared what he might have done to himself

had they succeeded in reducing him to 0%. His experience as well as my own prompted me to want to become a subject-matter expert on at least one aspect of PTSD so that I might better support him in the future and educate others on the condition.

Since there were far more studies on male veterans and studies which combined male and female veterans, I had been advised by several professors that I should focus on female veterans in particular. Because my experiences as a female service member and veteran seemed to be echoed by every female veteran I spoke to, to various degrees, I felt approaching the condition from an exploratory, cultural anthropological point of view and applying concepts familiar in anthropology-such as labelling, the "sick role," and medicalization-would be fruitful. Obtaining personal testimony from the female veteran interviewees would provide a voice for them and humanize them rather than leave them as impersonal statistics.

My own insight into the condition and having been in the military myself was particularly useful because it put me in the advantageous position to be able to translate the military lingo the interviewees used as well as provided them with a sense of security they might not have found with someone unfamiliar with the military or their condition. Even so, finding female veterans willing to talk about their condition and the traumas that caused it proved very difficult. Further, my assurances as a sister-in-arms and their trust in our bond of camaraderie enabled me to elicit stories that might not have been told otherwise. I have made an effort to not let my personal experiences color my findings, only utilizing their accounts, descriptions, and comparatively analyzing findings. My own story and relation to the data is meant to highlight my passion for the subject and curiosity regarding the condition. Like all the interviewees I spoke to, despite the

negative experiences I'd had while in the military and the recurring problems present today as a result of my service, I feel that armed with the knowledge I have now, I would do it all over again (albeit with a few different choices). This aspect as well as the various other aspects of having been enculturated into military culture and thrust into the diasporic community of veterans made me want to understand how military culture influenced the way we made decisions, especially when it came to seeking care for the commonly veteran-associated condition of PTSD.

CHAPTER 2: TOPIC REVIEW

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder, or PTSD, is a mental health condition brought about by increased symptoms and maladaptation to daily life after a traumatic event. PTSD is marked by episodes triggered by events or sensory input which usually, but not exclusively, reminds the PTSD sufferer of the traumatic event.

The DSM-5 and PTSD

The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) is the handbook utilized by mental health providers as a source of consistent and reliable descriptions and details regarding mental disorders. Created by the American Psychological Association (APA) and revised after exhaustive evaluation of research and conferences, the latest version of the DSM-5 was updated in 2013. The purpose of this manual was to facilitate a common language for clinicians to communicate about their patients through consistent descriptions, symptoms, and other criteria. As the authority on mental disorders, the section on PTSD from the DSM-5 has been provided in the Appendix and will be referenced frequently throughout the course of the study with the applicable Criterion.

PTSD Introduction

PTSD has existed as long as there has been trauma, as evidenced in classical works and ancient text, but it has only been since the American Civil War and the Franco-Prussian War that medicine has formally attempted to address the condition, then known as being “shell-shocked,” (Crocq & Crocq, 2000, pp. 47-49). Only when a large proportion of Vietnam veterans were suffering from PTSD and the inclusion of the

condition in the DSM-III did it finally become a common household name more accepted as a mental illness (Crocq & Crocq, 2000, p. 53).

The prevalence of PTSD varies by culture, individual, and circumstances. According to the DSM-5:

> In the United States, projected lifetime risk for PTSD using DSM-IV criteria at age 75 years is 8.7%. Twelve-month prevalence among U.S. adults is about 3.5%...Rates of PTSD are higher among veterans and others whose vocation increases the risk of traumatic exposure (e.g., police, firefighters, emergency medical personnel. Highest rates (ranging from one-third to more than one-half of those exposed) are found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide. (American Psychological Association [APA], 2013, p. 276)

It's also important to note that not all PTSD comes from having personally experienced a traumatic event. Trauma can be secondary-as in witnessing or even hearing about a traumatic event can cause "secondary PTSD." According to the APA:

> Witnessed events include, but are not limited to, observing threatened or serious injury, unnatural death, physical or sexual abuse of another person due to violent assault, domestic violence, accident, war or disaster, or a medical catastrophe in one's child (e.g., a life-threatening hemorrhage). Indirect exposure through learning about an event is limited to experiences affecting close relatives or friends and experiences that are violent or accidental (e.g., death due to natural causes does not qualify). (APA, 2013, p. 274).

High prevalence of PTSD in emergency dispatchers is largely a result of indirect exposure to trauma, and even close family members of PTSD sufferers can suffer secondary PTSD.

PTSD Overview

In order to understand what distinguishes PTSD as a mental health condition, one must consider the severity of the impact, duration of symptoms, and how much it obstructs daily life. Arguably, every living person has experienced bad events or trauma at some point in their lives, but not everyone develops PTSD. Sometimes, abnormal behavior after a traumatic event could be classified as acute stress disorder rather than PTSD. "Acute stress disorder is distinguished from PTSD because the symptom pattern in acute stress disorder is restricted to a duration of 3 days to 1 month following exposure to the traumatic event," (APA, 2013, p. 279). However, if it lasts longer than that or appears after that time period *and* meets at least one aspect from each of the Criterion categories A-H and at least two aspects listed in Criterion D and E in the DSM-5, it may be PTSD.

According to the interviewees, trauma is a bad experience which one has difficulty recovering from and which has a lasting effect on the individual. Whether one realizes the event is traumatic in the moment depends on the individual and the circumstances. Some events will be immediately recognizably traumatic. Others can be determined to have been traumatic after realization and introspection.

It is natural to behave differently after a trauma, but if the traumatic response lasts longer than a month or so or if it becomes debilitating to daily life, then it may be an indication that it is a chronic condition rather than a temporary one, seen as Criterion F in

the DSM-5 (APA, 2013, p. 272). Because of this, many healthcare facilities wait at least a month or look for particularly strong symptoms before treating a condition as PTSD. For instance, the National Institute of Mental Health states:

> While most but not all traumatized people experience short term symptoms, the majority do not develop ongoing (chronic) PTSD. Not everyone with PTSD has been through a dangerous event…Symptoms usually begin early, within 3 months of the traumatic incident, but sometimes they begin years afterward. Symptoms must last more than a month and be severe enough to interfere with relationships or work to be considered PTSD. (National Institute of Mental Health [NIMH], 2019, p. 2)

The variability in the time of onset, anywhere from immediately after the event (as long as it lasts a month) to delayed expression of 6+ years after the traumatic incident (APA, 2013, p. 276) can make identifying and treating the condition particularly challenging.

Brain Changes with PTSD

The brain has been shown to change both chemically and physically for those who suffer from mental illness. For PTSD, it is useful to consider the brain as a group of muscles which are being "buffed up" by overstimulation while others "atrophy," or tend to not get used as much. A PTSD sufferer generally has a more hyperactive amygdala (responsible for the fight or flight response), underactive hippocampus (in charge of memory), underactive prefrontal cortex (in charge of complex thinking and behavior), and an overactive hypothalamus-pituitary adrenal axis (which releases hormones in response to stressors); these changes in brain structure are sometimes chemical and

sometimes actual physical growth or shrinking (Bremner, 2006, pp. 446-447). This is because the brain adjusts to a traumatic event by increasing activity between neurons and strengthening connections in some parts of the brain while decreasing activity in other parts of the brain.

Also, trauma has different effects on brain growth and chemical production depending on when the individual experiences it. “Trauma at different stages in life will presumably have different effects on brain development [and] the few studies that have looked at this issue do suggest that there are differences in the effects of trauma on neurobiology, depending on the stage of development at which the trauma occurs,” (Bremner, 2006, p. 446). Since most service members are in during their late teens and early twenties (Ulmer et al., 2000, p. 8), their brains are not fully developed when they are exposed to the traumas of military service or when they get traumatic brain injuries (TBI). Another aspect which is important for the long-term results of care for PTSD sufferers is the time between the traumatic event and treatment. Early intervention “soon after the trauma is critical for long-term outcomes, since with time traumatic memories become indelible and resistant to treatment,” (Bremner, 2006, p. 453). Although the PTSD sufferer may never be completely the same as they were before, with medication and therapy, the chemical imbalance can be corrected and these parts can return to a more average size as seen in their peers without the condition, meaning daily functionality can return to comparatively more normal levels.

Anthropology and Veteran PTSD

The value of approaching the experience of veteran PTSD from an anthropological point of view is outlined in how the discipline utilizes a holistic

perspective-particularly in how the cultural environment shapes the experience(s) which are considered to be traumatic. “The cultural environment in which a post-traumatic response emerges is taken here to include historical and political economic context; local social structures and patterns of kin and other relationships; the physical environment; and local worldviews and norms, particularly as they pertain to ethnotheories of trauma and expectations for a good life,” (Finley, 2012, p. 267). In her study of the neuroanthropology of PTSD, Erin Finley interviewed OEF/OIF male combat veterans in and around San Antonio, Texas, in 2007-2008 and developed a neuroanthropological model of PTSD listing 6 key factors related to PTSD:

Cultural environment-refers to the historical and political economic context, local social structures/relations, physical environment, and local worldviews and traditions.

Stress-is the physiological, cognitive, and behaviors in response to traumatic stress.

Horror-is a sense of challenge to one's views of self and the world.

Dislocation-is the disruption of neurobiology, identity, sociality, or expected life trajectory.

Grief-is the mourning of interpersonal losses and changes in self, status, and social relations.

Cultural mediators-are what a culture considers to be an "acceptable" form of intervention or mediation between the other aspects. In the U.S., this would be a therapist, doctor, support group, family members, treatment options, etc.

Successfully reducing the symptoms of PTSD is often achieved when cultural

> mediators can interrupt the negative cycle of increasing frustration and despair at every factor. (Finley, 2012, pp. 266-282)

She found that the way "experiences of trauma and PTSD evolve over time provides an invitation to follow and observe that evolution, and to identify psychological, physiological, social, and cultural features that may mean the difference between chronic suffering, some form of resolution and healing, and even post-traumatic growth," (Finley, 2012, p. 283). Finley's neuroanthropological model of post-traumatic response is an integration of the perspectives presented in anthropology, psychology, psychiatry, neuroscience, and epidemiology, since in her estimation, each discipline was describing only one aspect of the condition (Finley, 2012, pp. 265-266). However, Finley felt that this work could be built upon, since "It goes almost without saying that gender is a central variable in shaping an individual's experience of the cultural environment, so the focus here on male veterans should be acknowledged as incomplete in describing the full range of combat trauma responses among this generation of veterans," (Finley, 2012, p. 267). This is another reason this thesis focuses on the female veteran perspective, particularly in the utilization of an anthropological point of view.

Military Culture

> The professional ethos of the U.S. military has traditionally centered on the imperative of combat. From the rigorous demands of the battlefield spring traditional U.S. military values such as a willingness to engage an armed opponent and sacrifice self, if necessary, to accomplish the mission; physical and moral courage; and discipline. From the U.S. Constitution and U.S. laws come the values of obedience to lawful authority; a respect for civilian control of the

> military; loyalty to and respect for comrades, unit, and nation; and service and advancement based on merit. (Ulmer et al., 2000, p. 8)

As a microcosm of American culture, the U.S. Military has its own culture as a way of reducing the differences found amongst its service members and increase cooperative capability. The U.S. Military is comprised of individuals from all across the United States as well as from other countries-since this is one way to become a U.S. Citizen-and provides a unified set of principles, language, dress, and rules which enable it to operate efficiently. Like all cultures, military culture has evolved and adapted over time, but has done so at a much different rate and is distinct from American culture.

Military culture is reproduced through the process of Basic Training, where citizens are stripped of their individuality and molded into a collective, cohesive unit and maintained by the rank structure and the Uniform Code of Military Justice (UCMJ) (Franke, 2000, pp. 177-178). Although aspects of one's natal cultures remain, the military may overlay or replace previous cultural beliefs, since not only does enculturation often take place before the brain has finished developing by the age of 25, but "immersion in military culture can be such an indelible experience that veterans will identify with it more than any other cultural influence even decades after leaving active duty service…[and] can occur after only short times of service and can take precedence over other common identities such as race, gender, sexual orientation, political party, or socioeconomic status," (Meyer et al., 2016, p. 26). Even within military culture, there are many sub-cultures, the first major subdivisions found based on branch. Each branch has its own differing language and some differing values, but overall, shares a unified core, much like that of the states' individual cultures within the overall American culture.

Further subdivisions occur based on where one is stationed, the history and functioning of one's unit, and further as one progresses through each subdivision of unit from branch to team-level.

Principles

The individual is expected to uphold the core principles taught to them during the enculturation process as reflected in the oaths taken throughout military service as well as the creeds and songs taught to them in training and in their unit. These principles can be divided into several major subsections: camaraderie, discipline, duty, and honor. Each of these principles is interconnected, the behaviors and values found within related to or dependent upon one another, each with their own set of subdivisions of behaviors and principles as well.

A major cornerstone of military principles is that of camaraderie, or the cohesiveness, acceptance, and willingness to support one another simply because they are all in the U.S. military. "Military culture includes a fraternal comradeship in arms, passed on from generation to generation, and has much to do with an array of symbolic unifying identifications associated with the wearing of military uniforms in highly regarded public service," (Krueger, 2000, p. 252). Camaraderie as found in the military runs deep and creates a sense of familiarity even among strangers. A way the modern military enculturates this ideal is in the terminology used, for instance, calling one's peers of similar rank their "Battle Buddies," or their "brothers- and sisters-in-arms." By referring to them as a sibling, this is a form of fictive kin, a term used in anthropology to indicate kinship ties not based on consanguineal or affinal ties, and creates a sense of familial ties through shared cultural values and similar experiences. Within camaraderie is selfless

service, or the capability to sacrifice themselves for the sake of their fellow service members. The actions of service members who sacrifice themselves for the sake of their fellow service members are the ones most praised and awarded with medals, raised to heroic status by their peers, higher-ranking officers, and the institution itself, even posthumously. However, there is so much more to this principle than sacrificing one's life for the good of the many. To the service member, it also means giving more of themselves in order to contribute to the unit and the mission. For some, this involves overdoing physical labor to the point of injury. For others, it is volunteering as often as they are capable and then some. In all cases, military culture heaps praise upon those who fully give of themselves for the sake of the unit and their country. Overall, camaraderie is the expectation of implicit trust, knowing that anyone present would be able to "jump on a grenade," both literally and figuratively, sacrificing oneself for the sake of many, and a bond strengthened by shared experience.

Another major cornerstone of military principles is that of discipline, or the capability to control one's own actions, gear, and maintain composure at all times (Redmond et al., 2015, p. 13). This composure, or military stoicism, is one feature which distinguishes military bearing from other ways of presenting oneself and can be seen in veterans long after military service has ended. In a military environment, orderliness, punctuality, and capability to follow orders are crucial, especially in a warzone. Within the aspect of discipline, there can also be found uniformity, or the erasure of the individual for the sake of conformity and sameness. Military dress codes are notoriously strict both in specificity and enforcement.

There is great symbolism given to wearing uniform clothing that distinguishes

> members of a military group from society at large and from other military groups. Rank insignia displayed on their uniforms connotes the job position and status of military personnel. The styles and types of uniform, coats of arms, body armor, distinctive headgear, unit identity sleeve patches, colorful award ribbons, and campaign medals pinned on the chest of military dress uniforms serve as signs of their wearer's degree of commitment and success in participating in military culture. (Krueger, 2000, p. 254)

Uniformity is also the way one carries themselves and regards themselves in relation to others. Uniformity displays a certain level of professionality, can be an indication of or practice for individual discipline, displays respect for one's superiors as well as the uniform, and probably most importantly in wartime, obscures rank and position-if everyone looks and acts the same, it is more difficult for the enemy to single out any individual, especially those whose loss would be detrimental to the unit. Uniformity is also interconnected with camaraderie since it is both part of the shared experience as well as reflective of the communitarian ideal. Discipline is thus displayed through stoicism and uniformity.

Another major cornerstone of military cultural principles is that of duty, or one's individual responsibilities and capabilities. A large part of duty is the occupational responsibilities inherent to one's specific job. In the Army, Navy, and Marines, this is referred to as one's MOS and in the Air Force, it is known as an Air Force Specialty Code, or AFSC. Although it can be known by different names depending on the branch, the use of MOS is broadly understood throughout the branches and as such, will be referenced this way. Service members must both be proficient in their base

responsibilities as well as their advanced responsibilities. On top of that, they are also responsible for whatever gear they have been issued, which can be worth thousands of dollars depending on their MOS. If it is lost or destroyed, it is their responsibility to come forward and replace it or perform duties equal to the value of what was lost. By displaying capability in their duties and responsibilities, service members may also attain higher rank, which warrants higher pay and even more responsibilities for personnel, equipment, resources, and missions with each rank attained (Redmond et al., 2015, p. 13). Another part of duty is self-sufficiency, or the capability of the individual both physically and mentally. Part of what distinguishes the U.S. Military from other countries' militaries is the encouragement of self-sufficiency, with the expectation that they can make a snap decision to act on behalf of their fellow service members as well as their country and be capable of enacting said decisions. Service members can beef up their individual capability by improving their physical fitness and volunteering for training exercises, certifications, classes, and competitions. Training and certifications are often considered to be a reward for exemplary performance. By properly performing the responsibilities given to them and maintaining their own capabilities for self-sufficiency, service members display the cornerstone principle of duty.

The final major cornerstone of military cultural principles is that of honor, or performing one's duties above and beyond what is expected of them, recognizing the outstanding contributions of other service members, acting in a manner which befits a U.S. service member, and properly respecting the uniform and the chain of command. This aspect of U.S. military culture comes from "the Continental Army's adaptation of the eighteenth-century British military officer corps code" which was largely "based on

the code of chivalry of feudal times," (Krueger, 2000, p. 255). Within this aspect also lies integrity, or absolute honesty and upholding the moral ideal. The military places so much emphasis on integrity that even lying to an Officer or NCO can mean full punishment under Article 91 of the UCMJ, which can range from 14 days of restrictions and extra duty to loss of rank and pay as well as restrictions and extra duty on top of it (Joint Service Committee on Military Justice [JSC], 2019, p. IV-25). When a mistake is made, it is expected that the one responsible would display integrity and come forward. Even if others know someone is responsible, the aspect of camaraderie dictates that they will not out the one responsible just as it is the onus of the one responsible to come forward. This ensures rewards and punishments are dealt out more fairly and that others do not suffer for the actions of the individual, which ties into the camaraderie aspect of sacrificing oneself for the good of the many. Another aspect of honor is respect: for the rank system, for one's superiors, and for one's fellow service members. This aspect is most commonly observed in interactions between ranks, specifically with officers. "The relationship in the workplace is to be built upon a mutual respect for the role the officer is to play. One day, the officer may be required to direct troops in combat, order them to kill the enemy, and in the process put themselves and others at risk of life and limb," (Krueger, 2000, p. 254). Lower-ranking service members are expected to salute or stand a certain way depending on the rank and type of officer addressing them-rigidly for a commissioned officer, or at "parade rest" for an NCO. By properly enacting these behaviors, a lower-ranking service member is showing respect for the ranks above them. Whether they respect the individual or not, they must display respect for the rank. Respect also extends to honoring the flag. When passing the flag outdoors, the service member is expected to salute the flag as they

would a higher-ranking officer. Service members also display respect out in the civilian world, using honorifics such as “Sir” or “Ma’am” when addressing others and sometimes even displaying the same stances as they would with higher-ranking individuals. By maintaining a certain decorum both in public and in private, the service member properly displays the principle of honor.

The unifying factor of the overall mission-protection of one’s home nation, its unifying principles, and the people within-provides an anchor to which the U.S. military can cling to as it weathers the storms of current events. By exploring the principles within U.S. military culture-camaraderie, discipline, duty, and honor-one can gain a greater perspective on the culture found within the military and the way it shapes individual identity and worldview.

Language

> The language used within a given community serves both to construct a vision of the world into which initiates are socialized and to draw a line between those in the group and those on the outside. In official language, this occurs through the use of technical terms—acronyms and jargon. In informal language, it is accomplished by knowledge of terms whose meanings are not available except through direct participation in the group—meanings that appear in no formal glossary. (Chambers & Anderson, 1999, p. 381)

Military jargon has been passed down and modified through generations of service members, sometimes taking on new meanings or adding new phrases to the lineup. Despite the fact that military jargon is usually spoken in English, to an outsider,

the proliferation of acronyms, malaphors, metonymies, amalgamations, portmanteau words, and various other linguistic forms can sound like a complete other language.

Nearly everything in the military has an acronym, from one's rank to the names of buildings at the military base or camp to even the larger unit structure. Using acronyms has several purposes in the military context: to delineate those service members whose duty is related to the acronym used, to obfuscate the subject so that outsiders or enemies will not readily understand what is being discussed, and to act as a common language between branches. For example, someone with an Enlisted-4 rank would be known as an E-4 across all military branches and as such, is the "common tongue" between the branches. Within the specific branch, the term E-4 is known by and is interchangeable with several other designations. For instance, in the Army, an E-4 is known as a Specialist or a Corporal, the latter distinguished as an NCO position. In the Navy, an E-4 is a Petty Officer Third Class. In the Air Force, an E-4 is a Senior Airman. In the Marines, an E-4 is a Corporal. On most Posts, another term for a military base, there is a retail store commonly known as the PX, which is short for Postal Exchange, a leftover term from the early 1900s when trading posts were more common. However, sometimes abbreviations take on additional meanings which imply familiarity and denote informal understanding as well.

> Abbreviations and acronyms are very frequent in official military documents and are routinely used in the U.S. military (thousands of them are listed in the DoD Dictionary). Therefore, military personnel tend to playfully resemanticize some of the abbreviations normally used in a formal, official context. Implicit criticism of military institutions is often part of this resemanticization process: NATO, for

example, stands for “No action talk only,” or “Nothing after two o’clock.” (Saber, 2018, p. 5)

The use of acronyms is both useful for brevity as well as a method of encryption, making it more difficult for those outside of the military to identify specific structures, leadership roles, or weak points by simply listening to service members converse. It is not uncommon for service members themselves to be unaware of what the acronyms stand for, since some of the acronyms (such as the PX) are rooted in historical sources and as such, the modern service member is not likely to encounter the full phrase or have it explained to them outside of personal research into the subject.

Military jargon is well-known for being near-incomprehensible to those unfamiliar with the culture. Commonly, the language is peppered with metaphors, such as “cannibalizing” to mean breaking down one object or taking spare parts from one object to repair another, or referencing something by a specific trait, such as a jet fighter being called a “fast mover,” (Saber, 2018, p. 6). Frequently, metaphors are used as a humorous way to associate two unrelated things.

> Humor appears to be the driving principle of metaphors belonging to U.S. military jargon, as in “fruit salad” (the medals and ribbons on a dress uniform), “scrambled eggs” (the golden embellishments found on some officers’ caps), “hangar queen” (an aircraft that never leaves its hangar, due to constant maintenance problems), “Power Point Rangers” (officers who mainly participate in meetings at the headquarters instead of serving on the field), or “Ali Baba” (a term that started to be used during the First Gulf War to designate enemy forces). (Saber, 2018, p. 6)

Malaphors, or the improper mix of two different common metaphors, are also very common. For instance, “This isn’t rocket surgery!” as a mix of “This isn’t brain surgery,” and “This isn’t rocket science!” is a common phrase used when a usually simple task is taking too long.

They also use a proliferation of metonymies, or words or phrases which represent a longer phrase or concept, such as in reference to deployment, saying, “I’m going to the sandbox,” using “sandbox” as reference to being deployed to the desert locations of Iraq or Afghanistan (Saber, 2018, p. 5). When they are in trouble or when they are about to do PT, they may also be told to “Get in the front lean and rest position,” which is the nomenclature used for the proper starting position for push-ups in the training manual. Therefore, when an NCO barks, “Get in the front lean and rest,” the service members know they need to get in the starting position for doing push-ups. They also refer to any sort of bathroom or restroom as a “latrine” and call snacks (which are expressly forbidden in the field) “pogey bait.” A “pogey” in the military is someone who is often in a support MOS who stays on post or camp which tends to be less physically fit. “Pogey” was originally derived from the abbreviation P.O.G., which is short for “People other than Grunts” but is now used as a derogatory name (Saber, 2018, p. 8). “Pogey bait” is therefore both an implication of less physical fitness as well as the propensity for these individuals, especially someone from a support MOS, to be bribed with snacks in order to get favors or better service.

Another common aspect of military language is amalgamation, or the combining of words, and portmanteau words, or words which are a combination of the meanings of two other words. For instance, “already in use in the Vietnam war, ‘medevac’ is both a

noun and a verb referring to medical evacuations by helicopter. ‘Voluntold’ is ‘an assignment that is technically voluntary but understood to be mandatory,’ ‘mandofun’ stands for ‘mandatory office dinner parties or get-togethers,’” (Saber, 2018, p. 8). “Mandofun” is also commonly referred to as “mandatory fun,” such as unit hiking trips for the purpose of building morale.

The proliferation of culturally-specific language as found in the military is largely uniform no matter where one is stationed, though there may be some region-specific language used for a short period of time. Language changes within military culture are based on additions from current events or particularly catchy and widespread use. Even though there are “dialects” as found within each individual branch, there is also a “common tongue” that enables communication and collaboration between them.

Daily Life in the Military

Overall, the military experience is one very different from their civilian counterparts. The daily experience of military service varies depending on one’s MOS, branch, duty station, unit, and deployment status, but can be generally summarized of one of complete immersion and constant participation.

When service members are living and working at their unit’s duty station and not out on deployment, they are considered to be in garrison. Active-duty service members are always either in garrison or on deployment, and National Guard or Reserves units are only in garrison during their training one weekend a month or when they are activated. Since a military base is essentially a self-contained community comprised of service members of one or several branches, civilian contractors, government workers, and military families and the facilities necessary to take care of this population, military

culture is reinforced through general isolation and constant contact with other members of the same culture (Redmond et al., 2015, p. 13).

Unlike their civilian counterparts, active-duty or activated Reserve or National Guard service members are considered to be on duty 24 hours a day, 7 days a week, are not guaranteed vacation time, must get permission to travel more than a set distance from base, and can be deployed on short notice (Redmond et al., 2015, p. 14). Typically, the daily schedule while in garrison consists of getting up before dawn, morning formation, PT, breakfast, participating in unit or MOS-specific duties, lunch, more duties, dinner, more duties, evening formation, then getting released to their quarters for personal time unless otherwise specified. Generally, duties involve cleaning common areas, community areas, landscaping, maintenance of equipment, blocking roads, and performance of one's MOS-specific job as applicable. Those who have pulled fire guard duty, charge of quarters (CQ) duty, or other duties start their duty as indicated and are only released once they are relieved by their replacements. Typically, these duties involve guarding a location or items in teams without rest until relieved, which may last anywhere from a few minutes to 24 hours later or more. They may also go on special training exercises, which can last from days to weeks, and do things such as camp out in a nearby field or forest while practicing for deployment. Certification and training, such as the PT test to determine physical capability, going to the range to maintain marksmanship, and practicing with equipment is another intermittent feature of military life. Also, service members may be sent to special individual training for certification on courses, equipment, or techniques either individually or with a group. Often, any travel takes place

after much organization and waiting, hence the common phrase, “Hurry up and wait!” Some aspects of this garrison experience can vary depending on the branch and unit.

On deployment, the garrison aspects are present but altered and depend mostly on the mission and location. PT, meals, and extra duties take place, but service members will be primarily performing MOS-specific duties, often in alternating teams to ensure 24-hour missions. Getting mortared or attacked may prompt an impromptu formation to make sure everyone is alive and accounted for if they are on the Forward Operating Base (FOB), which includes those who are off-duty. Escort missions outside the FOB can include anyone, even those without a combat-oriented MOS. Eating and showers must be quick, both because the facilities are limited compared to the population needing to use them and to save resources. Especially in the OEF/OIF conflicts, service members will turn on the shower just long enough to get wet, turn it off, soap up, and then rinse the suds off, thus limiting water usage, especially in places with only temporary facilities. Port-o-potties are also common in training exercises as well as on deployment.

A general understanding of daily living in the military provides contextual comprehension for the formulation and reasoning behind the functions of military culture. Further, understanding of daily life in the service can enable further appreciation for the behaviors, values, and prohibitions found in military culture and how they can later inform veteran culture. Thus, the highly regimented and strictly enforced schedules of service members provides context for several aspects of military culture, such as uniformity, situational acceptance, and pushing through pain or discomfort for the sake of the mission (Redmond et al., 2015, p. 14).

The Importance of Military Culture in Healthcare

The ideal in the military is to be fit for duty, but the nature of life, especially harsh military life, means that this is not always the case. There are institutions set up within the military to treat service members for any condition that might occur. However, some individuals take advantage of the military healthcare system's capability to exempt them from working, known in military culture as malingering, or feigning injury or illness in order to avoid PT or their duties. According to the DSM-5, "malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs," (APA, 2013, p. 726).

Because it is both harmful to unit fitness and has been known to occur, there is a tendency within military culture to treat every illness or injury as potential malingering, even though it is in actuality very rare. Authorities had estimated the prevalence of malingering to be 5% among military members, but from 2006 to 2011, only 1,030 out of 28 million health care visits by service members during the OEF/OIF conflicts were actual reported cases of malingering, less than 1% even during a time of war (Lande & Williams, 2013, pp. 50-53). However, the stigma surrounding the label of "malingerer" is strong. In order to avoid obtaining this label, many service members avoid getting even legitimate illnesses or injuries treated. Military culture reproduces this sentiment through informal interactions and dialogue, such as filtering access to the local outpatient clinic through approval by NCOs or officers (Jennings et al., 2005, p. 1002) and by using stigmatized names in reference to those who go regularly to the local clinic, such as

"Sick-Call Rangers" or "Frequent Fliers," as a way of implying they are malingering rather than seeking treatment for legitimate healthcare needs. This effect is even more pronounced when it comes to seeking mental health care, where stigmatization or perceived stigmatization by peers and leadership tended to be the most commonly cited reason as to why soldiers and marines who screened positive for a mental disorder did not seek mental health care (Hoge et al., 2004, pp. 20-21). Even though the military encourages seeking help if they need it, many service members will not seek psychiatric care out of fear of stigmatization, losing their duty fitness, their MOS, or their Clearance.

Instead, service members are encouraged to "shake it off," "suck it up," or "drink water; rub some dirt on it," minimizing the severity of physical illness or injury (Jennings et al., 2005, p. 1002). Frequently, treatment of military personnel involves a physical profile, or a form provided by a military physician which outlines physical restrictions for a specific period of time, and pain medication. For instance, 800 mg tablets of ibuprofen are so common and heavily relied upon that they are often referred to as "Ranger Candy," "Vitamin M," or "Sweet Tarts," (Jennings et al., 2005, p. 1001). Service members also avoid going to the doctor out of fear of being declared unfit for duty, particularly if they have an intensive or sought-after MOS. If one is not fit for duty for too long, they may be forcibly reclassed to the needs of the military, which may result in becoming "benched" in administrative duties, which is particularly frustrating for those in a physically-demanding MOS, such as Rangers or Pilots (Jennings et al., 2005, p. 1003).

What this creates is a culture of injury/illness denial and minimization. Out of fear of losing fitness for duty or being labeled as a malingerer, many service members refuse to seek treatment while they are in the service. This is exemplified by the sheer number

of veterans with extended health needs as compared to their civilian counterparts (Eibner et al., 2016, pp. 159-161). This is problematic for a number of reasons: namely that these usually young adults are becoming permanently disabled early in their lives and more importantly for living with said permanent disability after serving, obtaining a disability rating from the U.S. Department of Veterans Administration (VA) requires a service-connection, or a determination by a VA representative that the condition is a result of military service for each ailment being claimed. Service members can claim that which was not self-inflicted and which they sought treatment for while in the military or that which is reasonably attributable to military service but may not show up in their medical records (Wherry, 2018, p. 491). In order to have a stronger claim, repeated treatment for the condition helps prove a chronic condition and therefore, a permanent disability. As they exit the service, the service member is expected to take their physical medical records straight to a local VA to be input into the system so that they can claim conditions treated while in the military. Sometimes, the medical records get destroyed or lost in the bureaucratic stacks, meaning the service member would have a much harder time getting service-connected for any medical condition stemming from service (Wherry, 2018, p. 480). When it comes to doling out disability pay and treatment, by not understanding the military cultural denial and minimization of health concerns, the civilian VA inadvertently capitalizes on the refusal of service members to get treated for often very serious medical conditions while they are in the service.

Another important aspect of this is the inability of the service member to communicate their needs properly to the civilian doctors: largely as a result of cultural and linguistic differences as well as the association of the physician with the authoritative

nature of military physicians. As both physician and officer, military physicians take on a dual role-that of military authority as well as healthcare provider. As such, there may be a perception that patient-doctor confidentiality in a military medical setting may be compromised, especially if the military physician determines that the patient is a danger to themselves, the unit, or the mission. Military doctors are usually higher-ranking Officers outside of the command structure whose job is to maintain readiness of the unit through healthcare services. A military physician's healthcare orders are presented as a form called a physical profile, or profile, for short, which acts as a recommendation of limitations for the service member based on their injury or illness. Their command may or may not follow these recommendations, and they are not required to even consider them unless the service member can produce the appropriate form when asked. Similarly, medication prescribed by a military physician must be treated like a valuable item and kept in a secure location. Since there is no arguing or lying to an Officer or NCO as indicated in Article 91 of the UCMJ (JSC, 2019, p. IV-25), service members exit the military unprepared to take command of their health with civilian doctors, instead tending to treat them as an unquestionable authority figure.

The stigmatization of medical care within the military, particularly mental health care, has been well-documented, such as in Acosta et al.'s (2014) exploratory regression analysis of cultural barriers to care, perceptions and, in particular, stigma regarding seeking medical care among military service members. Since service members with mental health disorders or a possible need for services related to mental health report a higher rate of perceived stigma regarding seeking care, the military has been making efforts to de-stigmatize healthcare, an effort which appears to be bearing fruit (Acosta et

al., 2014, p. 17). Although this study could not find a direct link between stigma and care barriers, they did find "that stigma may *indirectly* affect treatment-seeking, affecting coping styles, attitudes and intentions toward help-seeking, and interpersonal outcomes, such as self-esteem," (Acosta et al., 2014, p. xvii, emphasis in original).

They also discuss the way military policy plays a role in seeking care. For instance, the UCMJ only outlines psychotherapist/patient privilege for those who are undergoing a courts-martial, meaning those outside of UCMJ proceedings may find themselves without military policy protected patient confidentiality (Acosta et al., 2014, pp. 83-87). Even so, it must be understood that the service member has limited rights while they are in the service and as such, the military psychotherapist is given eight exceptions to patient confidentiality rules. The military psychotherapist has a duty to break patient confidentiality "when necessary to ensure the safety and security of military personnel, military dependents, military property, classified information, or the accomplishment of a military mission," (JSC, 2018, p. III-37). Within Acosta et al.'s study, three key areas were identified that needed changing in order to reduce stigmatization of medical care: revision of policy terminology which reinforce mental health stereotypes, use of nonprofessionals to determine "military fitness" which can put some service members at risk for stigmatization, and more careful implementation of health screening and evaluation programs (Acosta et al., 2014, p. xix).

Overall, the minimization of health needs while in the service, the hesitance in seeking treatment while in the service, and the inability to move past the authoritative nature of military physicians means treating service members is difficult and only outlines the need for military cultural comprehension among healthcare providers.

Veteran Cohorts and Veteran Culture

After exiting the military, the influence of military culture is still present within veteran culture. While there are different subcultures of military culture based on branch, unit, duty stations, MOS, etc., the subdivisions as found in veteran culture tend to be more identified by the time one served and the conflicts which took place at that time. Each cohort is defined by current events, the way they are regarded by civilians, the nature of their conflict, and technological innovations while they were in the service.

The Gulf War-Era I/Desert Storm Cohort

As the cohort preceding the current generation of veterans, Desert Shield/Desert Storm veterans were the first to serve in Iraq, which at the time had over a million soldiers, making it the fourth-largest military in the world (Association of the United States Army [AUSA], 1991, p. 1). 3.1 million American veterans served during the Gulf War-era I conflict from August 1990 to August 2001 and had a similar percentage of female service members as found in the Gulf War-era II population (U.S. Bureau of Labor Statistics, 2019, p. 2). The purpose of this conflict was to stop the Iraqi invasion of Kuwait via the formation of an unprecedented coalition of various North Atlantic Treaty Organization (NATO) allies. It was during this time that new innovations such as teleconferences enabled state officials to instantly share information, give orders, and communicate with others across the globe. This conflict also saw the largest air campaign since the Vietnam War. As a result of this conflict, Iraqi troops were expelled from Kuwait and Saddam Hussein's aggression towards Iraq's neighbors was checked.

With different technological capabilities, especially before the advent of the internet and the mass instantaneous communication it enables, the Gulf War-era I cohort

had different technological capabilities and gear. For instance, the service records of many Gulf War-era I veterans were still hand-written since it was just before and during the transition to digital records, meaning if their medical records were lost, this cohort of veterans would have more difficulty or may not be able to get a service-connection for medical issues obtained during military service (Wherry, 2018, p. 480). As it is still done today, they also tended to use the hand-me-down gear and weapons of the previous cohorts of veterans, especially those not in a combat-oriented MOS. As a result of being closer in time to the Vietnam era, many of these hand-me-downs were likely to have come from that era, such as the heavy, wood-stocked M-14 rifle. Because this cohort felt supported by the American people and had strengthened morale, they are marked by increased confidence and an upswing in regard to perception of the military as opposed to the veteran cohorts between them and World War II (AUSA, 1991, p. 26).

Since the Gulf War-era II conflict is largely related to unresolved issues from the Gulf War-era I conflict and the methodologies employed during the First Gulf War were the outline for the processes employed in the Second Gulf War, there are many similarities in behaviors, attitudes, and type of conflict between the two. One of the major differences is in the warfare type-the First Gulf War was more similar to conventional warfare and the Second Gulf War is marked by insurgent warfare. Two of the interviewees are primarily Gulf War-era I veterans and one bridges the gap between Gulf War-era I and Gulf War-era II. The remaining three are primarily Gulf War-era II veterans.

The Post-9/11/OEF/OIF Cohort

For the Post-9/11 cohort, also known as the Gulf War-era II cohort due to similarities between them and the cohort before them, the unifying factor found in current events was the attack on the Pentagon, the Twin Towers, and the attempted attack on the White House on September 11, 2001. The attack on U.S. soil roused a sense of patriotism and fear of outsiders that has altered American culture itself, marking it as a watershed event for the United States as a whole. Although the majority of service members often go into the military for the purpose of having steady income, college tuition paid, and a stable life, those who joined for patriotism's sake increased drastically after 9/11 (Simon & Warner, 2007, p. 23). This means that this cohort tends to have a deep sense of respect and responsibility for their actions as a representative of the collective and are more likely to develop close connections to other service members in their units, increasing the cohesiveness of military culture even after separation. As a result of 9/11, attitudes towards the military vaulted them into heroic status in American culture, making it the epitome of service and selfless sacrifice for many Americans (Boon, 2005, p. 303). Arguably, by conferring hero status on veterans and service members after 9/11, American society has identified an "idealized reference group [used] to tell ourselves what it is we stand for," (Porpora, 1996, p. 211). "Perhaps not coincidentally, many of the traits traditionally ascribed to heroic acts (stoicism, physical strength, fearlessness, prowess in combat) have also been traditionally held as masculine ideals," (Farnsworth, 2014, p. 15). Because of this, many members of this cohort demonstrate a need to meet those expectations, often doing more than their body or mind could handle which is a

likely reason why roughly 20% of veterans have been injured in service (Parker et al., 2019, p. 13).

Another aspect which separates Post-9/11 cohort service members from other cohorts is the nature of the Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) conflicts, which are marked by asymmetric warfare against an insurgency on enemy soil. In this case, this means that a much larger force is fighting a much smaller force comprised of individuals united towards a specific goal. Of course, any type of warfare which takes place on the enemy's soil will have terrain familiarity as a major benefit to the enemy force.

The enemy is a small force of insurgents utilizing leftover munitions from the Soviet-Afghan War, which lasted from 1979 to 1989. For comparison, this type of conflict is most similar to the Vietnam War, in which guerillas familiar with the terrain hid various traps and utilized hidden pathways to ambush and surprise U.S. Forces, a factor which contributed to their success. Since the majority of insurgents do not have proper training in munitions or military tactics, they must rely on guerrilla tactics without the benefit of vegetation hiding their movements, instead planting old anti-tank or anti-personnel mines or rigging up other munitions in various objects such as trash, piles of rocks, corpses of animals, etc. These improvised explosive devices (IEDs) are responsible for the majority of injuries and deaths for service members within the current conflicts in Afghanistan and Iraq (Bird & Fairweather, 2007, p. 843). Also, the local nationals are often armed as they go about their daily business, carrying old AK-47s left by the Soviets for the purpose of protecting their herds or families. Since current military doctrine attempts to protect local civilians, soldiers must consider these armed individuals to be

peaceful civilians until they start shooting. This means that during routine missions, the local nationals can go from peaceful civilian to armed insurgency ambush within minutes. All of these factors in the OEF/OIF conflicts have necessitated a culture of constant awareness, where any individual or object can become deadly at any given moment. This is significant because for the Post-9/11 cohort of veterans, anything from trash on the side of the road to piles of rocks or roadkill had the potential to explode.

At 30%, Vietnam veterans are considered to have the highest rate of PTSD amongst U.S. military veterans as a result of the nature of that conflict, the reception back home, and of having been drafted into a generally unpopular conflict at the time (Kulka et al., 1990, p. xxvii). Currently the rates of PTSD amongst OEF/OIF veterans is estimated to be 23%, the second highest prevalence of PTSD found in current veterans behind Vietnam veterans (Fulton et al., 2015, p. 103). Even though the OEF/OIF veterans have had better reception from American culture than the Vietnam veterans faced, they still find the same difficulties reintegrating into society after service, such as a higher unemployment rate as compared to their civilian peers (U.S. Bureau of Labor Statistics, 2019, pp. 2-3). Post-9/11 veterans were also more likely to have been deployed and seen combat than their predecessors, likely due to the nature of the conflict and duration of the war-over a decade. According to the Pew Research Center, roughly 75% of Post-9/11 veterans were deployed at least once compared with 58% of those who served before them and were twice as likely to have served in a combat zone than their predecessors (Parker et al., 2019, p. 3). “Because they are more likely to have been deployed and to have seen combat, Post-9/11 veterans are also more likely to bear the scars of battle,

whether physical or not…36% say that – regardless of whether they have sought help – they think they have suffered from posttraumatic stress," (Parker et al., 2019, p. 3).

Veteran Culture

Veteran culture itself is much like the military in that it changes and adapts slowly as each new cohort of service members enters its ranks. Veteran culture is very similar to military culture in its values, behaviors, and prohibitions, but with a few key differences. For one, the subcultures as found in the military are less distinct in veteran culture and as such, there is more inter-branch and inter-cohort blending. There will still be a tendency to affiliate more with those of the same branch and cohort, but all veterans share an experience that is not found in the military: the U.S. Department of Veterans Affairs (VA). The process of obtaining benefits such as a disability rating, educational benefits, permission to wear the uniform after service, and even burial benefits are conducted through the VA. The VA is also the primary source of medical care for veterans, though access to care is not guaranteed for all veterans-just those who are eligible to receive VA services and who actively apply for them (Ritchie, 2019, p. 14). According to a cumulative analysis of VA healthcare utilization, roughly 62% of Post-9/11 veterans utilize the VA for healthcare (U.S. Department of Veterans Affairs [Dept. of the VA], 2015, p. 5), a number which is comparable to the 63-65% of total VA enrolled veterans who have used VA healthcare each year since 2003 (Bagalman, 2014, p. 2). Out of all eligible veterans, 24% of veterans have a disability rating, the most common rating being a 10% disability rating, and at least 5 service-connected disabilities per veteran receiving compensation (Veterans Benefits Administration [VBA], 2019, pp. 71-77). Both the

shared experience of having served as well as of having to deal with the bureaucratic hurdles of after-service care and benefits are uniting factors among veterans.

Finding themselves separate from other veterans and outside the military-structured life, many veterans seek comfort in the presence of other veterans. Some will spend time at the VA or other veteran organizations in order to connect with other veterans with shared understanding and experiences. Others will form close-knit friendships with other veterans they knew while in the service or new ones who live nearby. Some are related to or married to other veterans and can maintain that familiarity via familial connection. Regardless of the source of continued military cultural contact, its necessity to the veteran is seen in the way veterans seek each other out as well as their comparative success in reintegration (Redmond et al., 2015, p. 17).

Female Veterans

The female veteran experience is very different than that of their male counterparts. Aside from the obvious biological differences, there are also experiential differences which make the female service member's experience distinct from that of their male peers. Even though female veterans have the same access to veterans' organizations and the VA hospital, female veterans tend to remain separate from all other veterans, instead focusing on their educational, familial, and vocational work. By examining some of the features which make the female veteran's experience different, a greater picture of the limiting factors and reasoning behind the decision-making process may enable more effective treatment approaches specific to female veterans.

While it is true that the military has often been a male occupation throughout history, females have still found ways to support or join the military, even in unofficial

capacities (DeGroot, 2001, pp. 24-26). With the inclusion of females in the U.S. military since 1948, the percentage of females who have joined the U.S. military has been slowly but steadily climbing over the years. Still, they make up only a small percentage of the total military population. Since female service members comprise only roughly 16% of total military forces, they encompass an even smaller subgroup of the 1% of the population that serves in the Armed Forces at any given time, roughly only about 10% of the total veteran population (U.S. Department of Defense [DoD] Report, 2018, p. iii; National Center for Veterans Analysis and Statistics [NCVAS], 2017, p. vii). The scarcity of female veterans and service members means that there are far less reports and studies on the female veteran population than there are for male veterans or combined studies which cover both male and female veterans (Danan et al., 2017, pp. 1364-1365). Since there are not as many studies on female veterans, it seemed prudent to study the service member's experience and PTSD from the female perspective. Even though females make up roughly only 10% of the total veteran population, this percentage has been slowly but steadily rising since the advent of the all-volunteer force in 1973, a number which is projected to increase to 16.3% by 2043 (NCVAS, 2017, p. vii). The gendered experience is also dictated by physiological differences. Generally, females are twice as likely to develop PTSD than males even though males are more likely to be exposed to traumatic events, likely because females experience higher levels of associated risk factors (Gradus, 2007, p. 2; Christiansen & Hansen, 2015, p. 1).

Since previous cohorts had been barred from combat experience or even recognition as service members, it has been theorized that "the best hope for female empowerment might lie in unconventional wars or insurgent units where the apparatus

for women's exclusion is not well established and the pragmatism borne of desperation might offer them greater opportunity to defy the combat taboo," (DeGroot, 2001, p. 30). This theory was substantiated when the efforts of those females who have served on the frontlines during Gulf Wars I and II, conflicts marked by asymmetric warfare against insurgencies, were recognized and policies were changed to allow women into all military roles as of 2015. However, the traditionally masculine profession has not immediately accepted this. "Women who have trespassed into the military domain have often been redefined and placed in an uncomfortable limbo where they have lost the most admired aspects of femininity but are denied the status accorded male heroes," (DeGroot, 2001, p. 30). In an attempt to fit in, many female service members tend to overemphasize their strength and "masculine" traits while suppressing their feminine qualities. The deeply-instilled Western societal ideals that, as homemakers, women should not fight and doubts about their capability to fight have inhibited full integration into the traditionally masculine field (DeGroot, 2001, p. 32).

The gendered experience in the military and the need to prove themselves and be accepted by their male peers can be understood best through Judith Butler's concept of performance and gender identity.

> In effect, gender is made to comply with a model of truth and falsity which not only contradicts its own performative fluidity, but serves a social policy of gender regulation and control. Performing one's gender wrong initiates a set of punishments both obvious and indirect, and performing it well provides the reassurance that there is an essentialism of gender identity after all. That this reassurance is so easily displaced by anxiety, that culture so readily punishes or

> marginalizes those who fail to perform the illusion of gender essentialism should be sign enough that on some level there is social knowledge that the truth or falsity of gender is only socially compelled and in no sense ontologically necessitated, (Butler, 1988, p. 528).

Although many female service members are never directly in a combat situation, being on the fringes of the patriarchally-oriented military culture presents other challenges. Since it is far easier to oppose a smaller population than to include them, female service members often find that they have to overcompensate in order to "prove" their worth in a physical, male-oriented workplace. Because the female body is biologically structured differently from the male body, females are more capable in some respects, such as flexibility and lower-body strength, but less capable in others as compared to their male peers, such as upper-body strength and long-distance running. This overcompensation results in a surplus of injuries to female service members, represented by the statistics in that 20% received compensation for a service-connected disability and of those, 54% had a combined disability rating of 50% or higher (NCVAS, 2017, p. viii), a far higher average disability rating percentage than what is seen in the total veteran population, where the most common disability rating is 10% (VBA, 2019, p. 77). Military life is hard on the body, but for females with a desire to prove themselves, it can be debilitating.

However, this does not preclude the female service member from either experiencing combat situations or from being exposed to PTSD-inducing trauma. Although the military has attempted to keep non-combat MOS service members away from combat situations, the inherent nature of military service means that some female

service members have been in combat situations. Before 2017, with the inclusion of females into all military roles, combat situations for females tended to occur on patrol duties, guard duty, detainee operations, and missions which require transporting supplies or personnel between camps or duty stations or on attacks on the base, such as during enemy mortar fire. The majority of female service members with combat-related PTSD are most likely to have a specific MOS which requires going outside of base camp, such as combat military police (MP), truck drivers, improvised explosive device (IED) disposal, and combat medics. Although female service members were less likely to experience combat trauma than their male peers before 2015, there was still a possibility.

Since less female service members were less likely to experience combat trauma, the most common trauma source for female veterans with PTSD tended to come from MST, or experiences of sexual assault or repeated, threatening sexual harassment that a veteran experienced during their military service (Kimerling et al., 2007, p. 2163). When screened, among those veterans who have sought healthcare at the VA, 25% of female veterans indicate they have experienced MST (Dept. of the VA, 2015b, p. 1) which exceeds the rates reported in the general population (Suris & Lind, 2008, p. 252). For the acculturated female service member, military culture creates a schema of shared values and camaraderie, yet the violation of her person has created a betrayal that calls into question every aspect of her new military worldview. Through this and the subsequent isolation, the female MST survivor obtains an even more peripheral identity, separating them from both military culture and civilian culture and making it more difficult to go to spaces with large concentrations of other veterans-such as the VA or veteran

organizations. MST has been linked to PTSD, depression, alcohol and drug abuse, disrupted social networks, and employment difficulties (Murdoch et al., 2006, pp. S7-S8).

Unfortunately, the military environment enables the perpetrators of MST, since the perception of the UCMJ process tends to be one of rigid draconian punishment and the military itself has a much smaller ratio of females to males in its demographic make-up. As such, there is a tendency to Other the minority female rather than address the issues which cause this. When capitalized, "Othering" refers to the anthropological concept of defining oneself and one's group by distancing and contrasting themselves from another group. This aspect of military culture is visible in the informal interactions between service members when discussing the circumstances surrounding known cases of MST. For example, using role reversal to paint the victim as "punishing" the one she accuses by subjecting them to UCMJ proceedings, suggesting it was a case of post-coital regret and initiated as a way of saving one's social reputation, by suggesting the victim is promiscuous and therefore can't be trusted, or any number of other potential discourses. The capability for the military to shelter perpetrators of MST is well-known:

> In some ways, the military environment fosters sexual harassment. Military culture has traditionally emphasized aggression and the masculine role, and many of the men who join hold traditional beliefs about gender. Moreover, women have always been and are still a small and very visible minority, historically excluded from some of the most powerful and prestigious military roles. At the same time, the military is a large-scale formal organization with explicit method for communicating and enforcing its rules and regulations. Its members are trained to be highly disciplined and to uphold a high moral code. Therefore, the military

> might also be the workplace most able to stamp out sexual harassment, much as it was more successful than the civilian world in integrating racial minorities. (Chambers & Anderson, 1999, p. 653)

Despite this capability to stamp out sexual harassment due to the highly structured and disciplined organization and composition of the military, MST is still very common and underreported. Since military regulations are strict and clear when it comes to enacting justice for MST, other aspects of military culture must be at play which enable the proliferation of MSTs to continue-specifically in the stigma associated with the MST label, informal interactions and assumptions regarding the MST survivor, quick dispersion of rumors within the ranks, and subsequent tendency to not report the MST out of fear of being perceived as a liar or of becoming a social pariah.

There are many resources for female veterans who have experienced MST, but like most veterans, they do not realize what resources are available to them (Sayer et al., 2009, p. 246). At the VA, there are various MST support groups that meet up, especially in the larger VA Hospitals like the one in Houston, Texas. There are also non-governmental veteran organizations such as the Wounded Warrior Project, Impact a Hero, Warrior Support Foundation, and Grace After Fire with resources listed on their website for female veterans.

Female veterans also behave differently than their male counterparts, likely due to the Othering experienced while in the military or due to avoiding situations which remind them of the MST, if applicable. Because there are far fewer female veterans and the majority of veterans come from previous cohorts with far less females serving with them, they are often not recognized as veterans by their male counterparts. Even when they are,

the assumption is that they were in a support position and their contribution is subsequently diminished (DeGroot, 2001, pp. 26-28). Therefore, female veterans are far less likely to be found frequenting veteran organizations or the VA hospital than their male counterparts. There are few organizations where female veterans meet up and organize, instead remaining isolated-meeting with few if any other veterans, and even then, usually family members.

Instead, female veterans are focusing on their education, careers, and family, as reflected in a Veterans Affairs report on female veterans. Female veterans are more likely to have some college (44% compared to 32% of female non-veterans) or a college degree (34.5% compared to 28.1% of female non-veterans) than their non-veteran counterparts (NCVAS, 2017, p. viii). Female veterans aged 17-64 are also at a higher employment rate (71.5% compared to 70.1% of female non-veterans) and are more likely to work in the government sector (34% compared to 16% of female non-veterans) (NCVAS, 2017, p. viii). Female veterans tend to be less likely to live in poverty, with about 10% of all female veterans as compared to about 15% of non-veteran females living below the poverty line (NCVAS, 2017, p. viii). Female veterans are also more likely to have a veteran spouse than their male counterparts simply because there are far more male veterans than female veterans.

Overall, the female veteran experience is very different than that of their male counterparts as seen in the average disability rating being 50% or higher, a higher employment rate, higher educational attainment, and less interaction with other veterans than their male peers (NCVAS, 2017, p. viii). As such, understanding and study of the

female veteran's experience should be explored more in-depth with the aim of better meeting their unique healthcare needs.

Medicalization, Labeling Theory, and the "Sick Role

In order to understand the significance of the analysis of female veterans with PTSD, it is important to provide a comprehensive discussion of the theories used as well as how they were utilized in the process of analysis. By looking at the evolution of the theoretical orientations over time, starting with the "sick role," progressing onto labeling theory, and finally, to the broad concept of medicalization, each of which were first developed to understand the epidemiology of deviance, a picture of how PTSD sufferers come to understand their condition as well as their new sociologically-defined identity can be established.

The "Sick Role"

Building off of theories of deviance and the cognitive aspects of disease, Talcott Parsons formulated a concept known as the "sick role," in which an ill person takes on an identity as being ill both consciously and subconsciously. Part of this involves being motivated by "the privilege of exemption from ordinary day-to-day occupations," without being put at fault by others (Parsons, 1975, p. 259). Another aspect of this is the maintenance of the condition, or properly following healthcare provider's instructions and practicing treatment strategies regularly, in order to return to a certain semblance of pre-illness normalcy. In order to help sick individuals, Parsons suggested that healthcare providers "must take account of adaptive considerations, notably the pathological state of the organism and/or personality and the nature of the patient's adaptive problems in various aspects of his or her life," (Parsons, 1975, p. 260). This lead to Parsons' main

point, which was that the main problem of the "sick role" was of the asymmetric role relations between the sick and their therapeutic agencies, and felt that as such, it was the role of the medical profession to discourage the deviant behavior of no longer being a productive member of society and to help them return to functionality.

Since this theoretical orientation largely views even chronic illness as deviant because the individual can no longer contribute to society, a conception which veteran PTSD sufferers already contend with and which would be unhelpful to associate with them, this aspect is given less weight in this study. Instead, the aspects of "maintenance of the condition" as presented in the "sick role" are attributed more towards a need to accept the chronic condition and daily need for maintenance until it becomes the new norm for the PTSD sufferer as well as the asymmetric relations between doctor and patient. In the context of veterans with PTSD, equating decreased social productivity and capability with deviance is particularly unhelpful because they are already fighting the enculturated ideals of pushing past one's capabilities and refusing medical treatment in order to continue operational capability. Instead, acceptance of the "sick role" and of one's decreased capacity is necessary for veterans to begin the process of treatment and maintenance to a more normalized ideal.

Labeling Theory

Howard Becker's interactionist theory of deviance (otherwise known as labeling theory) is a theoretical orientation which is useful in exploring the progression and acceptance of the condition of PTSD. Becker's theory can be summed up as the idea that when one is given a "label," then one tends to adopt perceived aspects of said label and act on them. By decoding the actions of and empathizing with marijuana smokers, he was

able to identify how societally-defined conventionality (and unconventionality) informs the decision-making process and identity of his "deviants." Becker states that, "Whether an act is deviant, then, depends on how other people react to it…[and] just because one has committed an infraction of a rule does not mean that others will respond as though this has happened," (Becker, 1963, pp. 11-12). In the study of those who have been labeled as deviant, Becker cautioned a need to understand that one "cannot assume that these people have actually committed a deviant act or broken some rule, because the process of labeling may not be infallible; some people may be labeled deviant who in fact have not broken a rule," (Becker, 1963, p. 12). Since the circumstances of obtaining the label vary considerably, it is then important to understand that the only thing uniting these individuals is the label itself. Therefore, their similar behavior, values, and sub-cultural actions are a result of the experienced label rather than the events leading to the label of deviant.

This is useful in the study of PTSD among female veterans in that a diagnosis is an authoritative label that carries both institutional and societal implications. Since trauma sources, experiences, and symptom presentation, frequency, and severity vary from individual to individual, the primary unifying factors among veteran PTSD sufferers are the institutional label of the diagnosis and their military cultural background. Going from a military culture in which seeking medical care is discouraged for all but "life, limb, or eyesight," to a situation where they must seek the services of various specialists either weekly or monthly, depending on the severity of the condition, and take medications other than ibuprofen is a drastic change for veterans exiting the military culture which enabled survival in the harshest conditions they have faced. Turning

against those enculturated values is difficult for veterans, but having the diagnosis and societal understanding of the ramifications of said diagnosis both gives PTSD sufferers a way to understand their condition as well as a way to identify and gain the support of fellow PTSD sufferers, which make it easier to normalize and manage the condition. Suddenly, the label of PTSD enables the PTSD sufferer to see their actions as physiologically and cognitively adaptive behaviors rather than as evidence of insanity.

Medicalization

Medicalization is essentially the idea that daily living and the idiosyncratic twitches and twinges accompanied by inhabiting corporeal form become medical conditions when given a label by an authority figure-specifically a physician or scientist. Some have taken this as far as indicating that anything can be a medical condition, given the right amount of focus and labelling by medical professionals. Irving Zola, a medical sociologist who advanced ideas of medicalization, cautioned that the increased leakage of medical terminology and conceptions into daily life, specifically the propensity to label individuals with unpopular conceptions as ill "inevitably locates the source of trouble as well as the place of treatment primarily in individuals and making the etiology of the trouble impersonal," (Zola, 1975, p. 85) According to Peter Conrad, medicalization entered into the lexicon of sociologists and psychologists as a way to indicate behaviors which became medical conditions, but progressed on to have more subtle meanings, specifically when used in critique of overmedicalization and consumerism (Conrad, 1992, p. 210). For the purpose of this paper, medicalization will be used as defined by Arthur Kleinman which is "suffering is redefined as mental illness and treated by professional experts, typically with medication…[and] the fear seems to be pervasive that if we admit

what our condition is really like, we will fall apart, both as individuals and as a society," (Kleinman, 2007, pp. 9-10). Citing concerns that redefining experience into mental illness treated by professional experts, Kleinman fears that the human experience itself is in danger of being remade into something which can be controlled by consumption of products such as pharmaceuticals.

Among veterans, this is a common conception. Because the military discourages seeking medical treatment for the purpose of preventing malingering, even legitimate health problems are ignored and suffered through by service members in order to avoid the stigmatizing label of "malingerer." After exiting the military, the VA attempts to treat the myriad of conditions these service members had ignored for the sake of military cultural values, often resulting in what appears to be overmedication to many veterans. Because of this, many veterans prefer not to go to the VA, either by equating it to poor healthcare experiences while in the military or feeling that the VA is meant for older or more visibly injured veterans (Sayer et al., 2009, p. 246). They also avoid seeking treatment for several other reasons, such as concerns about losing autonomy through involuntary hospitalization, loss of job qualifications through medical intervention, and avoidance of discussing the traumas which led to PTSD (Sayer et al., 2009, pp. 244-245). The inability to communicate properly with someone seen as an authority figure also presents another dilemma: the veteran wishes to have agency over their care but cannot argue or question the doctor-the authority. The government bureaucratization and organization of the VA as well as the plethora of veterans from all service eras found on any given day only serves to increasingly create that connection for the veteran-that the VA is an extension of the military and they must behave as they did in the military-a

conceptualization which can be particularly problematic for the PTSD sufferer attempting to avoid reminders of their traumatic event(s).

Analysis Methodology

In order to understand the qualitative data collected in the course of interviews and participant observation, it is useful to categorize the information given and analyze frequency of themes. The methodology employed in the analysis of this thesis utilizes qualitative coding in the formation of conclusions drawn from data. By taking each sentence and breaking it down into levels of increasingly generalized categories, the thought processes of the analyst is revealed and quantitative frequency of themes can be used to draw conclusions.

Data-Driven Analysis

Famous anthropologist Sir Edward Evan Evans-Pritchard utilized a fieldwork methodology which formulated the direction of the study and conclusions after obtaining data, known as data-driven analysis. In order to address what he perceived as a fault in earlier anthropologists' tendencies to make broad generalizations based on deficient data, Evans-Pritchard instead studied the differences as well as universals as found in his data, most notably in his book on witchcraft among the Azande. His method, as outlined in Appendix IV of the book "Witchcraft, Oracles, and Magic Among the Azande," was to enter into fieldwork with a general theoretical framework in order to know what to look for and how to observe the field (Evans-Pritchard, 1937, pp. 240-243). Once in the field, he felt that he would then let the data drive him towards his focus. Even though he had begun his study considering other avenues, because witchcraft was important to the

Azande, it became important to him (Evans-Pritchard, 1937, p. 249). It was in this way that he allowed the data to drive his study's focus and conclusions.

In his estimation, one of the major drawbacks of this kind of qualitative coding was how it greatly extended "the writing-up period" of ethnography and made it difficult to take the time to read others' ethnographies and maintain being current while in the field (Evans-Pritchard, 1937, pp. 242-243).

Grounded Theory

Building upon the conceptions of data-driven analysis, Glaser and Strauss developed grounded theory (also known as qualitative coding, the constant comparative method, or as comparative analysis) as a deductive method of analyzing data by taking qualitative data and breaking it down into increasingly generalized themes. The purpose of this kind of analysis process is to enable data-driven conclusions or theory and to illustrate the decision-making process employed by the analyst for the reader. This method is used by a plethora of qualitative researchers in various fields, including sociology and anthropology.

The purpose of this method is to break down qualitative data (such as an interview transcript) into subsections based on the researcher's interpretation of the data. Rather than just sticking primarily with the "code" assigned to each sentence or paragraph (at the researcher's discretion), it also reveals the thought process utilized through the employment of themes and creation of categories as determined by the researcher. In this way, the thought process and conclusions of the researcher are revealed via association.

Although Glaser and Strauss developed this theory to provide a quantitative method of analyzing qualitative data and focus on how it can be applied to the generation

of theory through analysis of data gathered, they acknowledge that others will use the methodology for their own purposes.

> The term comparative analysis-often used in sociology and anthropology-has grown to encompass several different meanings and thereby to carry several different burdens. Many sociologists and anthropologists, recognizing the great power of comparative analysis, have employed it for achieving their various purposes. To avoid confusion, we must, therefore, be clear at the outset as to our own use for comparative analysis -the generation of theory. We shall first contrast our use of this method with certain other uses. Then we shall define and describe what kind of theory can be generated through comparative analysis. (Glaser & Strauss, 1967, p. 21).

Glaser and Strauss go on to outline three separate potential uses for this methodology, the third of which is the type used for this study.

> Currently, the general approaches to the analysis of qualitative data are these:
>
> 1. If the analyst wishes to convert qualitative data into crudely quantifiable form so that he can provisionally test a hypothesis, he codes the data first and then analyzes it. He makes an effort to code "all relevant data [that] can be brought to bear on a point," and then systematically assembles, assesses and analyzes these data in a fashion that will "constitute proof for a given proposition."[1]
>
> 2. If the analyst wishes only to generate theoretical ideas—new categories and their properties, hypotheses and interrelated hypotheses—he cannot be confined to the practice of coding first and then analyzing the data since, in generating theory, he is constantly redesigning and reintegrating his theoretical notions as he

> reviews his material.[2] Analysis after the coding operation would not only unnecessarily delay and interfere with his purpose, but the explicit coding itself often seems an unnecessary, burdensome task. As a result, the analyst merely inspects his data for new properties of his theoretical categories, and writes memos on these properties.
>
> We wish to suggest a third approach to the analysis of qualitative data-one that combines, by an analytic procedure of constant comparison, the explicit coding procedure of the first approach and the style of theory development of the second. The purpose of the constant comparative method of joint coding and analysis is to generate theory more systematically than allowed by the second approach, by using explicit coding and analytic procedures. While more systematic than the second approach, this method does not adhere completely to the first, which hinders the development of theory because it is designed for provisional testing, not discovering, of hypotheses. (Glaser & Strauss, 1967, pp. 101-102).

Various qualitative disciplines have utilized this methodology when drawing up theoretical orientation, hypotheses, and conclusions.

Glaser and Strauss eventually diverged in their utilization of grounded theory. As a positivist, Glaser preferred the empirical use of the approach to discover middle-range theories. Going on to work with Juliet Corbin, Strauss tended to view it more as a methodology, or "a way of thinking about and studying social reality," (Strauss & Corbin, 1998, p. 3). Strauss and Corbin instead focused on how the researcher could draw from his or her own experiences in the formulation of theories, which, while grounded in theory, could be malleable enough to be adjusted as necessary if the data was pointing in

a different direction. Using either the empirical approach of Glaser or interpretivist approach of Strauss, the researcher can be confident in their conclusions because they are drawn directly from the data.

The utilization of grounded theory in anthropology has been extensive. For instance, in 1997, Strauss and Corbin discuss several examples of projects utilizing grounded theory in their book "Grounded Theory in Practice," in order to outline its usefulness in various disciplines and fields. In 2009, Karen O'Reilly outlines the utility of grounded theory in anthropology in her chapter in "Key Concepts in Ethnography," providing a useful framework for the utilization of the methodology and the reflection of her own use of it in her own work. For the purpose of this thesis, this methodology was utilized in order to analyze the data extensively, determine frequency of themes, and draw conclusions.

Summary

Moving forward into the methodology, findings, and conclusions of the study, the theoretical orientations of performance and gender identity, adaptation, the "Sick Role," labeling theory, and medicalization allow for the interpretation of data findings. Utilization of qualitative coding as found in grounded theory enables the formation of data-driven conclusions via interpretive coding of each individual sentence and phrase and quantitative comparison of thematic frequency. Taking theoretical perspectives as the general framework and qualitative coding as interpretive framework enables the contextual understanding of the interviewees' experiences based on the frequency and duration of themes presented as well as introduction of themes otherwise not considered.

CHAPTER 3: RESEARCH METHODS

The following methods and procedures were approved by the University of Houston's Human Subjects Internal Review Board (IRB) to ensure the welfare of any person who may decide to participate in research projects undertaken by University of Houston faculty, staff, and students.

Selecting Interviewees

Interviewees were found via in-person recruiting and calls for volunteers on social media platforms. This proved to be a difficult task because frequently, the potential interviewees felt they weren't qualified for the study or simply didn't want to take part. Some initiated the process then stopped communicating abruptly, usually once the HRP-090-SOP informed consent form was produced. This is likely the result of not wanting official documentation regarding their condition or their traumas, as may be the case for MST survivors. Others simply refused to take part. Many of the potential interviewees stated they didn't think they were qualified for the study and often presented the concern that they had never been in combat as evidence for this lack of qualification, despite the fact that the study only called for those with self-identified PTSD. Even when this was pointed out, most still refused to take part in the study, likely because discussing the traumatic events that caused their condition would be too difficult for the potential interviewee. Because of this, the interviewees who did take part in the study tended to be those further along in the course of treatment and who have had the condition for a sufficient enough time to understand and be able to mitigate the severity of discussing the trauma. One interviewee was an exception, having only just decided to accept the diagnosis of PTSD and utilized the outlet of the interview to explore talking about the

traumas she faced in a setting outside the VA. The veterans with combat trauma as a source of PTSD tended to feel more comfortable discussing their experiences for several reasons: because they had been quickly identified by military healthcare or the VA as needing treatment, which meant most hadn't gone a long period of time without treatment, and also because they had military culturally "legitimate" PTSD.

Snowball sampling-or utilizing the interviewees' personal social network to find others willing to take part in the study-was attempted but was not effective because most of the interviewees either did not know anyone qualified for the study or, among those that did, the contact wasn't willing to take part in the study for the aforementioned reasons-feeling as if they didn't qualify because they hadn't been in combat or because they simply didn't want to take part. The relative isolation of female veterans was a previously unknown aspect of this subculture, so it was not expected that snowball sampling would prove ineffective.

For the purpose of this study, the interviewees were required to have at least lived in the Houston area at some point in their lives and as such, have had similar experiences with veteran culture after exiting military culture. Five of the six interviewees currently live in the Houston area, and the sixth interviewee had lived in the Houston area for several years before recently moving away. Each of the interviewees had experienced treatment at a VA medical center at least once within the last year.

The Interview Process

Interviews were carried out in unstructured, face-to-face public or semi-private settings. In a few cases, the interview took place through a video chat connection on the computer. One follow-up interview took place briefly over the phone. The interviews

typically took between 1-3 hours each. As directed by the IRB, interviewees were given an HRP-090-SOP Informed Consent Process for Research and the specifics of the study and purpose of the research was explained to them. Those who agreed to take part in the study then checked the appropriate boxes and signed the form, indicating their willingness to take part in the study.

As accounted for in the IRB as a method of protecting against potential PTSD episode triggering, throughout the course of the interview, the interviewees were observed for physical signs of increased mental duress, such as dilated pupils, sweating, fidgeting, increased voice pitch, and stiff posture. When they appeared to be under any kind of duress, the interviewer asked them if they wanted to stop or take a break and the interview proceeded only with their consent. The majority of the interviews were very casual and few signs of duress were ever displayed-only about a total of five times throughout the course of the roughly ten combined hours of all eight interviews-so the emergency contingency plan to stop the interview and escalate to further intervention as indicated in the IRB was not necessary. This is likely because the interviewees tended to be further along in treatment and because the interviewer was also a female Post-9/11 veteran with PTSD which helped to put them at ease, both in not having to explain the lingo and acronyms used as well as the trust from a shared sense of camaraderie.

Analysis

Since each interviewee consented to being recorded, the recordings for seven of the eight interviews taken from six interviewees were transcribed by the interviewer. For one of the interviews, the recording device failed, and only extensive notes were able to

be used. Since the interviewer took shorthand notes and types at roughly 90 words per minute, the thematic elements and frequency for the interview are represented fairly well.

Utilizing analytical experience in quantitative and aggregate analysis gained while serving in the military applied to qualitative coding, a data analysis technique, each interview was broken down sentence by sentence and where appropriate, by theme, and put into an excel spreadsheet in order to elicit themes and subject frequency. The interviewer's and others' contributions and conversational fillers like "uh" and "um" were removed before thematic subjects were identified. Questions and comments which had to do with the interviewer and small talk were also removed.

Each of the remaining sentences, comprising 4,304 lines in a spreadsheet, were then broken down into Level 1 Coding-or a simplification of the overall sentence which either identifies the subject matter or identifies unique word choice. After this, the Level 1 Coding was further broken down into what the researcher identifies as Level 2 Coding, or Level 1 Coding further refined. The Level 2 Coding was then used to identify the Overarching Themes being discussed, which fit into five subjects: the condition and experience of PTSD, experiences while in the military, experiences as a civilian both before and after military service, experiences with medical treatment, and generalizations of or discussion about other veterans they know. Each of these Overarching Themes were then broken down further into Major Themes which identified major subsets of the data. For instance, for "PTSD," the Major Themes were: symptoms, discussion of the traumatic event, what an episode is typically like, and how they understand their condition. Next, each Major Theme was broken down into Minor Themes, which provided further elaboration on the topic of the sentence. For instance, the Major Theme

"symptoms" was broken down into experiential groups, such as avoidance, behavior, emotion, memory problems, and sleep problems. After this, the final subgroup of Details was provided as a means of further refinement where necessary. For instance, in the Minor Theme "memory problems," details provided would be difficulty concentrating, long-term memory loss, and short-term memory loss. The number of categories created were necessary in order to elicit the best representation of both broad and specific detail within the interviews. The frequency and composition of the categories can be seen in Figure 8 and Table 1.

Once the data was all broken down into each of these categories and refined for consistency, it was then utilized to refine and isolate necessary data, revealing frequency of themes as well as specific details as needed. In order to find this, a spreadsheet function was used to count specific values in the appropriate columns in order to compare and contrast frequency of themes. Pie charts, sunburst charts, and bar graphs were used to explore and understand the themes presented. Frequency of themes and opinions were used to elicit trends as related to theoretical orientations as indicated in the literature review. Results were determined based on frequency of themes, discussion of military cultural trends, application of theoretical orientation, and use of the interviewees' personal accounts to illustrate conclusions drawn from the data.

CHAPTER 4: FINDINGS

The Interviewees

Each of the interviewees who took part in this study are female veterans with self-identified PTSD. The majority of the interviewees were Caucasian with one Latina and range in age from their early 30s to late 50s. Two of the six interviewees served primarily before 9/11, one was already in service before 9/11 and continued serving for years afterwards, and the remaining three only served after 9/11. The ranges of time in service are from one to ten years in service. The representativeness of data given self-selection and unsuccessful snowball sampling may have been skewed in favor of those who tend to be further along in their treatment, have been in combat, have been in the Army, and/or come from a Caucasian background, since only one interviewee was other than Caucasian. However, the differences in background, era of service, amount of time they served, age, and branch were unified by the prevalence of similar themes as seen in the analysis of theme frequency. In order to illustrate individual differences and the potential for increased theme frequency based on individual focus, an account and theme frequency chart was presented for each interviewee as well as in overall compilations. In order to ensure anonymity and to make it more difficult to identify the interviewees, the names and some details of the events have been left out or changed. Although pseudonyms were used for each of the interviewees, characteristics remain the same.

Maya

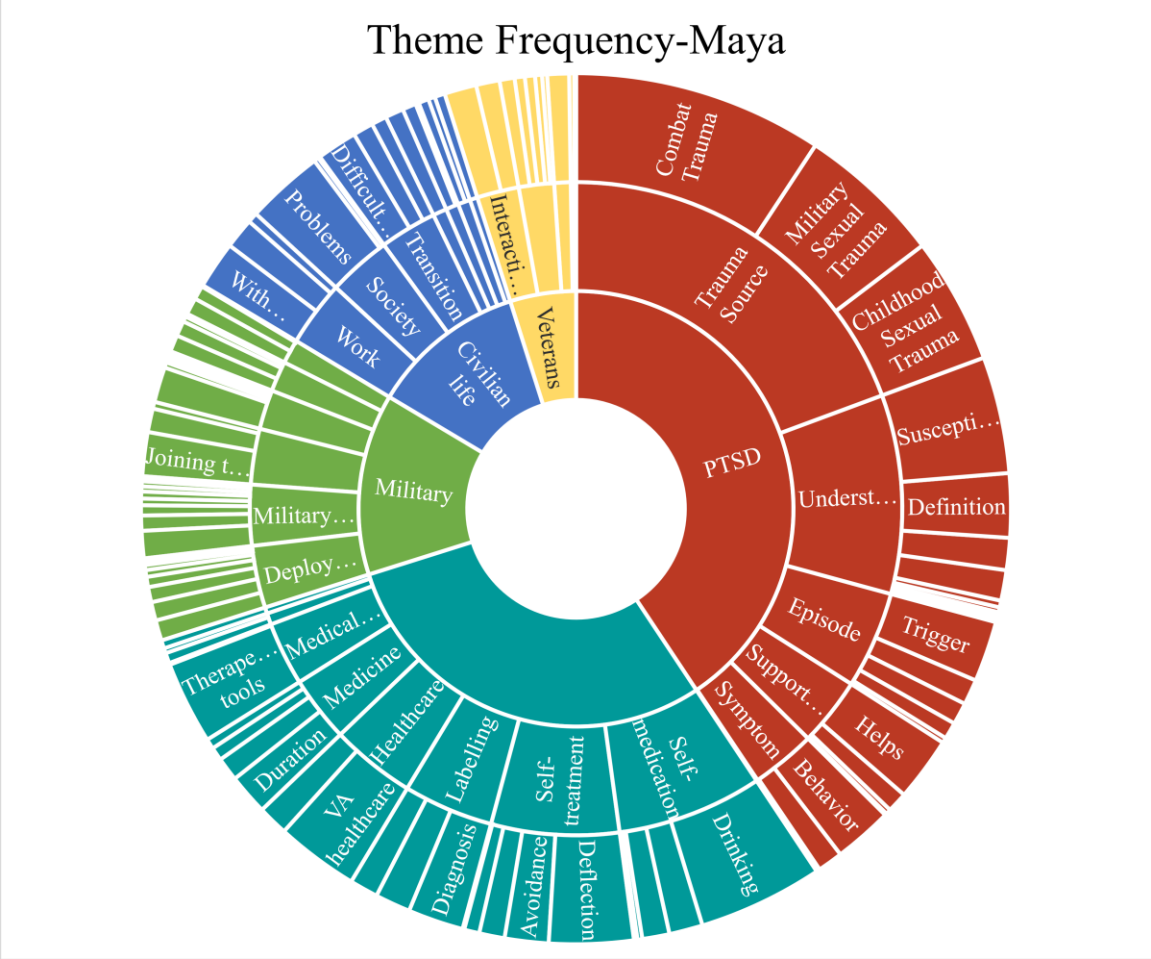

Figure 1: Frequencies of topics as indicated in Maya's interviews. Relative amounts are represented by size.

Maya was chosen as the case study for this thesis due to her varied experiences with trauma as well as her enthusiastic willingness to talk about her condition. Since discussion of the traumas is a self-described form of catharsis for Maya, she was more than willing to provide extensive details and answer any and all questions posed to her. Because of this and her long history with experience with and treatment of the condition, Maya provides great insight into the condition of PTSD and the various aspects related to it.

For various reasons, from having come from a military family to wanting to escape the cycle of poverty and change the direction of her life to something more positive, Maya decided to enter the U.S. Army as a combat MP in 1999. As such, she is the only interviewee whose time in service bridges the gap between Gulf War Era I and II veteran cohorts. During the process of entering the military, Maya uncovered evidence of having been sexually assaulted at the age of four by her biological father. She hadn't remembered anything about it, her first memory being the day she was returned to her mother and maternal grandparents after the assault. After a year in the military, with a newfound sense of confidence and strength, Maya confronted her biological father but didn't get closure from it.

After training, Maya was stationed in Germany. Around September 11, 2001, while in the military, Maya was recovering from an unnecessary appendectomy and uses the scar as a reminder of where she was on 9/11.

Shortly after returning from her first deployment to Kosovo in 2002, Maya experienced the second trauma-MST. She'd been out partying with some lower-enlisted soldiers she'd been deployed with when they met up with some soldiers she didn't know. Because they were also soldiers and she assumed her battle buddies knew them, Maya didn't question their inclusion in the partying that night. After everyone had entirely too much to drink (in Maya's estimation), they all went back to the hotel room and she passed out on the floor. She woke up to being raped by one of the soldiers she hadn't known but was too drunk to do anything about it. For several reasons discussed in more detail in a later chapter, Maya decided not to report the MST. Soon after, she ended up

with a Permanent Change of Station (PCS) to Fort Hood and was deployed to Iraq shortly after arriving as part of the invasion in 2003.

It was during this deployment that Maya suffered what she considers to be the precipitating trauma which caused PTSD. During an Iraq Currency Exchange (ICE) mission, where they were exchanging the new currency for the old currency with Saddam Hussein's face on it, her unit was ambushed. She and her team leader used their Humvee for cover, but he ended up getting blown up and shot. A rocket had hit his weapon and it exploded in his face, completely destroying it. Maya struggled to piece his face back together while calling for backup and eventually got help from her First Sergeant, who got permission for them to get out of there and medically evacuate (MEDEVAC) her team leader. In the following weeks, she had flashbacks, hallucinations, and struggled with the trauma of the firefight as she waited to hear whether he had survived or not. Despite her suffering, she was cleared for duty after only three days and was instructed to go to psych after returning from deployment. Soon after, they found the guys responsible for the ambush and while driving them back for detention, Maya considered wrecking the Humvee to ensure they died, with no regard for her own survival.

Maya returned from her deployment to Iraq and was diagnosed almost immediately after with PTSD in 2004. Up for renewing her contract with the military, Maya requested both a sign-on bonus and K-9 training, but was told she could either choose one or the other. After the firefight in Iraq and the knowledge that she would likely deploy again soon, Maya decided to exit the military. Without a plan in place, Maya started with trying to get a job and accepted the first one offered to her: a retail job. Despite having little to no training, she was put on the floor and left alone after just

having completed the training video (which didn't even cover the type of cash register they were using). Maya quit that same day, reveling in the freedom to do so after years of having been in the military without the capability to quit when presented with unfavorable circumstances. Soon after, Maya worked two jobs at the same time, then ended up going to school to get her bachelor's degree. She left those two civilian jobs and ended up going back into the Army as Reserves from 2005-2007 while she was still in college. After exiting the military for the second time, Maya graduated from college in 2008. After graduation, Maya moved back to the Houston area and got her current job working with veterans as a probation officer, which she loves.

Since her diagnosis in 2004, Maya has had continuous medical care and has tried various treatment strategies for PTSD. She has tried multitudes of medications, various therapeutic strategies, and maintains a balanced view of how to treat her condition and deal with the VA. Of all the interviewees, Maya has had the longest duration of continuous care for PTSD and has moved beyond military cultural behaviors and perceptions in the process of seeking care for and treating her condition. She has also found a way to demedicalize her condition by referring to her condition as just PTS, Post-Traumatic Stress, or even, PTSG, Post-Traumatic Growth. Due to her willingness to talk, provide details, and explain her perceptions, Maya's account elicited a greater image of the female veteran's experience with PTSD.

Amy

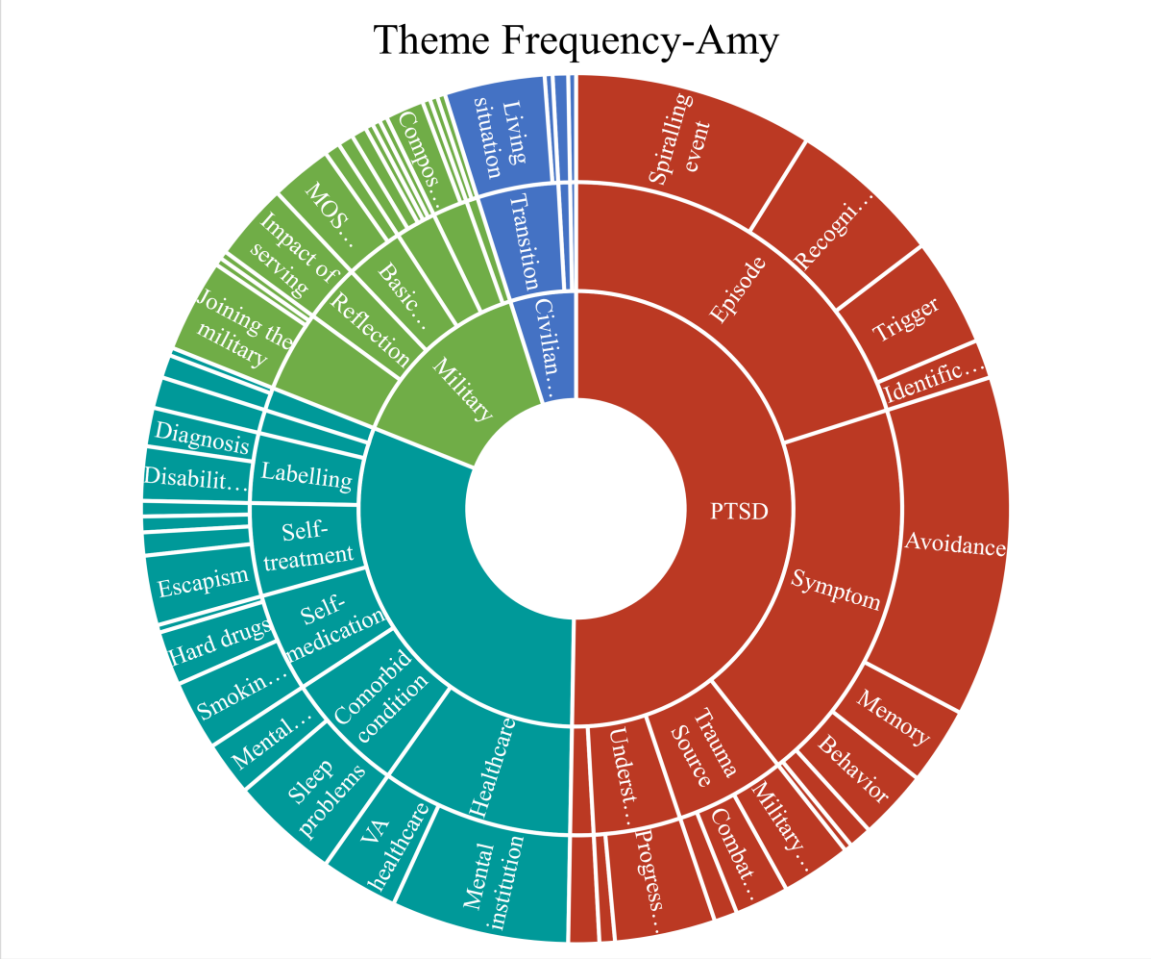

Figure 2: Frequencies of topics as indicated in Amy's interview. Relative amounts are represented by size.

Unlike the rest of the interviewees, Amy is only just beginning the healthcare journey of treating and dealing with the condition of PTSD. As a younger veteran, roughly in her early 30s, Amy is still working on reintegrating into civilian life. Only serving during the Second Gulf War, Amy was Army Reserves from 2007-2011, joining almost immediately after high school in order to escape a troubled home life in her small, rural town. Although she had initially joined as a mechanic, she was forcibly reclassed to Military Police (MP) shortly before she deployed in 2009. A large portion of her time in service was filled with training-first Basic Training, then AIT, then another AIT when

she was reclassed to MP. During her MP training, shortly before deployment, she was sexually assaulted by a fellow soldier and ended up getting a curable sexually transmitted disease (STD) from it. She didn't report it because she didn't know who had perpetrated the attack and couldn't remember what had happened, which she attributes to having had too much to drink the night of the attack.

Although she doesn't fully remember the events of her nine months of deployment, she knows from scattered memories and the accounts of her fellow soldiers that she'd been in a few combat situations-such as being mortared and bombed a few times and a friendly fire event. Amy was diagnosed with PTSD shortly after returning from Iraq in 2011, but didn't believe it because she felt fine. Around the same time, the father of her child, a drug addict at the time, attempted to kill her a few times while she was pregnant. Because of this event and the general unfamiliarity with pregnancy and its effects on the body, Amy had assumed any negative reactions she was having were more due to the condition of pregnancy or the attacks from her boyfriend than an overarching condition, namely PTSD. Only within the last few months has she determined that she likely does have PTSD from her time in the military and it is affecting her daily life and functionality. Initially citing fears of treatment only exacerbating her condition, particularly in the way talking about the traumas seemed to make her feel worse for about a week afterwards, she now feels that since she no longer has good days, seeking treatment now could not possibly make it any worse than it already is.

Charlotte

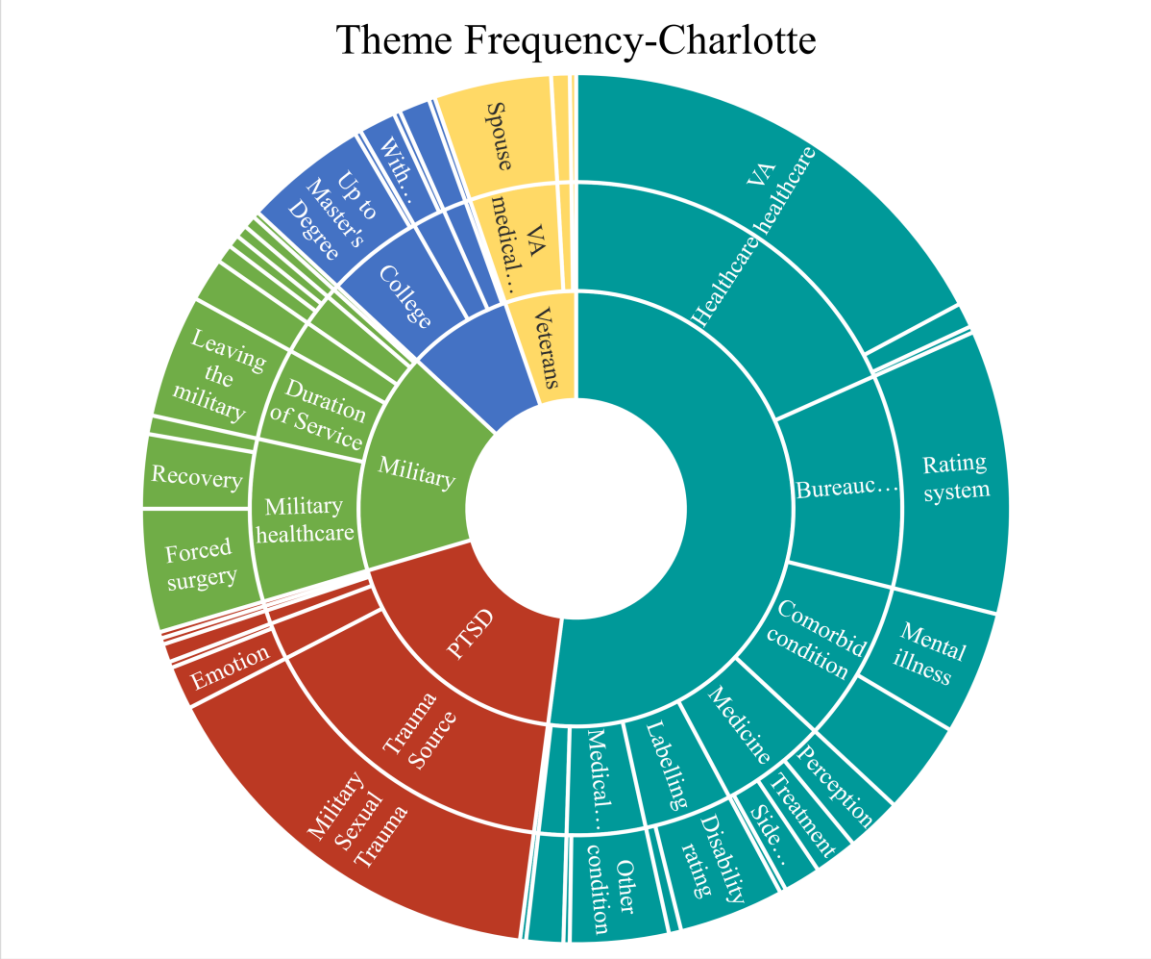

Figure 3: Frequencies of topics as indicated in Charlotte's interview. Relative amounts are represented by size.

Initially citing concerns that she didn't qualify for the study because she didn't have a VA diagnosis of PTSD and had never sought compensation for nor mentioned her MST to a healthcare provider, Charlotte agreed to discuss her experience on the condition of anonymity due to professional concerns. Since Charlotte works with and for veterans, she can maintain relations with other veterans in a new civilian setting in ways that most of the other interviewees cannot. Charlotte's husband is also a veteran, and they have two grown children. Charlotte entered the Army as a medical professional a few years later in

life than most of the other interviewees and was Active Duty Army from 1997-1999, shortly before 9/11, meaning she only served during the First Gulf War.

She had arrived at her unit when she was 23 years old and only three weeks later, she was sexually assaulted by an NCO in her unit during a unit party. She felt he'd targeted her likely due to her fit frame and summer tan, even going so far as to express concerns that she might have inadvertently led him on. Despite the fact that she was wary of him, the little alcohol she did have incapacitated her enough for him to have his way with her. Since she'd had so little, she suspects she may have been dosed with rohypnol, or roofied, at the time. After this, he never looked at her again. When the party-thrower apologized for what he suspected had happened, it also became apparent to her that the unit knew about this particular NCO's predilections, yet did nothing to prevent him from attacking her. She didn't want to report the MST because she felt partially responsible for it and because she was one of the only females in her unit and didn't want to have others associate females in the military with sexual assault or MST.

After this event, Charlotte reduced contact with her fellow soldiers and "changed the way [she] did things," running to her room instead of hanging out anywhere and never going to parties or functions again. She was in for only a few years and ended up developing temporomandibular joint dysfunction (TMJ) due to excessive clenching of the jaw, which after some reflection, she thinks comes from PTSD-induced anxiety and stress. While she was in the military, she developed allergic-induced asthma from a common allergy treatment. She had attempted to get treatment for this condition while she was in, but was advised by her command to allow herself to be medically discharged

and she decided to accept their recommendation. Soon after, she was medically discharged.

Charlotte has only recently started suspecting that she has PTSD from the MST because of her TMJ condition, since it is a common condition among PTSD-sufferers. She had also noticed several other symptoms of PTSD such as depression, anxiety, and frequent migraines from clenching her jaw. Having recently started the process of getting her disability rating raised to a more appropriate percentage considering her conditions, Charlotte is moving beyond the military cultural ideal of "sucking it up" and minimization and is now seeking the compensation she deserves. A large part of Charlotte's discussion entails her dealing with the VA and how she feels about VA and military healthcare, since much of her anxiety comes from negative medical interactions, and is reasonable considering her experience which induced the permanent health condition of asthma which prompted her to become medically discharged from the Army.

Deanne

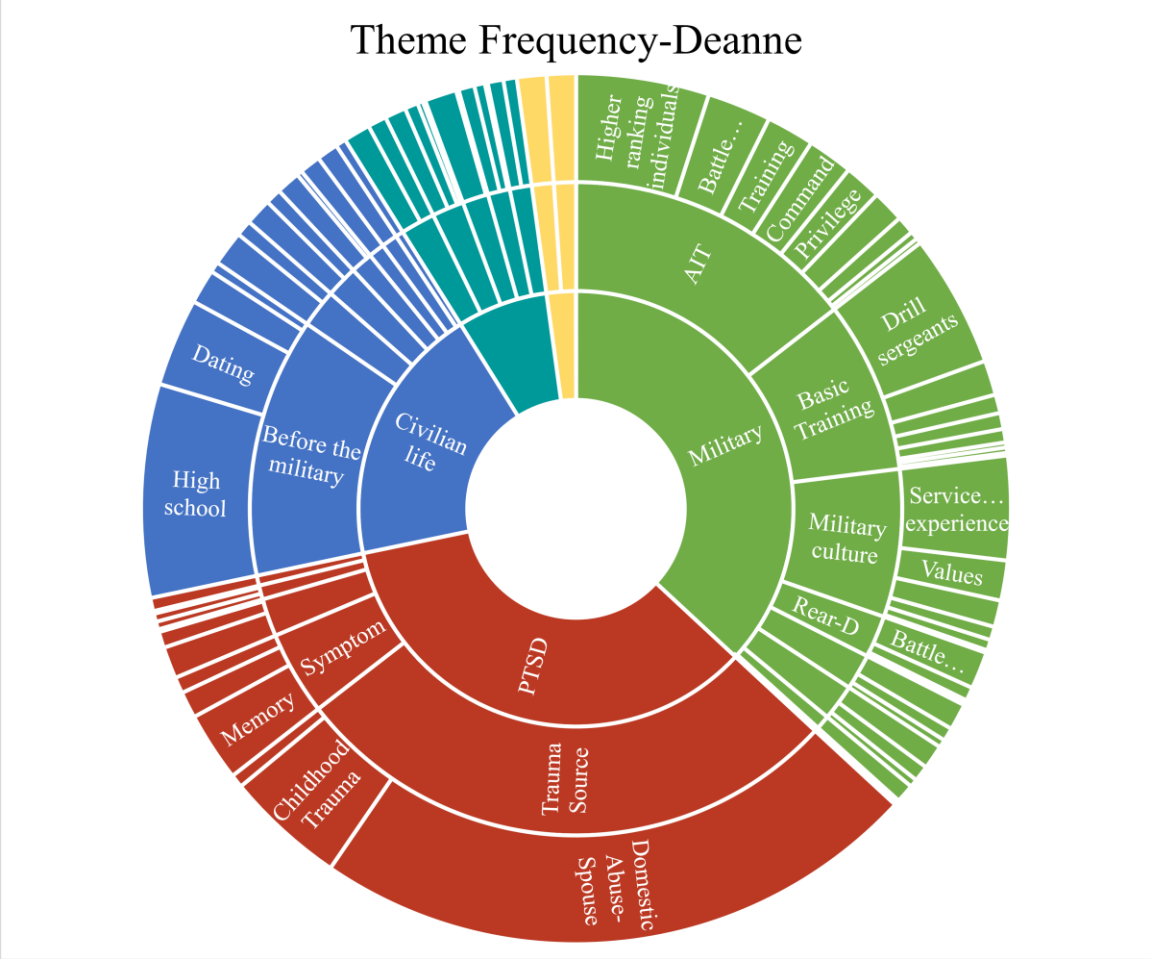

Figure 4: Frequencies of topics as indicated in Deanne's interview. Relative amounts are represented by size.

As the youngest interviewee and a Second Gulf War veteran, Deanne is in her early 30s and is married with several young children. Deanne comes from a small town of about 500 people roughly an hour away from Houston. Coming from a household with an emotionally abusive alcoholic father, Deanne entered the Texas Army National Guard as an analyst in 2007 for the structure and direction it would impart to her. She was in until 2011, when she exited the military because she was pregnant. Soon after discovering her condition, she married the Marine who had impregnated her and quickly realized he was abusive and controlling. Coming from a rural, close-knit community, Deanne felt that she

had been ill-prepared for the variety of people one is exposed to in the wider world and feels this is a reason she didn't recognize his propensities sooner. She feels the condition of PTSD primarily comes from her time with this abusive Marine husband.

Deanne exited the military shortly after AIT, making her the interviewee who was in for the shortest amount of time. However, because she hadn't been at her unit at least 180 days, she didn't qualify for VA benefits. She spent the next few years as a military spouse and attempted to get treatment for her growing depression and PTSD through military family care networks while suffering abuse from her Marine husband. Separate from her friends and family and the military family she'd become enculturated into, she found herself in a position where it was necessary to cooperate to survive. Deanne's recollections of this time are spotty, both due to her mind attempting to protect her from the realities of the situation and due to side effects from a depression medication which caused "blank spots" in her memory. Although she attempted to rejoin the military, she felt she was turned away altogether.

She broke away from the cycle of abuse, divorced her abuser, and eventually married someone who treated her well. However, she still doesn't qualify for VA healthcare and, due to her numerous responsibilities as student, housewife, and mother, hasn't taken the time to seek professional treatment for her condition. Instead, she self-manages in other ways.

Jane

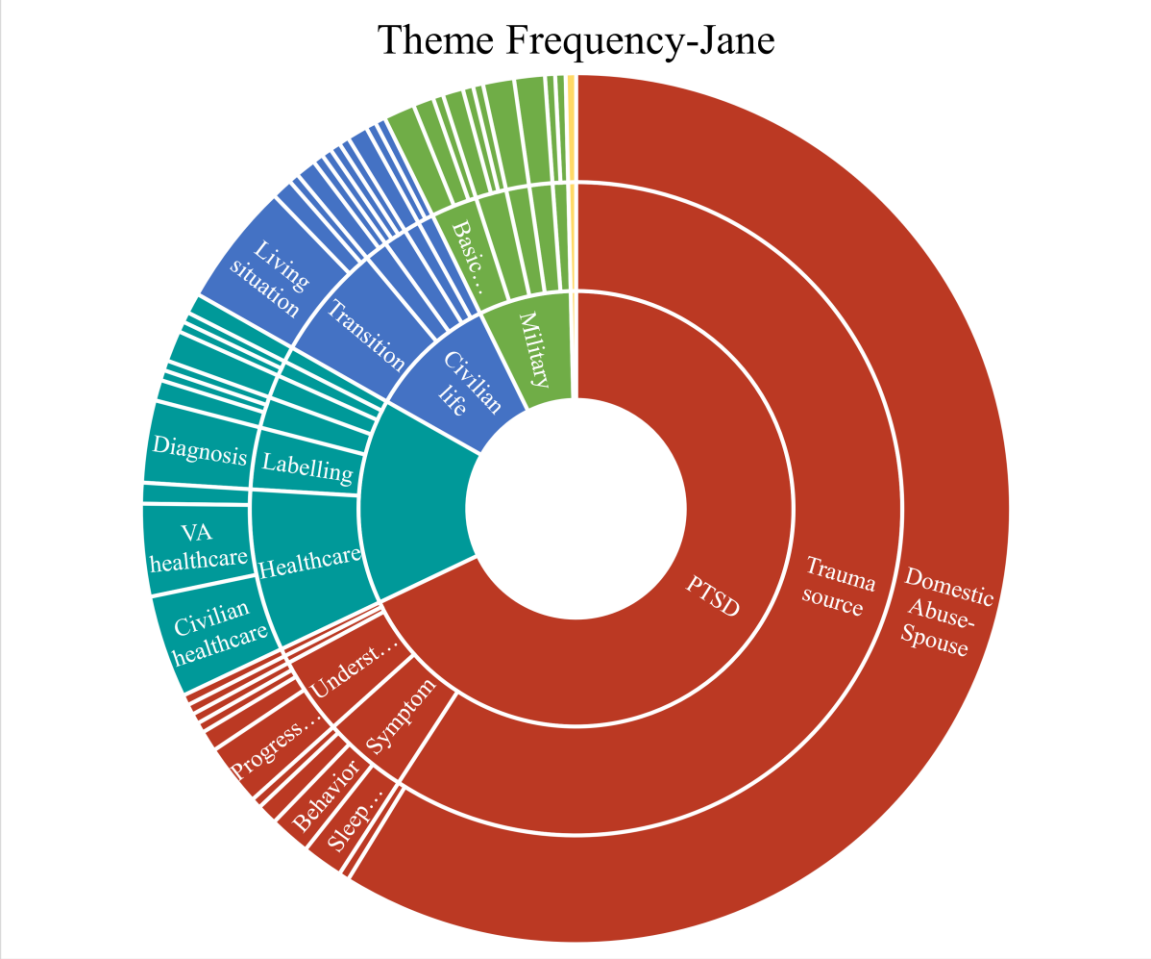

Figure 5: Frequencies of topics as indicated in Jane's interview. Relative amounts are represented by size.

The interview with Jane took place primarily over video chat on the internet because she now lives several miles away from Houston. Although she had been hesitant at first to participate in the study, Jane felt her story was one that would help contribute towards the understanding of the female veteran's experience with PTSD. Jane briefly mentions childhood trauma but doesn't go into detail. Instead, this Second Gulf War veteran focuses on what she perceives to be the primary source of her PTSD-domestic abuse by her military husband.

Jane had married a man in the Coast Guard in 1998 and soon after, chose to go into the Coast Guard as an administrative assistant in 2002. Jane mentioned that her husband was competitive and didn't like to lose, and left him for a brief period of time when his actions escalated to violence. Despite her experience and concerns, he managed to convince her to come back and remarry him. Determined that this time would be different, Jane made sure she had her own bank account, car, and credit cards in order to remain independent of him. He didn't like this newfound capability to challenge him, and over time, it escalated to an event in 2012 where he ended up breaking her ankle and pointing a gun in her face, which resulted in the police being called, an investigation, and a UCMJ court case. Although she had been steadily climbing in the ranks, he was far ahead of her in rank and when this happened, he used his greater pull and connections to hide the abuse and obtain better resources to fight the court case. Jane exited the military shortly after this event, feeling that his rank and connections in the unit gave him an advantage over her. For her, the Coast Guard was too small for the both of them and she decided to exit as soon as her contract was up only a few months later. Because of this event, Jane was diagnosed with PTSD and has had treatment and support from the VA and other veteran organizations since then.

At 10 years, Jane was in the military the longest out of all the interviewees. Unlike the other interviewees, Jane has a higher opinion of the medical care she has received from the VA, even going so far as to say it was better than the civilian care she'd gotten when she slipped on some grass while visiting a relative and broke her leg. She does mention that her bones tended to be more brittle as a side effect of some

medication she was on, but largely felt that her experience with VA healthcare was positive, especially regarding mental health.

Sara

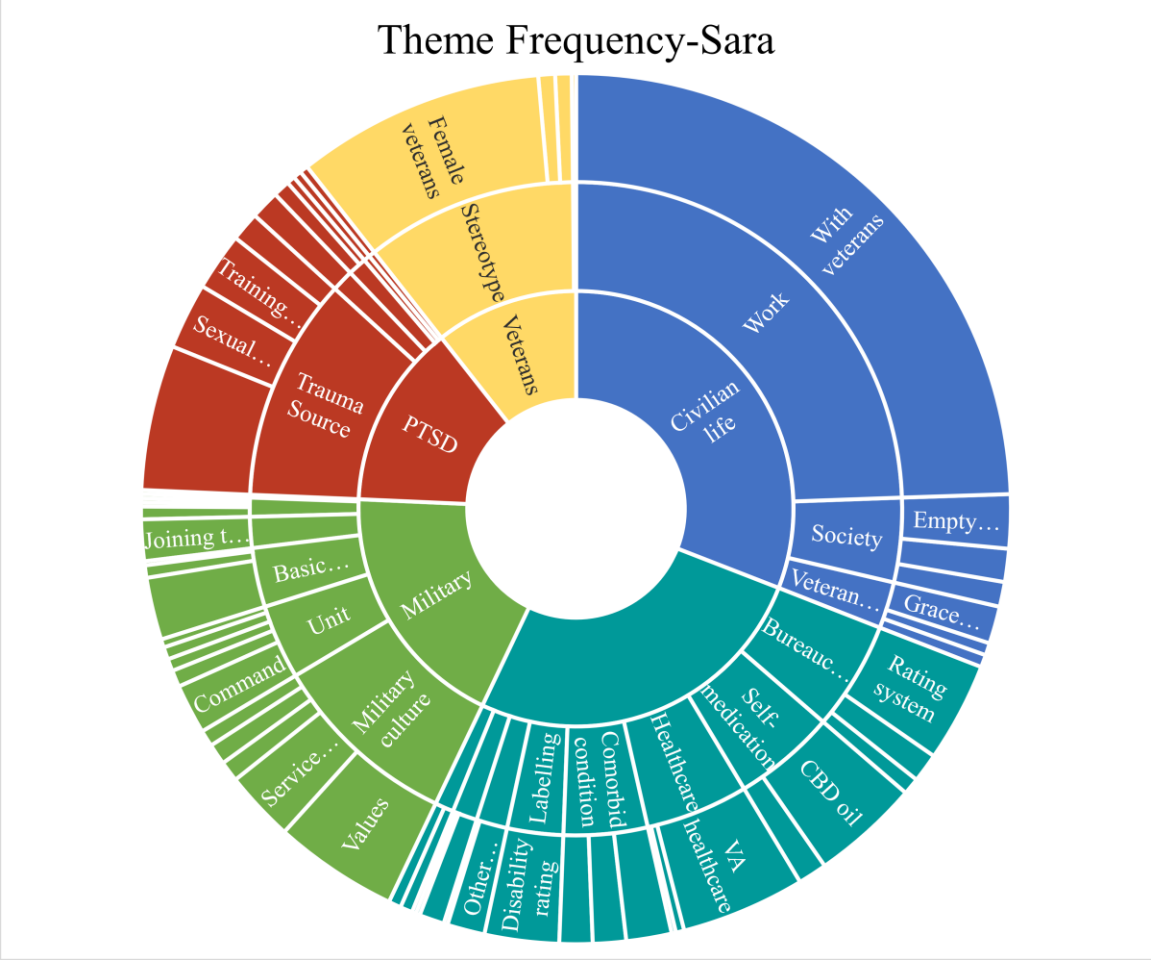

Figure 6: Frequencies of topics as indicated in Sara's interview. Relative amounts are represented by size.

As a former Drill Instructor, Sara is not afraid to voice her opinions. Currently working in service to veterans, the majority of Sara's account tends to cover her experiences with other veterans in her current job and general understanding of the veteran experience. Sara is a First Gulf War veteran with a purple heart from combat experience, meaning she was wounded in action. Sara exited the military after five years of active duty.

She had entered the Air Force as an MP and after displaying exemplary service, was sent to Drill Instructor school and became a Drill Instructor. During this time, she mentions having a young trainee die on the drill pad due to a preexisting, unknown heart condition. Although she doesn't indicate it expressly, it is obvious in her demeanor that this was a somewhat traumatic event. After serving her time as a Drill Instructor, Sara used her increased pull due to exemplary service to get deployed. Although she doesn't go into much detail, she mentions that she'd been blown up during this time, which is why she got the Purple Heart. The only interviewee to not have experienced MST, Sara does mention having been in a few compromising situations and some sexual harassment while she was in the military. She felt she had gotten lucky in that regard, since it seemed to her to be an all-too-common story. Sara also discusses an event where she caught her boyfriend cheating on her while she was in the military and broke it off immediately with no further discussion. He tried to explain his way out of it, eventually going so far as to threaten suicide by jumping off the dorm if she didn't talk to him. She ignored him until a fellow MP asked her to intervene, at which point she came out and told him to, "Jump, motherfucker!" Of course, she and the MP who brought her into the situation were punished, but she didn't feel he would have jumped and even if he had, wouldn't have killed himself. This is also possibly a minor trauma as indicated by the way her demeanor changed as she reflected that in retrospect, he might have managed to kill himself.

Working in and around veterans everyday enables Sara to maintain her military bearing and remain interactive with other veterans more than most of the interviewees. Her time in service as a Drill Instructor also illustrates her military enculturation, meaning she displays the most clearly indicated military lingo and values amongst all the

interviewees. Sara is also married to another veteran and has several children, ranging from grade school to high school.

Analysis of the Interviews

Since the purpose of this study was to relate the decision-making process of female veterans to the military culture they were enculturated into, the following major themes as elicited from the interviews will be discussed as related to military culture: PTSD, medicalization, labelling, and reintegration into civilian life.

Since each branch is different, it is important to note that four of the six interviewees were in the Army, one was in the Air Force, and one was in the Coast Guard. Also, the job they did while in the military, or MOS, can contribute towards not only what types of traumas they may have been exposed to, but also the specific subculture they encountered in the military. Three of the six interviewees were Military Police (MP) when they were in the military, and as such, not only tended to remain isolated from the other MOSs, but also spent more time on patrols and in combat operations. The importance of this can be seen in the fact that all three interviewees who were MPs had experienced combat trauma, which all three describe as the source of trauma which had the most impact. The other three interviewees each had a different MOS: one was an analyst, one was an administrative support specialist, and the third was a medical professional. For these three, the most impactful and therefore primary source of trauma was the MST.

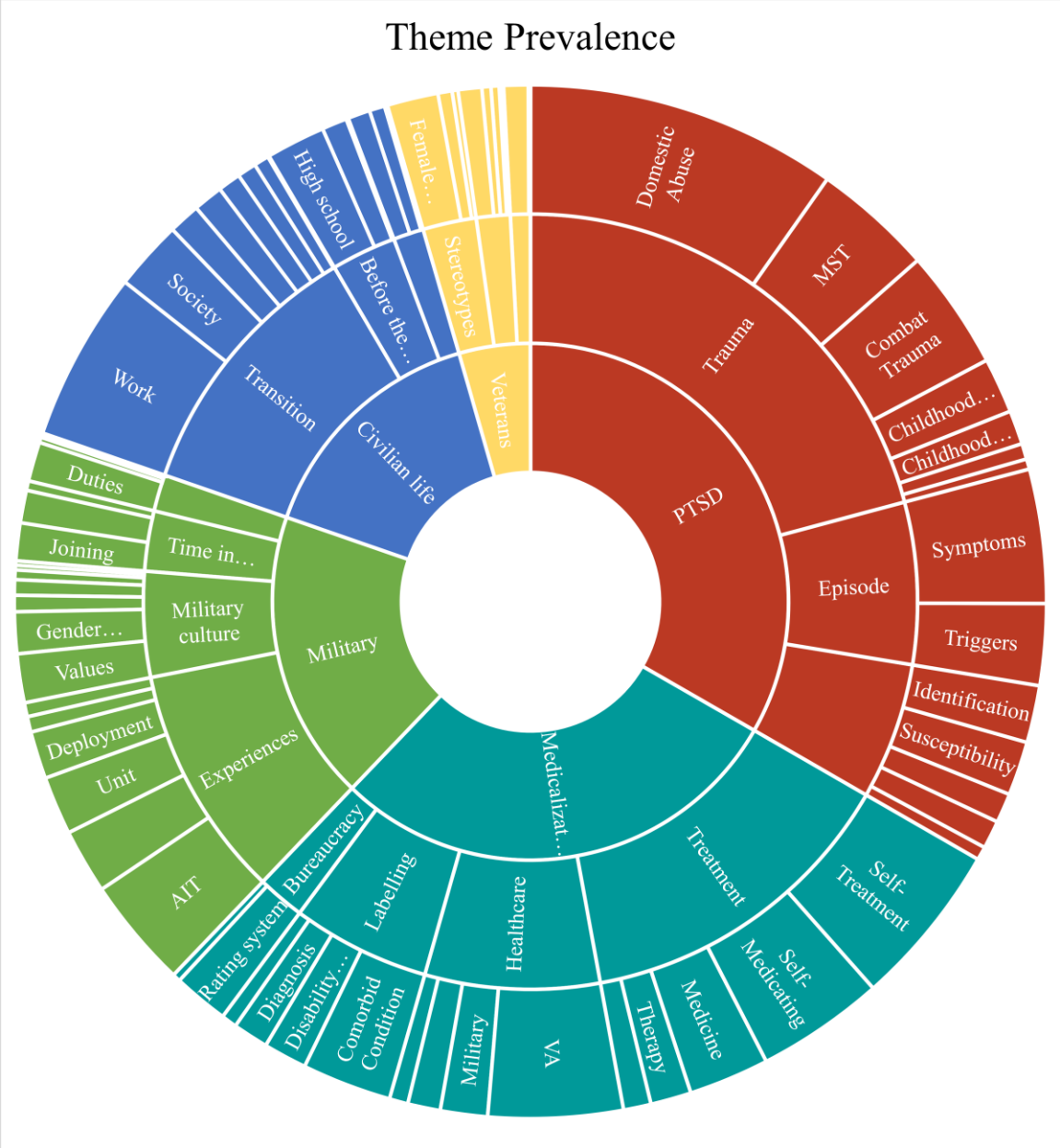

Figure 7: Summary of themes seen in the interviews as displayed in a "sunburst chart." Relative sizes indicate prevalence as found in the cumulative interviews as compiled from responses from all interviewees.

The data is first represented as a cumulative sunburst chart in which each sentence from the interviewee was broken down into main ideas or unique word choice, or level 1 coding, then further refined into what the researcher calls level 2 coding. The next step was to determine the overarching ideas represented by the topics discussed. From there,

two more categories were added in order to enable filtering and ordering to determine quantitatively the frequency of ideas and themes presented by the interviewees. The sunburst chart is meant to convey frequency of themes by relative size as well as the progression of the researcher's reasoning with each subsequent level. Although some interviewees tended to focus on one or another aspect in general, the cumulative prevalence of frequencies presented are representative of the female veteran's experience with PTSD. Table 1 provides a full breakdown of the Overarching themes, Major themes, Minor themes, and Frequency of themes.

Overarching themes	Major themes	Minor themes	Frequency
Civilian life	Before the military	Dating	34
		High school	80
		Hometown	2
		Marriage	1
	Support network	Family	30
		Friends	4
		Volunteering	21
	Transition	Beyond military culture	20
		College	40
		Difficulties	26
		Finances	2
		Living situation	43
		Self-Reflection	31
		Society	94
		Work	230
Medicalization	Bureaucracy	Policy	11
		Rating system	75
	Healthcare	Civilian	25
		Military	64
		Other	44
		VA	182
	Labelling	Comorbid Condition	121
		Demedicalization	21
		Diagnosis	48
		Disability rating	59
	Treatment	Medicine	109
		Other Conditions	37
		Self-Medicating	173

		Self-Treatment	222
		Therapy	55
Military	Basic information	Branch	7
		Duties	53
		Duty station	3
		Policy	2
		Unit	1
	Experiences	AIT	149
		Basic Training	87
		Deployment	64
		Rear-Detachment	21
		Reflection	19
		Unit	79
	Military culture	Behaviors	22
		Gender differences	56
		Language	21
		Perceptions	13
		Prohibitions	6
		Tradition	6
		Values	66
	Time in Service	ETS	44
		Joining	51
		Rejoining	13
PTSD	Episode	Symptoms	181
		Triggers	110
	Trauma	Childhood Sexual Trauma	75
		Childhood Trauma	46
		Combat Trauma	162
		Domestic Abuse	421
		MST	162
		Sexual Harassment	21
		Training Accident	14
	Understanding	Definition	40
		Identification	77
		Prevention	18
		Progression	38
		Susceptibility	73
Veterans	Example	Military values	2
		Others' Military Stories	11
		Service-connected conditions	4
		VA medical system	32
		Veteran experience	12
	Interactions	Acknowledgement	33
		Rumors	3
	Stereotypes	Female veterans	69

		Generalization	19
		Male veterans	8

Table 1: Full breakdown of themes determined through qualitative coding. Each successive level represents further refinement into more detail. Frequency of themes is presented in the fourth column.

In order to illustrate the themes found amongst the interviewees, a case study was chosen to act as an outline for the information presented. The case study for this project, known as Maya, is a female Post-9/11 Army Combat Military Police (MP) veteran with complex PTSD. Maya was an excellent choice as a case study because not only was she willing to be completely open about her condition which was diagnosed in 2004, but also because she has had more time and experience with the condition, tried various treatment strategies, and has had more time to reflect on it. In 2015, Maya was diagnosed with what is known as complex PTSD, a type of PTSD which is more multifaceted than the average condition since it is formed from more than one trauma source and as such, individuals with complex PTSD may present with more severe PTSD episodes and have far more triggers than the average PTSD sufferer. However, the APA did not include complex PTSD, sometimes known as Disorders of Extreme Stress Not Otherwise Specified (DESNOS), in the DSM-5 because criteria for complex PTSD can be found within the criteria for PTSD in general (Friedman, 2013, p. 554). On the other hand, the World Health Organization has included complex PTSD as its own category in its International Disease Classification (ICD-11) as code 6B41 if the individual exhibits both the PTSD diagnostic criteria (re-experiencing the traumatic event(s), avoidance of reminders of the event, persistent perceptions of heightened current threat) as well as additional symptoms, such as affect dysregulation, negative self-concept, and disturbed relationships (World Health Organization [WHO], 2019, p. 48). Since Maya was most recently diagnosed with complex PTSD by her healthcare provider, her condition will be

referenced as complex PTSD with the understanding that it falls within the DSM-5 category of PTSD. Maya's complex PTSD derives from three separate trauma sources: childhood sexual trauma, MST, and combat trauma.

Childhood Trauma

> *My very first memory is of…him. So he kidnapped me and my sister for two weeks, right? Brought us back and from my mom's words, my grandma's words and from the doctors notes that I read, he brought us back in deplorable condition, like really crazy. The worst diaper rash you've ever seen. Obviously, we hadn't been changed or anything in days. My first memory is of at four years old, him bringing us back to my grandma and grandpa's house to drop us off…who were standing at the end of the driveway. My grandpa, my grandma, my mom…and he punches my grandma in the face…Knocked her glasses off and my grandpa went chasing after him. That's my very first memory as a kid-four years old and I didn't know what was going on. I had no idea that we had just been returned after being kidnapped for two weeks and that we'd been sexually assaulted and all this and that. I had no idea. I had no memory of that.*

Although Maya doesn't remember the specific event of the childhood sexual trauma, she has been able to piece together what happened from medical records and firsthand accounts of family members who were there. The desire to understand the childhood sexual trauma started when she pulled her medical history in order to join the military at the age of 18. After seeing evidence that she had been assaulted as a child, she confronted her mother and pieced together a morbid picture of how her father had assaulted her when she was only four years old. She had not been aware that this had

happened to her before then because her first memory was of the moment when he had dropped her off after the assault. Her mother and grandparents had been waiting in the driveway as her father drove up to drop her off and an altercation took place where he punched her grandmother in the face, then was chased off by her grandfather. As a child, she hadn't understood why her father was not in the picture nor why her mother had not pursued late or missing child support payments from him despite the fact that they were very poor. Later on, she discovered it was because her mother had been trying to protect her from retraumatization and prevent him from gaining access to Maya ever again.

Maya had not understood the connection between this event and the rebellious activities of her youth until after discovery of the trauma itself. She had acted out in various ways, such as drinking alcohol and taking hard drugs from a young age, hanging out with the "wrong people," and violent tendencies to throw or break things when she felt overwhelmed. She describes it as, "I thought I was just an angry person." Now, armed with the knowledge of the traumatic event and the condition of PTSD, she is more accepting of how she had reacted yet still does not consider herself to have had PTSD at the time and would not retroactively identify it as PTSD. She considers this traumatic event to be of relatively low importance as compared to the other traumas that contribute toward complex PTSD-primarily because she does not remember the event and discovered it over a decade after it had happened. After obtaining a sense of agency and resilience from enculturation into the military way of life, she decided to contact her abuser directly in order to get his side of the story. Since he refuses to acknowledge or discuss what he had done, she feels that she'll have to carry this burden alone for the rest of her life because she can't get closure on it. It can be said that the rediscovery of this

information served as retraumatization for her, especially after trying and failing to get her abuser to admit to what he'd done.

According to the DSM-5, to label something as traumatic requires directly experiencing the traumatic event, witnessing the event as it occurred to others, learning that the traumatic event occurred to a close family member or friend (which must have been violent or accidental), or experiencing repeated or extreme exposure to aversive details of the traumatic event (APA, 2013, p. 271). Maya directly experienced the childhood sexual trauma but did not have any memory of it and said she had been an "angry person" most of her life. Both of these features are found within the diagnostic criteria portion of the DSM-5 when it comes to PTSD, specifically in regard to the inability to remember the traumatic event is found in Criterion D1 of the DSM-5 as dissociative amnesia and the personal description provided as just being an "angry person" can be seen in Criterion D4 as a "persistent negative emotional state," (APA, 2013, pp. 271-272). These features of diagnostic criteria were likely what was used by her healthcare provider when it was determined that the childhood sexual trauma was part of her diagnosis of complex PTSD.

Two of the other interviewees had also specifically mentioned having had childhood trauma but neither indicated it was to this degree. Jane did not elaborate beyond saying she had experienced childhood trauma and Deanne had indicated it was more emotional abuse from her father. Deanne frequently touched on the impact of having grown up with an alcoholic father, who had never struck her but instead emotionally abused her. She recounted how she had told the drill sergeants early on that, "I'm the daughter of an alcoholic. Nothing you say to me will hurt my feelings." In her

opinion, they eased up on her considerably after she told them that and she felt that her time in Basic was actually fun-if physically strenuous because of her tendency to talk back to them. Although Amy doesn't specifically mention having had childhood trauma, she did indicate that she went into the military in order to escape a bad home life. Her family had been addicts who "lived on pills basically all the time…they're very hard to deal with and my mom did not like me because of how much I look like my dad." Feeling like there was no other way to escape the situation, Amy went into the military.

The vast majority of the interviewees had also expressed having come from a poor background or the need to "escape a bad home life," as reasons for going into the military. According to the DSM-5, common pretraumatic factors which may be a risk factor for the development of PTSD "include lower socioeconomic status; lower education; exposure to prior trauma (especially during childhood); childhood adversity (E.g., economic deprivation, family dysfunction, parental separation or death); cultural characteristics (e.g., fatalistic or self-blaming coping strategies); lower intelligence; minority racial/ethnic status; and a family psychiatric history. Social support prior to event exposure is protective," (APA, 2013, 277). Since the majority of the interviewees had indicated they had come from lower socioeconomic status and several had mentioned to varying degrees childhood trauma or having come from a "bad home life," the DSM-5 description of risk factors for PTSD support the labelling of these events as childhood trauma. The interviewees had also indicated that they felt this was a common occurrence, a stance taken from both their own experience as well as from the accounts of other service members while they were in and veterans they have known since exiting the military.

Military Sexual Trauma (MST)

MST Overview

In U.S. Code 1720D of Title 38, the VA defines MST as "psychological trauma, which in the judgment of a VA mental health professional resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training," and sexual harassment is defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character," (U.S. Congress, 2014, p. 38).

When the VA screened incoming OEF/OIF female veterans, they found that 20% of the female veterans of this cohort screened positive for PTSD and 21% of them screened positive for MST (U.S. Government Accountability Office [GAO], 2009, pp. 1-2). As a common source for female veteran PTSD, it was expected that several of the interviewees would have experienced MST at some point in their military careers. In excess of the numbers seen by the VA, likely due to the fact that most of the interviewees had never reported the MST even to the VA, five of the six interviewees had experienced MST and all six had experienced sexual harassment or mistreatment based on their gender while they were in the military.

Taking into consideration that only 21% of female veterans screened positive for MST (GAO, 2009, p. 2) and applying that trend to the small pool of interviewees, where even though five of the six interviewees specifically mentioned having experienced MST, only one is officially tracked by the VA, it is easy to see how the proclivity for not reporting MST-even years after the event when many of the factors preventing them from reporting it are no longer relevant and would be protected by doctor-patient

confidentiality-might have skewed those numbers. A major reason for this may come from the way these interviewees tended to blame themselves in some way, shape, or form for the attack. In these cases, the reasoning for this is rooted deeply in military culture.

Of the six interviewees who took part in the study, five expressed having been an MST survivor. Four of these cases took place on base or in military housing while the fifth took place in a hotel shared with other soldiers. For three of the five cases, the unit knew about or suspected an MST had occurred. Two of those cases were the domestic abuse cases from their military spouse, both of which had individuals recognize that they may have been abused and offered to help, but they were afraid to accept it out of fear of retribution from their attacker. One of those cases went on to report her attacker after police intervention and seek legal action against him. For the third case, the unit had known her attacker was predatory but did nothing to prevent him from gaining access to her and later on, apologized for not doing anything about it. According to the DSM-5, "the disorder may be especially severe or long-lasting when the stressor is interpersonal and intentional (e.g., torture, sexual violence)," and evidence that these events were traumatic can be seen in all categories of the diagnostic criteria of the DSM-5 (APA, 2013, pp. 271-272). The following symptoms illustrate some of the diagnostic Criterion present for the MST survivors: Maya has had an involuntary intrusive recollection of the event during a routine gynecological procedure (Criterion B1), Deanne "freezes" when she encounters triggers such as the sound of a male voice yelling (Criterion B5), Amy avoids being around other people (Criterion D6), Amy feels like she can no longer maintain close interpersonal relationships (Criterion D6), Jane has also had trouble forming and maintaining close interpersonal relationships (Criterion D6), Charlotte

avoids recollection and acknowledgement of the event (Criterion C1), Amy and Deanne have had the inability to remember parts or most of the event (Criterion D1), and all of the MST survivors have expressed that they blame themselves in one way, shape, or form for the event (Criterion D2) (APA, 2013, pp. 271-272). Evidence of these events being trauma can be seen in all categories of the diagnostic criteria of the DSM-5 (APA, 2013, pp. 271-272).

MSTs by Strangers or Acquaintances

For the case study, Maya, it was a definitive traumatic event, though she hadn't reported it while she was in:

> *I wasn't supposed to use drugs while I was in, but I did. Not to the extent that I was using before. But when I got to Germany, a whole new world of drugs opened up to me that were hard to detect in a urinalysis because first of all, they didn't UA us that often. So knowing that weed would stay in my system longer than any other drug, I would use ecstasy because it was really easy to get and really cheap to get and it was the party drug in Germany. So I was in Germany for three months before I deployed to Kosovo the first time. I didn't start using ecstasy or any type of drugs until I got back from my first deployment to Kosovo. So by that point I had been in the army for…uh, probably a year, a little over a year or something like that…? I was using ecstasy before the MST. I was only around one other person that did ecstasy and that was the only person that I used with 'cause that was the person that showed me where to get it. And it was maybe once a month we'd go down, we'd drive to Frankfurt-45 minutes away-go to this gay club*

and in the basement-that's where they sold it-and we'd hang out at the gay club and just rave all night long…

[The MST] happened after my second deployment to Kosovo. Yeah, I got back from Kosovo and I think it was…December of 2002. And then I went to Iraq in March 2003, so… I mean…the deployment to Iraq and…my MST event were just maybe 3 months apart. I was stationed in Mannheim when the rape happened in Kaiserslautern, K-Town, Germany, about an hour, hour and a half away. And it was somewhere that I went and partied when I got back to Kaiser though, cause my platoon was attached to a different unit out of K-Town. So, I would go to K-town to party with the people that had I had met, other soldiers that we had been attached to. And it was some tall black dude that played for the army basketball team. Couldn't even tell you what he looked like to this day. Couldn't tell you his name, nothing… I didn't report shit.

So…the circumstances surrounding the event I should say, was I had went out partying in K-town with these two chicks that we were in Kosovo with. I don't know if they knew these three guys or if they just randomly met them. I have no idea. I just know that I was in K-town partying with them too. They hooked up with these guys. We were all at the club together. I got shit-faced fucking drunk. We all went back to the hotel room. I think it was the hotel because they were stationed in K-town. So, why we didn't go back to their fucking barracks, I don't know. But I remember just getting back to the hotel room, passing out on the floor, letting them do their thing and I wake up and…I kind of come to like in a drunken stupor with this dude on top of me and I can't even move, I'm so fucking

wasted. So did I change my behaviors? Not immediately. No. I still continued to get fucking wasted whenever I could…

Even after entering military service, where drug use is strictly forbidden and frequently tested for in an invasive manner-in that someone will actively observe the urination process while giving a sample to ensure integrity of the sample-Maya had continued using drugs and alcohol to manage the way she felt due to her childhood sexual trauma. The only break in drug and alcohol use was during her time in Basic Training, where there is a complete and total lack of privacy and general incapability to engage in such activity. By her own admission, she started using drugs again as soon as she was able to. After having come back from her first deployment and already come down on orders to PCS and expected immediate deployment afterwards, Maya decided to return to drug use. In an effort to dodge being caught and punished for her drug and alcohol use, Maya sought new, harder drugs that would not leave a trace in her system for as long as what she had used before. Because of this, she and her fellow soldiers would go out and party on the weekends, buying drugs such as ecstasy from the basement of the club they were in and going to the rave all night.

The night of the attack, she was out with some fellow soldiers to go to the club and binge-drink with her friends like she said she usually did on her free weekends. Some soldiers from their larger unit met up with them and they allowed them to come party with them, as expected in a military cultural environment where one's fellow service members are automatically assumed to be allies rather than a potential threat. Maya took it in stride because not only were these strangers her fellow soldiers, but also because she had assumed her friends knew them. After a night of partying, they all headed back,

drunk, to the hotel room they'd rented for the night. While her friends hooked up with some of the male soldiers that had joined them in the hotel room, Maya blacked out on the floor. After an indeterminate amount of time later, Maya regained consciousness with one of the male soldiers in the process of raping her. Too drunk and uncoordinated to stop him, all Maya could do was lay there until he finished. Unlike the childhood sexual trauma, Maya remembered this traumatic event and it left a deep impression on her despite her immediate reaction to "stuff it down" and promise herself she'd never let it happen again. Recently, a gynecological exam gave her flashbacks of this event, which indicated to her "that all that shit that I thought I had stuffed down ain't as far stuffed down as I thought it was." Like most of the rest of the interviewees who had experienced MST, she chose not to report it.

Although it is assumed that being in the military and having had martial training would preclude one from being subject to sexual assault, all three of the interviewees that had been raped by strangers were incapacitated. All three had been drinking the night of the attack to various degrees. Maya and Amy had blacked out from drinking and as such, found this as a reason to blame themselves for making them susceptible to the attack. The third case, Charlotte, had recognized the danger and had attempted to avoid it, but ended up being attacked anyway at a unit party. Charlotte had barely had any alcohol at all because she had been wary of her attacker before the party, seeing the way he had looked at her, and yet still found herself incapacitated. Because of this, she suspected she had been roofied during the unit party before the attack. Even though her unit had known he was a predator, they did not prevent him from "helping her back to her room," and the party thrower later apologized to her even though she had made no indication of the

attack nor did she report it. Instead, she avoided everyone, ran straight to her room, and never went to gatherings again, meeting DSM-5 diagnostic Criterion D2 (APA, 2013, p. 272). All three of these cases expressed feeling a certain amount of responsibility for what had transpired due to their alcohol intake and had listed this as one of the reasons they didn't report it, which also meets the DSM-5 diagnostic Criterion D3 (APA, 2013, p. 272).

Domestic Abuse MSTs

The other two MST survivors blamed themselves for different reasons-mainly that their attackers were in fact their military spouse who was abusing them and manipulating them into believing it was their fault-meeting the DSM-5 diagnostic Criterion D3 (APA, 2013, p. 272). Deanne felt responsible for her decision to marry her abuser because she had not recognized what he was before they married and afterwards, stayed with him for several years because they had a child together. Since Deanne had also faced childhood trauma with an alcoholic father that had frequently argued with her mother in front of her and her siblings, she had assumed that this was normal. However, her parents had never struck each other and so when the physical abuse from her spouse began, she wasn't sure how to handle it.

Shortly after getting pregnant while in AIT, Deanne got married to the Marine who had impregnated her and exited the military. In the Army, AR 635-200, Chapter 8 details the regulation which enables a pregnant female to exit the military without needing a MEB or anything other than medical proof that she is in fact pregnant (U.S. Department of the Army [DoA], 2016, pp. 75-80). Since this process is far easier than attempting to maintain a dual-military household where each spouse is in a different

branch, would enable one parent to remain in case both came up for deployment at the same time, and because they had decided she would be the one to provide early developmental care to the child, Deanne and her husband chose to have her exit the military to care for their unborn child. After she got out of the military, she moved in with him and his mother and sister.

When her in-laws moved out, her spouse began physically abusing her, even going so far as to break her teeth. He kept her suppressed emotionally by insulting her pre- and post-pregnancy body and telling her how worthless she was. She stated that after her child was born, she was in a state of postpartum depression and was given medication that had strong side effects, causing memory lapses which still make remembering the events of that time difficult. However, what she did remember was that she didn't enjoy sex with him after their child was born and if she refused, he'd just force it on her. Having never heard of spousal rape before, she just chalked it up to, "this is just what marriage is, I guess." He would later try to convince her that he would never intentionally abuse her and that when he had, he'd actually been black-out drunk and therefore couldn't be blamed for it because he hadn't been in control of his actions nor could he remember doing it. He had been able to continue the abuse by keeping her isolated, which was easier to accomplish because she was in a state of dislocation, living where he was stationed and totally removed from all support networks barring those given to her as a military spouse, which were essentially contingent on her abusive husband. Far from family, her hometown, and her "military family," since he was in a different branch and she was out of the service, Deanne could only rely on him. To keep her under his control, he wouldn't let her drive or do other things which might give her a sense of agency and

independence. All too often, she had to choose to survive over her own mental and physical health. To drive home her sense of dislocation, he even went so far as to drive her and all of her things far out to the beach and force her to burn it all in front of him as a symbolic denouncement of her life before him. In retrospect, she believed he was able to get away with it for as long as he did due to her general inexperience with the world and the kinds of people in it. She eventually managed to break away from him and is now in a much happier and healthier relationship, but the trauma has left deep scars on her body and psyche which she cannot get treated at the VA due to not having been in for a sufficient amount of time to qualify for VA benefits.

Deanne had expressed a general inexperience and naivete as the reason why she was trapped in an abusive relationship, but Jane's experience and understanding of her own situation is in direct contrast with that assumption yet she ended up in a similar situation. Being nearly a decade older than her husband and having experienced more in life, Jane felt like she was more capable in some respects and liked being able to make her own decisions. However, her husband quickly tried to squash that sense of independence and self-sufficiency by being competitive and getting violent when he lost- even over the simplest things, such as who could type faster. He'd been in the military when they met and so eventually, she decided to go in as well. During this time, she left him when she realized he had become increasingly violent, but he somehow managed to convince her to come back and remarry him, a decision which she says she still can't understand even in retrospect. Determined that this time it would be different, she'd made sure to solidify her own independence from him by getting her own bank account, credit cards, and car, whose existence often led to arguments with him. Just like before, when

he didn't get his way, he'd escalate to violence. Having been in longer as an officer, he was much higher ranking than her, which enabled him to get away with the abuse far longer than he might have otherwise. This fact was driven home for her when the abuse escalated to the point which necessitated police involvement.

Jane's precipitating event took place at a barbeque thrown around the 4th of July. Having already had family over for an extended period of time, tensions had been running high and her husband had been behaving strangely. This was not helped by the fact that she had been flaunting her independence in front of him as well as being sarcastic with him when he challenged her on it. Even though she had been feeling ill, he decided to invite many of their friends over for a barbeque. During the barbeque, he was increasingly inappropriate, even going so far as to offer a teenage boy sexual access to her. Understandably, she was disgusted and stepped away from the barbeque. Later on that night, while she was holding their infant grandchild and talking about how she felt they should go back to church, he attacked her suddenly and violently. It quickly escalated to the point where he ended up breaking her ankle and held a gun to her face. Despite all of this, it wasn't Jane who called the police, but her daughter, the mother of the grandchild who had been in the midst of the action. When the police arrived, Jane answered their questions and had chosen not to press charges, but due to the severity of the situation, the police chose to press charges against him instead. Even from the back of the police car, he managed to call her to in order to continue arguing over whether they would go back to church or not. He ended up being court martialed on 16 counts, primarily on "Behavior unbecoming of an officer."

A notable aspect in her account is how the unit enabled the abuse and appeared to take the husband's side in the aftermath. This can be due to one or both of two factors: either because of his rank or because he was a male and not part of the military minority Other-females. After he posted his own bail, the unit allowed him to return to the home the very next morning. When she heard he was on his way, she fled the home to stay with her mother, fearing he'd attack her again or worse, kill her. He used his rank and influence to pull in favors of other officers, going so far as to have them tell her to stay quiet about it and to act like everything was normal. He even tried to have them force her to run during a PT test to pretend like her ankle wasn't broken. In her opinion, he also managed to get far more in loans to get a good lawyer and had made friends with the judge due to his charisma and higher rank. For Jane, the decision to leave the military was informed by the way the unit had sided with her abuser over her and the feeling that they would continue to do so in the future. As such, she felt like, "the Coast Guard is too damn small for the both of us."

The Role of Military Culture in the Decision to Report the MST

Like the majority of the other interviewees who had experienced MST, Maya blamed herself for being in the situation, which is found in the DSM-5 as Criterion D3 (APA, 2013, p. 272). The reason for this is multifaceted, since there are other factors at play which they and the military as a whole could not have accounted for which resulted in them choosing not to report the attack.

For the interviewees, there are a few common threads when it comes to blaming themselves: the idea that they somehow led their attacker on, that the choices made before the event meant they were responsible for it, and/or that they would get in trouble

somehow. After the MST, several of the cases expressed a certain feeling of ambiguity regarding the circumstances surrounding the event. They wondered if it is possible they could have seemed to give consent whilst blackout drunk, that by dressing provocatively outside of military uniform they somehow had indicated a certain level of interest, or in being married to their abuser they had somehow locked themselves into an abusive relationship. Although Maya's case provides no avenue for ambiguity, she still blamed herself. She didn't know her attacker, didn't give consent, and never saw him again. While some may argue that Maya's excessive intake of alcohol meant she could have given consent but was actually blacked out at the time, anyone who knew Maya would have known that she would never have given consent even if she were capable of doing so because she is a lesbian. Yet even though the circumstances surrounding her attack were seemingly unambiguous, Maya chose not to report the attack. Initially citing the fact that she couldn't remember what he looked like and therefore it wouldn't have done any good to report him, a sentiment echoed by another interviewee, Amy, his MOS was distinctive enough that she could have identified him from a relatively short lineup had she chosen to report it. The reasoning behind her choice to not report it is deeply rooted in military culture and how it had informed her decision as it had for the other interviewees.

Due to the way the military enforces its strict rules and regulations, even if there is a serious case such as an MST, there is a perception amongst service members that all other infractions uncovered in the investigation would also be punished. In Maya's case, this was the most important reason why she did not report it-because if she had, it meant that not only would she get in trouble for the alcohol and possible drug use, but she and

most importantly, her friends, would also get in trouble for fraternization. In the Army, AR600-20, paragraph 4-14 outlines the rules regarding fraternization, or prohibited personal relationships (which includes casual friendships and romance) between military service members of different ranks and positions (DoA, 2006, pp. 25-27). The reason for this is to prevent actual or perceived abuse of power, nepotism, favoritism, and various other potentially deleterious effects to the cohesiveness of the unit. As an NCO, Maya should not have been hanging out with lower-enlisted individuals even if they had known each other before she became an NCO. Therefore, not reporting the MST was displaying the military cultural value of camaraderie by suffering in silence rather than implicating her fellow soldiers.

This is not an isolated incident and cases which support this idea of suffering in silence for the sake of camaraderie can be drawn from several of the interviewees. For instance, when Deanne was in AIT, she and her friends would hang out and get drunk with the MOS-Transfers, or MOS-Ts, individuals who are changing military job specialties, who were old enough to buy alcohol and would provide it to their underage fellow soldiers. Deanne mentioned that drinking while underage is often tacitly accepted among NCOs and Officers for various reasons, often citing, “If you can die for your country you should be able to drink,” before allowing it or looking the other way. However, by both fraternizing and partaking in underage drinking, Deanne felt she and her friends were in a dangerous situation which could have easily turned even uglier than it did. Because Deanne’s battle buddy was drinking in excess and was blacked out, the MOS-Ts had offered to take her to their barracks to hide the fact that they had given her alcohol. However, since Deanne and her battle buddy were lower-enlisted, they had been

banned from even entering the MOS-T barracks as a way of preventing fraternization between NCOs and lower-enlisted individuals. Deanne had assumed this was because they thought the lower-enlisted individuals would steal things, but she had been suspicious of the way the MOS-Ts were trying to take her incapacitated, small, lesbian friend into their barracks and as such, had insisted she would watch her and "not tell anyone" about it. In retrospect, Deanne suspects their goal had actually been to take advantage of her buddy. In either case, the MOS-Ts were reluctant to let her go, citing fears that if the battle buddy ended up in a hospital for alcohol poisoning, then they would be implicated in providing minors with alcohol. Deanne insisted that she wouldn't tell anyone where the alcohol had come from and they reluctantly let her go back to her own barracks to watch over her buddy, but not before threatening her several times to stay quiet about it. Whether or not this case could have become an MST, the fact remains that the severely inebriated battle buddy was hidden rather than brought to a hospital because they had perceived the draconian military judicial system would have punished everyone involved regardless of the outcome. Luckily, she and everyone involved came out of it okay but there are many cases where this does not happen.

The severity of military regulations and enforcement within the unit pales in comparison to when the UCMJ must be invoked for serious cases requiring prison time or worse. Because of the perceived severity of the UCMJ, many of the interviewees expressed a certain hesitation to come forward, citing fears that judicial proceedings would not only bring to light even the slightest infractions they or their friends may have committed, but mainly that it would re-traumatize them by forcing them to publicly relive the experience. The common assessment among the interviewees was that these are

usually years-long trials where they would first be put on trial in order to prove they are telling the truth and not just trying to "slander" their attacker before any action was taken against the attacker. This also meant that the MST would become public knowledge and their fellow service members would find out about it and make their own judgments on the situation, fair or not. A few of the interviewees made it clear that it is a common assumption within the military to think that a female who has claimed MST is actually just regretting their decision to have sex with their fellow service member or is somehow using the MST report and proceedings to punish their "victim," reversing the roles of attacker and victim. The interviewees also indicated that another common reaction in the military is to assume that somehow not reporting the MST is an admission of guilt for being a "slut" on the part of the victim. Reversing the narrative to blame the one claiming victimhood as perpetrator is likely an aspect of military culture taken from the patriarchal structure and overwhelmingly asymmetric ratio of males to females-it is not only easier to blame a minority which has less support just by sheer numbers but to also Other the females who are "invading" the male space of the military.

This perceived propensity to Other females in military culture is presented in the experiences of the interviewees, many of whom had shaped the way they acted in order to better represent female service members. They mentioned volunteering for activities beyond their physical capability or refusing to report mistreatment by a superior officer in order to not appear to be "complaining" or "weak" during their time in the military. However, this behavior takes on a different context when it comes to MST because by choosing not to report the attacker, there is the potential for the attacker to victimize another later on down the line. Even though it is the victim's prerogative not to extend

the trauma by going through court proceedings, the camaraderie aspect of military culture also establishes a sense of duty towards the collective, creating a cognitive dissonance on the part of the victim when it comes to their right to report it or not for their own sake. Some of the interviewees mentioned a certain hesitance when they think back on their decision not to report it, citing fears that perhaps they had enabled their attacker to not only get away with what they had done to them but to also allow them to potentially revictimize another later on, but in the end, feel they had made the right decision for their own well-being. Several of the interviewees had mentioned not wanting to report the MST because they were one of the few females or the first and only female in their unit and as such, not only didn't want to be labelled as an MST, but also didn't want to propagate the misconception that females are apt to report MSTs.

Combat Trauma

As mentioned previously, three of the six interviewees had faced combat trauma. Two of these interviewees had also suffered MST, but consider the combat trauma to be of the highest impact in regard to their condition. Considering the realities of combat and war, it is no surprise that this would be considered to be the most traumatic event they had experienced, but arguably, military culture plays a role in that estimation as well. All three of the combat trauma cases were MPs and as such, had more missions outside the military base for guard duty, detainee operations, and other missions. Evidence of these events being trauma can be seen in all categories of the diagnostic criteria of the DSM-5 (APA, 2013, pp. 271-272).

The case study, Maya, does not consider herself to have had PTSD before the combat trauma despite the severity of the other traumas. Even though she had displayed

symptoms of PTSD before the combat trauma, it was the combat trauma itself that she considers to be the precipitating trauma that caused her to develop full-blown PTSD. The following is her account of the combat trauma:

> *We were on what was called an ICE mission and that's where they were exchanging out the money that has Saddam's face on it. They were changing it out and getting rid of it. And my squad was at one bank and one of our other squads was at another bank, just a couple of miles from each other…in the city of Samarra, and you can actually find articles about this firefight we got into- happened on November 30th, 2004. And they knew we were coming, and they ambushed us. As soon as we pulled up to the bank, it was like an ambush from 360 degrees. I don't know, they say it was only a 45-minute gun battle. My squad was in it, but it felt like fucking hours. But anyways, me and my team leader were outside of the truck and were laying down suppressive fire and I'm by the passenger side door and he's at the rear of the vehicle by the rear passenger side door. I turn around to reach into the Humvee to grab some more ammo and as I'm turned around grabbing ammo, I just hear this explosion and I turned back and I just see him hit the door and just slump down to the ground.*
>
> *And I was like, "Oh, fuck." And so, you know, we were on the door. His face was fucking gone. Like, no nose, no fucking jaw. Just all fucking bloody, eyes all fucked up, and I instantly thought he was dead. It took, it seemed like five minutes it took me to snap to, but it's more like 30 seconds. But I just went into, you know, fucking do your job kind of mode and I'm just instantly putting him onto his side so he wouldn't choke on his blood. Grabbed both of our [first aid packs], used his*

and had to use mine and it still wasn't good enough cause I mean I tried… Trying to piece somebody's face back together. I mean it was just his entire fucking face so that…God it only covers so much. So, I just did the best I could [to] wrap it up. And then just laid him on his side so he wouldn't choke and aspirate. At that point there was really not that much else I could do. You can't give somebody mouth to mouth that has no fucking face left. There was really nothing more that I could do at that point other than try to get the rest of my squad's attention. Like "Guys, we gotta get the fuck outta here. Like there's … I've done what I can. He needs way more intensive care." So, at that point, after I rolled him onto his side, there was an Abrams tank in the field behind us, so I'm waving at the Abram's tank to get their attention. And I start waving at them, 'cause I was in the middle truck and started waving at my front truck, turn around, start waving at the back truck because there was too much traffic going on the radio, because I mean it was chaos throughout the city 'cause our platoon's other squad was also getting ambushed. Like they knew we were fucking coming that day. So, finally, my platoon Sergeant who happened to be riding in the back truck came running up and I was like, "I don't know what to do man. I don't know what to do. This is this..." He's like, "no, you got this. You just focus on him, see if you can get him to wake up." I got the radio, [and] he radioed whatever. Then [after] a couple minutes, they gave us the clearance to fucking throw him in the truck. And I get the fuck out of there. And we drove several blocks away to this place called the CMOC.

I don't remember what CMOC stands for these days, but anyways, it's where there were some mortarmen, there was a mortar platoon, a PSYOPs platoon, and then in the building next to them was some special forces that could have been Delta force. I don't know, either way. They were fucking operators and they had a makeshift cache unit set up in their building. And so, we rolled up it into the CMOC compound and fucking carried him into the cache. And I don't…like I said, my timing is all off. It felt like we were there for an hour, but probably more like 20-30 minutes. They got him stabilized, threw him in a little transport. It was a track-wheeled transport, almost like a Bradley fighting vehicle, but it's more of like a troop carrier. I forget what the proper name…

It was a tracked vehicle, but it had the big ass red cross on the side. It's what they use to transport, you know what I'm saying? Put him in that. And we escort that over to someplace in the city away from the fighting and then they fly out a fricking black Hawk to MEDEVAC in and load him up, take him off. One thing I'm forgetting to say is that when he came to in the Humvee, while we were driving to the CMOC, he like all of a sudden just regained consciousness and starts flailing at the bandages. Fucking ripping what was left of his face. It was fucking terrifying. Like his…what his face looked like still haunts me to this fucking day.

In summary, Maya had been out with her unit on an ICE mission when they were suddenly ambushed. Even though it had only been about a 45-minute firefight, to her it felt like hours. She and her team leader were using the Humvee as cover as they returned fire. As she reached back to get more ammo, she heard an explosion and to her horror,

saw her team leader get blown back and slump to the ground, his face blown off. Somehow, he was still alive, so she quickly went into combat lifesaver training (CLS) mode and tried to slow the bleeding and keep him alive. For Maya, this felt like a wholly inadequate effort but knew it was his best chance at survival. After doing what she could, she frantically tried to signal the rest of her unit which, in the midst of a chaotic firefight, was difficult to do. Finally, she managed to get her Platoon Sergeant's attention and he came to help, also signaling the medic to come over and help stabilize him. After contacting the command center, he got clearance to MEDEVAC the team leader. They piled into a truck and she and the medic tried their best to keep the team leader stable, but while they were in transport, the team leader regained consciousness and started panicking, ripping the bandages off of his face along with some of the remaining tenuously held flesh. They managed to stop him and get him onto a Black Hawk to be shipped to a specialized medical facility, and then she was sent to psych, a term used for psychological evaluation, and was cleared for duty after three days.

The military didn't tell her or her unit whether the team leader had survived or not, so Maya was experiencing a lot of anxiety over the fate of her team leader. She'd also experienced hallucinations while trying to recover, seeing her bloodied team leader in the room with her, which meets the DSM-5 Criterion B3 (APA, 2013, p. 271). After she was cleared for duty just three days later, her unit soon found those who had ambushed them and detained them for questioning. While driving the detainee responsible for her team leader's injuries, Maya seriously contemplated crashing the Humvee to make sure he died and didn't care if that killed her as well in the process (DSM-5 Criterion E2) (APA, 2013, p. 271). In order to find out what had happened to

him, her First Sergeant spent part of his Rest and Relaxation (R&R) time traveling and trying to locate him. He eventually found the team leader, who had no memory of the firefight and had assumed that Maya had flipped the Humvee or something. Of course, the First Sergeant set him straight and made sure he knew that he survived largely because of Maya's intervention, but Maya herself feels like her role was minimal. She attributes his survival to the medic instead, despite the fact that she was the first one on the scene trying to keep him alive and the one who got help. In fact, she felt that since she'd been where he was only moments before, it should have been her who was shot and blown up.

Maya had known immediately during the firefight that this was a traumatic event, and the symptoms of PTSD set in almost immediately after. Psych had informed her that there was a good chance she would develop PTSD, but because it had not been enough time according to their diagnostic criteria to be considered full-blown PTSD, they instructed her to check in with them frequently and to get checked out again once the unit returned from deployment. Maya did as she was told and because the military acknowledges combat as the most severe and likely trauma source to cause PTSD, she was observed carefully and diagnosed almost immediately after getting PTSD.

This is further solidified as a military cultural value as seen in Sara's account. For Sara, the combat trauma is the only event she acknowledges as a trauma even though she had mentioned a couple of other events to which she had an obvious reaction. Although she didn't go into details about her combat trauma, Sara indicated that she'd been blown up while outside the wire and attributes her survival to the training she received from a mentor. Like most service members, Sara was eager to deploy and viewed the ability to

"go overseas to an undisclosed location," as a reward for exemplary performance. However, when she was blown up, she quickly changed her stance and felt it had been idiotic to volunteer to deploy to a war zone, which is succinctly summed up as "Boom. Oh, ya dumbass." She further solidifies the military cultural value of deploying as, "Yeah, so I mean that was actually a positive thing in the military, being able to leave your base and go TDY, [short for temporary duty travel], somewhere else."

Unlike the other two interviewees with combat trauma, Amy does not recall the majority of her traumatic event (DSM-5 Criterion D1) (APA, 2013, p. 271). Her mind essentially blocked access to those memories in an effort to protect her from them, a feature seen in several of the other interviewees for various traumas, such as Maya's inability to remember her childhood sexual trauma and Deanne's inability to recall a large part of her time married to her abusive ex-husband. However, the parts of the two events she does remember is traumatic enough. In one event, she experienced friendly fire, where friendly forces mistook her unit as enemy forces and fired upon them. Friendly fire incidents are more common than would be expected in the current age of technology and capability for communication, and it is always an especially traumatic event because one's comrades are the ones doing the attacking. Friendly fire events can be proven through evidence of exposure to depleted uranium, which has been used in U.S. military munitions and armor since the early 1990s, and deposited as currently embedded shrapnel, bullets, the trace amounts leftover after removal of said shrapnel and bullets, as well as having inhaled particles if one was in or near a military vehicle which was blown up (U.S. General Accounting Office, 2000, pp. 5-6). For the other incident, she recalls having been on a catwalk while on guard duty for a detainee facility when

they were mortared and bombed. Otherwise, she has little recollection of her time in Iraq. Similarly to Maya, Amy was instructed to see psych and get evaluated for the potential for PTSD due to the severity of combat trauma. She was diagnosed rather quickly but chose not to believe it because she "felt fine" and because she couldn't remember the events anyway (DSM-5 Criterion D1), so didn't think they could affect her (APA, 2013, p. 271). However, over time she has come to realize that it is affecting her very deeply and that she needs to seek treatment.

The weight given to combat veterans and the impact of combat trauma is a direct result of the weight it is given by military culture, as evidenced in the interviewees' accounts and estimations of the value of deployment. Of course, it is in the military's best interests to elevate combat veterans to heroic levels because it encourages people to take the necessary risks involved in going to war; risks which may mean death, dismemberment, or incapacitation. The cadences sung while marching or running normalize the experiences of war, elevate the more dangerous jobs, and commiserate with the suffering of military life. Cadences from various eras of military service are still sung while new ones are added or updated for the modern military, but they all have a similar theme: the acceptance and normalization of war and the violence it entails as well as the sense of dislocation from generally, one's roots, and into a new military family.

The Experience of Having PTSD

According to the interviewees, PTSD is largely experienced in three ways: triggers, symptoms, and episodes. A trigger is anything which causes a PTSD episode or symptoms to "flare up." Symptoms are the emotional and physiological effects felt by the PTSD sufferer which were not present before the condition and vary in severity and

frequency. A PTSD episode is an event where the sufferer is reminded of the event and has an immediate emotional and physiological reaction which can last anywhere from minutes to hours. Usually, after a PTSD episode, the sufferer will experience more frequent and severe symptoms for days or even weeks afterwards.

Symptoms

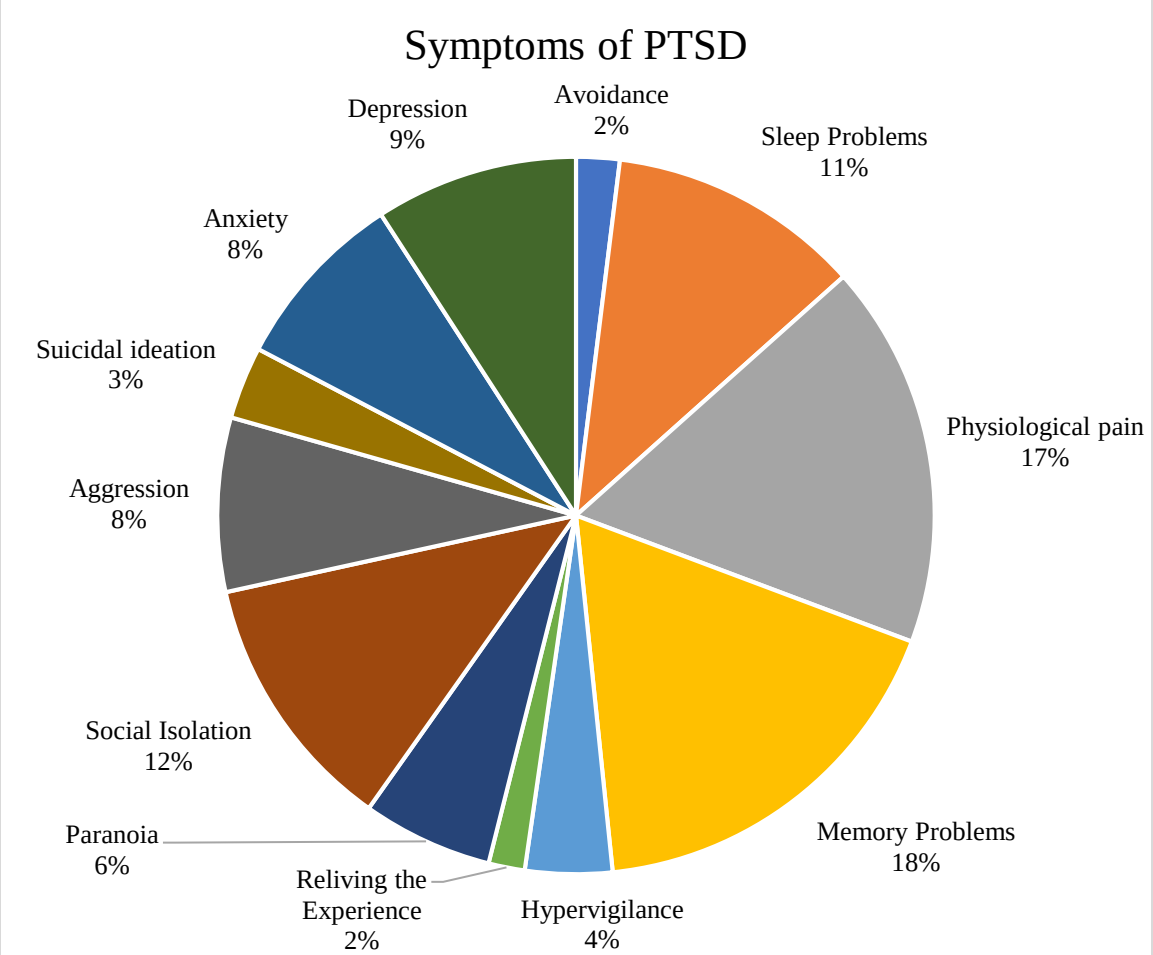

Figure 8: Symptoms as indicated by the interviewees. Percentages represent frequency as seen throughout the cumulative interviews as compiled from responses from all interviewees.

The symptoms experienced by each of the interviewees can be said to fall into the following major categories: behaviors, emotions, memory problems, physiological problems, and comorbid mental illness.

Behaviors include aggression, shaking, throwing things, yelling, avoidance, and even "shutting down" which is similar to dissociation, or a sense of disconnection between self and one's surroundings. Maya describes herself as having been "an angry person" throughout her childhood and teenage years. When she felt overwhelmed by her emotions-likely due to the emotional strain of the childhood sexual assault-she would express it by flipping tables or chairs, punching walls and doors, picking anything up near her to throw it, and screaming and yelling, features found in the DSM-5 as Criterion E1 (APA, 2013, p. 272). She can largely control her anger reactions now, but has admitted to having thrown and shattered her phone while she was in college. Amy describes feeling largely threatened by being out in public and as such, avoids interacting with other people as much as possible, even to the point of avoiding getting treatment at the VA for her condition. Avoiding the VA is unfortunately a common reaction among the interviewees, since many see it as representative of a government that they felt betrayed them, puts them in proximity with other veterans which may trigger an episode (particularly in the case of the MST survivors), provides sub-standard care in their estimation, and because being out in public and dealing with the condition reopens old wounds and makes them feel like they are in danger-which can cause them to panic. A few others discuss avoiding thinking or talking about the traumatic event because it can cause them to relive the experience which in turn, causes their symptoms to flare up.

PTSD emotional symptoms can include feeling helpless, hopeless, angry, anxiety, paranoia, sadness, and fear. Maya describes a typical PTSD episode as starting out as sad, then becoming angry, and then back to feeling sad (Criterion E1) (APA, 2013, p. 272). Amy describes the fears involved in her avoidance behavior-thinking that anyone

approaching wants something from her (Criterion D2), that going and getting treatment might make her condition worse (Criterion C1), and that she might ruin relationships with others beyond repair due to her condition (Criterion D2) (APA, 2013, pp. 271-272). Charlotte largely mentions fear and anxiety as symptoms she frequently suffers (Criterion D4) (APA, 2013, p. 272).

A good portion of what the interviewees discussed involved symptoms related to memory problems, such as the inability to remember the traumatic event or the events surrounding it, difficulty recalling recent events, and difficulty concentrating, which all fall under Criterion D1 (APA, 2013, p. 271). Several of the interviewees describe the inability to recall the trauma as "fuzziness" or as a "blank spot" or "blackness." Taking into consideration other factors, Maya's inability to recall the childhood sexual trauma could be chalked up to her age at the time, Deanne's blank spots in her memory could be attributed to the side effects of the medication which caused memory lapses, but Amy had not been in the same situation as either of the other two except for perhaps the admission of going through hard drug withdrawal during her deployment. For these cases, memory loss is most definitely a symptom of PTSD as indicated by their doctors since the "blank spots" in their memory occur only around the same time as the trauma, seen in the DSM-5 as Criterion D1 (APA, 2013, p. 271).

The interviewees also discussed the inability to retain new information for very long and the need to rely on lists in order to maintain daily productivity (Criterion E5) (APA, 2013, p. 271). This is especially evident in Charlotte's account, where she describes needing to rely on lists in order to get through her day and in Sara's case, where sticky notes and events are listed all over her calendar to ensure she remembers to do

them. It should be noted that one of the defining features found in all of the interviews was a propensity to contradict themselves, sometimes within the same breath. For Maya, it was describing episodes as being predictable events, and as such, being able to preempt known triggers but at other times, describes episodes as being unpredictable with no warning signs one was coming on. This propensity for contradiction is most likely an inadvertent illustration of the symptom of memory problems, specifically short-term memory loss and possibly difficulty concentrating rather than an intentional need to contradict what they had previously said (Criterion E5) (APA, 2013, p. 272).

PTSD is not just a mental disorder, but also a physiological one. For the interviewees, the most common physiological problem associated with their condition is pain. For Charlotte and Jane, the pain comes from subconsciously (or unconsciously) clenching their jaws until their teeth crack, a condition which requires expensive dental care and which causes headaches and other issues. Deanne also has tooth problems, but these were a direct result of the physical abuse. Due to the expense of getting teeth repaired, Deanne hasn't had them fixed for almost a decade. In Sara's case, the pain is associated with the bomb blast that marked her combat trauma, and includes arthritis and military neck, a condition in which whiplash causes the bones of the neck to lose their natural curve, instead being held straight by the surrounding muscles and causing headaches and neckaches. Two other interviewees also discuss frequent headaches or migraines. The interviewees also mention how the sheer intensity of the pain can cause them to lose the ability to focus, making it more difficult to recall or retain conversations and other events. For many of the interviewees, there are also sleep problems such as nightmares, insomnia, being a light sleeper, and interrupted sleep due to pain (Criterion

E6) (APA, 2013, p. 272). Sara actually cannot sleep on a regular, flat bed because it puts too much pressure on her neck injury and causes her arms to go numb. Instead, she finds she must sleep in a recliner with an airline neck pillow in order to prevent further physiological pain and issues.

The interviewees also each express having a comorbid mental illness, primarily anxiety and depression, a feature which is discussed in the DSM-5 (APA, 2013, p. 280). The most common comorbid conditions were anxiety and depression. Those who chose not to seek a disability claim for PTSD (primarily the MST cases) didn't have an official PTSD diagnosis and tended to only have an official diagnosis of anxiety and/or depression. The four with an official diagnosis of PTSD are the three who had combat trauma and Jane, since her MST was officially reported.

Triggers

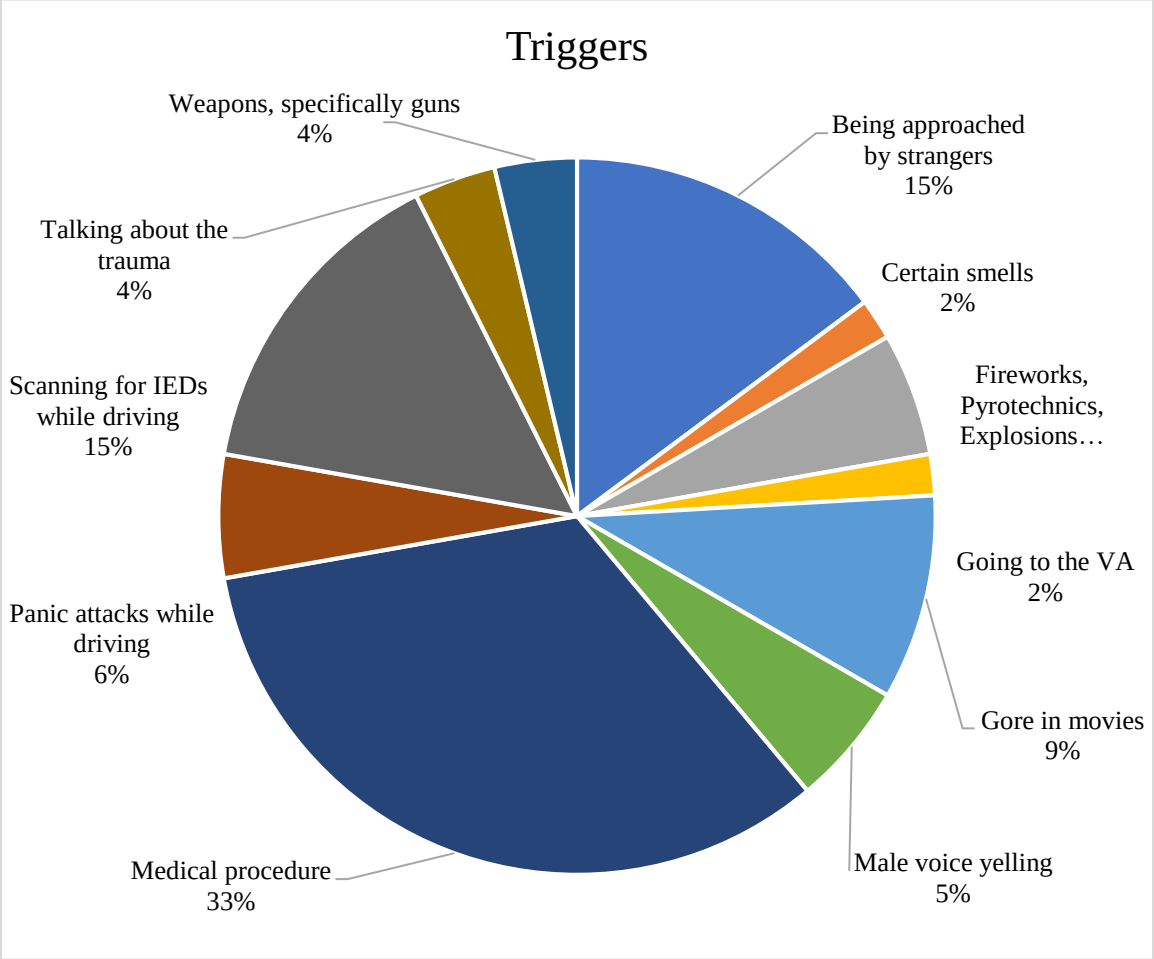

Figure 9: A pie chart representing triggers as found in the interviews. Percentages represent frequency as seen throughout the cumulative interviews as compiled from responses from all interviewees.

Triggers are most often something which reminds the PTSD sufferer of the traumatic event, but in actuality, anything can be a trigger. In the DSM-5, what is known to the interviewees as "triggers" are categorized as aspects found in Criterion B4, B5, E3, and E4 (APA, 2013, pp. 271-272). Triggers vary by the individual, but there are several common triggers shared amongst the interviewees, such as hearing fireworks, gunshots, seeing pyrotechnics, seeing trash on the side of the road, and driving in general. Each interviewee expressed having multiple triggers, with some shared with others and others

unique to the individual. What is interesting to note is that even those interviewees who had not been in combat or even deployment shared some of the triggers with those who had, such as fireworks and scanning for IEDs while driving. One interviewee who had never deployed even considers handling a weapon such as a gun or rifle as a trigger. Those who had experienced MST tended to mention social physical proximity of individuals as being a trigger. Those with childhood trauma mentioned triggers such as hearing a man yelling.

The interviewees, particularly Maya, stressed the need to both identify and take preemptive action when a known trigger is coming (Criterion E3) (APA, 2013, p. 272). For instance, like most combat veterans, fireworks are a common trigger for Maya. In order to lessen the impact of the trigger, Maya finds that if she is the one lighting up fireworks, it is easier to deal with because she knows when to expect the boom. Most of the interviewees also listed driving and scanning for potential IEDs while driving as a trigger. Since IEDs were the most common source of combat death during the Gulf Wars, particularly the OEF/OIF conflict, every service member was trained to look out for and avoid trash or anything on the side of the road and carefully observe bridges for signs of being wired to blow. Once they returned home, like many veterans, the interviewees found they could not "turn off" the need to scan for and avoid potential IEDs because it had become ingrained as a survival instinct. Other interviewees expressed passing suicidal thoughts of running themselves off the road or crashing into things, thereby associating driving with danger as well. Suicidal ideation falls under Criterion E2 and is discussed further in the DSM-5 as being often associated with PTSD (APA, 2013, pp. 272-278).

Another kind of trigger is what Maya calls a "spiraling event," or an event which is not necessarily a trigger in and of itself but is something which can cause the symptoms of PTSD to flare up and for episodes to become more common. For many of the interviewees, this is a major life event or loss, such as losing a job, having to change housing situations, or the death of a loved one. Even the death of pets can be a spiraling event for some of the interviewees, causing a sense of isolation and dislocation which makes them engage in avoidance and too often, self-medication or other self-destructive habits.

PTSD Episodes

For the interviewees, PTSD episodes are considered to play out similarly regardless of how the trigger is related to the trauma. For Maya, it usually starts out as feeling sad, then getting angry and possibly violent, then back to feeling sad. Deanne describes episodes as "coming in waves," with an ebb and flow of cyclical increasing and decreasing of symptom severity within various lengths of time. For most, like Amy, it is a daily struggle with the symptoms which can get slowly but inexorably worse over the period of several months or years. For others, it is definitive bursts of severe symptoms. Several interviewees describe it as "shutting down," which can be described as dissociation, or disconnecting completely from the present and staring off into space, sometimes not even feeling like they are still in their own bodies, a feature discussed in the DSM-5 as depersonalization (APA, 2013, p. 272).

The Progression of the Condition

The DSM-5 discusses the development and course of PTSD as the following:

PTSD can occur at any age, beginning after the first year of life. Symptoms

> usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before criteria for the diagnosis are met. There is abundant evidence for what DSM-IV called "delayed onset" but is now called "delayed expression," with the recognition that some symptoms typically appear immediately and that the delay is in meeting full criteria…Frequently, an individual's reaction to a trauma initially meets criteria for acute stress disorder in the immediate aftermath of the trauma. The symptoms of PTSD and the relative predominance of different symptoms may vary over time. Duration of the symptoms also varies, with complete recovery within 3 months occurring in approximately one-half of adults, while some individuals remain symptomatic for longer than 12 months and sometimes for more than 50 years. Symptom recurrence and intensification may occur in response to reminders of the original trauma, ongoing life stressors, or newly experienced traumatic events…Individuals who continue to experience PTSD into older adulthood may express fewer symptoms of hyperarousal, avoidance, and negative cognitions and mood compared with younger adults with PTSD, although adults exposed to traumatic events during later life may display more avoidance, hyperarousal, sleep problems, and crying spells than do younger adults exposed to the same traumatic events. In older individuals, the disorder is associated with negative health perceptions, primary care utilization, and suicidal ideation. (APA, 2013, pp. 276-277)

For many of the interviewees, the condition of PTSD progressed slowly over time, seen in Criterion F (APA, 2013, p. 272). For Maya, PTSD became apparent soon

after the precipitating traumatic event and was immediately diagnosed and treated, but noticed that over a period of time it got worse and worse. However, having been in continuous treatment for the condition, she was able to get it under control and return to a functionable state relatively quickly. The other two combat trauma cases were also quickly diagnosed with PTSD, but Sara didn't discuss much about it, only stating that everyone coped differently. Amy, on the other hand, expressed a certain amount of disbelief when she was diagnosed with PTSD and as such, didn't go in for checkups or into treatment for the condition for several years. It can be said that she had delayed expression of PTSD, since she didn't notice the effects besides a blank spot in her memory for the combat experiences until years later (APA, 2013, p. 276). She had initially chalked up her increasingly erratic behavior to post-partum depression and as a reaction to her previous boyfriend attempting to kill her, despite the fact that she was told it was PTSD from the combat trauma. She had dismissed it because she couldn't remember the combat trauma and as such, didn't see how it could affect her. Only recently has she acknowledged that she does in fact have the condition and needs treatment in order to get back to being fully-functionable-largely due to the fact that she is struggling with daily life now, unable to keep or obtain new relationships and struggling to maintain housing and a job, seen as Criterion G (APA, 2013, p. 272). Amy figures that since she doesn't have good days anymore, then seeking treatment now can't possibly make it worse. As the only MST with an official report, Jane was also quickly diagnosed and treated for PTSD.

For the other two with MST as their precipitating trauma, it was a much slower process and took far longer to get a diagnosis of even a comorbid mental illness, most

likely because they didn't report or seek treatment for MST at the VA. Deanne doesn't qualify for VA services because she got out of the military before the minimum time in service, so she has never been screened for PTSD or MST by the VA and therefore hasn't been treated for it. In order for her to get treatment for it, she would have to get service-connected for the MST or seek civilian mental health care, a cost a mother of several young children has difficulty rationalizing. As a social worker, Charlotte doesn't want to seek service-connection for MST because she feels she needs to maintain her role as one who helps others rather than one who needs help. Charlotte is service-connected for depression, but it was linked to an injury from military healthcare instead of the MST, which she has never told them about. Jane's MST was service-connected quickly and her treatment started early due to the public nature of the UCMJ proceedings against her attacker, so her case is more like the combat trauma cases in that sense. It's important to note that the military and the VA system treats MST as traumatically impactful as combat, often offering the same resources to MST as they would for combat survivors, but differ in the way it is handled. In the military, only official reports of MST can be fully treated this way whereas the VA is often having to retroactively treat MST cases because they were not reported for one reason or another.

Another aspect of the development of PTSD was the delineation of identity before and after the condition of PTSD. After diagnosis, a common feature found in the interviewees was the propensity to delineate their sense of self when it came to before they developed PTSD with how they perceived themselves to be after they developed the condition, creating a strict temporal divide in their assessment of self. Several of the interviewees had expressed the sentiment, "I was fun before I went in," largely in

reference to the fact that now that they have PTSD, they are no longer willing to go out and party or take risks as they once had (Criterion D5, D6, and G) (APA, 2013, p. 272). They also indicated a certain level of social isolation, both intentional and unintentional (Criterion D6) (APA, 2013, p. 272). For Amy, the loss of close personal relationships with both her significant other and with close family was one of the main indications that she truly did have PTSD and needed treatment. Angry outbursts and a lack of understanding on their part meant that Amy was inadvertently pushing them away. Others, like Charlotte, discussed how her behaviors changed after the traumatic event, making her less willing to be social in order to prevent being sexually assaulted again, a part of her determination to "process it differently."

Medicalization and Labelling

A key feature of each of the interviewee's stories is how being diagnosed changed the way they perceived their condition and the way they treated it. By medicalizing behavior and giving them a label to ascribe their irregular behavior, the interviewees found themselves able to accept their condition and find solutions which would enable them to return to a semblance of normalcy.

Diagnosis

The process of being diagnosed with PTSD is difficult since it requires access to mental healthcare, an established history of trauma, and continuous symptoms over a set period of time. For several of the interviewees, getting a diagnosis from a medical professional or from their VA disability rating enabled them to change the way they viewed their irregular behavior. Instead of feeling out of control of their own thoughts and feelings, they now knew that it was an established condition which caused them to

act irregularly. The interviewees largely didn't seem to care where the diagnosis came from as long as they had one to explain their behaviors.

For Maya, no medical professional officially gave her the diagnosis of PTSD. She had been given a soft diagnosis in Iraq after the firefight in that the doctor had suggested she likely had the condition, the first time she'd ever heard of it, but was not officially diagnosed at that time. Instead, she obtained her official diagnosis when she got her disability rating decision in the mail, which consists of a packet that lists the decisions for each individual item the veteran claimed for service-connection. Maya is indifferent about the fact that she was not told by a medical professional, just simply glad that she has the diagnosis and the rating. Of course, Maya had expected to be service-connected for PTSD after the soft diagnosis in Iraq and because the military healthcare system had kept an eye on her since the firefight. Sara and Jane had also been diagnosed relatively quickly by psychological services after their precipitating traumatic event and chose to comply with suggested treatments and as such, seem to be coping well.

Amy, on the other hand, dismissed her diagnosis even though it was given just as quickly as the other combat trauma interviewees, and so her condition has progressed to being far worse than the others, limiting her ability to function daily. Deanne is in a similar state because she had not been in long enough to qualify for VA healthcare and as such, must either seek civilian mental healthcare or get her MST service-connected by going through the disability rating process. Charlotte doesn't feel the need to get her MST service-connected, and instead, later got a comorbid mental illness service-connected to another potentially comorbid condition to the PTSD-her TMJ.

The majority of the interviewees got their diagnosis from the VA in one way, shape, or form. Several of the interviewees were told they had PTSD as soon as they got out of the military and quickly started and maintained treatment at the VA. Others got it from looking through their disability rating paperwork. Some had been told by a military healthcare provider they likely had it, but the official diagnosis came later from the VA. In all cases, the ability to attribute their irregular behavior to a known condition enabled them to see their behavior as symptomatic rather than as evidence of having descended into madness.

Disability Rating System

The process of obtaining a disability rating from the VA is notoriously difficult and wrought with distrust of the process and of the VA. The process is relatively simple and is described in detail on the official VA.gov website under "Benefits," but can be summed up as indicated by the interviewees as the following: a veteran will take their medical records to the VA, fill out a form listing every condition they sought medical care for while in the military, and go to the scheduled appointments the bureaucratic side of the VA sets up in order to discuss their ailments and the source. After that, a bureaucrat takes the data from the appointments and compares it against the military healthcare record and makes a determination about whether it is truly service-connected, how disabling the ailment is for daily functioning, and how much the veteran should get in compensation. Where this process used to take years, the initial rating now takes maximum one year due to legislation meant to ensure disabled veterans who need it are given their rating rather quickly. However, in the experience of the interviewees, the first

rating given is often low and needs to be appealed or further evidence provided in order to get it raised, a process which can still take years.

Even when the interviewee managed to get their condition service-connected, all of them mentioned how they and other veterans they knew were rated low at first and had to fight to get the rating raised to where it should be. Part of this comes from the military cultural practice of minimizing health conditions, hence why so many are advised by other veterans who have already gone through the process to remember what their condition is like on their worst days and discuss that rather than how they may be feeling on the day of their appointment, which may not be as bad as usual. Charlotte and Sara, who both deal with the VA rating system as part of their post-military work, stress the importance of doing this because it shows the true impact of the condition and is not what some service members would consider to be less than truthful, especially since the raters are only getting a snapshot of the condition from the appointment rather than seeing the range of the condition. They describe how due to the general stoic nature of veterans and service members as imparted to them during the process of Basic Training, part of this involves forcing themselves to react to the pain they are experiencing rather than trying to just hold back like they normally would, which is difficult for veterans first seeking their disability rating. They become so used to minimizing and normalizing the pain that it becomes second-nature and as such, many disability ratings regarding pain (already rated low to begin with) are likely even lower because the civilian healthcare provider doing the evaluation isn't familiar with the subtle twitches and deflection techniques many veterans use to cope with their condition as influenced by military culture. Charlotte, who is in the process of getting her rating raised, and Sara, whose job it is to help veterans get

a rating, also discussed what it meant to get a 0% rating on a condition, which they say is a good thing because it is at least an admission by the VA that the condition is service-connected rather than not service-connected. They say that it is far easier to get a service-connected percentage raised than it is to argue that a condition is service-connected at all.

The process of getting a condition service-connected involves comparing the current disability level of the condition against military medical records to ensure it is in fact due to military service. Since following directions is a value in military culture, many new veterans will do exactly as they're told and take the physical copy of their medical records straight to the VA and hand it over. Charlotte in particular is dubious of this because she'd heard too many stories of the VA losing medical paperwork and dropping veterans' disability pay because there was no longer evidence of service-connection for the disability. Because of this, she opted to keep her original records rather than hand them over to the VA. Despite the fact that the VA didn't have her original records (some of which were hand-written because she was in before and during the transition to digital records), she somehow managed to get service-connected for several conditions. Like the others, her rating was low at first and only recently has she decided that she deserves a higher rating, a sign of moving beyond the military enculturation that encouraged her to accept what she got without complaint. Charlotte expresses much anxiety over "getting a good rater," because to her, what is considered a disability is determined not by a system, but by the individual rater whose job it is to interpret the results against said system.

Maya had also been rated low at first but due to her nature, the sheer trauma, and cultural acceptance of combat trauma, had no qualms about seeking a higher rating when she determined she needed one. Deanne hasn't applied for the rating yet because she

doesn't feel like she can, considering she isn't even given VA healthcare due to not having served for two years. Sara isn't interested in getting her rating raised any further because she feels that she can't just accept a check-she needs to remain in the workforce and keep herself busy. Amy considers the process to be so daunting that she hasn't even attempted to do it yet, even though she needs the money and she would be likely to get a good rating, which may be a reflection of her avoidance of the VA or perhaps as a need to control the labels attributed to her.

Another part of the frustration of getting a disability rating comes with the way the rating is calculated, which is considered to be incomprehensible for many veterans (Sayer et al., 2004, p. 15). For the majority of the interviewees, the way the ratings are calculated is not fully understood. This is neatly summed up by Maya, who says, "their rating system is really screwy." For instance, she described how getting a 30% for one condition could only contribute 10% towards the overall disability rating. The most important rating is the final rating done after all the other conditions are added up, but the majority do not understand how this works and have difficulty explaining it. They also discuss how certain ailments tend to rate higher than others and how much they are "worth," such as how a damaged joint rated at 10% is considered high despite its interconnected importance to the rest of the body and how problems with joints can cause a cascade of other ailments.

For some, like Amy, the biggest issue is having to go in and get treatment in order for the disability to remain "current." Despite the fact that avoidance is one of the main symptom groups of PTSD, seen in the Criterion C grouping of the DSM-5 (APA, 2013, p. 271), several interviewees state that the VA considers the condition to have improved

to the point of no longer needing treatment if someone doesn't go to the VA for a long period of time. Maya and Charlotte go to the VA for their mental healthcare anyway, so don't face possible reduction or removal of their benefits due to consistent treatment. Sara, however, avoids the VA because not only does her work put her at odds with the VA at times, but also because she doesn't trust them to treat her competently. Instead, Sara sees her civilian healthcare provider as necessary and when called in for a reduction hearing provides her civilian health records to corroborate her condition, a practice which she knew to expect and therefore took preemptive action against. Some of the interviewees also have a veteran spouse who have also gone through this process. For instance, Charlotte's husband has service-connected PTSD as determined by the VA, but due to his military enculturation as a pilot, refuses to seek medical attention at all. Charlotte fears that this means he'll get his rating taken away or reduced and encourages him to go, but since he avoids the VA and displays the military enculturation of avoiding healthcare in order to remain combat ready, it is likely he will not go in until he is forced to do so by a reduction hearing.

Perception of the VA

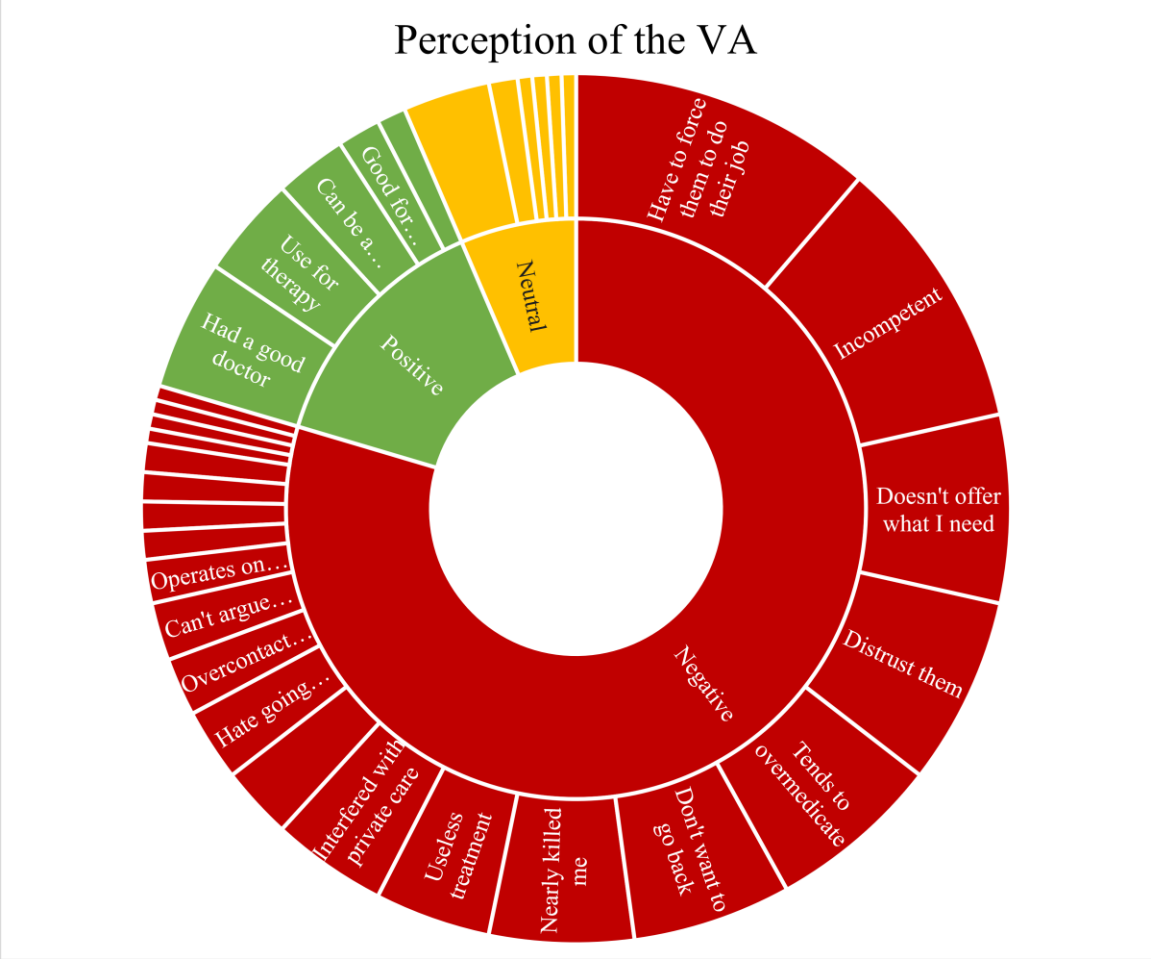

Figure 10: A sunburst chart representing perception of the VA as found in the interviews. Relative sizes represent frequency as seen throughout the cumulative interviews as compiled from responses from all interviewees.

While one interviewee had generally only good or neutral things to say about the VA, the majority of what the rest of the interviewees had to say was negative. This determination was based on nomenclature, tone, and subject matter of the experiences discussed. Unlike some of the other subjects discussed regarding the transition back into civilian life, the majority of the opinions of the VA came from the direct experiences of the interviewees rather than rumors, examples from other veterans they knew, or simple conjecture.

The interviewees largely considered the VA to be too quick to treat the symptoms rather than the root cause of a condition and therefore, more likely to overmedicate. Several of them had mentioned having been put on every type of antidepressant, anti-anxiety, and antipsychotic pill there was, to varying degrees of success. They'd also discussed how every time they went to the VA, they were given a new pill to take or instructed to take an increased dosage of the same pills they already had. Since part of military enculturation involves minimizing health concerns to prevent loss of combat readiness and malingering, veterans tend to avoid taking any kind of pill other than pills for pain management, specifically ibuprofen. To go from an environment where even legitimate health problems are labeled as "malingering," to one where every symptom is separately managed through medication is cognitively contradictory for veterans. Sara discussed how even though she preferred not to take medication, she knew she needed some of it but still had problems getting refills from the VA because when her doctor was rotated out (as is done every year or so), she has had to argue with her new doctor about whether they or the specialty clinic were responsible for refilling her prescription a few times already. Charlotte expressed frustration that she had a large bin in her closet full of medications she was expected to take and that if the root cause of the problems was addressed instead, then she wouldn't need so many of them. Charlotte feared that with each medication prescribed to her, the chances for negative interactions between them increased and felt that the VA in particular didn't properly manage interactions between medications. As part of regaining her sense of agency, she takes as few pills as necessary and studies and keeps track of all the pills and interactions between them. Charlotte's anxieties and paranoia are largely centered around having a negative interaction between

medications, a legitimate concern considering how a simple allergy shot had given her a permanent condition necessitating a medical discharge when she'd been in the military. As a result, further association of the VA medical center with military medicine only deepens her mistrust in their capabilities.

The most common complaint the interviewees had was how certain doctors treated them. Some doctors were perceived as being willfully antagonistic while others were perceived as incompetent. Still others they had experienced would try to order them to take a medication or do a therapy they didn't want to do, abusing the aspect of military culture which ensures service members follow the order of those above them in the hierarchy in an effort to force treatment compliancy. Maya frequently found herself arguing with doctors, some of which would call the VA police over to escort her to mental health, to which she'd respond by going to patient advocacy. Sara frequently argued with her doctors over whether they were in charge of renewing her prescriptions. When she proved one wrong, she was left a message on her voicemail stating that she was due for her annual appointment "unless you don't want to see her anymore, in which case, there's no need to call us back. Goodbye." She felt that this was a suggestion that they didn't want her to come back. Another experience she'd had with a doctor involved the doctor just asking her how they can better help their veteran patients, since they knew she worked with veterans for a living. While she was happy they were interested, during her narrow appointment window was not the time to discuss that, especially when she was there for her own healthcare needs.

Even though the majority of the interviewees expressed a largely negative view of the VA, they also felt that the VA could be a good resource if used properly. Part of this

involved learning how the VA system worked and who to talk to when the treatment they received was not up to their standards. Several of the interviewees mentioned a necessity to learn how to advocate for their healthcare needs through patient advocacy. For instance, because Maya was arguing with a doctor abusing the authoritative aspect of culture, the VA Police were called by the doctor and were told to forcibly escort her over to mental health. Knowing how to navigate the system, Maya told the VA police that she was in treatment with mental health and this was not an issue with her condition, but instead with the doctor's superiority complex. She instructed them to take her to patient advocacy instead and was able to air her grievances. The problem was fixed by the next time she needed to come in. Sara has also had to utilize patient advocacy many times and often instructs other veterans struggling to get the medications or treatments they need on how to properly utilize that service. Consider the fact that many veterans never move beyond military culture to be able to argue on their own behalf against an authority figure and the capability and seemingly ubiquitous perception of abuse or neglect by the VA system becomes easily explainable.

The interviewees also discussed how many of the issues found at the VA were likely due to being overly restricted by bureaucracy, specific abrasive doctors, and attempting to take on more than it can handle. They also overwhelmingly approved of the mental healthcare provided at the VA, several like Sara and Charlotte utilizing the mental healthcare of the VA even when they had private primary care doctors. The only issue with mental healthcare expressed by those who use it was Charlotte, since the doctor had tried to take her off of their privately prescribed medication for diabetes which nearly killed her. In this case, Charlotte felt that the VA is still a good resource for mental health

and therapy, but would never allow them to adjust her other medications again. Amy had described her experience with mental healthcare that they were “screaming it at me” that she had PTSD because she couldn’t remember the events of the traumas she’d been exposed to. This and feeling worse for at least a week after an appointment for her PTSD are the reasons why she hasn’t tried to seek treatment again. Jane prefers her VA treatment over civilian treatment, though this might be because her VA clinic is where she currently lives rather than the Houston VA hospital.

Methods of Dealing with the Condition

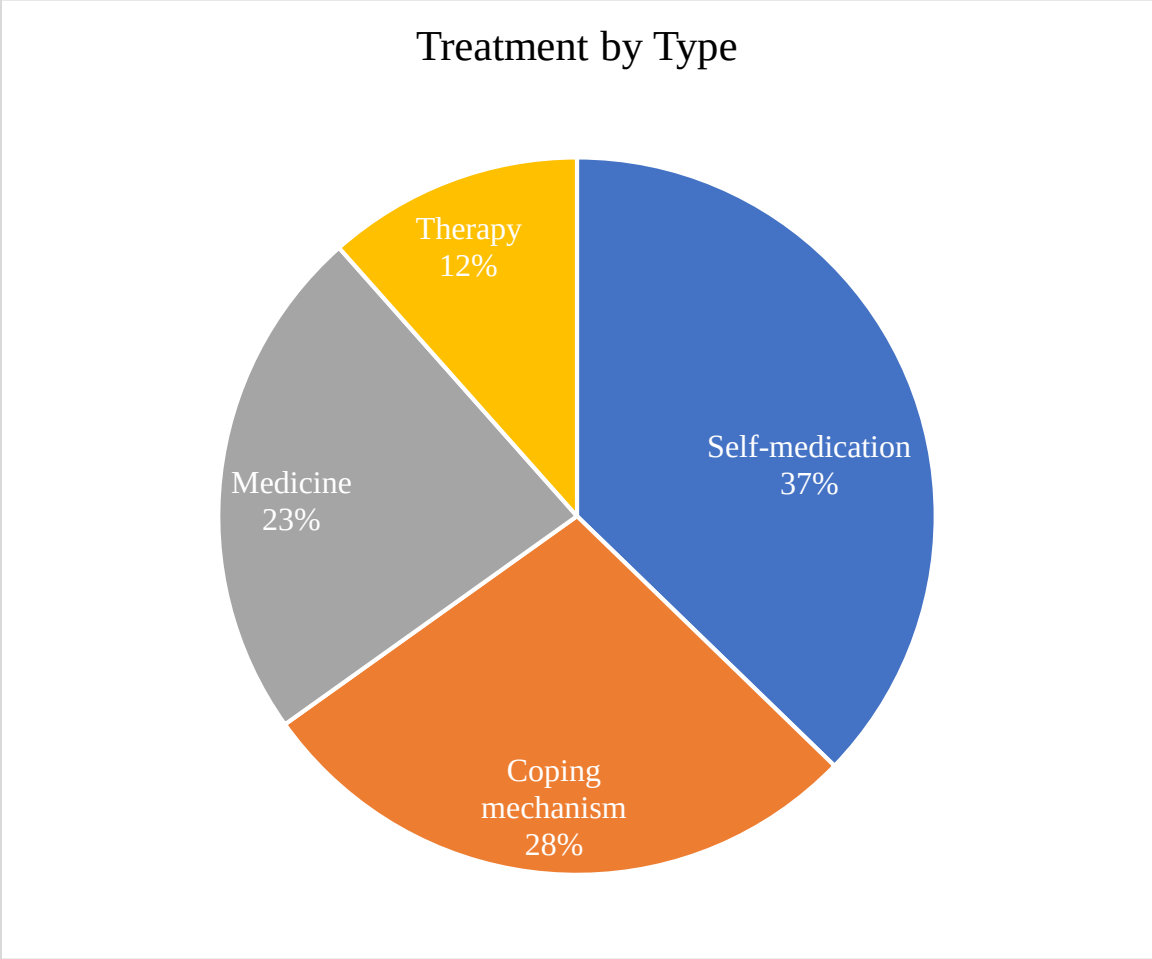

Figure 11: A pie chart representing the treatment strategies employed by the interviewees. Percentages represent frequency as seen throughout the cumulative interviews as compiled from responses from all interviewees.

When seeking a method of managing their condition, the interviewees would rely on instilled military cultural values as well as personal preference to determine what was most effective. The interviewees overwhelmingly preferred coping mechanisms over medication and therapy and were more willing to accept therapy over medication where possible. Due to the severity of their condition and the perceived authority of the doctors, they would take the medication but often preferred to limit medication use or to get off of it completely given the chance. Generally, the interviewees tended to utilize multiple

treatment strategies at once, such as taking prescribed medication, going to therapy, going to appointments, self-medication with drugs or alcohol, and their preferred coping mechanisms such as hobbies, leaning on their support networks, and staying busy. Any perceived exclusivity regarding the representation of these categories comes from the categorical nature in which they have been presented.

Self-medication

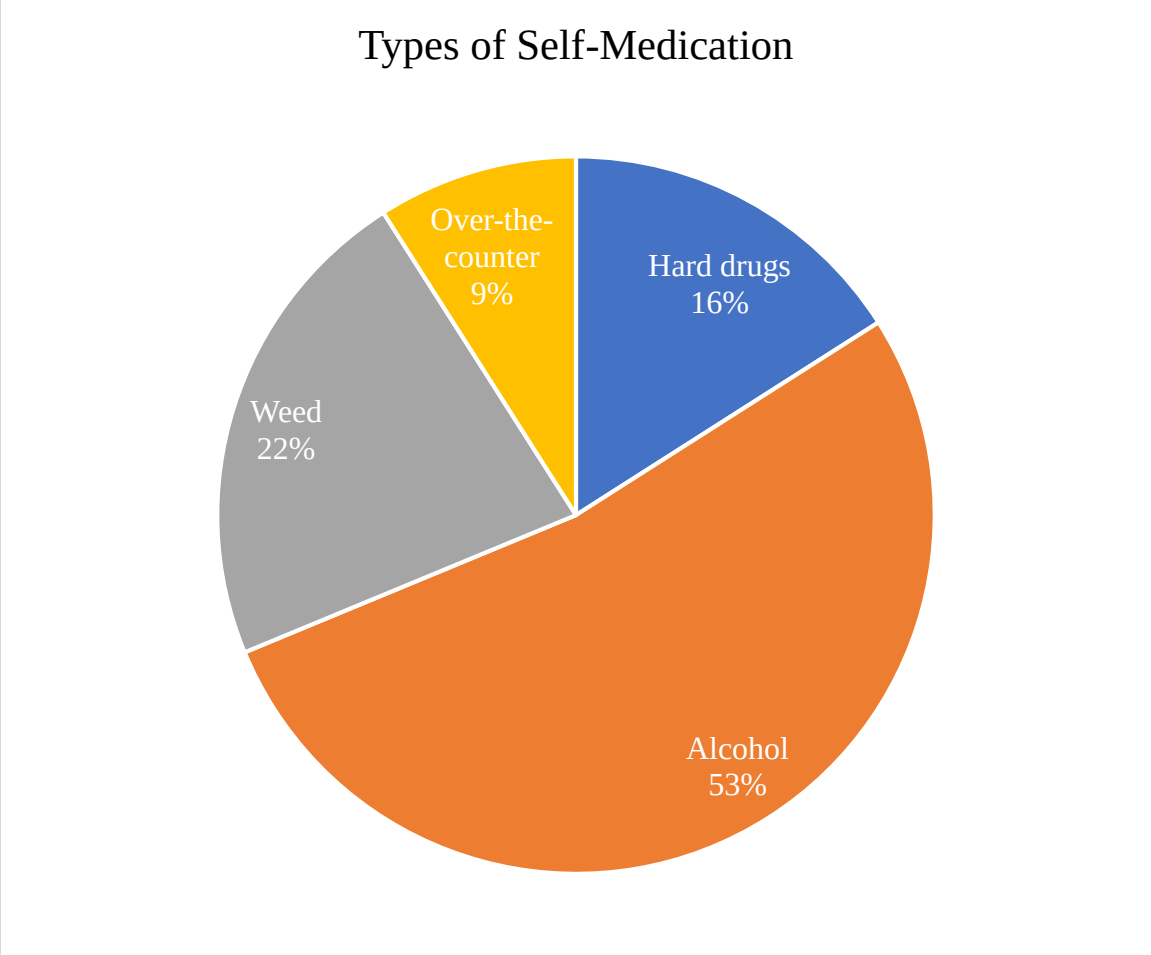

Figure 12: A pie chart indicating self-medication by type as indicated by the interviewees. Percentages represent frequency as seen throughout the cumulative interviews as compiled from responses from all interviewees.

The treatment strategy of choice was definitively self-medication, although several interviewees had described a general diminishing of this strategy's efficacy as

time went on. Substance use disorders are listed in the DSM-5 as being common comorbid conditions for PTSD, so it is no surprise that it is fairly common among the interviewees (APA, 2013, p. 280). Alcohol use was by far more the more popular choice for self-medication over any other drug type. This is likely due to the widespread tacit approval of alcohol in the military, as evidenced by both frequency of drinking found amongst service members and veterans as well as several cases of looking the other way when underaged drinking occurs as discussed by the interviewees. For Maya, who has admitted she self-medicates with alcohol, drinking is a way to numb the way she feels, a strategy she has employed since she was in her mid-teens. However, it has recently lost its appeal after dealing with alcoholics in her civilian career and learning about its effects on the body. The majority of the interviewees who drink stated they only do so socially, but after further discussion it becomes clear that they mean they aren't drinking just because others are, but so that they *can* be social. In other words, in many cases they are using alcohol as a crutch to diminish the paranoia and avoidance symptoms normally experienced in large gatherings so that they can be in a social gathering. In some cases, it is in fact just social drinking. For them, the distinction comes from the reason for drinking as well as the amount imbibed.

Another substance used in self-medication is marijuana. Several of the interviewees had expressed using marijuana in the past, but since the onset of PTSD, it has not only diminished in efficacy but has made the symptoms of paranoia and panic attacks far worse. What is interesting about this is that those interviewees who did use weed in the past all described it the same way and were not prompted in any other way except the question as to whether they used it to manage their condition. Since Deanne

doesn't have access to VA medical care, she can only rely on weed and alcohol to manage how she feels and so far, hasn't experienced the diminishing efficacy of weed that the others described. Others, like Sara and Maya, stated that the legal CBD oil derived from cannabis was the most effective form of pain relief they had tried but due to fears about testing positive for tetrahydrocannabinol (THC), didn't use it as often as needed so that they wouldn't lose their job.

Like Maya, a few of the other interviewees had mentioned being on hard drugs while in the military in order to get around the drug tests their units administered. Having come from a hard-drug familial background, Amy ended up having to come off of the drugs while on deployment, making an already stressful situation far worse. Now, none of the interviewees are on hard drugs, having "gotten over it," and no longer interested in the effects it has nor willing to risk their careers or health for it.

By far the currently most abused form of self-medication would be the overuse of over-the-counter pain medications, specifically ibuprofen. Sara and Charlotte expressed that they depend on ibuprofen to make it through daily activities, often taking 4-8 pills every day in order to manage their pain despite the fact that their doctors had recommended they cut down their use to only taking a couple a week. Even so, it barely cuts the pain. Sara also excessively uses lidocaine cream and alternates her use of ibuprofen with IBC powder in an effort to reduce the damaging effects it is likely having on her liver and stomach. Neither of these individuals want to take a lot of pills, refusing to take all but what is specifically prescribed and necessary for their conditions. This is interesting because they are also the ones taking far more ibuprofen than they should be and are aware of this fact, but continue to do so anyway. For them, use of pain

medication is necessary for daily functioning, since, as indicated by Sara, “It’s hard when you hurt to be nice.” The wide acceptance and overuse of painkillers is reflected in military culture, since the only form of medicine the military encourages is the use of ibuprofen, even referring to 800 milligram pills as “Ranger Candy” to indicate both its frequent use as well as diminished potential side effects and severity by referring to it as “candy,” (Jennings et al., 2005, p. 1001). Otherwise, one is just expected to “drink water and rub some dirt on it,” and keep on keeping on, a sentiment expressed by each of the interviewees to one degree or another.

Coping mechanisms

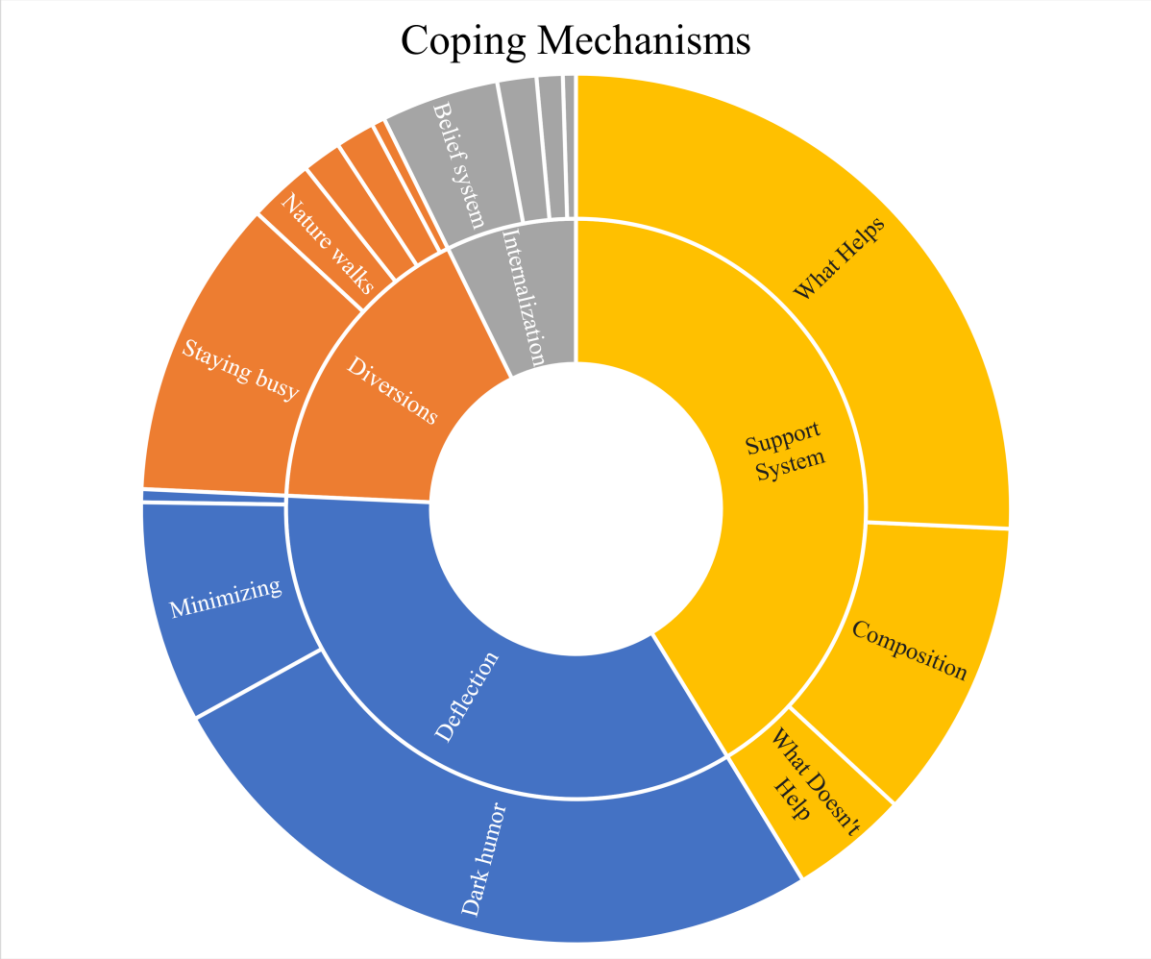

Figure 13: A sunburst chart representing the coping mechanisms utilized by the interviewees. Relative size represents frequency as seen throughout the cumulative interviews as compiled from responses from all interviewees.

The interviewees overwhelmingly preferred coping mechanisms over therapy or medication largely because it gives them back their agency when it comes to managing their condition. This was especially appealing in that it satisfied the military cultural ideal of denying medical care in favor of rugged self-sufficiency. Here, a coping mechanism is defined as that which the interviewees utilizes on their own, without professional medical intervention or instruction. Such methods fall into the following major categories: support system, deflection, diversion, and internalization.

The most frequently utilized coping mechanism for the interviewees was their support system, which is here defined as leaning on their spouse, family, or friends when needed. Throughout the course of their conditions, every interviewee has needed to lean on their support system at one point or another. While not everything members of the support system does is helpful, the interviewees were able to identify certain features which made a support system more effective in helping them, such as being able to talk to them about anything, just listening without trying to fix it, building a larger support system, working together to solve problems, not pressing the issues when they don't feel like talking, recognizing need for treatment, talking them down when they were too overwhelmed, indicating when they needed to seek more help, and understanding what the interviewee was going through. In other words, the most helpful things a person part of the PTSD sufferer's support system can do is be a nonjudgmental, active listener who can help with problems when asked but not press the issue, yet at the same time, be capable of pointing out when the sufferer is in need of treatment and firm enough to get them to seek it out when it is needed. The interviewees indicated the least helpful things their support systems could do is try to fix the problems for them without being asked and when they are intentionally pushing their buttons.

For the interviewees, the support systems are primarily comprised of their spouse, direct family members, friends, and in some cases, a pet. It should also be noted that since the loss of a loved one, even a pet, can be considered a spiraling event, some of the interviewees, such as Amy, have been hesitant to formulate new relationships or to get a new pet-even years after the last one died. Others, like Jane, are interested in having a pet but cannot get one due to the restrictions on their lease. A pet fulfills the need for a

nonjudgmental listener and can sometimes use limited capability to indicate when the sufferer is not doing very well, but also comes with responsibilities and more dependence on the sufferer than most of their human loved ones. While this may seem like a negative aspect at first glance, it is in fact a helpful aspect in some cases since it also provides a sense of responsibility on the part of the PTSD sufferer to take care of something wholly dependent upon them, an aspect echoed by the interviewees with children (albeit to an entirely different degree). While enlisted in the military, the only service members capable of having a pet are those with special permissions or those with civilian dependents, so as a veteran, having a pet can be a novelty denied to them while they had been in the service. Instead, service members are largely expected to lean on their battle buddies.

The second most frequently used coping mechanism for the interviewees was deflection, usually in the form of dark humor, minimizing the condition, and sarcasm. This form of self-treatment is what is most influenced by military culture, since minimizing the impact and dark humor are highly encouraged in most aspects of the military. For instance, a common phrase, "Embrace the suck," refers to the need to accept the current, bad situation in order to move forward. Another is "Getting blown up could ruin your whole day," minimizing the severity of actually getting maimed or killed by being blown up. There are a plethora of military phrases meant to encourage this strategy of resigning oneself to inevitability when it comes to negative situations or lack of comfort. Out of the pool of interviewees, Maya and Sara utilize this the most. Sara highlighted the ubiquity of dark humor in the military in her account of her ex-boyfriend threatening to jump off the barracks. When she was asked by her fellow MPs to help talk

him down, she told him to "Jump, motherfucker!" After the service, dark humor is still frequently utilized. For instance, Maya used to wear the dysfunctional veteran attire, since it would say, "Medicated for your safety," or "Stay back 500 feet." Although she no longer wears the attire due to its propensity to normalize and stereotype veterans as dysfunctional and dangerous, she still uses dark humor to cope with that which can be disturbing. Maya succinctly describes dark humor as the following:

> *You go into the military and you develop a dark sense of humor because you're around a lot of…I mean, if you think about it, we see shit that most people won't ever see in their lifetimes. And we have to find a way to deal with that…So we develop this dark sense of humor and then we come back and we tell our dark jokes and people don't get it. They're like, "What the fuck is wrong with you?" and it's like "Well, I could explain it to you but you're still not going to get it. So…"*

Another common coping mechanism utilized by the interviewees is the use of diversions, or any activity which keeps them busy or distracted and prevents them from having too much time alone with their own thoughts, which is reflected as an avoidance behavior in the DSM-5 as Criterion C1 and C2 (APA, 2013, pp. 271-275). The most common diversionary tactic is staying busy, which is piling on more work and responsibilities so they don't have time to think about anything else. Several of the interviewees indicated that this is one of the few defining features of female veterans, who tend to be difficult to get in contact with and are not often found hanging around veteran organizations like their male counterparts. Staying busy includes taking on more responsibilities at work, going to college, taking care of the home, taking care of family

and friends, and volunteering with veteran organizations. Other forms of diversions involve hobbies such as playing sports, going on nature walks, and arts and crafts. Others simply take naps or sleep in excess.

Another coping mechanism is internalization, or using one's internal machinations to deal with their condition such as a belief system, meditation, or creature comforts such as comfort food or self-care. For some of the interviewees, their belief system is a method of understanding and providing external control on the unpredictable and upsetting nature of PTSD episodes and symptoms. Deanne and Maya utilize meditation to help manage aspects of the condition. For Deanne, meditation is used to fall asleep. Maya indicates she doesn't feel she meditates as much as she should, but that it can help in practicing mindfulness. Jane mentioned her faith as a way of coping with her condition. For others, it is creature comforts such as consumption of fatty or unhealthy food, also known as comfort food. Amy prefers to eat ice cream when she is feeling particularly stressed or down, which she even did during the interview as a way of alleviating stress. Another aspect of internalization is self-care activities, such as doing a spa day or altering one's appearance through a makeover. As indicated by Sara, the culturally defined go-to method of dealing with change outside of one's control for females is making a change, especially a change in one's physical appearance-such as cutting or dyeing one's hair or changing the way they dress. Not too long before the interview, Sara had recently cut her previously waist-length hair to a bob cut as a way of controlling her surroundings after the death of a friend. She indicated that doing so enabled her to feel a sense of control over her current situation. Others describe

internalization as simply “self-managing” their condition, taking control of their healthcare strategy and utilizing the coping mechanisms that work for them in particular.

Professional Medical Treatment: Medicine

Most often, the interviewees felt that while medication could be useful, they preferred not to take it, especially for mental health issues. Most of them had been switched to various drugs at varying concentrations in order to treat their condition, but felt that the majority of the time, the efficacy of the treatment was not worth the side effects of the medications. Maya had even decided she was done with medications only a few months before the interview and stated that she not only felt fine, but that she no longer had frequent suicidal ideation like she did when she had been on the medication. Charlotte had discussed an overwhelming anxiety over drug interactions and side effects, a justifiable fear considering the military healthcare system had given her a permanent condition from a simple allergy shot and also that the VA had nearly killed her by taking her off her diabetes medication without giving her a new medication to replace it, telling her she didn’t need it. After this, she was feeling ill and checked her blood sugar and her device indicated that it was at 500 milligrams per deciliter, far above the recommended target range. It was at this point that she decided, “I can’t let the VA mess with my diabetes.” Deanne had been on a medication which caused memory lapses and periods of being blacked out while she’d been with her abuser. Amy expressed concerns that medications, especially antipsychotics and antidepressants, were more addictive than hard drugs. Since she’d been addicted to hard drugs before and had even gone cold turkey while deployed, she understood the difficulties associated with coming off of a highly addictive substance and never wanted to do so again. It must be noted that a hard drug

user had refused to try prescription medications for mental health because she feared it would be more addictive than the hard drugs she was familiar with. This might be due to the experience of coming off of the hard drugs while deployed, but is more likely a result of culturally informed perception of psychotropic drugs.

Professional Medical Treatment: Therapy

Since veterans tend to eschew the use of medication to treat their ailments (barring ibuprofen, of course), therapy is the most accepted course of treatment for PTSD. The majority of the interviewees were fine with going to therapy and utilizing the tools given to them to help manage their condition, especially Maya, who had tried the gamut of therapies offered by the VA to help her manage her condition without the need for medication. The interviewees were most often offered Acceptance and Commitment Therapy (ACT), which is largely meant to help them accept the reality of their condition using mindfulness behavior-change strategies. Some had also tried Cognitive Behavioral Therapy (CBT), which is meant to help them restructure the way they consider the trauma and their condition in order to help them manage how they feel, and Cognitive Processing Therapy (CPT), which is a subcategory of CBT therapy developed specifically for trauma victims.

The reactions and perceived efficacy of the therapies are a mixed bag. Maya feels that the tools she learns from therapy help her manage her condition well, such as talking about the traumas in order to normalize exposure to thinking about them, practicing mindfulness to recognize when her feelings are getting out of control, and breathing or counting to help ground her when the feelings get to be too much. Jane has had intermittent therapy and appreciates its efficacy, stating that if she needs it, she can set an

appointment rather quickly. Charlotte is on the opposite end of the spectrum, feeling that the only purpose of the ACT therapy she'd engaged in was to get her to understand and accept she'd be in pain for the rest of her life, which she felt she'd already managed on her own. Deanne struggles to utilize therapy because when she tries to confront the traumatic memories, she blanks out and feels everything goes black, though when she does manage to remember things, she describes having a "burst of productivity," as if unlocking the memories reduces some of the burden it places on her.

Military

Before the Military and Reasons for Joining

The choice to enter the military was shaped by the circumstances surrounding the individual before entering the military. All of the interviewees who talked about their lives before the military indicated that they had grown up poor or disadvantaged in some way, shape, or form. Most of these interviewees also mentioned having grown up out in the country, far removed from suburban or urban areas and the experiences presented therein. It was this general inexperience with life and the kinds of people one can meet that some, like Deanne, attribute as contributors towards the events leading up to their traumatic events.

The interviewees also discussed aspects of life before the military such as their time in High School and how their circumstances shaped their personality growing up. Others described in detail how they faced an abusive household growing up, such as Deanne's alcoholic father and Amy's antagonistic mother. Others merely hinted at a troubled home life before joining the military by projecting this idea of going into the military for the sake of escaping a bad home life onto all female veterans, as Jane and

Sara did. Yet Sara's experience with many other female veterans as well as the other interviewees tends to corroborate this idea.

Another commonly cited reason for joining the military is the ability to pay for college, since one of the major perks offered by serving in the military is the opportunity to have their higher education paid for-either through the G. I. Bill, Vocational Rehab (Voc Rehab), veteran-specific scholarships, or other programs. Some states also provide extra benefits on top of that, such as the Texas Hazlewood Act, which pays for further schooling once the G. I. Bill benefits run out. One interviewee admitted that she'd told her family the ability to go to college was the main reason for joining the military so that she wouldn't start a fight by telling them the real reason: to escape a bad home life. Since four of the six interviewees have a degree, one of which has a master's degree as well, and a fifth is currently seeking a degree, the findings of the National Center for Veterans Analysis and Statistics that female veterans tend to have a higher education and employment rate than either their male peers or female civilians is reflected among the interviewees (NCVAS, 2017, p. viii).

Some interviewees, like Maya, mentioned a family history of service as a reason for going in as well as a general need for structure and positive momentum towards their life goals. In all cases, regardless of the reason for going in, each of the interviewees indicated that the military became much more than that and even despite their experiences and the mental and physical injuries they endured, they would do it all over again given the opportunity.

Reasons for Exiting the Military

Each of the interviewees had their own reasons for exiting the military which can be seen as a reflection of veterans all across the United States. For several, it was a non-desire to keep going after having served their full enlistment contract, especially if they were not offered bonuses and perks, as is the case for Maya. Having freshly gotten back from the deployment and combat trauma, she was hardly enthusiastic about deploying ever again, but knew the chances were high it would happen again if she stayed in since she was a combat MP. Because of the mental distress she faced from the combat trauma and the fear of dying during deployment, Maya felt that if the military wanted to keep her, then it would need to give her the K9 training she wanted as well as an enlistment bonus. She explained that it is common for those up for reenlistment to ask for a bonus or special training, and oftentimes they would end up getting both. Still traumatized by the firefight, the only thing that would convince her to stay in would be getting both. When they told her she'd have to pick one or the other, she chose not to stay in at all. Jane had a similar mindset and similar circumstances. Having recently had her ankle broken and a gun pointed in her face, she decided that the way the Unit seemed to side with her abusive husband was an indication that she didn't belong there. To her, her entire branch was, "too damn small for the both of us," and she was glad she left the service.

For others, it was hardly a choice they wanted to make, but did so out of necessity. Charlotte had been given a routine allergy shot and had a severe adverse reaction to it which caused allergy-induced asthma. Because it is notoriously difficult to convalesce while in the military and a permanent condition such as this would be near-impossible to control in a military setting, Charlotte was advised by her command to get

MedBoarded. Knowing that the process depended on a supportive command as well as the fact that they are notorious for taking years to complete, Charlotte agreed to it. Much to her delight, it went through within only a few months. For Deanne, it was because she got pregnant while she was still in AIT, a fresh trainee, and her soon-to-be husband had been in longer and was more established in the military than she was. Since the military has provisions that allow pregnant women to get out of the military in order to take care of their children, not only was it easier for Deanne to get out than it would be for her husband, but she felt she could still rejoin given the right circumstances. Sara didn't indicate why she exited the military, but since she had served for five years, her contract likely ran out and she didn't choose to renew it.

Rejoining the Military

Nearly all of the interviewees missed being in the military, especially the military cultural aspects which made them feel safe and comfortable, most of them citing aspects such as camaraderie and knowing that others "had my back." Since many of them had felt estranged from their civilian peers, it is only natural that the sense of dislocation would cause some of them to seek to return to the military.

Maya decided to go back into the military after a little over a year because she missed the camaraderie and structure. In order to reduce her chances of redeployment, she went into the Reserves, which in comparison, can be considered to be a part-time military job which only requires its members to spend one weekend a month and two weeks per year training to keep their skills sharp and tend not to deploy nearly as often as Active Duty. She was in the Reserves for two years and has remained a civilian since then.

Deanne had attempted to go back into the military, but due to the fact she left the service before she'd been with her unit for 180 days, she did not qualify for reentry into the military without having to go through Basic Training all over again. Also, since she was Texas National Guard and attempted to rejoin the military as California National Guard because her husband was stationed in California, there were other, more complex policies at play. The National Guard is similar to being in the Reserves in the frequency they meet for training, but different in that they can be called up to help with relief efforts and take another oath to serve the governor of their state as well as the Constitution, the President of the United States, and U.S. military. Deanne felt that when she attempted to rejoin the military, they simply turned her away altogether.

Time in the Military

The frequency of themes found in the interviews regarding their time in the military tended to depend on the individual-how long they had been in, where they were stationed, and their branch of service.

For instance, because Deanne wasn't in the military for very long, the majority of her discussions about the military involve her time in training-both Basic Training and AIT. She describes the living conditions, the amenities on base, and the general interactions between trainees and the drill sergeants or NCOs. Deanne describes an environment where she didn't feel welcome as a female, being regarded as incapable during her time in training due to her physical build and how she had simply been treated as "a secretary," when she got to her unit. In her estimation, the military environment she found herself in was a difficult one for females, wrought with unwanted touching and

frequent sexual comments. For instance, while she was in Rear-D, there was an NCO who was frequently inappropriate with her and the other females.

> *Well they just made you feel like complete and utter shit. And then they would make sexual-type comments, you know, like not really toward me 'cause I was big and pregnant. It was just, "Damn, what baby daddy number is this?" and that kind of stuff…*
>
> *And then to [my battle buddy] it was really sexualized stuff and a few times, and I don't know if it was consensual or what because she would go off with people…they would go and talk or have a smoke break or whatever. But it was always… to me, obviously sexual shit going on. And I can tell you in the beginning at least, she was not for it because she was horrified. She was young. She was 18…*
>
> *And yeah, there was also inappropriate touching. I don't care. I was pregnant, they touched my belly all the time and I would tell them to stop. I would say "I'm not comfortable with that," and they would still be like, "Oh, is he kicking today?" and touch me! Get into my space and touch my body! And there was no one to report it to. There was no one there…they were it! What am I gonna do? Report it to the other guy? He's doing the same kind of crap, but to her, and now that I think about it…how fucked up that could have been. You know, it's different whenever you're looking back than to when it was happening, 'cause when it was happening, it just seemed like "Oh, this is normal. This is how it is. This is how it is." It just…Yeah, it just comes in waves.*

Maya primarily discussed her time at her unit while she was in the military, specifically in relation to deployment, such as time between deployments and during deployment. This is expected because her precipitating trauma is combat trauma. She largely viewed her military experiences as positive, especially in regard to her time at her unit.

> *I got to Germany, my platoon Sergeant picked me up and they literally just got back from the field. Like he showed up to the welcome center to pick me up and still had his face camo'd out, picks me up, he's got a big old dip in his mouth, driving back to the base, to the barracks and he's like, "Welcome." He goes, "I'm gonna take you in, introduce you to a couple of the guys and they're going to be like your big brothers."*
>
> *I was like, "Alright."*
>
> *And I was the first female in their platoon and that's literally what they were. They were all big brothers. They always had my back. They were looking out for me…*

Amy has difficulty remembering her time at her unit and in deployment due to extensive memory loss, but like Maya, indicated that she "had fun" while she was in the military and enjoyed the majority of the interactions she'd had with her unit. She also remembered some of the bad things as well, but largely considered her interactions and experiences in the military as positive, especially since she can't remember most of the combat events.

> *There's a lot of stuff I do remember and a lot of stuff I just can't, there's a lot of things that I just don't remember. I honestly, I thought [deployment] was a*

vacation. I mean, I remember having some fun there. I remember not so many fun things, but I can't remember some things that a lot of my battle buddies can that have told me that I was apparently there for. Um, I can remember…I can remember being shot at by our own people. I do remember that. I remember being on a catwalk. We were a prison guarding basically the pretty bad people…Basically all the meanest guys that you think of that were on death row, we had them. I remember being on the catwalk and I remember being mortared and bombed a couple of times, but it kind of goes blank after that.

I remember playing volleyball. I remember our daily routine. I can remember, you know, all that stuff. But there's, there's things that you're not supposed to forget-the bonds that you build with the people that you're there with and I can't remember half their names. So I don't even talk to them anymore.

Sara had largely discussed her current work, but did spend some time discussing what it was like in the military, specifically in how personality-dependent one's experience can be and how one's command can make or break the experience. Sara largely has a positive recollection of her time in the military with a few exceptions, such as the following:

Yeah, it's not easy being a female in the military in my career field.

I had an incident and the guy ended up having to get transferred because I wasn't the type to ever complain. But we would come home from the field and my roommate at the time, she had a different crew chief than I did. And I came home and just cried and I'm not a crier. And I'm like, "Oh my God, this guy's gonna kill me." You know? I mean, he's making me do shit that he doesn't even make the

guys do because the guys aren't strong enough to do it. He's treating me like shit just because I'm a girl.

And so she said something to her crew chief without telling me. And then people started watching, like he would call over when I was in a different missile field. He would call over and say, "Hey. Hey what's going… I want to know what's going on over there with [Sara]."

…They watched and they saw what was going on without me ever complaining...If there weren't those good guys there to pay attention and look…because they knew, especially her crew chief, he knew the type of person, he said, "[Sara's] not going to complain ever. She's not going to, but this has got to stop." So then the flight Sergeant started paying attention and he was like, "Oh no." Well then later after all that happened, he ended up getting transferred to a different base 'cause he got caught fooling around on his wife and I don't know what all happened there, but he got shipped off…

Sara's largely positive experiences with command relate to the individual who trained her, her crew chief, who imparted to her military cultural ideals and in her estimation, enabled her to survive when she was blown up.

And my crew chief man, you know, he was a blessing because he had served in Panama and through the shitty stuff and just trained me. That's what saved my life in the desert. If I hadn't been trained under him and had him for a crew chief, there's no telling what would have happened over there. I don't know what I would've done. I probably would have lost my frickin' mind the second the shit hit the fan, but I didn't.

And I got in trouble on gates one day cause I carded the general and…And that's because that's how he trained me. And the SP commander called me and he goes, "I know what you did and I know why you did it, but don't do it again." I said, "okay," then boom, come to find out they were watching us the whole time, so I probably saved that asshole's life, you know?

…When I came back, I told [the] Sergeant, I was like "…It's boring now being out in the field, if you're not training or constantly exercising, you can get bored. Why not beef up your skills?" So that's what we did.

Sara's example shows how strict adherence to the rules, such as carding everyone who comes through the gates during guard duty, is required but often overlooked. The reason for policies such as this makes distinguishing important people, such as an official everyone should recognize like the General, more difficult for an enemy observing them. Also, the sheer difference in rank can make some lower-ranked too intimidated to do something like card a General, but Sara's strict discipline and adherence to the rules meant that the General was not recognized as being a person of distinction by the enemy. Also, not having too much down time and filling that time with training or obtaining new skills is something else the military insists on, since boredom, youth, time, and physical capability can lead to particularly destructive shenanigans (Redmond et al., 2015, p. 14).

When that trust and connection is broken, such as in the case of MST survivors, the structure of the military and enculturation breaks down. For instance, Charlotte discussed a general disconnection from her fellow soldiers at unit after the MST because they had known about her attacker's tendencies but did nothing to prevent it.

I would run to my barracks, to my room. I did not associate with any of the guys in the barracks just because after the fact I had one of them whose party it was, it was his party's going away, come and apologize. Like they kind of knew that he was that way, but they still allowed him near me, around me and came to apologize to say you know, "I'm sorry that happened," or whatever. I had no friends on the base. I was like, "I'm not having anything to do with these people. I'm not going to any parties you have. I'm not hanging out with you." So that's how I process that. Just never gonna do that again. Not going to drink, you know…

Yet on the other hand, Charlotte felt her command was excellent and very supportive of her, especially after her allergy-induced asthma was caused by military physicians.

I spent the majority of my week-this is how supportive my unit was-a good portion of my week would be going to the motor pool, picking up a car and driving [81 miles away] to see that pulmonologist and allergist and whatever. And I did that for a while and my unit did not want me to leave and my doctor-he was also a Colonel-was like, "You know, if I were you, I'd get out."

The point of that was that he thought that my future command may not be as supportive as my current command. And so I decided I was going to [do it.] My commander was like, "You know this, this takes a long time. Like these MedBoards-they can go on for years."

And I was like, "Okay, that's fine. I'm going to go ahead and try and do it."

I was home in six weeks then like that. Out; done. I got a phone call that "your MedBoard came through, they MedBoarded you. You're out!"

Jane similarly disconnected from her unit because her attacker, her higher-ranking spouse, seemed to have the support of the unit. Jane does admit that after it was all said and done, several members of her unit came forward in support of her and to discuss how they'd never liked him, but it was not enough in the face of perceived institutional support for him.

Overall, the experiences of the interviewees while they were in the military are representative of the experiences of other females in the military-from the struggles they faced to the support they received.

Reintegration into Civilian Life

Reintegration back into civilian life for the interviewees tended to be an experience wrought with uncertainty and freedom-the freedom to choose what to do next and where to move, yet the uncertainty and difficulty of attempting to reintegrate into a life now unfamiliar to them without the structure or guidance of the military.

College

According to the interviewees, one of the main things which convinced them to join the military was the capability to obtain a college education without needing to go into serious debt. It should be noted that four of the six interviewees obtained at least a bachelor's degree after service, which supports the finding that female veterans were the demographic with the highest average degree level and employment rate in the U.S., a statistic which Sara had proudly quoted in her interview and is corroborated in a study by the National Center for Veterans Analysis and Statistics (NCVAS, 2017, p. viii). One

interviewee is currently working on her bachelor's degree, the other three have already obtained their bachelor's degree, and out of those, one has a master's degree as well.

There are many veteran's benefits offered for the purpose of obtaining a higher education which vary by state, location, and the individual's situation. The G. I. Bill, which is provided by the federal government, is a benefit that all but one interviewees have utilized so far. There are two types of G. I. Bill: the Montgomery G. I. Bill and the Post-9/11 G. I. Bill. Veterans can choose one or the other, each providing their own benefits and drawbacks. The major difference between the two is how the benefit is paid. For the Montgomery G. I. Bill, the payment goes directly to the student who then uses it to pay the school, get their books, and keep the rest as a housing stipend (NCVAS, 2017, p. 27). For the Post-9/11 G. I. Bill, the tuition is paid directly to the school and the student receives a monthly housing stipend and a book stipend at the beginning of the term (NCVAS, 2017, p. 27). If one enters the military with college education debt, the military helps them pay for that debt and after service, the veteran still qualifies for the G. I. Bill. For the case study, Maya, transition back into civilian life was wrought with difficulties. Like two other interviewees, the first thing she did was go back to college, but in Maya's case, it was primarily for the housing allowance provided by the G. I. Bill which could keep her afloat after exiting the military rather than having any specific higher education goal in mind. Maya ended up receiving her bachelor's degree in 2008 while she was still in the Reserves, but has since utilized more of her education benefits to further her career.

Once the G. I. Bill runs out, there is the potential to use Vocational Rehabilitation and Employment (Voc Rehab) to further one's education. This is meant for those

veterans who need to switch careers after using all their G. I. Bill or those who need further certifications or training to work in their specific field (NCVAS, 2017, p. 33). For this, the veteran applies for Voc Rehab through the VA and a counselor meets with them to determine what they would need in order to meet their goals. The counselor then determines how much this would cost and how much time it would take to be feasibly done, then writes a plan and submits it for review. After the processing of the review is approved, then the veteran can utilize those benefits much like they would for the G. I. Bill. For Charlotte, the Voc Rehab program was a windfall because her counselor was retiring the next day and she surmised he was going to give her whatever she wanted as a way of treating himself since he couldn't be punished for giving her too much after he retired (which happened to be the very next day). After meeting with her to discuss her options, he offered her a plan that would enable her to become a social worker, a job which she had not considered up to that point, getting her a bachelor's and master's degree but requiring that she finish all of it within 48 months. Because her husband was still in the military and they would be PCSing within a couple of years, she needed to finish it early anyway so she decided to accept the offer. After he signed her paperwork, he put a sign on his door that said, "Gone fishing," and retired.

Other services and programs are offered locally or by the state to help veterans get an education. A good example of this is the Texas Hazlewood Act, which veterans can use to obtain education at a Texas institution of higher learning after their G. I. Bill benefits have been exhausted.

The experience of getting a degree after military service was different for each of the interviewees, with a few common threads such as being older and having more

responsibilities than their college peers. Maya had managed to graduate college with honors while heavily dependent upon self-medicating with alcohol. She didn't take any summers off and just went straight through the required course load because she needed the housing stipend provided by the G. I. Bill. Charlotte similarly pushed herself to finish her education quickly both because she had a 48-month limit for her Voc Rehab benefits as well as an upcoming PCS. Deanne, who is currently in college getting her bachelor's degree, is having a different experience and indicates that she feels a sense of dislocation and not belonging in college, both because of the divide between her and her college peers as well as a general disinterest by society in helping her, a feeling she sees reflected in how her professors treat her.

Work

After being in the military, most of the interviewees found a way to continue to serve in some way. For most of the interviewees, this was done by working for organizations which help veterans or for the government.

Sara and Maya work in fields which deal with Veterans Treatment Court, or Vet Court, a program set up to help veterans struggling with PTSD or other mental health disorders or cognitive impairment who have fallen on the wrong side of the law. According to them, Vet Court was established in recognition that these veterans may be acting based not on their own personal failings but as a result of their condition inflicted during military service, and as such, attempts to help rehabilitate them instead of letting them get lost in the prison system. If a veteran qualifies for Vet Court, then they can receive mental health counseling, medication, therapy, and are less likely to get a harsh sentence than they would otherwise. In order to qualify, the veteran must not have

committed a disqualifying criminal charge, such as sexual offenses, and have an honorable or general discharge so that they can receive care from the VA, which is the healthcare provided to Vet Court program recipients as part of a collaboration effort. Deanne's abuser was being treated in a Vet Court program the last time she spoke to him, which she suggested is likely a result of his propensity towards alcohol and physical abuse.

The majority of the interviewees have found a way to continue to serve by working for government agencies or companies which help veterans, a feature which several interviewees had indicated is a feature of female veterans in general. This is reflective of the military cultural value of selfless service as well as camaraderie, which each of these interviewees continues to display by choosing to help their fellow veterans. Both Sara and Maya are former MPs, so working in a court system would be a natural choice as a civilian job. By working with Vet Court, they are managing to support their battle buddies as well. Charlotte had worked for the VA and other governmental programs that help veterans. Jane had worked for the government, but instead of specifically helping veterans, she had worked for the Census.

The rest of the interviewees do not share any commonalities in their workplace choices. For instance, the daily struggles caused by Amy's condition make working in the public sector difficult. Currently, she works at a laundromat, which is a good fit for her because she is largely left alone by the customers. The daily maintenance tasks in the military are reflective in her current duties, which is probably another reason why she doesn't mind working there. Deanne had worked as a secretary for a while and greatly enjoyed it because it was an all-female workplace without the sexual tension or gendered

mistreatment she'd experienced in the military, but eventually left that job to pursue her bachelor's degree and take care of her children. Maya had worked in the civilian sector as well for a brief time in both retail and security, but was glad to move on to her Vet Court job since she has a sense of satisfaction from helping veterans. Unlike the other interviewees, Maya was able to shake the military cultural values quickly and when mistreated at a job, was able to just walk away and quit, a novelty to her after having been in the military.

Society

Several of the interviewees expressed feeling a sense of estrangement from society and their civilian peers, both because they were part of military culture and also because they felt society often doesn't recognize veterans as it should, especially female veterans.

According to the interviewees, civilians appear to be lazy, inattentive, and self-centered. Several of the interviewees expressed feeling like civilians didn't care about them or that they couldn't or wouldn't understand them. Going out into public, they feel stressed because they are having to overcompensate for the general lack of awareness by the civilians around them. Having come from an environment that encouraged and often required "keeping my head on a swivel," or constant hypervigilance, this is a sudden and extreme change. Some expressed that they felt the need to overcompensate for the sake of those not paying attention around them, making going out a stressful experience for them. Because of this, several of the interviewees stated that they would go out of their way to avoid the public, especially large gatherings and crowds.

They also discussed how civilians' blind hero-worship of the military was something that actively bothered them, largely because they felt that civilians assumed that being in the military meant that someone was a good person which in their experience, was not the case. For Deanne, this was particularly frustrating because her abusive husband had gotten alcohol from the public even though he was underage and used having blacked out as an excuse to beat her. Others who worked with veterans, like Sara, expressed the general distaste for the way the government and society treats veterans, since taking away benefits and pay seemed to be the government's go-to solution for trimming the national budget and civilians let it happen. Sara felt that this was particularly egregious since veterans ask for so little and get even less. Deanne has felt generally unappreciated since she exited the service, especially now that she's in college. The interviewees tended to feel invisible after taking off the uniform, both because they were now a veteran and more specifically, because as a female veteran, they often went unrecognized unless they told someone or wore something indicating as such.

An example of this can be seen when Maya and her spouse had been exiting a store when a civilian woman told the spouse to thank her husband for his service because she was wearing a shirt with the phrase "Veteran's wife." Since Maya was right there, her spouse pointed at her and said, "You can thank her yourself since she's standing right there." The woman apologized and thanked Maya for her service. Although to go unrecognized is a common occurrence for female veterans, since they don't have many outward, easily recognizable signs that they had served and because society itself doesn't have a template for what the "female veteran" should be, this might have also been a case of misunderstanding the relationship between Maya and her wife.

Maya's spouse had also dealt with some of this propensity toward assuming females aren't veterans when she went to the grocery store and parked in a disabled spot. Both Maya and her spouse are disabled, and as such, they have plates that say "Disabled Veteran" on them which they can use to park in a disabled spot. However, Maya's spouse was confronted by a civilian who felt that she was selfishly taking a disabled spot she hadn't earned. The spouse tried to argue that they were disabled veteran plates but the individual just argued that even if her "husband" was a disabled veteran, it doesn't mean she can park in disabled spots when she drove the car. The individual refused to even look at the plates and eventually left in a huff, certain that they were right.

Maya also discussed how older individuals had refused to acknowledge her as a veteran during a Veteran's Day Parade. Even though she'd been wearing her camo and a shirt to indicate that she was a veteran, when a firehouse captain and co-captain in the Parade approached her area, they thanked the male veterans standing next to her for their service, looked at her, and then walked away without saying anything. Her first reaction was to feel angry for having been deliberately shunned, but she quickly quelled that anger. Since many female veterans are not as distinctive as their male veteran counterparts, sometimes the only way they can be recognized is if they are wearing something that indicates as such or if they say so (Ritchie, 2019, p. 9). Despite this, the older man not only didn't ask to clarify that she was in fact a veteran, but in his refusal to say anything to her, seemed to indicate that even if she was, her service was of lesser value to him than that of her male counterparts.

Interactions with other Veterans

Although female veterans tend to remain distanced from veterans in general, they still maintain some contact with other veterans. Several of the interviewees had discussed the ability to recognize other veterans, sometimes even being able to even recognize what those veterans' MOS had been while they were in based on the way they carried themselves or spoke. For Maya, this is incomprehensible because other veterans frequently recognize that she had been an MP, yet she often can't recognize others except for Marines. After some discussion, she said it is possible this is a result of the relative isolation of MPs compared to other MOSs, because as police, MPs were often avoided or downright disliked by the other service members, who viewed them as a source of authority and therefore a potential source of punishment.

Stories heard directly from other veterans or about other veterans also tended to leave an impact on the interviewees because in the military, it is common practice to "do what others are doing," as a way of making sure they are doing what they are supposed to, even if they haven't been told. The interviewees who work with veterans tended to have more stories about their interactions with them, like Sara, Maya, and Charlotte. For instance, stories about what injuries tend to get rated higher or success stories in getting the treatment they were looking for at the VA allow the interviewees to approach the problems they face from a different angle by "doing what others are doing." Charlotte discusses how she tries to approach getting her rating increased by understanding the stories of those who have successfully navigated the process before her, such as making sure she discusses the full range of her condition rather than just the snapshot of how she is feeling the day of her rating appointment.

In other cases, it is more of an update on the current state of the military. For example, Sara mentioned rumors about how certain units are misbehaving, allowing officers to abuse their power by remaining at the same duty station through a simple clerical procedure. Sara had encountered a veteran discussing such an event, who struggled with anxiety because his unit had treated him and his buddies so poorly that his roommate had committed suicide. However, because it was highly unprecedented, Sara couldn't help him because there was no way for her to prove this to the VA.

Others talk about how veterans they know or have heard of have been treated at the VA. The recent influx of veteran suicides on VA campuses is troubling to Maya, who feels that they must have felt so hopeless and so mistreated that the only way they felt they could get their message across was by committing their last act within the grounds of the institution. For her, what was even more frustrating about this was that she felt the VA was burying these stories for the sake of their image.

Stereotypes

In order to understand how the interviewees view the label of veteran, they were asked to consider what aspects and characteristics are seen in the stereotypical veteran and a few common themes emerged. First of all, despite the fact that they themselves were veterans, the first thing they thought of was the stereotypical male veteran-likely because it is societally conventional and in conceptualizing what a "stereotype" would be, they were drawing from general societal understanding.

Sara in particular appeared to have a poor opinion of disabled male veterans, which was largely based on her interactions with them at her job. She stated that her idea of the stereotypical male veteran was someone unable to cope with their PTSD, so they

spend all their time and money at the bar drinking their problems away and complaining about the VA or getting meth to numb the pain. She felt that the reason they could do this was because, unlike female veterans, they weren't responsible for children and tended to be alone or divorced. Instead, she felt they would hang out at the VA or other veteran organizations for a "pity party." For the most part, the others didn't have this negative viewpoint, instead indicating that they felt more of them had PTSD but wouldn't admit it and instead, tended towards self-medication. The only consistency they had with Sara's description was the idea that male veterans tended to congregate at the VA hospital and other veteran organizations.

The stereotypical female veteran was far more difficult to pin down, even for the female veteran interviewees, but essentially, each had discussed female veterans as removed from other veterans, staying busy with work and home life, and being generally hard to find and contact. For the interviewees that work with female veterans, the general consensus was an inability to find them or contact them when necessary. Sara in particular indicated that she felt female veterans moved around a lot and tended to change their phone numbers, but that she knew they must be out there because they were referring other veterans they knew for Sara's work. Sara also indicated that the female veteran tended to have a family and children, so they were likely busy taking care of the family and pursuing their careers. She also cited the statistics presented to her by her organization that female veterans tend to have a higher education and employment rate than either their male peers or female civilians, which has been corroborated by the National Center for Veterans Analysis and Statistics as a feature of the female veteran condition (NCVAS, 2017, p. viii).

For veteran stereotypes, the general themes presented by the interviewees tended to be a general inability to fit in to civilian life, being "behind" their peers in both work experience and education, being older than their new peers at their educational or work experience, and a general aversion to the VA. Incidentally, these are all experiences they had personally had, but they had also presented the stories of other veterans they knew as supporting examples for these stereotypes.

Sara in particular likely had strong opinions based on two factors: that she had been a Drill Instructor and therefore less culturally prone to sympathy as well as the nature of her work, which involves dealing with veterans who have broken the law and therefore are less well-adjusted than other veterans may be. Maya works in a similar environment but had more sympathy for the veterans she encountered likely due to her own estimation that had she been caught at her lowest point, she would have been one of them since "There are so many times that I could've been on the other side of my desk as a probationer as opposed to being a probation officer." Both cases draw on their own personal experiences as well as their interactions with veterans in their work.

Representing Veterans

Playing on the military cultural theme of being a representative of those like her, Maya also discussed the importance of how others perceived her and how her actions represented veterans. Initially having embraced the "Dysfunctional Veteran" stereotype and merchandise, likely due to its reinforcement of the dark humor aspect of military culture, Maya would wear shirts that said things like, "Medicated for your safety," and "Dysfunctional Veteran: stay back 500 feet." This both normalized the feeling of being removed from society as well as played on the dark humor of veterans. However, after

having a discussion with the director of Operation Impact, Maya changed the way she thought about it. Since these “funny” shirts normalize the stereotype of the violent, dangerous veteran, she now felt that this was a disservice to her fellow veterans and isn’t something that should be joked about, especially since mass shootings have become more visibly frequent over the years. Continuing to joke about things such as that would only further distance veterans from civilians and stereotype veterans as violent, making it increasingly harder for struggling veterans to find jobs and work alongside their civilian peers.

CHAPTER 5: CONCLUSION

Understanding is key to treatment, both for the PTSD sufferer as well as those who support them. In an effort to facilitate this understanding for utilization in the treatment process, the military cultural perspective of a female veteran with self-identified PTSD has been elicited through exploratory research and application of anthropological perspectives. By analyzing accounts of the interviewees, conducting thematic frequency analysis, and application of anthropological and sociological theoretical orientations-such as labelling, the "Sick Role," and medicalization, several trends emerge. Namely, that an anthropological approach provides contextual understanding of the female veteran's experience through exploration of military culture, the gendered experience of the military and veteran life, the role of labels and medicalization in identity formation after diagnosis, and most especially, the cumulative nature of PTSD.

The Role of Anthropology

When attempting to understand how to help veterans with PTSD, it is useful to approach the subject from an anthropological point of view. Since anthropology is the study of culture and veterans have become enculturated into military culture and later veteran culture to the degree that it alters their worldview and identity, as seen in the interviews, then the approaches and theoretical orientations of anthropology may be able to elicit perspectives otherwise unexplored. The process of interviewing and ethnography, the methods of looking at and analyzing the data presented, and the application of anthropological theory and understanding provide insight into not only the experience of

PTSD, but the reasoning behind healthcare treatment choices, medicine, and what is perceived to be helpful from the perspective of the PTSD sufferer themselves.

Throughout the course of the interviews, the use of certain language and the contextual understanding of the language was crucial to understanding the perspective of the interviewees. Discussion of perceptions of medication, acceptance of some medications over others, and perceived efficacy of treatment could all be better understood through the lens of military culture. Although these examples seem distinct from one another at first, viewing the tendency to overuse pain medication, association between the VA and military healthcare, use of prescribed medications even when it was considered ineffective or potentially harmful, and avoidance of the VA were all aspects informed by military culture. Since injury/illness minimization is prevalent in the military, the interviewees tended to want to take the bare minimum of necessary medications-barring pain medications of course. Experiences with military healthcare tended to be negative, such as Maya's unnecessary surgery and Charlotte's negative reaction and subsequent permanent condition to an allergy shot-aspects which were seen in perceptions of the VA, which was largely viewed as ineffective and inconsiderate of their needs. The implicit trust in the authority of the military physicians meant that the interviewees would take (or not take) medications as prescribed by the VA doctors without question, even when it caused continuous problems. For instance, Maya continued to take psychoactive medications even when they caused frequent suicidal ideation and Charlotte trusted the removal of her diabetes medication until she was nearly hospitalized for high blood sugar. It is only after they managed to move past military cultural ideals and practices that they were able to fully gain agency over their healthcare

needs, as seen in Maya's determination to go without antipsychotic drugs, Sara and Charlotte's use of private primary care over the VA, and Charlotte's determination to manage her own medication interactions through study and comparison. Without understanding of the cultural background which informed these perceptions and decisions, these examples appear unrelated.

Further, contextual understanding of military language was crucial towards comprehension of the overall points being made. Without cultural context, many of the phrases used may have appeared threatening or incomprehensible. Sara's use of, "Simulate LT dead," may initially appear to be a threat, but is in fact a directive to ignore the lieutenant-usually because they are making bad calls and the older enlisted individuals can take charge better if everyone pretends the lieutenant isn't present. Implications within this concept and phrase outline several cultural factors of the military: that lieutenants tend to be younger individuals (often younger than those they are in charge of), the divide between the "blue-collar" (enlisted) and "white-collar" (officer) career paths in the military, and the way service members can find creative solutions around the absolute authority of the command structure-particularly when it is ineffective or dangerous. Another aspect of language found in the interviews are military lingo, such as Amy being "voluntold" to reclass to an MP has a specific underlying meaning. Since "voluntold" is not actually a word, the concepts and implications are primarily understood within the military context. "Voluntold" is lingo used in the military which means that someone was given the directive to "volunteer" for a duty they otherwise would not have volunteered for, usually an unpleasant one. Even though there is the semblance of choice in the matter, it is understood that this is just the appearance of

choice and they must, in fact, perform the duty regardless of whether they wanted to or not. This outlines several features of military culture: the absolute authority of higher ranks, dark humor, and acceptance.

Utilization of anthropological theory helps to contextualize and explain the language, generalizations provided by the interviewees, and underlying meanings presented in the interviewees' accounts. Application of labelling theory, the "sick role," medicalization, and feminist theory through an anthropological lens rather than a sociological or psychological lens provides perspective and context for the behaviors, values, and prohibitions found among female veterans by using their cultural background and understanding they provide in context with their peers to elicit a greater understanding of how to interact and treat them. Anthropology is useful in the study of the female veteran experience with PTSD because despite the difference in years, hometown, geographic location, and time they served, the similarities between the accounts and the common themes found spanning the cumulative interviews can be identified through their shared military culture.

The Gendered Experience

As seen in the interviewees' accounts, the female service member's experience in the military is one fraught with contradictions: being told that everyone in uniform is the same yet in many cases, treated as being different based on their gender. Judith Butler's theory of performance and gender identity provides the framework for the actions and reactions of the interviewees as they navigated the largely male-oriented space of the military (Butler, 1988, p. 520).

Within the traditionally masculine profession of the military, acceptance of and performance of gender roles within historically defined constructions comes with consequences (Butler, 1988, p. 522). This is best exemplified by Deanne's account, where initial performance of historically feminine tasks-such as making coffee-soon after arriving at her unit precluded her to "secretarial" duties, regardless of any other qualifications she possessed. This may have also opened her up to a more divisive, gendered experience. Inappropriate touching when she was pregnant and comments such as "Which baby daddy number is this?" set the tone for her experience in the military-one where she felt like she was seen only as a sexual object, there for the gratification and service of her male peers.

Even those with a more positive outlook on the gendered experience in the military were still subject to the gendered construction of roles in the military. Although Maya and Sara both felt supported and protected by their male battle buddies in their unit, feeling like someone was always looking out for them, they were still treated differently than their male peers-specifically in how they were seen as those in need of protection. As the first female in her unit, Maya's introduction by her platoon sergeant was "I'm gonna take you in, introduce you to a couple of the guys and they're going to be like your big brothers." She did feel like they were her big brothers and largely felt welcome in her unit. Yet this trust and feeling of being protected by them wasn't enough for her to come forward after her MST, even in an unofficial capacity. When the Me-Too Movement took off a few years ago, Maya had posted on social media in solidarity with the movement a simple "#metoo" with no other information.

Nobody that I was stationed with in Germany knew what had happened to me until, what was it last year that the Me-Too Movement kind of just took off? I think it was last year when the whole Brett Kavanaugh thing was going on or whatever…I posted…#metoo and I had 80 people that had been stationed with me [ask], "What are you talking about?"

And how they would know to ask, I don't know, because "I was only stationed with you for three years out of all our lives. How do you know that it happened over there?"

But they just…somehow knew to ask me. They maybe had this feeling that and I was like, "Yep."

And they were like, "Why the fuck didn't you say anything? Like we could have taken care of this, we could have taken care of you."

And I'm like, "No you couldn't. There was nothing that anybody could do about it. Nothing. I appreciate, you know, you having my back and your support and your love, but there's nothing that ya'll could have done."

And they're pissed that I didn't say anything. I was like, oh well. Hindsight is 20/20.

Even in this simple exchange years later, the prescribed gender roles within the military are visible. Instead of offering further support, they became angry with her because she had chosen not to say anything at the time, despite the fact that this decision was made in order to not only protect those who had been with her at the time, but also for her own well-being. When the role of culturally constructed female in need of

protection was eschewed, even in favor of the victim's agency over her own well-being, the immediate reaction was anger towards her for not disclosing the MST to them.

Within the military, the expectation of denying one's own gendered differences while being treated differently is a contradictory reality. This is best seen in Sara's account of dealing with an abusive flight sergeant: by giving her more difficult tasks that Sara described as being too dangerous for her to do alone, it was her understanding that he was hoping she'd get injured, killed, or transferred by mistreating her. The abuse only ended because her roommate had noted Sara's demeanor every day after returning to her room, discovered the root cause, and told her chain of command what was happening without asking Sara, thus prompting others to observe the situation and step in since Sara herself wouldn't ask for support. Sara's successful performance as "silent sufferer" only further exemplifies Butler's discussion of performance and gender identity, namely that as "a constructive identity, a performative accomplishment which the mundane social audience, including the actors themselves, come to believe and to perform in the mode of belief," (Butler, 1988, p. 520). Part of this is from the military cultural expectations of gendered performance, and another part is from countermanding said expectations by going against what was expected of her by the flight sergeant-to quit or complain.

Further, the cases of MST can be used to deconstruct the performance and gender identity of female service members. Each interviewee who had experienced MST expressed the feeling of having been responsible somehow for their attack, a feature seen in the DSM-5 under Criterion D3, or the "Persistent, distorted cognitions about the cause or consequences of event(s) that led the individual to blame himself/herself or others," (APA, 2013, p. 272). As a result of this and the military cultural values of camaraderie,

selfless service, and duty, none of the MST survivors wished to report their attacker, instead taking it upon themselves to suffer in silence. Of those, only one went on to take their attacker to court, largely because the civilian police chose to press charges against him when she refused. The main reason for this as indicated by the interviewees was so that they wouldn't represent females as needing protection, as being prone to victimization, and as being sexual objects. Each one felt that it was "only a few bad apples" in the military who were perpetrating these acts, yet the propensity for military culture to Other females is largely what enabled these predators to run rampant with little to no repercussion, a feature of military culture which is well-known (Chambers & Anderson, 1999, p. 653).

Sara's understanding of the conceptualization of MST cases is most reflective of the concerns and attributes all the interviewees presented: the fear of being perceived as illegitimate, of representing females poorly if they came forward, and how the process of reporting and going through UCMJ proceedings wasn't worth it. Sara framed it as, "It's hard to truly find legitimate MST and combat wounded." Her estimation comes from military cultural perceptions as confirmed through her interactions with veterans going through Vet Court proceedings, some of which have changed their stories after the fact to try and claim MST even when it was not the case. Yet Sara admits she feels lucky she wasn't subject to MST because of those "good guys" who always watched out for her, even rescuing her when others had handcuffed her to a bed "as a joke." The fact that each of the interviewees echoed the sentiments above as reasons for not reporting the MST indicates the prevalence of the above conceptualizations spanning decades of military service, through both the First and Second Gulf Wars. These conceptualizations provide

an environment which shields the perpetrators of the attacks and puts the onus of seeking justice on the victim-most of which wanted the event to be over with for their own sake and illustrates the performance of gender roles as "female service member."

Performance and gender identity as informed by military culture continue after exiting the service, but in a different context. Since there is no clear concept of what a "female veteran" should be, each of the interviewees takes on a role and provides an aspect of what this constitutes. Some go on to serve veterans through their work. Others volunteer. Still others like Amy deny their role and attempt to regain their sense of self outside of the military context, even to their own detriment. Many take on more traditional feminine roles (mother, wife, and caretaker) alongside these other roles. The need for a defined role is further explored in the conceptualization of labelling and the importance of labels to the individual.

Labelling, the "Sick Role," and Medicalization

The concepts of labelling, the "Sick Role," and medicalization are interconnected and can be used to illustrate and enhance the concepts of the others, particularly when it comes to the veteran experience and more specifically, the condition of PTSD. Coming from an institution where military culture stigmatizes and minimizes health problems into a veteran culture struggling with the aftereffects of years of hard use and health neglect, the conceptualization of what it means to have PTSD goes through a myriad of changes.

Labelling

Throughout the course of the interviews, evidence of the influence of labels (service member, MST survivor, veteran, female veteran, etc.) are clear. Each of the interviewees attributed meanings to the labels given to them, some more desirable than

others, and found ways to control which labels applied to them or redefined labels when ambiguity was present.

Among the interviewees, the label of "service member" was one of pride. Wearing the uniform, representing all others who wear (and have worn) the uniform, and performing their duties to the best of their ability were aspects expressed by each of the interviewees. Further, as female service members, they felt the need to represent their gender well in the traditionally masculine workspace of the military. Each discussed volunteering for extra duties, going above and beyond what was asked of them, and suffering in silence when they were mistreated. Even when it was to their own detriment, representing all female service members was more important to them than their own well-being or safety, which is most visible in the MST cases and the reasoning behind not reporting it. They indicated that they felt by coming forward about the MST, as the only or first female in their unit, they would somehow be representing female service members poorly.

Attempts to control which labels applied to them suggested a deeper meaning and sense of identity formation as related to the label, a feature which is in-line with Howard Becker's interactionist theory of deviance, or labeling theory. For instance, none of the MST survivors wanted to officially report the attack and seek justice, and the only one who did only did so at the behest of the responding police. Not only did these interviewees refuse the public label of MST immediately after the attack, but also in the private setting of healthcare years later. For the initial denial of the label, several reasons were offered. For instance, not wanting their male battle buddies to know that they had been the victim of MST was a commonly cited reason. If their battle buddies knew, they

feared that they might be perceived as "weak," and have their capability during deployment questioned. Of course, this would not likely have been the case. In fact, Maya regarded her battle buddies like older brothers who would have sought retribution on her behalf, and when they discovered what had happened years later, reacted with anger. Although Charlotte wasn't as close with her battle buddies, she did mention that had her supportive command known what had happened, they would have "hung the dude." Yet the concept of obtaining the label of MST survivor while they were in was undesirable enough to forego the justice they deserved, even in those cases where they felt they would have been supported.

What is more likely is the fear of becoming what they perceived everyone else to think of as an MST survivor. By being surrounded by an environment where the victim/perpetrator role-reversal rhetoric is common and behavioral conformity is expected, belief in said rhetoric is more likely to occur (Butler, 1988, p. 520). This common discourse and victim reversal within the largely male-oriented military culture likely contributed to this conception-that they were somehow responsible for the attack because they feared any perceived illegitimacy would invalidate their claims. Years later, when asked why they didn't report it to the VA-even when their account cannot be used to punish others or when they felt somehow responsible-most responded that they didn't think it was necessary. Even after exiting the military, the conceptualizations surrounding "MST" are still associated with the label. This is likely why the majority of the interviewee MST survivors chose not to seek a disability rating nor diagnosis of conditions stemming from the MST, even though treatment for the conditions associated with it is still necessary-since admittance of the event not only makes it "real," but labels

them and thereby associates undesirable attributes to them as informed by military culture.

Another label associated with the interviewees takes place after exiting the service-the label of veteran. Built upon the military cultural conceptions of honor and personal responsibility, "veteran" is now ascribed in place of "service member." Even though it is a much broader, more diverse group than what was experienced in the military, particularly in age-range, the label allows veterans to identify with and connect with each other. Since many veterans typically do not display outward signs of having served, such as the telltale gait, buzz-cut, or obvious build after years of having been out of the service, they display their status through apparel and accessories. However, there is an associated cost within the military cultural context: by wearing something which identifies them with a group, they are also representing that group. Much like how wearing a uniform or identifying oneself as a service member marks the individual as a representative of the U.S. military, wearing something which identifies them as "veteran" creates a similar responsibility towards all their fellow veterans-past, present, and future. This is one reason why Maya no longer wears the dysfunctional veteran apparel-by normalizing the dysfunction and violence of veterans who have struggled with reintegration through humorous apparel, it attributes these characteristics to the overall label of "veteran."

However, when the associations with a label are not well-understood, there is a sense of ambiguity when it comes to identity formation. Female veterans, as marginal members of the service and now veteran population, tend to not be recognized as veterans. Any outward display of military service is often attributed to having been a

military spouse, military brat (child dependent of a service member), or athlete. This is likely one reason why they do not tend to congregate at veteran organizations or the VA hospital like male veterans are known to do. Perhaps a part of this is the lack of definition when it comes to what it means to be a female veteran as seen in the variation of ways of living after the service and answers given when the interviewees were asked what they thought a typical female veteran would be. Without a societally constructed representation of what it means to be a female veteran in particular, many of them return to a semblance of their pre-military lives. Others redefine or attempt to define their roles as female veterans, such as in the propensity to continue serving through volunteering or work. Both working in Vet Court and volunteering with various veteran organizations, Maya is trying to set a precedent for what the label of "female veteran" means. This sentiment is somewhat echoed by the rest of the interviewees, the majority of which work in capacities which allow them to help other veterans or work for the government, which provides more access to other veterans as well as the structure they had once had in the military, an aspect reflected in the larger female veteran population as well (Dept. of VA, 2017, p. viii).

Medicalization and the "Sick Role"

Although it had been expected that even veterans in treatment for PTSD would tend to avoid admittance of their condition out of fear of "falling apart," as seen in Arthur Kleinman's definition of medicalization (Kleinman, 2007, pp. 9-10), it was found that diagnosis from an authority figure was actually a source of relief. Once they had obtained the label of PTSD via diagnosis by a medical professional, previously unrecognized symptoms became explainable and treatable, thus enabling the possibility to return to a

semblance of pre-illness normalcy. Some embraced this change, taking on the positive aspects of the "sick role" in the way they became aware of the ever-present specter of their next PTSD episode, necessitating a need to learn to manage their condition, utilize new therapeutic tools to help restructure their thought processes, and recognize when further intervention was necessary.

For Maya, getting the diagnosis of PTSD allowed her to ascribe new meaning to the emotional and physical symptoms she had been experiencing. Whereas before the diagnosis, "I thought I was just an angry person," Maya now knew that the way she acted out in her youth was a result of hidden, long-forgotten trauma. Fully embracing the medicalization aspect of her condition and the "sick role," Maya has diligently followed the directions of her healthcare providers and tried every treatment strategy available to her, from a myriad of medications to every kind of therapy provided by the VA and civilian organizations. Despite her seeming enthusiasm for acceptance of and utilization of medication as prescribed by the medical authorities, Maya is determined to no longer rely on medication, primarily utilizing therapeutic tools and her support network to manage her condition, features discussed as aspects of the patient's active participation in the treatment process (Parsons, 1975, p. 271). For example, among the interviewees, part of this capability to self-manage the condition is accomplished by recognizing when they will be exposed to known triggers-such as fireworks-and by taking measures to mitigate the triggering of her episodes. Further, staying busy enabled them to function without becoming bogged down by their condition, preferring not to give themselves too much time alone with their own thoughts. Both this and the denial of medication are deeply

rooted in military culture, which promotes activity as a method of dealing with down time and minimizes health concerns.

The sentiment of not wanting to be on medication is echoed by every interviewee, each of which discuss a certain amount of trepidation when it comes to taking medication for their condition, often citing fears of the addictive qualities of drugs or the negative side effects. Charlotte, in particular, has a lot of anxiety over the overmedication she perceives in the VA, which is understandable considering her experiences with serious side effects and improper care. Deanne had suffered memory loss and "blackouts" from an antipsychotic medication she'd been on while she was being abused. Amy, who has been on hard drugs and had gone through withdrawals while deployed to Iraq, is afraid of the addictive properties of medication used to treat PTSD, outlining the general perception regarding medicine found within the military. Despite these fears and hesitance, the majority of the interviewees diligently assume the "sick role," as evidenced by taking the medication and therapies prescribed to them (Parsons, 1975, p. 258). However, there is another aspect at play as informed by military culture: respect for authority-particularly the authority of doctors. Parsons covers this aspect in his exploration of the "sick role" as "the relation of sick person and health care agency is inherently asymmetrical on the hierarchical axis," and that the problems associated with healthcare adherence and treatment come from problems with that asymmetrical role (Parsons, 1975, pp. 261-277). Adherence to the doctor's instructions in the cases where it is to the interviewees' detriment tended to create a further divide between the interviewee and their attending physician, necessitating a need for them to control against mismanagement of their medications (such as in Charlotte's case), refusal of treatment

altogether due to the prolonged negative reaction to treatment (such as in Amy's case), or a desire to move beyond the need for prescribed medication (such as in Maya's case).

Since the ascription of a medical label to an activity, behavior, or experience by a medical or scientific authority is what makes something medicalized, for service members, this authoritative capacity is compounded exponentially because military physicians have the dual role of both physician and officer. Since the commands of officers can't be violated without potential UCMJ retribution, several of the interviewees viewed the authority of their military physicians as more that of the officer's authority than physician's suggestions. After the service, they treated their VA physicians as the same unquestionable authority until over time, they perceived themselves to have a more equal if not reversed relationship in regard to healthcare authority. This is exemplified by Maya's prolonged diligence in taking the psychotropic drugs she had been prescribed, despite the suicidal ideation it caused, and in Charlotte's account of having stopped a diabetes medication when she was instructed to do so, despite her misgivings and the eventual result. In both cases, the interviewees moved beyond this asymmetrical perception with the doctor as an authority to one which is more equal or reversed-since it is their body and as civilians, they are no longer in the purview of military command structure, they were now the one with the authority over healthcare decisions and can choose what healthcare strategies and medications they take or not take.

The relevance of the interconnectedness and importance of acceptance of medicalization and the "sick role" is best illustrated by Amy's account. Initially denying her diagnosis since she felt fine and instead ascribing any differences in her condition to pregnancy or the abuse by her boyfriend, Amy came to notice a gradual decline in her

capability to function. Now seeing a clear demarcation in her timeline as before and after acquisition of the condition of PTSD, a sentiment other interviewees had expressed as well, Amy now delineates her conceptualization of self based on how she was before the condition as compared to how she is now: “I used to be very laid back, easy going. I was really fun to be around before I went to Iraq and even really right after I came back from Iraq,” whereas now, “I can’t have fun like I used to,” and “there’s no days that are really that good for me.” The other interviewees similarly express before-and-after demarcations, such as Deanne’s admission of decreased physical and mental capacity after the condition and Sara and Charlotte’s struggles with managing both the physical and emotional aspects of the condition.

Still, despite recognizing the need to seek treatment, Amy struggles to bring herself to go to the VA for treatment. While avoidance of the VA is a symptom she recognizes, she finds it difficult to accept treatment there or to even accept outside help for her condition. Along the same vein, Amy indicates she has pushed away her support network because she (and they) didn’t understand her condition and these relationships are damaged beyond repair. It is the relative perception of daily struggling and decreased capacity as a result of denying the condition, the label, and the “sick role,” and subsequent fallout from years of allowing the condition to fester which sets Amy’s account apart from the rest. This seems to indicate the importance of acceptance of the “sick role,” medicalization of the condition, and the label of PTSD as a crucial part of the process of managing the condition.

Demedicalization

In regard to medicalization and labelling, it became clear that obtaining the official diagnosis of PTSD was both a relief and a source of anxiety. Now having the official label to both justify and understand their evolving condition, the interviewees could now move forward with treatment and acceptance of the "new normal." However, the case study, Maya, brought up a different concept which seemed to be related to successfully managing the condition-particularly, the ability to demedicalize the condition.

While the other interviewees managed to move beyond some aspects of military culture and accept or deny parts of the medicalization and labelling of their condition, Maya in particular managed to change the narrative of medicalization by redefining the condition as something other than a disorder. Preferring not consider herself as sick or as having a disorder, she instead drops the "D" in PTSD, instead calling it Post-Traumatic Stress or better yet, Post-Traumatic Growth. Instead of treating the condition as a serious medical condition, it is now considered more as an idiosyncrasy or quirk, much like a specific allergy, trick knee, or weak ankles. Even though she has determined that her condition is permanent, this aspect of accepting the condition and moving beyond it as a condition goes against the conceptual label given to her, a process which she has managed to do with military culture as well. Erin Finley also discusses the concept of post-traumatic growth as a positive end-goal for the PTSD sufferer, as a process indicative of resolution and healing (Finley, 2012, p. 283). Perhaps this concept is one of the reasons Maya is managing her condition so well, despite the diagnosis of complex PTSD and the interconnected complexities involved in her condition. Maya was the only

interviewee to discuss aspects which fall within the concept of demedicalization, but the merits of ascribing oneself to a mindset which precludes one from the label of having a disorder may be helpful for someone coming from a military cultural setting, particularly when the minimization of health concerns and general non-desire to seek medical treatment is taken into consideration.

PTSD as a Cumulative Condition

This Study and the Concept of the Wall of Resilience

Throughout the course of the study, each interviewee had mentioned multiple traumatic events with varying degrees of significance, the latest of which is usually considered to be the "precipitating event" or the trauma which they consider to have caused PTSD. Since the case study's traumas which contributed towards complex PTSD were assigned a level of impact reflective of the distance from the precipitating trauma, with the precipitating trauma at the highest level of impact and the childhood trauma at the lowest rated level of impact despite the severity of all three traumas, examining the other interviewees' perception of the minor traumas mentioned in the same vein elicited a significant theme: that the progression of the condition of PTSD appears to be cumulative.

Maya's understanding of PTSD is reflective of this idea in that each person is born with a certain level of resilience, which for the sake of illustration can be described as a brick wall which will be referred to as the "Wall of Resilience." With each subsequent trauma, a proportionate weight to the perceived impact is added to the top of the wall, thus putting more stress on the wall. Having a good support system or coping mechanisms can lessen the burden on the wall, perhaps shoring it up with wood planks

for the sake of illustration, but when the weight gets to be too much and the wall cracks or breaks, then the wall will never be the same as it had been before and it is at this point that the condition of PTSD can be said to have manifested. After it has cracked or broken, professional help is needed to keep the wall from crumbling entirely, and the PTSD sufferer can use the tools provided in therapy to repair the damaged parts of the wall with different, more professional materials and utilize medication to slow the crumbling of the wall while they repair and shore up the wall. Self-treatment options such as self-medicating with alcohol can be said to be simply covering up the damage on the wall, such as putting plaster over it to hide the cracks.

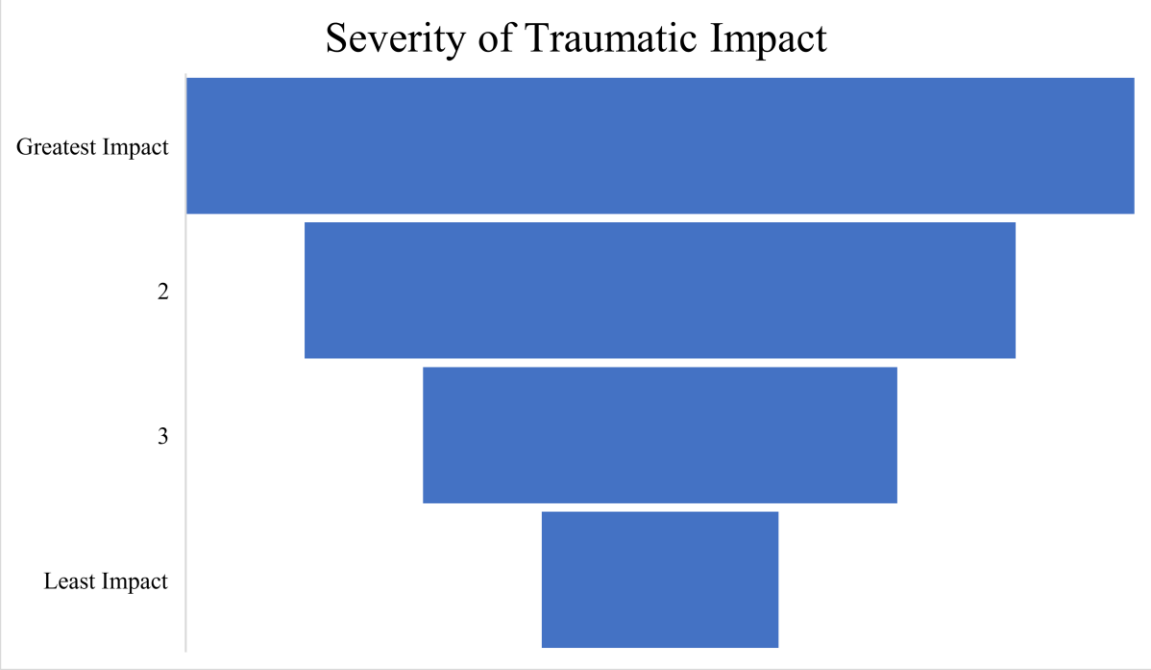

Figure 14: Proposed levels of severity by trauma type represented as "weights."

Since each subsequent trauma is given more weight than the last, we can see how the Wall of Resilience could crumble entirely without the intervention of medication or therapy. The lowest level of impact would be that which was disadvantageous and somewhat impactful, but perhaps not even listed as a "trauma source," such as growing

up poor or disadvantaged. The next level up would be minor traumas, or traumas which were temporary such as childhood trauma, sexual harassment, and a traumatic event one does not even remember at all. The next level up from that would be that which is considered to be a major trauma, or one which causes extensive mental distress but not to the point of being considered the precipitating event for PTSD. For the interviewees with combat trauma, this would be the MST, since they did not consider their MST to have caused PTSD. The highest level would be the precipitating event, or the event which the individual considers to be the source of PTSD. For some of the interviewees, this was the MST. For others, it was the combat trauma.

Since the severity of impact is reflected in each subsequent level, it can be said that the weight of the impact increases exponentially with each level. This is particularly useful in understanding the way each of the interviewees perceives the progression of PTSD since each have varying levels of functionality and perceived impact of the traumas as well as different traumatic sources. By viewing each of the traumatic sources as adding a proportionate amount of weight as given by the interviewee, a picture of how the weight is added to the wall of resilience can be built. In doing so, it may be possible to apply this method to other cases of PTSD and potential cases of PTSD which have not yet developed but may do so in the near future. By providing therapy and medication to help shore up the damage to the wall before it totally breaks, it may be possible to prevent or mitigate the permanent onset of lifetime PTSD. Utilization of the descriptive example of the Wall of Resilience can at the very least provide a useful illustrative framework for understanding of the condition, both for the PTSD sufferer as well as those who support them.

Other Studies with the Same Conclusion

The idea that PTSD appears to be a cumulative condition is a conclusion which other studies appear to have come to as well. The study most similar to this one is "Posttraumatic Stress Disorder: The Burden to the Individual and to Society" by Ronald Kessler. Kessler discusses the idea that many studies seem to have different lifetime PTSD prevalence percentages because they don't take into account, "the fact that a great many people report exposure to multiple traumas over the life course," (Kessler, 2000, p. 7). Kessler similarly takes into account the weight each respondent gives to the traumatic events they had suffered throughout the life course, but instead only calculates two out of the total assessments of PTSD, one as their self-identified most traumatic event and a second chosen at random from the other traumas listed. They then "weighted to adjust for between-person differences in number of lifetime traumas," and combined the data in an effort to provide a combined, unbiased portrait of lifetime duration of PTSD (Kessler, 2000, p. 7).

The methodology used by Kessler was largely based on his collaboration with Breslau et al.'s study on the relative importance of different traumas as experienced by a community in Detroit. Seeing a distinct lack of studies which look at any other but the precipitating trauma, Breslau focused instead on the lifetime prevalence of the population. Results were calculated two times: the first time with just the precipitating trauma and a second time with the inclusion of a random minor trauma. They concluded that "this analysis confirms the suspicions that previous studies, by focusing on the worst traumas, overestimated the conditional risk of PTSD. The conditional risk of PTSD based on the representative sample of traumas was approximately one third lower than that

based on the worse traumas," (Breslau et al., 1998, p. 632). They had also concluded that PTSD "in late adolescence and young adulthood might be more likely than in later years to result from experiencing assaultive violence and be of longer duration," and that "women's risk of PTSD following exposure to trauma was approximately 2-fold higher than that of men," even though there were few differences in trauma types between men and women (Breslau et al., 1998, p. 632). What they found was that the highest risk of PTSD is linked to combat, rape, and sexual or physical assault. Since female service members are more likely to experience any or all of these precipitating traumas, this may explain why the percentage of female veterans with PTSD is far higher than what is found in the female nonveteran population.

The concept that the precipitating trauma source which caused the condition of PTSD was discussed in more detail in Breslau's "Psychiatric sequelae of posttraumatic stress disorder in women," as well as likely reasons for comorbid mental illnesses. They explored the various theories as to why comorbid mental illness is found in PTSD sufferers, such as the possibility that PTSD increases the risk for other disorders, the traumatic event may have caused a comorbid mental illness as well as PTSD, the connection between depression and PTSD, and the potential that preexisting disorders may increase the risk for PTSD. What Breslau et al. found in their 1997 study was this:

> (1) The lifetime prevalence of exposure to traumatic events and PTSD in this sample of women was 40% and 13.8%, respectively. (2) Lifetime comorbidity of PTSD with any of the psychiatric disorders covered in the analysis (i.e., major depression, anxiety, and substance use disorders) was 73%. (3) Posttraumatic stress disorder signaled significantly increased risks for first-onset major

> depression and alcohol [abuse or dependence]. (4) Women exposed to trauma and in whom PTSD did not develop had an increased risk for first onset alcohol [abuse or dependence] but not major depression. (5) The risk for first-onset major depression in women with prior PTSD was of the same magnitude as in women with a history of 1 or more of the other anxiety disorders. Posttraumatic stress disorder in women with preexisting anxiety disorders enhanced significantly the risk for first-onset major depression. (6) Preexisting major depression increased women's vulnerability to the PTSD-inducing effects of traumatic events and risk for exposure. (Breslau et al., 1997, pp. 85-86)

Many of these results mirror what was found among the interviewees, since a majority of them had comorbid anxiety and depression and several would self-medicate their condition with alcohol or other drugs.

Comparison with these studies lends a reasonable degree of legitimacy to the findings presented in this paper. The cumulative nature of PTSD, the varying weights of trauma as ascribed by the PTSD sufferer, and the precipitating trauma being the major source of PTSD are all supported by these studies.

The Role of Military Culture in Decision-Making

The role of military culture in the decision-making process was clearly illustrated by the accounts of the interviewees. Enculturation into the military way of life is known to be a difficult experience, especially for the majority of new trainees are fresh out of High School (Redmond et al., 2015, p. 13). Being broken down as an individual and rebuilt into a collective unit divests one from their natal culture and instructs them in the ways of a new one while they are young (Ulmer et al., 2000, p. 8) and their brains are still

developing. The skills, values, behaviors, and language learned in the military are the result of generations of development and adaptation to the dangerous environment inherent to military service (Krueger, pp. 254-258).

However, once they returned home, many veterans find that the behaviors and safety measures employed in everyday life in the military are now maladaptive (Finley, 2012, pp. 268-270). This further solidifies the sense of diasporic removal from their new culture, or dislocation, hence the propensity to gravitate towards veteran institutions and organizations. Yet the female veteran remains largely isolated from her peers and does not have the same military cultural support network she had before. Some female veterans may get this cultural interaction with their veteran spouse or family members, as some interviewees had. Others only get it at their check-ups and appointments at the VA. Still, the sheer percentage of female veterans in the government workforce may have found a substitute for military camaraderie and structure by working amongst their veteran peers within the bureaucratic structure of government office, as seen in the several interviewees who work with veterans or for the government.

In all cases, the way female veterans seek treatment and conceived of their condition appeared to be largely informed by military culture. The acceptance and overuse of ibuprofen was a common theme found in the interviewees, a leftover from their time in military service when being combat ready was more important than one's health, especially for "minor" conditions. The distrust and general lack of enthusiasm for taking any other kind of medication, especially for mental illness was another part of that. Their experiences at the VA and other healthcare providers, where it is a struggle to maintain one's agency in the face of authority, even though one is expected to do so, was

evident in their decisions to maintain undesirable treatment strategies. Learning about and copying the actions of their fellow veterans who have successfully navigated the VA system as part of their military enculturation informed the way they sought treatment for their condition as well as their disability ratings. Where possible, they also utilized treatment strategies which enabled self-reliance. They also frequently utilized both military lingo as well as the conceptualizations inherent to military service, such as dark humor, discipline, and selfless service. Those female veterans who seemed to be doing best with their condition were those who managed to move beyond certain aspects of military culture, such as taking back their sense of agency and accepting their condition as present but not allowing it to stop them from accomplishing their goals.

Final Remarks

Throughout the course of this paper, examination and exploration of the themes found throughout the course of the interviews were used to better understand the experience of female veterans as they navigate the condition of PTSD. Even though this study only called for those with self-identified PTSD, the interviewees are considered to be accurate in their testimonies because the description of their symptoms and experiences match the guidelines as set by the American Psychiatric Association's DSM-5 description of PTSD and its features as represented in the criteria listed throughout the accounts provided by the interviewees.

Utilization of the holistic methodology of anthropology in the application of concepts-such as labelling, the "Sick Role," medicalization, and gender performance and identity-has been used to elicit the way military culture informs the decision-making process in regard to seeking (and not seeking) treatment for the condition of PTSD as

well as navigating civilian life after service. The commonality of the accounts of the interviewees as seen in the themes presented by them provide a common ground, despite the variation in age, time in service, branch of service, and conflict they served in, which is here identified as military culture. By examining the choices and actions each of the interviewees have taken by their own accounts through the lens of anthropology and contextualized by military culture, the experience of the female veteran with PTSD is better understood.

Reflection for Successive Studies

The inclusion of more interviewees and their accounts would have been beneficial in this study. Some limitations identified in the study include a need for a broader set of interviewees more reflective of the female veteran population. The frequency of topics as well as trauma source may be skewed in favor of the high proportion of female combat veterans, each of which had the same MOS as Military Police. Also, the similar demographic factors shared between the interviewees may have also played a role, since they were all in the "blue collar" track of the military, also known as being enlisted, and came from poor or disadvantaged backgrounds. The majority of the interviewees were also Army, as well as one from the Air Force and one from the Coast Guard; there were no interviewees representative of the Navy or the Marine Corps. Also, a large proportion of the interviewees came from a similar ethnic background-primarily Caucasian with one Latina. By increasing the pool of interviewees and including a sample more representative of current military composition, different trends may emerge. Additionally, a study on female veterans in different parts of the United States may provide new and intriguing perspectives not seen in the sample from the Houston area. Similarly, the

nature of retrospective interpretation of the experience in the military may be subject to recall errors, specifically when it comes to the memory issues associated with the condition of PTSD.

REFERENCES

Acosta, J. D., Becker, A., Cerully, J. L., Fisher, M. P., Martin, L. T., Vardavas, R., Slaughter, M. E., & Schell, T. L. (2014). Mental health stigma in the military. Santa Monica, CA: RAND Corporation. Retrieved from www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR426/RAND_RR426.pdf

American Psychiatric Association. (2013). American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA. Retrieved from www.psychiatry.org/patients-families/ptsd/what-is-ptsd.

Association of the United States Army. (1991) The U.S. Army in Operation Desert Storm: An Overview. Arlington, VA. Retrieved from https://www.ausa.org/sites/default/files/SR-1991-The-US-Army-in-Operation-Desert-Storm.pdf.

Bagalman, E. (2014) The Number of Veterans That Use VA Health Care Services: A Fact Sheet. 2014. Washington, DC, US. Retrieved from https://fas.org/sgp/crs/misc/R43579.pdf.

Becker, H. (1963). Outsiders: studies in the sociology of deviance. New York: Free Press.

Bird, S. M., & Fairweather, C. B. (2007). Military fatality rates (by cause) in Afghanistan and Iraq: A measure of hostilities. International Journal of Epidemiology, 36(4), 841–846. https://doi.org/10.1093/ije/dym103

Boon, K. A. (2005). Heroes, metanarratives, and the paradox of masculinity in contemporary western culture. *Journal of Men's Studies*, 13, 301-312. doi: 10.3149/jms.1303.301

Bremner, J. Douglas. (2006). Traumatic stress: effects on the brain. Dialogues in clinical neuroscience, 8(4), 445–461.

Breslau, N., Davis, G., Peterson, E., & Schultz, L. (1997). Psychiatric Sequelae of Posttraumatic Stress Disorder in Women. Archives of General Psychiatry, 54(1), 81–87. https://doi.org/10.1001/archpsyc.1997.01830130087016

Breslau, N., Kessler, R., Chilcoat, H., Schultz, L., Davis, G., & Andreski, P. (1998). Trauma and Posttraumatic Stress Disorder in the Community: The 1996 Detroit Area Survey of Trauma. Archives of General Psychiatry, 55(7), 626–632. https://doi.org/10.1001/archpsyc.55.7.626

Butler, J. (1988). Performative Acts and Gender Constitution: An Essay in Phenomenology and Feminist Theory. Theatre Journal, 40(4), 519–531. https://doi.org/10.2307/3207893

Chambers, J., & Anderson, F. (1999). *The Oxford companion to American military history*. Oxford University Press.

Christiansen, D., & Hansen, M. (2015). Accounting for sex differences in PTSD: A multi-variable mediation model. European Journal of Psychotraumatology, 6(1), Article 26068. https://doi.org/10.3402/ejpt.v6.26068

Conrad, P. (1992). Medicalization and Social Control. Annual Review of Sociology, 18, 209–232. https://doi-org.ezproxy.lib.uh.edu/10.1146/annurev.so.18.080192.001233

Crocq, M. A., & Crocq, L. (2000). From shell shock and war neurosis to posttraumatic stress disorder: a history of psychotraumatology. *Dialogues in clinical neuroscience*, *2*(1), 47–55.

Danan, E. R., Krebs, E. E., Ensrud, K., Koeller, E., MacDonald, R., Velasquez, T., Greer, N., & Wilt, T. J. (2017). An Evidence Map of the Women Veterans' Health Research Literature (2008-2015). Journal of general internal medicine, 32(12), 1359–1376. https://doi.org/10.1007/s11606-017-4152-5

DeGroot, G. J. (2001). A few good women: Gender stereotypes, the military and peacekeeping. *Women and International Peacekeeping*, *8*(2), 23-38.

Eibner, C., Krull, H., Brown, K., Cefalu, M., Mulcahy, A., Pollard, M., Shetty, K., Adamson, D., Amaral, E., Armour, P., Beleche, T., Bogdan, O., Hastings, J., Kapinos, K., Kress, A., Mendelsohn, J., Ross, R., Rutter, C., Weinick, R., Woods, D., Hosek, S., & Farmer, C. (2016). Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs. *Rand Health Quarterly*, *5*(4), 13–13. http://search.proquest.com/docview/1861487145/

Evans-Pritchard, E. (1937). Witchcraft, oracles and magic among the Azande. Oxford: The Clarendon Press.

Farnsworth, J. K. (2014). Dialogical tensions in heroic military and military-related moral injury. *International Journal for Dialogical Science*, *8*(1), 13-37.

Finley, E. P. (2012). War and dislocation: a neuroanthropological model of trauma among American veterans with combat PTSD. The encultured brain: an introduction to neuroanthropology, 263-290.

Franke, V. (2000). Duty, Honor, Country: The Social Identity of West Point Cadets. *Armed Forces & Society*, *26*(2), 175–202. https://doi.org/10.1177/0095327X0002600202

Friedman, M. (2013). Finalizing PTSD in DSM-5: Getting Here From There and Where to Go Next. *Journal of Traumatic Stress*, *26*(5), 548–556. https://doi.org/10.1002/jts.21840

Fulton, J. J., Calhoun, P. S., Wagner, H. R., Schry, A. R., Hair, L. P., Feeling, N., Elbogen, E., Beckham, J. C. (2015). The prevalence of posttraumatic stress disorder in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans: A meta-analysis. Journal of Anxiety Disorders, 31, 98–107. doi: 10.1016/j.janxdis.2015.02.003

Glaser, B., & Strauss, A. (1967). The discovery of grounded theory; strategies for qualitative research. Chicago: Aldine Pub. Co.

Gradus, J. L. (2007). Epidemiology of PTSD. National Center for PTSD. U. S. Department of Veterans Affairs. Retrieved from https://www.ptsd.va.gov/professional/treat/essentials/epidemiology.asp

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, *351*(1), 13-22. Retrieved from http://search.proquest.com.ezproxy.lib.uh.edu/docview/223938962?accountid=7107

Jennings, B. M., Loan, L. A., Heiner, S. L., Hemman, E. A., & Swanson, K. M. (2005). Soldiers' experiences with military health care. *Military Medicine, 170*(12), 999-1004.

Joint Service Committee on Military Justice (JSC). (2019). Manual for courts-martial, United States (2019 Edition). Retrieved from https://jsc.defense.gov/Portals/99/Documents/2019%20MCM%20(Final)%20(20190108).pdf?ver=2019-01-11-115724-610

Kessler, R. (2000). Posttraumatic stress disorder: The burden to the individual and to society. Journal Of Clinical Psychiatry, 61, 4–14. Retrieved from https://www-psychiatrist-com.ezproxy.lib.uh.edu/JCP/article/_layouts/ppp.psych.controls/BinaryViewer.ashx?Article=/JCP/article/Pages/2000/v61s05/v61s0502.aspx&Type=Article

Kimerling, R., Gima, K., Smith, M. W., Street, A., & Frayne, S. (2007). The Veterans Health Administration and military sexual trauma. *American journal of public health*, *97*(12), 2160–2166. https://doi.org/10.2105/AJPH.2006.092999

Kleinman, A. (2007). What really matters: Living a moral life amidst uncertainty and danger. Oxford University Press.

Krueger, G. (2000). *Military culture.* (Vol. 5, pp. 252–259). American Psychological Association. https://doi.org/10.1037/10520-111

Kulka, R.A., Schlenger, W.A., Fairbanks, J.A., Hough, R.L., Jordan, B.K., Marmar, C.R., Cranston, A.S. (1990). Trauma and the Vietnam War generation: Report of findings from the National Vietnam Veterans Readjustment Study. New York: Brunner/Mazel.

Lande, R. G., & Williams, L. B. (2013). Prevalence and characteristics of military malingering. *Military medicine*, *178*(1), 50-54.

Meyer, E., Writer, B., & Brim, W. (2016). The Importance of Military Cultural Competence. *Current Psychiatry Reports*, *18*(3), 1–8. https://doi.org/10.1007/s11920-016-0662-9

Murdoch, M., Bradley, A., Mather, S. H., Klein, R. E., Turner, C. L., & Yano, E. M. (2006). Women and war. *Journal of general internal medicine*, *21*(3), S5-S10.

National Center for Veterans Analysis and Statistics. (2017). Women Veterans Report: The Past, Present and Future of Women Veterans. U.S. Department of Veterans Affairs. Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2015_Final.pdf

National Institute of Mental Health. (2019). Post-Traumatic Stress Disorder. U.S. Department of Health and Human Services. Retrieved from www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml.

O'Reilly, K. (2009). Grounded Theory. In Key Concepts in Ethnography. Retrieved from https://doi.org/10.4135/9781446268308.n17

Parker, K., Igielnik, R., Barroso, A., & Cilluffo, A. (2019). The American Veteran Experience and the Post-9/11 Generation. Pew Research Center. Retrieved from https://www.pewsocialtrends.org/wp-content/uploads/sites/3/2019/09/09.10.19_veteransexperiences_full_report_updated.pdf

Parsons, T. (1975). The Sick Role and the Role of the Physician Reconsidered. The Milbank Memorial Fund Quarterly. Health and Society, 53(3), 257-278. doi:10.2307/3349493

Porpora, D. V. (1996). Personal heroes, religion, and transcendental metanarratives. *Sociological Forum*, 11, 209-229. doi:10.1007/BF02408365

Redmond, S. A., Wilcox, S. L., Campbell, S., Kim, A., Finney, K., Barr, K., & Hassan, A. M. (2015). A brief introduction to the military workplace culture. *Work*, *50*(1), 9–20. https://doi-org.ezproxy.lib.uh.edu/10.3233/WOR-141987

Ritchie, E. C. (2019). Outline of Military Culture and Military and VA Health Systems. In *Veteran Psychiatry in the US: Optimizing Clinical Outcomes* (pp. 9-15). Springer, Cham.

Saber, A. (2018). Lexicogenic matrices and institutional roles of U.S. military jargon. *Lexis*, *11*(11). https://doi.org/10.4000/lexis.1179

Sayer, N. A., Spoont, M., & Murdoch, M. (2004). The VA disability compensation program: what providers should know. *Federal Practitioner*, *21*(5), 15-20.

Sayer, N., Friedemann-Sanchez, G., Spoont, M., Murdoch, M., Parker, L., Chiros, C., & Rosenheck, R. (2009). A Qualitative Study of Determinants of PTSD Treatment Initiation in Veterans. *Psychiatry*, *72*(3), 238–255. https://doi.org/10.1521/psyc.2009.72.3.238

Simon, C., & Warner, J. (2007). Managing the all-volunteer force in a time of war. Economics of Peace and Security Journal. 2. 20-29. 10.15355/epsj.2.1.20.

Strauss, A. L. & Corbin, J. (1997) Grounded Theory in Practice. Thousand Oaks, CA: Sage.

Strauss, A., & Corbin, J. (1998). Basics of qualitative research : techniques and procedures for developing grounded theory (Second edition.). Thousand Oaks: Sage Publications.

Suris, A., & Lind, L. (2008). Military Sexual Trauma. Trauma, Violence, & Abuse, 9(4), 250-269.

U.S. Bureau of Labor Statistics. (2019). Employment Situation of Veterans – 2019. Retrieved from https://www.bls.gov/news.release/pdf/vet.pdf

U.S. Congress. (2014). Veterans Access, Choice, and Accountability Act of 2014. Retrieved from https://www.govinfo.gov/content/pkg/BILLS-113hr3230enr/pdf/BILLS-113hr3230enr.pdf.

U.S. Department of Defense. (2018) 2018 Demographics Report: Profile of the Military Community. Retrieved from https://download.militaryonesource.mil/12038/MOS/Reports/2018-demographics-report.pdf

U.S. Department of the Army. (2006). Army Regulation [AR] 635-20. Personnel-General. Headquarters. Washington, DC. Retrieved from https://www.nrc.gov/docs/ML0807/ML080790409.pdf.

U.S. Department of the Army. (2016). Army Regulation [AR] 635-200. Active duty enlisted administrative separations. Headquarters. Washington, DC. Retrieved from https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/AR635-200_Web_FINAL_18JAN2017.pdf.

U.S. Department of Veterans Affairs. (2015). Analysis of VA health care utilization among operation enduring freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) veterans. Washington, DC: Department of Veterans Affairs. Retrieved from https://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2015-qtr1.pdf.

U.S. Department of Veterans Affairs. (2015). Military Sexual Trauma. Retrieved from https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.

U.S. General Accounting Office. (2000). *Gulf War Illnesses: Understanding of Health Effects From Depleted Uranium Evolving But Safety Training Needed*. National Security And International Affairs Div. Washington, DC. Retrieved from https://www.gao.gov/new.items/ns00070.pdf

U.S. Government Accountability Office. (2009). VA Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans. Retrieved from http://www.gao.gov/new.items/d09899t.pdf.

Ulmer, C., Collins, J. J., & Jacobs, T. O. (2000). *American Military Culture in the Twenty-First Century: A Report of the CSIS International Security Program*. CSIS.

Veterans Benefits Administration. (2019). Veterans Benefits Administration Annual Benefits Report Fiscal Year 2018. Department of Veterans Affairs. Washington, DC. Retrieved from benefits.va.gov/REPORTS/abr/docs/2018-abr.pdf

Wherry, J. L. (2018). Interminable Parade Rest: The Impossibility of Establishing Service Connection in Veterans Disability Compensation Claims when Records Are Lost, Destroyed, or Otherwise Unavailable. *Brooklyn Law Review*, *83*.

World Health Organization (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Zola, I. (1975). In the name of health and illness: On some socio-political consequences of medical influence. *Social Science and Medicine*, *9*(2), 83–87. https://doi.org/10.1016/0037-7856(75)90098-0

Appendix

Excerpt from the DSM-5

Posttraumatic Stress Disorder

Diagnostic Criteria-309.81 (F43.10)

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse).

   Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

   Note: In children older than 6 years, repetitive play may occur in which themes

or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

   Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

   Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or

more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” ‘The world is completely dangerous,” “My whole nervous system is permanently ruined”).
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.

6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization**: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization**: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

   Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6

months after the event (although the onset and expression of some symptoms may be immediate).

Posttraumatic Stress Disorder for Children 6 Years and Younger

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.

   Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.
3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

   Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

   Note: It may not be possible to ascertain that the frightening content is related to the traumatic event.
3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum,

with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to reminders of the traumatic event(s).

C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s):

Persistent Avoidance of Stimuli

1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).
2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).

Negative Alterations in Cognitions

3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
4. Markedly diminished interest or participation in significant activities, including constriction of play.
5. Socially withdrawn behavior.
6. Persistent reduction in expression of positive emotions.

D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of

the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
2. Hypervigilance.
3. Exaggerated startle response.
4. Problems with concentration.
5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

E. The duration of the disturbance is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.

G. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization**: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization**: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as

unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Diagnostic Features

The essential feature of posttraumatic stress disorder (PTSD) is the development of characteristic symptoms following exposure to one or more traumatic events. Emotional reactions to the traumatic event (e.g., fear, helplessness, horror) are no longer a part of Criterion A. The clinical presentation of PTSD varies. In some individuals, fear-based reexperiencing, emotional, and behavioral symptoms may predominate. In others, anhedonic or dysphoric mood states and negative cognitions may be most distressing. In some other individuals, arousal and reactive-externalizing symptoms are prominent, while in others, dissociative symptoms predominate. Finally, some individuals exhibit combinations of these symptom patterns.

The directly experienced traumatic events in Criterion A include, but are not limited to, exposure to war as a combatant or civilian, threatened or actual physical assault (e.g., physical attack, robbery, mugging, childhood physical abuse), threatened or actual sexual violence (e.g., forced sexual penetration, alcohol/drug-facilitated sexual penetration, abusive sexual contact, noncontact sexual abuse, sexual trafficking), being

kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war, natural or human-made disasters, and severe motor vehicle accidents. For children, sexually violent events may include developmentally inappropriate sexual experiences without physical violence or injury. A life-threatening illness or debilitating medical condition is not necessarily considered a traumatic event. Medical incidents that qualify as traumatic events involve sudden, catastrophic events (e.g., waking during surgery, anaphylactic shock). Witnessed events include, but are not limited to, observing threatened or serious injury, unnatural death, physical or sexual abuse of another person due to violent assault, domestic violence, accident, war or disaster, or a medical catastrophe in one's child (e.g., a life-threatening hemorrhage). Indirect exposure through learning about an event is limited to experiences affecting close relatives or friends and experiences that are violent or accidental (e.g., death due to natural causes does not qualify). Such events include violent personal assault, suicide, serious accident, and serious injury. The disorder may be especially severe or long-lasting when the stressor is interpersonal and intentional (e.g., torture, sexual violence).

The traumatic event can be reexperienced in various ways. Commonly, the individual has recurrent, involuntary, and intrusive recollections of the event (Criterion Bl). Intrusive recollections in PTSD are distinguished from depressive rumination in that they apply only to involuntary and intrusive distressing memories. The emphasis is on recurrent memories of the event that usually include sensory, emotional, or physiological behavioral components. A common reexperiencing symptom is distressing dreams that replay the event itself or that are representative or thematically related to the major threats involved in the traumatic event (Criterion B2). The individual may experience

dissociative states that last from a few seconds to several hours or even days, during which components of the event are relived and the individual behaves as if the event were occurring at that moment (Criterion B3). Such events occur on a continuum from brief visual or other sensory intrusions about part of the traumatic event without loss of reality orientation, to complete loss of awareness of present surroundings. These episodes, often referred to as "flashbacks," are typically brief but can be associated with prolonged distress and heightened arousal. For young children, reenactment of events related to trauma may appear in play or in dissociative states. Intense psychological distress (Criterion B4) or physiological reactivity (Criterion B5) often occurs when the individual is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g., windy days after a hurricane; seeing someone who resembles one's perpetrator). The triggering cue could be a physical sensation (e.g., dizziness for survivors of head trauma; rapid heartbeat for a previously traumatized child), particularly for individuals with highly somatic presentations.

Stimuli associated with the trauma are persistently (e.g., always or almost always) avoided. The individual commonly makes deliberate efforts to avoid thoughts, memories, feelings, or talking about the traumatic event (e.g., utilizing distraction techniques to avoid internal reminders) (Criterion Cl) and to avoid activities, objects, situations, or people who arouse recollections of it (Criterion C2).

Negative alterations in cognitions or mood associated with the event begin or worsen after exposure to the event. These negative alterations can take various forms, including an inability to remember an important aspect of the traumatic event; such amnesia is typically due to dissociative amnesia and is not due to head injury, alcohol, or

drugs (Criterion Dl). Another form is persistent (i.e., always or almost always) and exaggerated negative expectations regarding important aspects of life applied to oneself, others, or the future (e.g., "I have always had bad judgment"; "People in authority can't be trusted") that may manifest as a negative change in perceived identity since the trauma (e.g., "I can't trust anyone ever again"; Criterion D2). Individuals with PTSD may have persistent erroneous cognitions about the causes of the traumatic event that lead them to blame themselves or others (e.g., "It's all my fault that my uncle abused me") (Criterion D3). A persistent negative mood state (e.g., fear, horror, anger, guilt, shame) either began or worsened after exposure to the event (Criterion D4). The individual may experience markedly diminished interest or participation in previously enjoyed activities (Criterion D5), feeling detached or estranged from other people (Criterion D6), or a persistent inability to feel positive emotions (especially happiness, joy, satisfaction, or emotions associated with intimacy, tenderness, and sexuality) (Criterion D7).

Individuals with PTSD may be quick tempered and may even engage in aggressive verbal and/or physical behavior with little or no provocation (e.g., yelling at people, getting into fights, destroying objects) (Criterion El). They may also engage in reckless or self-destructive behavior such as dangerous driving, excessive alcohol or drug use, or self-injurious or suicidal behavior (Criterion E2). PTSD is often characterized by a heightened sensitivity to potential threats, including those that are related to the traumatic experience (e.g., following a motor vehicle accident, being especially sensitive to the threat potentially caused by cars or trucks) and those not related to the traumatic event (e.g., being fearful of suffering a heart attack) (Criterion E3). Individuals with PTSD may be very reactive to unexpected stimuli, displaying a heightened startle

response, or jumpiness, to loud noises or unexpected movements (e.g., jumping markedly in response to a telephone ringing) (Criterion E4). Concentration difficulties, including difficulty remembering daily events (e.g., forgetting one's telephone number) or attending to focused tasks (e.g., following a conversation for a sustained period of time), are commonly reported (Criterion E5). Problems with sleep onset and maintenance are common and may be associated with nightmares and safety concerns or with generalized elevated arousal that interferes with adequate sleep (Criterion E6). Some individuals also experience persistent dissociative symptoms of detachment from their bodies (depersonalization) or the world around them (derealization); this is reflected in the "with dissociative symptoms" specifier.

Associated Features Supporting Diagnosis

Developmental regression, such as loss of language in young children, may occur. Auditory pseudo-hallucinations, such as having the sensory experience of hearing one's thoughts spoken in one or more different voices, as well as paranoid ideation, can be present. Following prolonged, repeated, and severe traumatic events (e.g., childhood abuse, torture), the individual may additionally experience difficulties in regulating emotions or maintaining stable interpersonal relationships, or dissociative symptoms. When the traumatic event produces violent death, symptoms of both problematic bereavement and PTSD may be present.

Prevalence

In the United States, projected lifetime risk for PTSD using DSM-IV criteria at age 75 years is 8.7%. Twelve-month prevalence among U.S. adults is about 3.5%. Lower estimates are seen in Europe and most Asian, African, and Latin American countries,

clustering around 0.5%-1.0%. Although different groups have different levels of exposure to traumatic events, the conditional probability of developing PTSD following a similar level of exposure may also vary across cultural groups. Rates of PTSD are higher among veterans and others whose vocation increases the risk of traumatic exposure (e.g., police, firefighters, emergency medical personnel). Highest rates (ranging from one-third to more than one-half of those exposed) are found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide. The prevalence of PTSD may vary across development; children and adolescents, including preschool children, generally have displayed lower prevalence following exposure to serious traumatic events; however, this may be because previous criteria were insufficiently developmentally informed. The prevalence of full-threshold PTSD also appears to be lower among older adults compared with the general population; there is evidence that subthreshold presentations are more common than full PTSD in later life and that these symptoms are associated with substantial clinical impairment. Compared with U.S. non-Latino whites, higher rates of PTSD have been reported among U.S. Latinos, African Americans, and American Indians, and lower rates have been reported among Asian Americans, after adjustment for traumatic exposure and demographic variables.

Development and Course

PTSD can occur at any age, beginning after the first year of life. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before criteria for the diagnosis are met. There is abundant evidence for what DSM-IV called "delayed onset" but is now called "delayed expression," with the

recognition that some symptoms typically appear immediately and that the delay is in meeting full criteria.

Frequently, an individual's reaction to a trauma initially meets criteria for acute stress disorder in the immediate aftermath of the trauma. The symptoms of PTSD and the relative predominance of different symptoms may vary over time. Duration of the symptoms also varies, with complete recovery within 3 months occurring in approximately one-half of adults, while some individuals remain symptomatic for longer than 12 months and sometimes for more than 50 years. Symptom recurrence and intensification may occur in response to reminders of the original trauma, ongoing life stressors, or newly experienced traumatic events. For older individuals, declining health, worsening cognitive functioning, and social isolation may exacerbate PTSD symptoms.

The clinical expression of reexperiencing can vary across development. Young children may report new onset of frightening dreams without content specific to the traumatic event. Before age 6 years (see criteria for preschool subtype), young children are more likely to express reexperiencing symptoms through play that refers directly or symbolically to the trauma. They may not manifest fearful reactions at the time of the exposure or during reexperiencing. Parents may report a wide range of emotional or behavioral changes in young children. Children may focus on imagined interventions in their play or storytelling. In addition to avoidance, children may become preoccupied with reminders. Because of young children's limitations in expressing thoughts or labeling emotions, negative alterations in mood or cognition tend to involve primarily mood changes. Children may experience cooccurring traumas (e.g., physical abuse, witnessing domestic violence) and in chronic circumstances may not be able to identify

onset of symptomatology. Avoidant behavior may be associated with restricted play or exploratory behavior in young children; reduced participation in new activities in school-age children; or reluctance to pursue developmental opportunities in adolescents (e.g., dating, driving). Older children and adolescents may judge themselves as cowardly. Adolescents may harbor beliefs of being changed in ways that make them socially undesirable and estrange them from peers (e.g., "'Now I'll never fit in") and lose aspirations for the future. Irritable or aggressive behavior in children and adolescents can interfere with peer relationships and school behavior. Reckless behavior may lead to accidental injury to self or others, thrill-seeking, or high-risk behaviors. Individuals who continue to experience PTSD into older adulthood may express fewer symptoms of hyperarousal, avoidance, and negative cognitions and mood compared with younger adults with PTSD, although adults exposed to traumatic events during later life may display more avoidance, hyperarousal, sleep problems, and crying spells than do younger adults exposed to the same traumatic events. In older individuals, the disorder is associated with negative health perceptions, primary care utilization, and suicidal ideation.

Risk and Prognostic Factors

Risk (and protective) factors are generally divided into pretraumatic, peritraumatic, and posttraumatic factors.

Pretraumatic factors

Temperamental. These include childhood emotional problems by age 6 years (e.g., prior traumatic exposure, externalizing or anxiety problems) and prior mental disorders (e.g., panic disorder, depressive disorder, PTSD, or obsessive-compulsive disorder [OCD]).

Environmental. These include lower socioeconomic status; lower education; exposure to prior trauma (especially during childhood); childhood adversity (e.g., economic deprivation, family dysfunction, parental separation or death); cultural characteristics (e.g., fatalistic or self-blaming coping strategies); lower intelligence; minority racial/ethnic status; and a family psychiatric history. Social support prior to event exposure is protective.

Genetic and physiological. These include female gender and younger age at the time of trauma exposure (for adults). Certain genotypes may either be protective or increase risk of PTSD after exposure to traumatic events.

Peritraumatic factors

Environmental. These include severity (dose) of the trauma (the greater the magnitude of trauma, the greater the likelihood of PTSD), perceived life threat, personal injury, interpersonal violence (particularly trauma perpetrated by a caregiver or involving a witnessed threat to a caregiver in children), and, for military personnel, being a perpetrator, witnessing atrocities, or killing the enemy. Finally, dissociation that occurs during the trauma and persists afterward is a risk factor.

Posttraumatic factors

Temperamental. These include negative appraisals, inappropriate coping strategies, and development of acute stress disorder.

Environmental. These include subsequent exposure to repeated upsetting reminders, subsequent adverse life events, and financial or other trauma-related losses. Social support (including family stability, for children) is a protective factor that moderates outcome after trauma.

Culture-Related Diagnostic Issues

The risk of onset and severity of PTSD may differ across cultural groups as a result of variation in the type of traumatic exposure (e.g., genocide), the impact on disorder severity of the meaning attributed to the traumatic event (e.g., inability to perform funerary rites after a mass killing), the ongoing sociocultural context (e.g., residing among unpunished perpetrators in postconflict settings), and other cultural factors (e.g., acculturative stress in immigrants). The relative risk for PTSD of particular exposures (e.g., religious persecution) may vary across cultural groups. The clinical expression of the symptoms or symptom clusters of PTSD may vary culturally, particularly with respect to avoidance and numbing symptoms, distressing dreams, and somatic symptoms (e.g., dizziness, shortness of breath, heat sensations).

Cultural syndromes and idioms of distress influence the expression of PTSD and the range of comorbid disorders in different cultures by providing behavioral and cognitive templates that link traumatic exposures to specific symptoms. For example, panic attack symptoms may be salient in PTSD among Cambodians and Latin Americans because of the association of traumatic exposure with panic-like *khyâl* attacks and *ataque de nervios*. Comprehensive evaluation of local expressions of PTSD should include assessment of cultural concepts of distress (see the chapter "Cultural Formulation" in Section III).

Gender-Related Diagnostic Issues

PTSD is more prevalent among females than among males across the lifespan. Females in the general population experience PTSD for a longer duration than do males. At least some of the increased risk for PTSD in females appears to be attributable to a greater

likelihood of exposure to traumatic events, such as rape, and other forms of interpersonal violence. Within populations exposed specifically to such stressors, gender differences in risk for PTSD are attenuated or nonsignificant.

Suicide Risk

Traumatic events such as childhood abuse increase a person's suicide risk. PTSD is associated with suicidal ideation and suicide attempts, and presence of the disorder may indicate which individuals with ideation eventually make a suicide plan or actually attempt suicide.

Functional Consequences of Posttraumatic Stress Disorder

PTSD is associated with high levels of social, occupational, and physical disability, as well as considerable economic costs and high levels of medical utilization. Impaired functioning is exhibited across social, interpersonal, developmental, educational, physical health, and occupational domains. In community and veteran samples, PTSD is associated with poor social and family relationships, absenteeism from work, lower income, and lower educational and occupational success.

Differential Diagnosis

Adjustment disorders. In adjustment disorders, the stressor can be of any severity or type rather than that required by PTSD Criterion A. The diagnosis of an adjustment disorder is used when the response to a stressor that meets PTSD Criterion A does not meet all other PTSD criteria (or criteria for another mental disorder). An adjustment disorder is also diagnosed when the symptom pattern of PTSD occurs in response to a stressor that does not meet PTSD Criterion A (e.g., spouse leaving, being fired).

Other posttraumatic disorders and conditions. Not all psychopathology that occurs in

individuals exposed to an extreme stressor should necessarily be attributed to PTSD. The diagnosis requires that trauma exposure precede the onset or exacerbation of pertinent symptoms. Moreover, if the symptom response pattern to the extreme stressor meets criteria for another mental disorder, these diagnoses should be given instead of, or in addition to, PTSD. Other diagnoses and conditions are excluded if they are better explained by PTSD (e.g., symptoms of panic disorder that occur only after exposure to traumatic reminders). If severe, symptom response patterns to the extreme stressor may warrant a separate diagnosis (e.g., dissociative amnesia).

Acute stress disorder. Acute stress disorder is distinguished from PTSD because the symptom pattern in acute stress disorder is restricted to a duration of 3 days to 1 month following exposure to the traumatic event.

Anxiety disorders and obsessive-compulsive disorder. In OCD, there are recurrent intrusive thoughts, but these meet the definition of an obsession. In addition, the intrusive thoughts are not related to an experienced traumatic event, compulsions are usually present, and other symptoms of PTSD or acute stress disorder are typically absent. Neither the arousal and dissociative symptoms of panic disorder nor the avoidance, irritability, and anxiety of generalized anxiety disorder are associated with a specific traumatic event. The symptoms of separation anxiety disorder are clearly related to separation from home or family, rather than to a traumatic event.

Major depressive disorder. Major depression may or may not be preceded by a traumatic event and should be diagnosed if other PTSD symptoms are absent. Specifically, major depressive disorder does not include any PTSD Criterion B or C symptoms. Nor does it include a number of symptoms from PTSD Criterion D or E.

Personality disorders. Interpersonal difficulties that had their onset, or were greatly exacerbated, after exposure to a traumatic event may be an indication of PTSD, rather than a personality disorder, in which such difficulties would be expected independently of any traumatic exposure.

Dissociative disorders. Dissociative amnesia, dissociative identity disorder, and depersonalization-derealization disorder may or may not be preceded by exposure to a traumatic event or may or may not have co-occurring PTSD symptoms. When full PTSD criteria are also met, however, the PTSD "with dissociative symptoms" subtype should be considered.

Conversion disorder (functional neurological symptom disorder). New onset of somatic symptoms within the context of posttraumatic distress might be an indication of PTSD rather than conversion disorder (functional neurological symptom disorder).

Psychotic disorders. Flashbacks in PTSD must be distinguished from illusions, hallucinations, and other perceptual disturbances that may occur in schizophrenia, brief psychotic disorder, and other psychotic disorders; depressive and bipolar disorders with psychotic features; delirium; substance/medication-induced disorders; and psychotic disorders due to another medical condition.

Traumatic brain injury. When a brain injury occurs in the context of a traumatic event (e.g., traumatic accident, bomb blast, acceleration/deceleration trauma), symptoms of PTSD may appear. An event causing head trauma may also constitute a psychological traumatic event, and traumatic brain injury (TBI)-related neurocognitive symptoms are not mutually exclusive and may occur concurrently. Symptoms previously termed *postconcussive* (e.g., headaches, dizziness, sensitivity to light or sound, irritability,

concentration deficits) can occur in brain-injured and non-brain-injured populations, including individuals with PTSD. Because symptoms of PTSD and TBI-related neurocognitive symptoms can overlap, a differential diagnosis between PTSD and neurocognitive disorder symptoms attributable to TBI may be possible based on the presence of symptoms that are distinctive to each presentation. Whereas reexperiencing and avoidance are characteristic of PTSD and not the effects of TBI, persistent disorientation and confusion are more specific to TBI (neurocognitive effects) than to PTSD.

Comorbidity

Individuals with PTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder (e.g., depressive, bipolar, anxiety, or substance use disorders). Comorbid substance use disorder and conduct disorder are more common among males than among females. Among U.S. military personnel and combat veterans who have been deployed to recent wars in Afghanistan and Iraq, co-occurrence of PTSD and mild TBI is 48%. Although most young children with PTSD also have at least one other diagnosis, the patterns of comorbidity are different than in adults, with oppositional defiant disorder and separation anxiety disorder predominating. Finally, there is considerable comorbidity between PTSD and major neurocognitive disorder and some overlapping symptoms between these disorders. (APA, 2013, pp. 271-280, emphasis in original)

Survey on the Perception of PTSD

Before conducting the interviews, a survey was created and utilized as a sort of preliminary research which enabled greater understanding of the challenges found in locating interviewees, developing methodology, analysis of findings, and conclusions. Presented as a Google form survey posted to a social media platform, 20 individuals responded. Inclusion of this survey and the analysis in the Appendix is meant to illustrate how it was used to formulate greater understanding of how to select interviewees which might provide the most detailed, medically accurate information and elucidated lines of questioning which might have otherwise not been utilized.

Research Methods

A link to a quick survey was created in Google forms and was posted to a social media platform. Of the hundreds of individuals who were potentially exposed to the post, only 20 responded. The survey format was created with open-ended questions (a blank field where the respondent can type anything they want) or radial buttons (choose one or the other). The questions posed in the survey are as follows:

- How old are you? (Open-ended question.)
- What is your sex? (Radial buttons: male or female.)
- Do you have family members who have served in the military? (Radial buttons: yes or no.)
- Have you ever served in the military? (Radial buttons: yes or no.)
- What is Post-Traumatic Stress Disorder (PTSD)? How does it tend to manifest? (Open-ended question.)

The survey could be filled out by smart phone, computer, or tablet. The survey gave each respondent an identification number and took a timestamp of when the survey was completed.

The radial questions allowed for analysis by age, sex, prior military service, and having come from a military family. The open-ended questions allowed the respondents to fill in their own definition of PTSD, describe how they think it occurs, and list symptoms. Demographic data was used to find trends in general answers and understanding and the open-ended answers were broken down much like the interview transcripts later on, with their perceived conditional type listed, frequency of PTSD, and each symptom listed individually.

Responses were analyzed by individual and by symptom. Correlation matrixes of top variables (those with 3 or more mentions) were used to identify frequency and similarity of responses. The data was used primarily in the formation of early concepts and questions for the interview process.

Findings for the Survey on PTSD

This survey was created in order to gauge how the general public, some of which are veterans, view the condition of PTSD in order to better formulate how interviews would be conducted, which interviewees to focus on as a case study, and what questions should be formulated. What was found was a general sense of uncertainty regarding the condition.

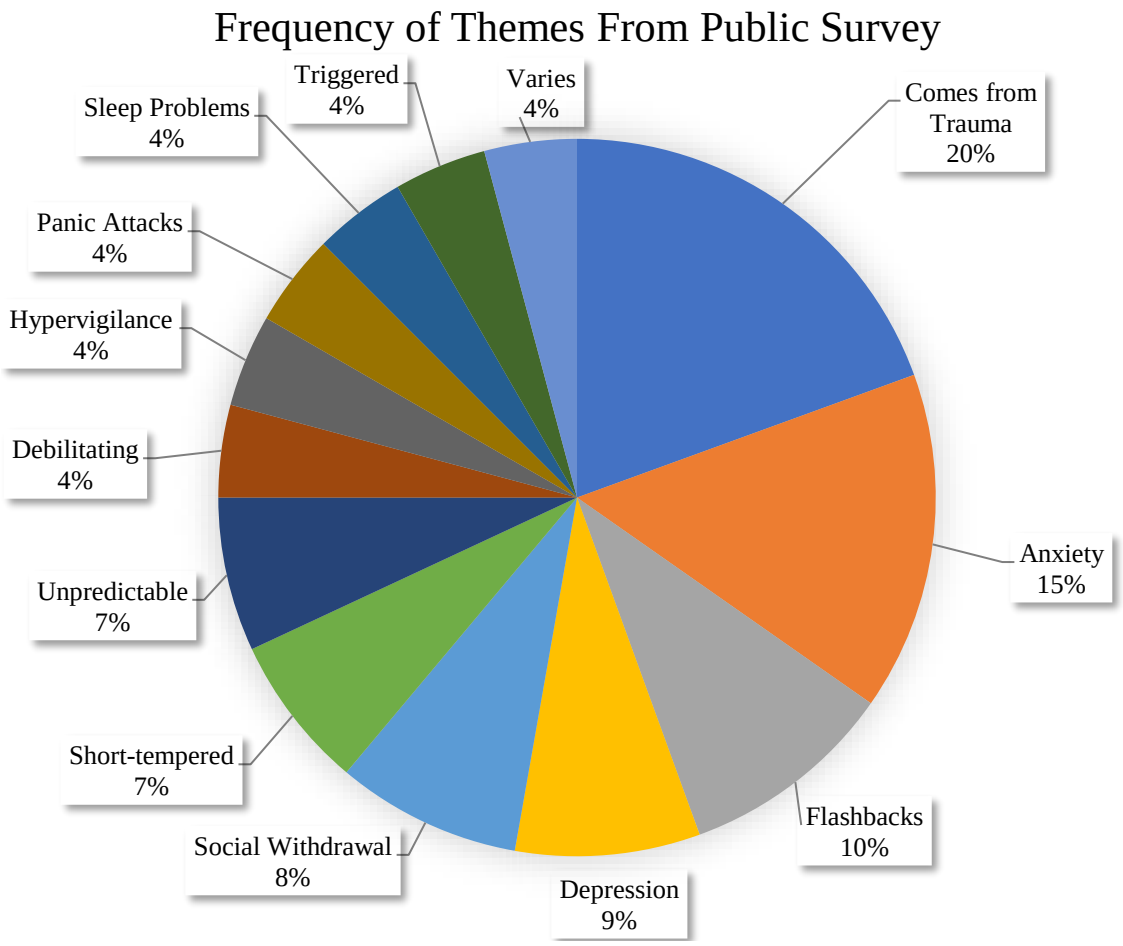

Figure 15: The symptoms that display 3 or more responses and the percentages of symptoms as found in the public survey on the conception of PTSD.

For the majority of respondents, uncertainty was presented as an assertion that the symptoms of PTSD vary by individual. This is a positive thing for the average person to perceive about PTSD, since the symptoms do in fact vary by individual and even in the same context, an individual can have a different response. However, this might be a perception based on familiarity with the condition since 52% had served in the military before and an overwhelming 91% had family who have served in the military. This is not to indicate that PTSD is solely a military or veteran's condition, but that they are more likely to have had or been exposed to someone who has the condition if they are closely

affiliated with the military, which allows them to provide information outside the public discourse.

Before filling out the survey, some individuals had expressed concern that they didn't know what PTSD really was and wanted to look it up before taking the survey, as if the survey were a test and they had to provide the "right" answer. They were then convinced to just take it and answer with what they know. This is likely why many responses utilized the symptoms that can be found in the name of the disorder, such as "anxiety" and "comes from trauma." Since the responses are all anonymous, it cannot be certain that the responses which provided the least information or the most "generic" information came from those with professed lack of knowledge on the subject.

As for similarities in individuals, it is fairly easy to tell which individuals tended to have the most medically accurate answers: Individuals 20, 2, and 3. Individuals 12 and 10 provide the least information, so likely will be indicated by the program as the negative correlate. A response mean for the individuals was run in order to determine statistically which ones might be better sources of information based on detail provided and medical accuracy.

ID	Comes from Traur	Anxie	Flashbac	Depressi	Social Withdraw	Short-temper	Unpredictat	Debilitati	Hypervigilan	Panic Attac	Sleep Probler	Trigger	Vari	Response Me
20	3	1	6	4	14	7	0	0	0	10	13	0	0	7.86
2	3	1	0	0	10	8	0	0	4	0	9	0	0	6.40
6	1	0	0	0	0	0	6	2	0	5	0	0	0	4.33
19	1	0	0	2	6	4	0	0	0	0	5	0	0	4.25
17	1	0	3	0	0	0	5	0	0	0	0	4	0	4.00
1	1	0	0	0	0	0	0	0	0	3	0	0	4	3.50
3	2	1	4	3	0	6	0	0	0	0	0	0	0	3.50
5	0	0	0	0	3	0	4	0	0	0	0	0	0	3.50
7	2	1	4	3	0	0	0	0	5	0	0	0	0	3.25
15	2	1	3	0	0	0	5	0	0	0	0	4	0	3.25
18	0	1	4	3	6	0	0	2	0	0	0	0	0	3.20
9	1	0	2	0	3	0	0	0	0	0	0	4	0	3.00
13	1	0	0	2	0	0	0	0	4	0	0	0	0	3.00
4	0	0	0	0	0	0	0	0	0	0	0	0	2	2.00
8	2	1	0	0	0	0	0	3	0	0	0	0	0	2.00
11	0	1	0	0	0	0	3	0	0	0	0	0	0	2.00
14	2	1	0	0	0	3	0	0	0	0	0	0	0	2.00
16	2	1	0	0	0	0	0	0	0	0	0	0	3	2.00
10	0	1	0	0	0	0	0	0	0	0	0	0	0	1.00
12	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00
Totals	24	11	26	17	42	28	23	7	13	18	27	12	9	64.04

Table 2: Survey-Response Means per Individual. The response means is sorted by largest at the top to smallest at the bottom as found in the public survey on the conception of PTSD per individual. The average of the responses is 3.20.

The average of all the responses is 3.20, meaning everyone from Individual 18 and up will provide more medically accurate, descriptive information than those below by virtue of their willingness to answer the question with as much information as they can. This does not, however, indicate the quality of said responses.

The quality of the answers comes from both being medically accurate and detail provided. Individual 20 is the only one to list a physiological symptom alongside the psychological symptoms, lists more symptoms than any other individual, and even list PTSD as an emotional condition. Individual 2 also provides a lot of detailed, medically accurate information, which is indicated by the amount of information provided as well as the addition of a few key terms which did not get listed more than 3 times, such as "self-doubt," which is crucial to understanding the condition.

Using this information as a basis, understanding of which potential answers provided the most details and medically accurate information indicated what should be looked for in potential interviewees, such as the accounts by Individual 2 and Individual 14. The rest of the really detailed answers came from individuals who have not served, including the respondent who provided the most medically accurate, in-depth description

of the condition, Individual 20. When the survey was initially created, there was an erroneous assumption that non-service members would not be as medically accurate about the condition. However, after realizing that most of the most medically accurate information came from non-service members, it became clear that most of them had family members who had served. This probably means they had both more of a vested interest in understanding the condition as well as a privileged position to observe those with the condition up-close, possibly even experiencing secondary PTSD to a certain degree in at least one point in their lives due to said exposure. As to why prior service members do not list as much medically accurate information regarding the condition, it could be assumed that they are either avoiding knowing more about it out of fear for recognizing their own pathology or had only chosen to provide the public discourse presented on the subject.

Next, a correlation matrix was run in order to determine whether there are the same relations among the concepts and individuals. The program would not allow the use of the ID as the labels, saying it uses string variables only. Since ID is a nominal measure and not an ordinal measure, it was determined that not using it as a label was satisfactory.

Proximity Matrix

Correlation between Vectors of Values

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	1.000	-.304	-.251	.767	-.204	.225	-.257	-.110	-.238	-.140	-.181	.000	-.174	-.110	-.257	.670	-.247	-.315	-.291	-.033
2	-.304	1.000	.132	-.211	.182	-.366	-.164	-.205	.097	-.132	-.248	.000	.003	.333	-.409	-.205	-.390	.198	.911	.705
3	-.251	.132	1.000	-.188	-.275	-.314	.276	-.105	-.072	-.035	-.195	.000	-.022	.685	-.035	-.105	-.048	.136	.192	.112
4	.767	-.211	-.188	1.000	-.122	-.157	-.196	-.143	-.170	-.083	-.108	.000	-.135	-.143	-.196	.788	-.169	-.188	-.191	-.261
5	-.204	.182	-.275	-.122	1.000	.501	-.286	-.209	.166	-.122	.722	.000	-.197	-.209	.421	-.209	.458	.299	.239	.131
6	.225	-.366	-.314	-.157	.501	1.000	-.323	.064	-.290	-.157	.648	.000	-.221	-.187	.362	-.187	.386	-.272	-.341	-.074
7	-.257	-.164	.276	-.196	-.286	-.323	1.000	-.093	-.053	-.026	-.199	.000	.782	-.093	-.008	-.093	-.026	.180	-.275	-.219
8	-.110	-.205	-.105	-.143	-.209	.064	-.093	1.000	-.165	.167	-.085	.000	-.088	.199	-.093	.199	-.194	-.017	-.249	-.331
9	-.238	.097	-.072	-.170	.166	-.290	-.053	-.165	1.000	-.170	-.220	.000	-.224	-.165	.430	-.165	.447	.426	.144	.147
10	-.140	-.132	-.035	-.083	-.122	-.157	-.026	.167	-.170	1.000	.243	.000	-.135	.167	-.026	.167	-.169	-.035	-.191	-.202
11	-.181	-.248	-.195	-.108	.722	.648	-.199	-.085	-.220	.243	1.000	.000	-.175	-.085	.626	-.085	.603	-.195	-.248	-.319
12	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	1.000	.000	.000	.000	.000	.000	.000	.000	.000
13	-.174	.003	-.022	-.135	-.197	-.221	.782	-.088	-.224	-.135	-.175	.000	1.000	-.088	-.238	-.088	-.234	-.093	-.150	-.274
14	-.110	.333	.685	-.143	-.209	-.187	-.093	.199	-.165	.167	-.085	.000	-.088	1.000	-.093	.199	-.194	-.280	.225	.021
15	-.257	-.409	-.035	-.196	.421	.362	-.008	-.093	.430	-.026	.626	.000	-.238	-.093	1.000	-.093	.978	-.131	-.405	-.383
16	.670	-.205	-.105	.788	-.209	-.187	-.093	.199	-.165	.167	-.085	.000	-.088	.199	-.093	1.000	-.194	-.280	-.249	-.331
17	-.247	-.390	-.048	-.169	.458	.386	-.026	-.194	.447	-.169	.603	.000	-.234	-.194	.978	-.194	1.000	-.095	-.365	-.337
18	-.315	.198	.136	-.188	.299	-.272	.180	-.017	.426	-.035	-.195	.000	-.093	-.280	-.131	-.280	-.095	1.000	.386	.409
19	-.291	.911	.192	-.191	.239	-.341	-.275	-.249	.144	-.191	-.248	.000	-.150	.225	-.405	-.249	-.365	.386	1.000	.800
20	-.033	.705	.112	-.261	.131	-.074	-.219	-.331	.147	-.202	-.319	.000	-.274	.021	-.383	-.331	-.337	.409	.800	1.000

This is a similarity matrix

Table 3: Survey-Correlation Matrix of Top Variables by Respondent. The correlation matrix of the top variables (with 3 or more mentions) listed between cases as found in the public survey on the conception of PTSD.

For this correlation matrix, it appears individual 12 was chosen as the baseline by the program as indicated by its values being 0 except in relation to itself. This was then used to examine how the top respondents were grouped. Individual 20, the interviewee with the most detailed, medically accurate description, is shown to be most similar to Individuals 19, 2, 18, 9, 5, 3, and 14, in that order. This confirms the earlier assertions about which interviewees would yield the most detailed, in-depth interviews, which are Individuals 2, 14, 9, 5, and 3. Individual 19 is not prior service, so wouldn't qualify for the study. What was curious about this correlation was that Individual 14 was listed as the least similar to Individual 20 in the positive relationships, since their answers were fairly salient, and they listed a lot of details. It seemed reasonable that Individual 14 would have definitely been listed as being more similar to Individual 20 over Individuals 9, 5, and 3, who are fairly succinct and at times, incorrect according to the medical understanding of PTSD. Of course this is only a correlation matrix and not an indication of which individuals would have the most medically accurate, experiential answers. The

individuals listed above Individual 14 have more of the same answers as Individual 20, which is likely why they were listed above Individual 14.

As for those who are least similar to Individual 20, the program indicated Individuals 12 and 10. What is interesting about this is that the program chose Individual 12 as its baseline, whose two answers are unlike any others' and seem politically motivated rather than informative, since they state "PTSD is a rare disorder that has been taken advantage of by service members to get something they did not earn nor deserve." After they took the survey, this individual made contact and indicated that they had meant it to be a political statement and described why they chose to discuss it this way, despite instructions on the survey indicating it was meant to be anonymous. Because the others cannot be identified as being most similar to this account via sorting, the next one as indicated by the program to be least similar to Individual 20 was utilized as the negative correlate: Individual 10. For correlation, Individuals 11, 14, 8, and 16 are indicated as being most similar to Individual 10 in that order. It was surprising that Individual 14, one of the interviewees who had indicated more detailed, medically accurate information, also appeared in this correlation. However, since Individual 10 only lists "Anxiety" as a symptom, one of the top listed ones, it's understandable it would correlate the answers which use the same terminology. Also, the majority of the ones similar to 10 are prior service, which had been expected to a degree. The majority of the positive correlations to the most detailed, medically accurate answer, Individual 20, tended to be prior service.

Proximity Matrix

Correlation between Vectors of Values

	Comes from Trauma	Anxiety	Flashbacks	Depression	Social Withdrawal	Short-tempered	Unpredictable	Debilitating	Hypervigilance	Panic Attacks	Sleep Problems	Triggered	Varies
Comes from Trauma	1.000	.492	.371	.287	.405	.657	-.164	-.024	.341	.345	.570	.057	-.037
Anxiety	.492	1.000	.354	.271	.180	.333	-.227	.136	.119	.004	.208	-.183	-.175
Flashbacks	.371	.354	1.000	.738	.405	.300	.001	-.034	.052	.397	.327	.302	-.276
Depression	.287	.271	.738	1.000	.482	.430	-.352	.002	.284	.376	.418	-.264	-.253
Social Withdrawal	.405	.180	.405	.482	1.000	.715	-.229	-.041	.106	.546	.920	-.120	-.219
Short-tempered	.657	.333	.300	.430	.715	1.000	-.302	-.221	.171	.356	.810	-.227	-.217
Unpredictable	-.164	-.227	.001	-.352	-.229	-.302	1.000	.113	-.233	.093	-.219	.446	-.225
Debilitating	-.024	.136	-.034	.002	-.041	-.221	.113	1.000	-.171	.089	-.160	-.172	-.165
Hypervigilance	.341	.119	.052	.284	.106	.171	-.233	-.171	1.000	-.155	.171	-.175	-.168
Panic Attacks	.345	.004	.397	.376	.546	.356	.093	.089	-.155	1.000	.631	-.156	.072
Sleep Problems	.570	.208	.327	.418	.920	.810	-.219	-.160	.171	.631	1.000	-.164	-.157
Triggered	.057	-.183	.302	-.264	-.120	-.227	.446	-.172	-.175	-.156	-.164	1.000	-.169
Varies	-.037	-.175	-.276	-.253	-.219	-.217	-.225	-.165	-.168	.072	-.157	-.169	1.000

This is a similarity matrix

Table 4: Survey-Correlation Matrix of Top Variables by Symptom. The correlation matrix of the top variables (with 3 or more mentions) listed between variables as found in the public survey on the conception of PTSD.

As for similarities between symptoms, “Varies” is listed as only being similar to “Panic Attacks,” which was surprising since it is one of the top symptoms. The rest are negative correlates. Also, the relationship between “Comes from Trauma” and “Anxiety” is not as high as expected. “Short-tempered” and “Sleep problems” are listed above “Anxiety” in the correlation matrix. Almost everything is a positive value in relation to “Comes from Trauma” except “Debilitating,” “Varies,” and “Unpredictable.”

Next, the correlation was run again with all symptoms since there was a possibility that only including the top variables changes the correlation.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	1.000	-0.134	-0.072	0.632	-0.093	0.227	-0.050	0.024	-0.057	-0.050	-0.081	-0.067	-0.077	-0.021	-0.050	0.658	-0.077	-0.115	-0.094	0.043
2	-0.134	1.000	0.110	-0.117	0.126	-0.184	0.012	-0.044	0.155	-0.035	-0.127	-0.117	-0.046	0.135	-0.132	-0.044	-0.161	0.144	0.589	0.468
3	-0.072	0.110	1.000	-0.083	-0.115	-0.117	0.350	0.055	0.099	0.052	-0.069	-0.083	-0.001	0.377	0.142	0.055	0.095	0.184	0.260	0.118
4	0.632	-0.117	-0.083	1.000	-0.067	-0.083	-0.075	-0.058	-0.067	-0.036	-0.058	-0.048	0.120	-0.067	-0.075	0.701	-0.075	-0.083	-0.083	-0.137
5	-0.093	0.126	-0.115	-0.067	1.000	0.398	-0.105	-0.081	0.235	-0.050	0.552	-0.067	-0.105	-0.093	0.440	-0.081	0.440	0.270	0.270	0.106
6	0.227	-0.184	-0.117	-0.083	0.398	1.000	-0.097	0.148	-0.094	-0.061	0.458	-0.083	-0.113	-0.072	0.382	-0.038	0.366	-0.092	-0.129	-0.015
7	-0.050	0.012	0.350	-0.075	-0.105	-0.097	1.000	0.106	0.167	0.089	-0.052	-0.075	0.452	0.031	0.228	0.106	0.167	0.286	-0.001	0.014
8	0.024	-0.044	0.055	-0.058	-0.081	0.148	0.106	1.000	0.024	0.237	0.006	-0.058	-0.012	0.183	0.106	0.312	-0.012	0.117	-0.038	-0.094
9	-0.057	0.155	0.099	-0.067	0.235	-0.094	0.167	0.024	1.000	-0.050	-0.081	-0.067	-0.077	-0.021	0.548	0.024	0.521	0.441	0.291	0.212
10	-0.050	-0.035	0.052	-0.036	-0.050	-0.061	0.089	0.237	-0.050	1.000	0.237	-0.036	-0.056	0.144	0.089	0.237	-0.056	0.052	-0.061	-0.063
11	-0.081	-0.127	-0.069	-0.058	0.552	0.458	-0.052	0.006	-0.081	0.237	1.000	-0.058	-0.091	-0.028	0.540	0.006	0.500	-0.069	-0.100	-0.053
12	-0.067	-0.117	-0.083	-0.048	-0.067	-0.083	-0.075	-0.058	-0.067	-0.036	-0.058	1.000	-0.075	-0.067	-0.075	-0.058	-0.075	-0.083	-0.083	-0.137
13	-0.077	-0.046	-0.001	0.120	-0.105	-0.113	0.452	-0.012	-0.077	-0.056	-0.091	-0.075	1.000	-0.050	-0.077	-0.012	-0.097	-0.033	-0.049	-0.155
14	-0.021	0.135	0.377	-0.067	-0.093	-0.072	0.031	0.183	-0.021	0.144	-0.028	-0.067	-0.050	1.000	0.031	0.183	-0.050	-0.094	0.184	0.008
15	-0.050	-0.132	0.142	-0.075	0.440	0.382	0.228	0.106	0.548	0.089	0.540	-0.075	-0.077	0.031	1.000	0.106	0.939	0.079	-0.097	-0.081
16	0.658	-0.044	0.055	0.701	-0.081	-0.038	0.106	0.312	0.024	0.237	0.006	-0.058	-0.012	0.183	0.106	1.000	-0.012	-0.069	-0.038	-0.094
17	-0.077	-0.161	0.095	-0.075	0.440	0.366	0.167	-0.012	0.521	-0.056	0.500	-0.075	-0.097	-0.050	0.939	-0.012	1.000	0.063	-0.113	-0.102
18	-0.115	0.144	0.184	-0.083	0.270	-0.092	0.286	0.117	0.441	0.052	-0.069	-0.083	-0.033	-0.094	0.079	-0.069	0.063	1.000	0.385	0.267
19	-0.094	0.589	0.260	-0.083	0.270	-0.129	-0.001	-0.038	0.291	-0.061	-0.100	-0.083	-0.049	0.184	-0.097	-0.038	-0.113	0.385	1.000	0.544
20	0.043	0.468	0.118	-0.137	0.106	-0.015	0.014	-0.094	0.212	-0.063	-0.053	-0.137	-0.155	0.008	-0.081	-0.094	-0.102	0.267	0.544	1.000

Table 5: Survey-Correlation Matrix of Symptoms by Respondent. The correlation matrix of individuals with all symptoms listed as found in the public survey on the conception of PTSD.

For this correlation matrix with all symptoms, there is no clear baseline individual chosen by the program. Instead, Individual 20 was used as the baseline based on the previous correlation as well as their medically accurate, detailed description. It came out much like it had for only the top symptoms but switched the order of Individuals 5 and 3 (now 3, then 5) and included Individual 7, who provides a fairly medically accurate description upon reexamination. As for negative correlate, it was sorted based on Individual 10, which only had one answer. It came up with Individuals 8, 11, 16, 14, 15, 7, 18, and 3, much more than with only the top symptoms and including several which had been the top correlates to Individual 20 in the original analysis.

Since there were so many individuals listed as being positively correlated to Individual 20, it was determined that only focusing on the relationship between “Comes from Trauma” and “Anxiety,” would yield more specific results. A positive correlation with “Comes from Anxiety” is only present in roughly half of the symptoms, with

"Short-tempered," "Mistrust," "Self-Destruction," and "Sleep Problems" as the top ones just above "Anxiety." This is correct in accuracy of symptoms for the condition itself, but it was not expected based on the answers. Looking back at the original answers, it became clear that the individuals with the most medically accurate answers included these symptoms, so this is likely the reason for the positive correlation being listed this way by the program.

Utilization of Prior Research-Survey on PTSD

The full methodology and analysis of the survey is presented in the Appendix, since it was not part of the majority of the work for this thesis. Instead, this survey was utilized in order to understand how to approach the topic of PTSD from a general understanding viewpoint and to identify which potential interviewees would be most informative and provide the most detail based on their answers. This survey also helped to formulate questions and consider avenues of questioning previously unidentified. After doing some research on the topic of PTSD, the primary aspects listed by the positive-correlate survey takers identified comorbid conditions and some general behavioral symptoms. By understanding how to ask about comorbid conditions and get a list of symptoms from the interviewees, a more complete picture of the condition of PTSD could be elicited during the later interviews. Another crucial aspect that emerged from the survey was the general variability of the condition, since trauma source, symptoms, and triggers can vary from individual to individual. After much examination on the reasoning behind this variability, it was determined that there was another underlying factor to PTSD, later identified through analysis of the interviews and discussed in the conclusion as resilience, the cumulative nature of PTSD, and demedicalization.