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Competing constructivisms: the negotiation of PTSD and related stigma among post-9/11 veterans in New York City

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Abstract

Posttraumatic stress disorder (PTSD) stands as a form of psychopathology that straddles moral and psychiatric domains. Grounded in discrete instances of trauma, PTSD represents an etiological outlier in an era of increased attention to the genetics of mental illness and a prime location for social constructivist analyses of mental illness. This examination of PTSD narratives—as voiced in qualitative interviews and focus groups with 50 veterans of the recent Iraq and Afghanistan wars living in New York City—attends to the processes through which veterans conceive and navigate PTSD symptoms and diagnoses. In so doing we highlight the social constructivist positions undertaken by veterans themselves as they varyingly challenge and internalize symptomology in dialogue with psychiatric definitions and the stigma associated with PTSD. Findings demonstrate the rejection of classic psychopathological etiology—in brain disease, for example—by many veterans as well as the complex balancing of benefit and stigma that veterans undertake when making decisions about presenting to psychiatric clinicians. Drawing on veterans' accounts, we argue for greater cultural specificity in characterizing the diagnosis-seeking behavior of trauma survivors and a greater appreciation for the contradictions and compromise related to both acceptance and rejection of a mental health diagnosis.

INTRODUCTION

The term posttraumatic stress disorder (PTSD) dates to the publication of DSM-III in 1980 (Scott, 1990) and, as an emergent diagnostic category, has generated a lively intellectual dialogue ranging from more explicit social constructivism and cultural relativism to universalizing historiography. Since at least the 19th century, folk categories for combat-related maladies such as “soldier’s heart,” “shell shock,” and “combat fatigue” have existed (Bergen-Cico, 2012; Courtwright, 1982), and several recent explorations seek to establish the continuity of PTSD from ancient Greece to modern times (Shay, 2002, 2010; Tritle, 2002). These assertions are countered by other recent work exploring PTSD as a further case

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study in Western—and more recently, American—cultural diffusion that threatens to bracket the diversity of human response to trauma and the observation that some groups are “better able to integrate and give meaning to terrible events” than others (Watters, 2010, p. 88).

In 2013, with the arrival of the DSM-5, PTSD was respecified as one of a new class of “trauma and stressor-related disorders,” resulting in what has generally been seen as a more inclusive categorization, sensitive to the variable expressions of distress associated with PTSD (American Psychiatric Association, 2013; Department of Veterans Affairs, 2012; Kulka et al., 1990; Scott, 1990), its often delayed onset and variability in severity and intensity over time (Andrews, et al., 2007; Buckley, Blanchard, & Hickling 1996), and the different constellation of symptoms which might merit a clinical diagnosis (Grubaugh et al., 2005; Jakupcak et al., 2007; Authors, 2015). Even as PTSD has become entangled with the broader process of biomedicalization (Clarke et al., 2003) by which conditions previously held to be the product of weak moral constitutions or other individual failings have been re-categorized in dialogue with new technoscientific diagnostics, treatments, and procedures, as legitimate diseases (see, e.g., Vasterling & Brewin, 2005), clinical and theoretical suspicion about the rapidly escalating claims to PTSD globally have complicated any simple narrative about the destigmatization of PTSD. As Fassin and Rechtman note, the origins of PTSD as a replacement for “traumatic neurosis” in the 1980s with DSM-III were grounded in psychiatrists’ efforts to destigmatize a condition treated “as a mark of cowardice or malingering” and shift etiological focus from the victim or sufferer to the traumatic event itself (2009, p. 89).

If anything, however, this purported emphasis on traumatic events and the rapidly escalating claimants within the VA healthcare system have made presentation with PTSD symptoms more fraught, on several fronts. The first concerns the public discourse surrounding the economic burden of PTSD related to recent wars and more inclusive diagnostic criteria that have emerged as a central point of concern for researchers and policymakers. A study of veterans who served post-9/11 and received care through Veterans Administration (VA) clinics and hospitals found that over 35% received a mental health diagnosis, PTSD being the most prevalent (Cohen et al., 2010). The costs of PTSD and major depression for 1.6 million returning veterans during their first two years of civilian life alone have been estimated at between \$4.0 and \$6.2 billion (Tanielian & Jaycox, 2008). Secondly, the recognition that disability benefits are being granted, often without clinicians having accessed individuals’ military records to confirm combat or other service-related trauma (McNally & Frueh 2013), has led to widespread suspicion about the extent to which veterans are strategically performing, or malingering, PTSD. (Resnick, West, & Payne, 1997). Taken together, the costs and the clinical mistrust of fraudulent claims to PTSD disability benefits have fueled increasingly commonplace criticism in the US and abroad of the current psychiatric investment in PTSD as “an accurate description of objective reality and as a discovery of what was present but previously unseen” (Scott, 1990, p. 295).

As Summerfield has cogently argued while discussing the costs of PTSD treatment to England’s National Health Service, PTSD occupies a contentious place between psychiatric and moralistic discourses. “The psychiatric category,” he explains, “is the instrument by which a moral charge is fashioned into a medicolegal one” (Summerfield, 2001, p. 322). The

“invention” of PTSD (see also: Young, 1997), he claims, represented the confluence of a set of historical processes and dominant Western formulations of personhood and individual rights by which aggrieved persons came to be able to pursue compensation for traumatic experiences on the grounds of resulting psychopathology. Others have pointed to the distinct roots of PTSD in victimology (Fassin and Rechtman, 2009), a framework which explicitly frames the moral and criminological dimensions of suffering without the same emphasis on pathologizing the cognitive, affective, and behavioral sequelae of traumatic experience that has characterized PTSD discourse and debate in the US. Acknowledging the moral character of much post-war suffering, the US Departments of Defense (DoD) and Veterans Affairs have supported further research into “moral injury” an experience which, whether grounded in service-related experiences such as bearing witness to or “learning about acts that transgress deeply held moral beliefs and expectations” or post-service feelings of betrayal by the Military and/or VA (Hoge, 2010; Maguen & Litz, 2012), can be an integral part of PTSD for many veterans. Though “moral injury” has largely been understood through the lens of PTSD (Hoge, et al., 2004; Litz et al, 2009), official VA briefings on the topic note that, unlike PTSD “which is a mental disorder that requires a diagnosis, moral injury is a dimensional problem [with] no threshold for establishing [its] presence” (Maguen & Litz, 2012). This is a rhetorical and clinical claim that effectively denies the legitimacy of emotionality within the PTSD-as-disease framework and the recognition of moral and neurophysiological entanglements in the conceptualization of PTSD pathogenesis and treatment praxis (e.g., Walker, 2016).

While social constructivist analyses of the overlapping discursive and practical fields through which a diagnostic category becomes a kind of “self-fulfilling prophecy” by which people organize what they “feel, say, do, and expect to fit prevailing expectations and categories (Summerfield, 2001, p. 96),” provide valuable insight, it bears noting that not all constructivist analyses of forms of human pathology or suffering are liberating—a point Ian Hacking makes with regard to work on anorexia (1999). The assertion made in the *American Journal of Psychiatry* that “it is rare to find a psychiatric diagnosis that anyone likes to have, but PTSD seems to be one of them” (Andreasen, 1995, p. 964) would seem to bespeak a cynicism not dissimilar from that of PTSD clinicians committed to the more accurate detection of malingered PTSD (Elhai et al., 2002; Hall & Hall, 2007; Resnick, West, & Payne, 1997) and suggest the value for closer empirical attention to the sociocultural praxis of military personnel and veterans.

PTSD Illness Experiences

If moral rhetorics are at the heart of any field of PTSD discourse, the ways in which they formulate events and human agents can only be as diverse and numerous as the forms of trauma experienced and the cultural processes of turning trauma into meaning (Watters, 2010). This analysis is concerned, in particular, with the ways US military veterans conceive of PTSD and their own agency in relation to it. In so doing, we follow in a long line of social scientific research that distinguishes between the biological and physical manifestation of “disease” and “illness,” the personal experience of a disease (Bell, 2000; Eisenberg, 1977; Kleinman, Eisenberg, & Good, 2006). As Conrad and Barker (2010, p. S67) explain, “The emphasis is on how meanings of phenomena do not necessarily inhere in the phenomena

themselves but develop through interaction in a social context.” For those afflicted by mental illness, as Janis Jenkins points out for those suffering from schizophrenia, however, “the construction of shared meaning, usually taken for granted, can become fraught...[and] often entail a tremendous struggle” (2004, p. 30). In this regard, veterans’ experiences of PTSD are constituted in dialogue with family, friends, doctors and other caregivers whose perceptions and cultural narratives about mental illness may not align with a sufferers’ own (Bury, 1991; Charmaz, 1999; Conrad, 1987; Kelly & Field, 1996). Everyday interactions with others and varied illness labels can result in dramatic turning points in one’s understanding of their illness (Kleinman, 1980), particularly if stigmatization or betrayal is experienced (Charmaz, 1999). Or, in some instances, sufferers may learn how to experience and understand their illness dialogically, through interaction with others (Mattingly, 1998).

Similar to the richly dialogic processes by which those with bipolar disorder come to negotiate the situation of their illness within both “disordered neurons” and within a world of social relations and context-dependent emotionality (Martin, 2007, 2010), PTSD discourse stands at an epistemic crossroads—as a “brain disease” grounded in traumatic social experience. As such, this paper follows a long sociological tradition of examining how individuals are socialized into new statuses (Katz, 2001), and suggests some of the ways individuals learn to inhabit, negotiate, and even disavow their illness by interacting with other sufferers (Spoont et al., 2009).

Even for veterans who have not received an official diagnosis of PTSD, popular and military discourse about PTSD has become ubiquitous as to invariably circumscribe the personal interpretations veterans make of their military experiences and related emotions. While the label of PTSD can add a kind of unifying legitimacy to groups of symptoms, it also may instantiate new understandings of the difficulties of re-adjustment to civilian life such that experiences that were previously understood in different ways gain new significance. For some, a PTSD diagnosis comes as a relief, to some extent normalizing posttraumatic experience and evoking empathy in others (Conrad & Barker, 2010; Finley, 2011; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009), while for others, the meanings clustered around a PTSD diagnosis can involve stigma and shame which, particularly for veterans, can serve as barriers to the formation of supportive social and therapeutic relationships (Link et al., 1997).

An important question remains unanswered, however: is destigmatization best achieved through pathologization—of PTSD as a bona fide *disease* marked by the reduction of hippocampal volume, for example (Bremner, 2006; Bremner, Elzinga, Schmahl, & Vermetten, 2007; Nutt & Malizia, 2004)—or through a process of normalization in which even observable changes to brain morphology and functioning are attributed to neuroplasticity in the service of survival, PTSD’s hallmark symptoms ultimately providing a protective barrier against further victimization (Cantor, 2009)? To embrace the latter approach is to side with some of the more radical social constructivist theorists of mental illness, including Thomas Szasz who, more than 50 years ago, opined that all mental illness could be more productively reframed as “problems in living” (1960), a framework almost diametrically opposed to that of biomedicalization. Where the former seeks remediation of stigma and marginality through normalization, the latter posits increasingly rarefied

scientific specification as the path to greater social acceptance and understanding of mental illness—as sickness. Debates about the relative merits of each date back some time at this point (e.g., Mehta & Farina, 1997; Conrad 1992), and celebratory psychiatric and public health narratives have been widely subjected to Foucaultian critique (see, especially 1965), often combining the emphasis on how the rationalization of diagnostic frameworks for confronting mental illness have served as forms of state social control (Horwitz, 2002; Bowers, 2003). Rather than attempt to help resolve outstanding questions about the relative merits of PTSD-as-disease model, however, we aim here to highlight veterans' experiences in navigating both the opportunities and constraints embedded in a PTSD diagnosis. Following both calls to investigate stigma from a sufferer's perspective (Link and Phelan, 2001) and Goffman's emphasis on the social strategies for living with and "managing" a stigmatized identity (1963), this analysis highlights veterans' accounts of learning to recognize and live with PTSD's symptoms as well as their own conceptualizations of PTSD and, for many, deeply critical perceptions of the military, the VA, and psychiatric practice more generally. As the range of literature cited above indicates, social constructivist analyses of PTSD are hardly novel at this point, but what is needed is a greater emphasis on the narratives and indigenous etiologies of people with posttraumatic stress themselves. In exploring how a cohort of veterans in NYC have learned about the condition (in some cases contending with the diagnosis), navigated stigma, and negotiated social performances and expectations of PTSD symptomatology, we highlight the interplay between the experience of PTSD and the diagnosis itself, adopting an anthropological approach to constructivist analysis that seeks to "locate contemporary illness experience in continuous cultural historical processes" (Gaines, 1991, p. 236) by illuminating a local field of engagement with both popular and psychiatric knowledge claims about PTSD.

DATA AND METHODS

This study used individual interviews and focus groups to examine mental health, substance use and larger civilian readjustment challenges among formerly enlisted service members who returned to NYC neighborhoods. The study involved a longitudinal, 5-year panel study of 269 recent veterans. (Golub and Bennett, 2014) Eligibility criteria required that veterans served post 9/11 and had separated from the military within 24 months of enrolling in the study. Study participants were discharged from service between August 2008 and March 2012, as verified by their DD214 cards. All interviewees were formerly enlisted and had been deployed to combat theatres in support of conflicts in Afghanistan and Iraq. The 269 participants were recruited via a chain referral sampling technique, respondent-driven sampling (Heckathorn, 1997, 2002). A subset of 40 participants from the larger sample participated in a qualitative study component designed to reflect important themes emerging from the full sample (Bennett, Elliott, and Golub, 2013). Interview and focus group participants provided their full informed consent and were compensated \$40 for their participation. Participants completed an informed consent procedure and all procedures involving human subjects were approved by the study's Institutional Review Board.

Interviews

The project director and a senior research associate conducted all individual, in-depth qualitative interviews with a sample of 30 recently separated NYC veterans. Interviewee selection was stratified based on the larger study's sample by race/ethnicity (14 Black, 8 Latino, 8 Caucasian) and gender (25 male, 5 female). The majority (62%) had served in the Army. Roughly 50% of the interviewees in the qualitative subsample self-reported having been diagnosed with PTSD; an additional 20% self-reported PTSD symptomology, while the final 30% (9 participants) were included to provide outsider perspectives on PTSD within military and veteran personnel. Interviews lasted between 1.5 and 4 hours and used the framework of a life-history interview to structure a set of open-ended questions around participant's own styles and strategies for presenting an autobiographical account of their childhood, enlistment, military experience, and their recent transition back into civilian life. Questions and follow-ups sought to explore participant's mental health (and experiences of mental health diagnoses and treatment), substance use, and social readjustment experiences.

Focus groups

Focus groups are ideal for identifying the range of perspectives on a topic found within a community or population as well as some of the political and ideological fault lines separating members of a group (Stewart, Shamdasani, & Rook, 2007). Project staff assembled two focus groups of 10 participants each: one composed of homeless Black and Latino veterans (7 male; 3 female) and the other of Caucasian, Black and Latino veterans enrolled in community or four-year colleges (7 male; 3 female). Within the first and second focus groups, 9 and 7 participants reported having PTSD diagnoses, respectively. This focus group sample included both veterans who had a formal diagnosis and those who self-diagnosed. Even though not all of the participants had received an official PTSD diagnosis, all of them spoke about the condition first-hand. Many also spoke more generally about how they perceived that PTSD had affected the veteran community. The focus group protocol covered participants' perspectives and experiences of readjustment to civilian life in terms of mental health, substance use, and obtaining housing, employment, and benefits. Focus groups lasted roughly 2 hours and were conducted by the project director who was accompanied by a research assistant.

Analysis

Project staff digitally recorded and transcribed the interviews and focus groups. They also reviewed the transcripts for accuracy and entered them along with accompanying field notes into ATLAS.ti for electronic storage, coding, and data analysis. Two of this article's authors analyzed the interview and focus group data using a combination of *a priori* and emergent code categories. We took an inductive approach to emergent themes suggested by participants informed by the tenets of grounded theory (Charmaz, 2000; Glaser & Strauss, 1967) and conducted an iterative team-based process of reading, coding, and discussing transcripts to illuminate some of the forces and processes that underlie lived experiences of PTSD (Miles & Huberman, 1994). This rigorous yet flexible approach involves exploring emergent ideas, developing and elaborating on typologies, and creating connections between key themes and personal experiences. Two of this paper's authors coded the interview and

focus group transcripts independently and then met in person with the larger project team to discuss and reach consensus about interpretations of the data.

RESULTS

I'm so tired of hearing that PTSD is a mental illness. To me, it's not mental; it's emotional. It's about people's emotions. –*George, African-American Army veteran*

The veterans in our study illustrate at least four significant ways PTSD is navigated and negotiated in the interplay between lived experience and diagnostic labels. First, we attend to narratives of social learning and the ways in which veterans learned to map behaviors, feelings, and symptoms that constitute PTSD onto their own struggles in the civilian world. Second, veterans confronting PTSD narrated how they came to interpret their actions and behaviors in the social world as symptomatic, whether of psychopathology or of a more inchoate (but wide ranging) set of asymmetrical social and institutional relations. Third, veterans explained the stigma that comes with a PTSD diagnosis or, for some, simply as a consequence of being a veteran. Finally, we address what might be called struggles over ownership of PTSD and the ways in which veteran participants contemplated the costs and benefits of presenting a PTSD narrative to psychiatrists to obtain treatment and related disability benefits.

Learning PTSD

Veterans whom we interviewed spoke of the various forms of stress endured both before and during their military service as the foundational traumas from which their PTSD symptoms emerged. Very often, forms of distress were only later understood to be symptomatic, often due to a lack of exposure to information about PTSD. A number of veterans with whom we spoke described a lack of information offered by the military about trauma, whether upon enlistment, during service, or upon exit through the military's Transition Assistance Program (TAPs). Anthony, an African-American Army veteran who served in both OEF and OIF, explained that his earliest understandings of PTSD were colored by misconceptions about its causes and the military's avoidance of frank discussion with new recruits:

When I first enlisted, they kind of danced around it because the time I enlisted there wasn't really much conflict going on. This was '99 and PTSD, it was kind of taboo. At that time from what I knew it was a Korean War or Vietnam thing. It was a product of Agent Orange and these other things that had happened over there.

Similarly, a veteran who enlisted in 2002 remarked that PTSD was not frequently discussed by military personnel. He explained how he learned about PTSD vicariously, through interaction with his superiors.

PTSD wasn't really much discussed even though it was kind of blatant, the effects of it. Everywhere from being on boot camp to being on bivouacs to even being deployed, anyone who had more time in than you, usually sergeants and above, they had PTSD because they been in the shit. So it's kind of like you just adopted the same mannerisms as far as how you deal with stuff, you know. That's pretty

much what it was, adapting to the people you were surrounded by. *Vlad, Caucasian, Marine veteran*

This observational learning taught the veteran not just how to recognize symptoms of PTSD but that suppressing and compartmentalizing stress constituted the only socially sanctioned performance of PTSD in his unit.

For several veterans, the earliest forms of exposure to PTSD came not through military service or presentation at VA hospitals but through independent research or contact with family members. Jay, an African-American Marine veteran, explained that his struggles after separation from the military led to extensive use of the internet, by which he arrived at his own presumed diagnosis and began piecing together self-help treatments:

You have to look up certain psychological disorders. By reading up on it, you see if you can relate to the signs and symptoms and narrowing it down.

Another veteran with a formal PTSD diagnosis described how he first learned about PTSD from a family member who had served in the Vietnam War:

I came from a family of Marines. I had a great uncle who would actually give me the run down on risk as far as being in the military and what could happen. He had been in Vietnam and I noticed he couldn't hear loud noises [or see] bright lights. I'd see him in the middle of the night on the floor rolling around and that was my first real introduction to PTSD. *Blue, African-American Army veteran*

The notion that PTSD was not itself pathological—and therefore largely unnoticeable—until return home surfaced in a number of interviews. Coqui, a Latino Army veteran, explained that the “alertness” or so-called “hyper-vigilance” that was a key to survival while deployed only became a burden upon return to civilian life: “Being over there, you have to be alert. [Back in the States, you might overreact to] a car coming. You still have to be alert.” Blue further explained how PTSD is in fact a healthy response to serious threat and that the problem lies with the return to civilian life where the potentially lifesaving dimensions of PTSD no longer have any obvious utility:

PTSD, when I first saw the acronym, I asked [my uncle]. He explained it was a reaction when an individual goes through a heightened level of vigilance; their body chemistry from their brain to their endocrine system changes. So it's a survival mechanism that is built into us. When you go through a traumatic experience where your life is on the line you have certain triggers that prime you in case you're ever in that situation again to increase your chance of survival. So that's the definition he gave me and I looked at it like you're just basically saying you've been through some shit and you know your body tells you when it's about to happen because he explained the physical symptoms to me.

Noting that veterans learn behaviors during deployment that may become understood as PTSD in civilian society evokes questions about the deviancy or disordered-ness of PTSD at the same time as it recognizes the difficulties faced during re-adjustment. Characteristic dimensions of PTSD that may be normative and even beneficial during deployment can quickly be reframed as pathological and debilitating upon re-entry to civilian life.

Hailing to the call: PTSD diagnoses

The veterans presented narratives of how they came to realize that they had PTSD through interpretations of their own behaviors and feelings and interactions with others. Veterans came to accept a PTSD diagnosis by linking it to some of their specific and troubling behaviors and feelings. In a reciprocal fashion, the diagnosis also gave new meaning to their behaviors and emotions. For one participant, assigning new meaning to his feelings and behaviors post-deployment involved interaction with others, his environment and social institutions. He described a realization he experienced while reading a military pamphlet that described hypervigilance as characteristic of PTSD:

I didn't really understand that I had PTSD until I really looked at the pamphlet. You know how the VA upon discharge they give you the whole get back into society thing?

It's like you're in a state of readiness, hyper-vigilance. That's what I read in the pamphlet, hyper-vigilant. What the fuck is hyper-vigilance? I know what vigilant means but hyper-vigilance? Shit. Read it. Ohhh, yeah! You know? I'm sleeping and I'm hearing my own heartbeat when I'm sleeping and then the wood in the structure changes because of the temperature. I'm up. Like what's going on?

This veteran's eventual diagnosis was further informed by family and friends' concerns about his unusually vigilant behavior. He explained that his mother, noticing that he was behaving differently, showed concern:

That's usually how it starts—people ask you how you're feeling. "Are you okay?" Because there'll be certain behaviors that anyone who knows you knows is different.

Another participant who had been deployed during both OEF and OIF and had suffered 7 bullet wounds before enlisting experienced a triggering episode of heightened response that led him to believe he had PTSD. He explained:

I had a Chevrolet truck and I was just trying to make sure I had the flange right because I was swapping engines. Something happened and it backfired. I had never been that afraid in my life. I didn't know what happened. I just remember...Bam! And I almost pissed my pants. This fear...after that it was all downhill. Something always happened. Something always triggered me and I started seeing people and I got diagnosed and I went through treatment. *Jeff, African-American Army veteran*

For Angel, a Latino Marine veteran, evidence of PTSD came in the form of family discord, not so much the hallmark symptoms of PTSD described by Jeff and other participants:

Before I started drinking, some of my symptoms were coming out. I would have a lot of arguments with my daughter and it was getting real bad. I know after like talking to them [his family] I was like, "What the heck did I do?" and stuff like that. Then I started getting into more drinking and whatever.

If distinct moments of social interaction were sometimes described as revealing of underlying illness, others described their pointed refusal to see their reintegration struggles in terms of pathological experience. As Goliath, an African-American Army veteran,

explained, his exposure to intense combat trauma and personal injury on the battlefield led to several rejected opportunities to explore a PTSD diagnosis. When asked if he went through psychological testing as part of his separation from the military, he replied:

I went through it and I told the psych[ologist] the same thing as the Chaplain:
“Ain’t nothing wrong with me. These motherfuckers tried to kill me and I fucking killed them. Hooah! I’m still here. See you later. I’m going to go raise a family down the road. I’m going to go do what I got to do. I’m going to go get drunk.”

Participant narratives about the ways they came to accept PTSD as a framework for interpreting their experiences highlight the reciprocal social process of constructing or resisting a PTSD diagnosis. While for some the mapping of a diagnostic label onto symptoms and social struggles was presented as, above all, a relief, while for others the suggestion that PTSD might be at the root of their post-separation challenges was described as fundamentally threatening and to be resisted, even at the expense of disability benefits to which they may have been entitled. To engage this process of refusal among military veterans is to explore the stigma held to surround PTSD among military and veteran populations.

PTSD and Stigma

Despite the claims coming from certain psychiatric quarters that PTSD is the rare psychopathological diagnosis that individuals readily accede to, almost all of the veterans with whom we spoke indicated serious concerns about the stigma ascribed to PTSD and the negative consequences of accepting or seeking out an official diagnosis. Several veterans expressed feeling alienated and misunderstood by friends, family and other people due to ignorance about PTSD or an unsympathetic regard for those who suffer from it. In a focus group, Anthony, a Latino Army veteran, explained how he had learned that, where his PTSD was concerned, it was “better to be silent than to speak and be misunderstood.” Chandler, an African-American Army veteran, then explained how his PTSD resulted in a loss of family ties and expressed frustration with the widespread misunderstanding of the condition among civilians:

You are limited and I have actually seen it. My family completely turned their back on me after several PTSD incidents. My aunt has called the police on me with just having an argument and there are a lot of things the civilian population just doesn’t get. A lot of civilians don’t know what PTSD is. They don’t understand it. I’ve said to people, “I have PTSD; I can’t handle this,” and they say, “What’s PTSD?” It’s the biggest joke in the world.

For several other participants, including Liz, an African-American Army veteran who had recently presented at the VA for screening, explained that her reticence to seek psychiatric care was grounded in a concern for her son:

So I know what it is. I just wouldn’t say it. I didn’t want to acknowledge it. Uhm... for my son. I didn’t want people to think I was crazy, but you know at times you grow up and you realize you need help with something.

Other veterans cited military training and what Caucasian Marine veteran, Boggs, described as an emphasis on “Type A behavior” as a primary reason for not acknowledging or seeking treatment for PTSD symptoms:

I didn't really know much about psychology or how it affected me or what this PTSD stuff was but I knew that I was having some type of symptoms, you know. I wasn't sleeping. I was staying up just watching TV. I was drinking then [at] six in the morning. I'm going to work out, um, you know, I'd do the PT [physical training] formation. The Type A behavior in the military is applauded. It's praised. So, not too many people realize they have certain symptoms until they get out.

Beyond questions of social functioning and status, most veterans with whom we spoke expressed concern over the professional and legal consequences of a PTSD.

Alfredo, a Latino Army veteran, expressed concern about how the stigma of an official PTSD diagnosis could impact one's career: “Some jobs are limited to you. Let's say you want to be a child social worker. You could have PTSD in the military and you are good now but if it's in your file you are limited.” Others spoke of the deep suspicion of veterans in civil service agencies—law enforcement chief among them—that had once welcomed veteran employees but had come to reject applications from those with mental health diagnoses. As Coqui explained, background checks made the assertion that one's mental health is a personal issue that one need not disclose on job applications laughable:

If I [want to] join DEA they do a background investigation ten years back before they put you in, so you think they're not going to dig in through the department of defense? Yeah, they find out. They're going to find out you have a disability of this amount. Yeah, so why would you even hide it?

Family issues and dating were also raised frequently in the context of discussions about PTSD. As Alfredo explained, having a PTSD diagnosis comprised a serious vulnerability in attempting to secure joint custody of his child after a divorce: “I just put the claim in and I was scared to do it at first, because of my son. I don't want him taken away. But I just think I need to say something to somebody about it.” Jay explained how he had “hardly seen his family since separation.” Asked why he replied that it was due to “fear of a Chris Benoit [a professional wrestler who murdered his wife and son before hanging himself] moment,” although that fear was itself “probably part of the PTSD.” Wolverine, an African-American Army veteran, recounted his recent experience of a divorce and his struggle with the controversial stereotype of the Black, alcoholic, PTSD-suffering veteran that had recently been depicted through the character of Beau Willie in Tyler Perry's *For Colored Girls*, a film adaptation of Ntozake Shange's 1975 stage play:

I'm from Brooklyn. I was 140 pounds when I went in the Army, 19 years old, fucking great. I've got one kid, he was just born...new private, yeah, all right. Sign this, money up, and send it home. No longer a deadbeat dad! And then I come home, and everybody is watching these freaking movies degrading these goddamn veterans, so it's just like Vietnam. Tyler Perry makes this movie, it's very popular with the African-American community, you know? You're an African-American moviemaker. You make this fucking movie with a veteran throwing kids from the

fucking window. Women ask me, “Are you going to kill me? Are you going to push me from a building?” I was actually talking to a girl with two fucking kids [who] asked me if I would do shit like that. That was the last day I talked to her. You know how hard it is for me to get a date?

In their discussions of the misunderstandings, ignorance and stigma related to PTSD, our veteran participants demonstrate a sensitivity to the cultural meanings attached to PTSD and suggest that seeking a PTSD diagnosis, treatment, and a related disability benefit is far more fraught than is often suggested in social constructivist critiques of PTSD psychopathology. In the final section of our presentation of data we turn more explicitly to the forms of value and compromise implicit in the negotiation of a PTSD diagnosis and in the aftermath of receiving a disability status from the VA.

Complex negotiations

Service-related disability ratings for veterans range from 0 to 100% and are tied to the extent of the injury and the extent to which an injury or mental health condition had service-related origins. A 30% disability ranking or higher also provides additional allowances for dependents and spouses (Department of Veterans Affairs, 2013). Eric, a Latino Navy veteran, explained that the benefit structure for PTSD, unlike other service-connected injuries and conditions, was known to most veterans and begins at a 30% disability rating:

The PTSD, it is 30%. That’s the only one I knew about. I mean it’s always in the books, I mean being talked to you [by other service members and veterans]. I think the only [disability] they really mentioned was the PTSD one. Everything else you only find out when you go there [to the VA] and you’re injured and then they say, “Okay, this is what’s going to get you, this is the percentage for this.”

The potential for using a PTSD diagnosis to secure benefits—whether felt to be deserved or not—was presented as a well-established fact in our participants’ narratives, and several, like John, a Caucasian Army veteran without a PTSD diagnosis or symptoms, spoke to the ease with which veterans might exaggerate or falsify a PTSD diagnosis to receive disability benefits:

It’s hard for the doctor to tell if you are faking it or you really need it. It’s no fault to the doctor, only to the person themselves. There are a lot of people who claim a lot of things but what they are claiming is not true. I know a lot of people who claim depression so they can get the PTSD [diagnosis and benefits] and get service connected. And I find it to be wrong. I’ve deployed twice and I haven’t been shot at or blown up, I’m not going to claim PTSD. And these people who have gone on less missions than I have and nothing has happened to them, are claiming PTSD. I see that too, and morally it’s not right.

Detection of “malingered PTSD” (Hall & Hall 2007) has become an important priority within the VA and elsewhere, adding to the difficulty of presenting with posttraumatic symptomatology for many veterans. While the incidence of cases in which veterans strategically wielded PTSD for benefits is impossible to determine, it is important to note that a number of veterans in our study spoke to having witnessed dramatizing behavior in others for strategic purposes. For veteran participants in our study, however, the more

pressing challenge in terms of self-presentation was upholding non-pathological performances that cast oneself as whole and unharmed by military experience. For those especially whose traumatic experiences were complicated by moral injury or unrelated to combat duties (such as in the case of military sexual trauma), fears about whether one would be accused of malingering or whether one's experiences merited psychiatric attention at all stood as major barriers to seeking psychiatric attention. Shame about the nature of one's service or the causes of one's posttraumatic stress led some to try to conceal PTSD symptoms. As Michael, a Caucasian Navy veteran who deployed during the Iraq and Afghanistan conflicts but expressed insecurity at the nature of his veteran's status and the peripheral role he played in the broader conflicts explained:

I went through a screening and tested positive for PTSD based off of other life events and my experience in the Coast Guard. And I'm was in denial about it because it was hard enough for me to even to take pride in my service. I'm embarrassed, I don't know why, but I'm embarrassed. How do I justify it to the other guy sitting next to me that maybe had to kill women and children in Afghanistan? It's just like a failed expectation at that point that I don't know how to express to other people what might be going on. And then I feel like I failed, and then to try to benefit from it...I don't know, I just always wanted things to be different, I don't want it to be my reality that this is what's happening that I have PTSD. [With treatment] the other scary thing is that you've got to allow yourself to be vulnerable. You've got to – it's no longer a secret, it's no longer not talked about and now it's out in the open.

Discussing the potential to internalize and confront PTSD or conceal it, these veterans spoke to benefits and costs, as well as the ethics and implications of misrepresentation. As Dee, an African-American Army veteran whose worsening sleeplessness, social anxiety and depression, dated to an order to throw a grenade blindly over a village wall, resulting in the deaths of two non-combatant adults and a child, explained his lack of faith in therapy due to the constant need to monitor his own self-presentation:

I could talk [to a therapist] as a regular person if there is nothing attached, but I feel like I'm talking to avoid getting thrown into the inpatient. I feel like they go for what I say, like, they write it down and they're waiting 'til I slip up to make the right determination. They've been offering me inpatient and I've just been denying them. I want to talk to someone about this who is just an average person, who is not judgmental, I could tell him anything and they don't have to report it to a supervisor. I'm fearful of becoming like this vet who ultimately can't get around, like you know like my PTSD is rated as 70% from the VA. I don't want it to be a 100% because I'm going to have to be an inpatient veteran. If you're diagnosed with 100% PTSD that means you can't walk the streets. I know someone who said the wrong thing to the VA and got stuck into a PTSD special place, where you don't come out at your will. I don't want to say I'm scared, but I feel like they could decide if I'm a regular person or not, and that's one thing I don't want.

For others in our participant group, the negotiation over one's diagnosis never reaches the point of such a self-consciously Goffmanesque performance (1959) in which personal

liberty and disability compensation hang in the balance. For George, the African-American Army veteran whose distinction between emotional and mental domains opens our findings here, the decision to forgo a likely diagnosis and the treatment and benefits that would have accompanied it (despite his sometimes severe symptoms), is described as a fundamental rejection of very terms by which PTSD is conceived:

Yeah, well my personal experience was that I had talked to my psychiatrist at the VA and I was pretty careful on how I approached it because ...he is a part of the system and an institution. And I've always thought that my PTSD diagnosis was due to a lot of my emotional stuff that happened to me, as opposed to anything that was wrong with me mentally. So I choose to use emotional illness as opposed to mental illness. I guess because how stigmatized mental illness is, you know, I didn't want to be looked at as some kind of alien. I felt that I didn't want anybody defining me. I didn't want to be put in a box. A lot of times what happens is that when a person is labeled mentally ill, a lot of times they withdraw. They go in isolation, they feel stigmatized and it's hard for them to engage other people about it.

For George, and countless other veterans who might readily qualify for PTSD treatment and disability benefits, the perceived burden of accepting a diagnosis for mental illness trump the benefits and access to treatment that diagnosis brings, (Acosta et al., 2014; Golub, Vazan, Bennett, & Liberty, 2013). To access benefits and treatment is, in George's formulation, to accept the pathologization of emotionality itself. As Jay opines, the very bureaucratization of his return to civilian life and the forms of impersonal engagement required may have themselves played an etiological, "triggering," role in his own PTSD experience:

My reintegration into civilian life was very negative, because there were so many hoops to jump through and so much red tape, and I got this little atom of resentment, and maybe a bit of depression. Just to get my benefits I have to go through all this?! I think, if there were any underlying issues, the reintegration was a culture shock I felt like nobody. I thought me and everyone else who has ever joined, you give all you have, which is pretty much your life, and I get here and I can barely get a deal on my car insurance. I wanted to be an asset and function in society, but you've got a better chance of coming out of prison and doing well than coming out of the military. That probably triggered a lot!

In framing his return to civilian life as a process of re-learning what it is to be "somebody"—or perhaps learning to live as a "nobody"—Jay effectively glosses the demand for recognition that runs through so many of the PTSD illness narratives we have collected. However remunerative a PTSD diagnosis can become during that process of status-change, the overwhelming finding of our inquiry is that acceding to a psychiatric diagnosis is a poor substitute for the bedrock of social agency and self-efficacy: being able to parent one's children, earn a living wage, and be treated with respect as an "asset in society."

Discussion

Ian Hacking writes cogently of the brands of social constructivism that dominate academic discourse. Most, he explains, share an agenda of "unmasking" the processes by which states

or conditions that are intrinsically sociohistorical have come to appear as natural. To date, much of the social constructivist critique of PTSD (particularly in its American manifestations) has sought to illustrate the blurring of academic and discursive domains by which the moral claims being made by victims of trauma are refashioned as psychopathology, a critical currency in medico-legal redress and disability compensation (e.g., Andreasen, 1995; Summerfield, 2001; Watters, 2010; Young, 1997). While these early analyses make an important contribution, they have tended to do so in ways that are, what Hacking would identify as, “ironic” in nature, rather than genuinely “reformist.” That is, they present a powerful understanding “of the architecture of the world, but are ironically forced to leave it much as it is” (Hacking, 1999, p. 20). Where diagnostic protocols and related benefit structures are concerned, however, we contend that social constructivist analyses of mental illness may enforce genetic and neurological determinism, resulting in a delegitimized ontological status for PTSD. PTSD sufferers may not, on the whole, fulfill the diagnostic requirements characterizing other categories of psychopathology, nor does PTSD share in the etiological expectations of most mental illness—its origins being social by definition—but where else is post-traumatic suffering to be given a meaningful social valence if not within clinical psychiatric practice?

In collecting and analyzing narrative accounts of a predominantly minority group of formerly enlisted military veterans who have returned home to low-income New York City neighborhoods, we sought initially to document the dispositions of participants with regard to PTSD diagnoses and ground the claim that PTSD-related disability compensation has given individuals cause to malingering posttraumatic symptomatology or (Hall & Hall, 2007; Resnick et al., 1997), at least, to welcome a diagnosis and its presumed destigmatizing impact (Andreasen, 1995). As we began to review narrative data, however, the realization that many military veterans view decisions about how and when to present with PTSD symptoms as highly fraught and, in some cases, hold social constructivist critiques of PTSD. This precipitated a greater attention not just to the ways veterans navigate a world already prefigured but to the potentially rebellious ways in which they seek to refashion PTSD discourse through their own social practice.

At an ethnographic level, we find that stigma related to PTSD remains endemic, and not just for those presenting with symptoms or requesting psychiatric screening. Stereotypes of murderous, drunken minority veterans appeared in several participant narratives, and concerns about personal resilience and entitlement to benefits—often in light of the nature of the trauma involved—ran through many more. A number of participants explained why they chose to avoid contact with VA psychiatrists, to address PTSD symptoms in their own ways (Elliott, Golub, Bennett, & Guarino, 2015; Elliott, Golub, Price, & Bennett, 2015), or on their own terms. In their rejection of the stigma related to “mental illness,” a number of the participants quoted throughout appear to offer a more militant social constructivist critique than contemporary academics, reminiscent at times of Szasz’s wholesale denouncement (1960) of psychopathology as a kind of Marxian mystification aimed at locating in individuals the ills of society. To actually address the stigma that continues to stand as an obstacle to treatment for so many veterans, several of our more contemplative participants have suggested, requires that both conditioned (and fundamentally adaptive, in the context of warfare) physiological responses to threat and complex emotional struggles with civilian life

cease to be evaluated as the grounds for psychopathology. To *normalize* these conditions by claiming a societal ownership for them (and the wars from which they emerge) is the first step in a refigured set of social and ideological relations.

Without a concerted effort toward an interdisciplinary coalition that might valorize social conditions and experiences with the aid of biomedical research (rather than in opposition to it), PTSD will continue to reside in a state of ontological uncertainty that gives rise to stigma and the Catch-22 logic characterizing our participants' negotiations over diagnoses and disability percentages. Job opportunities and even personal liberties can be sacrificed for disability compensation, but, at least in the contexts of low-income urban social imaginaries, the stigma persists.

In conclusion, then, what we would argue is that the indigenous social constructivism of veteran participants points toward a Szasian conclusion—that medical anthropology and sociology's intervention into psychiatric domains ought to avoid the world-as-it-is and the search for better diagnostic tools and behaviorist therapies. Instead, we argue for the investment in an alternative discourse that recognizes the complex agency of those struggling with posttraumatic stress and promotes the social normalization of PTSD-related suffering as part of a much more quotidian "struggle with living" that, in one form or another, is endemic to those who go to war. In part, this strategy may be furthered by a reconfigured disability model for awarding PTSD-related benefits within the VA system and elsewhere. As McNally and Freuh note, the current model makes determinations about disability percentages and compensation levels absent of social context—often treating as identical those with hugely varying capacity for social and occupational reintegration (2013, p. 535). The extent to which this sort of more socially-informed agenda might cohere across diagnostic categories and into realms of psychopathology more thoroughly circumscribed by genetics and neuroscience remains to be seen. What is clear is that for those veterans whose experiences of PTSD suffering, diagnosis and treatment is so devoid of potential for personal and social meaning-making as to represent "a jumble of words," "word soup," or "worthless labels" (to cite a few of the tropes of vacuity that emerged in our interviews), any attempt to valorize social symptoms and sequelae of military service and remediate suffering without prerequisite psychopathologization is a productive step toward a more dialogic and shared process of meaning-making around PTSD.

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