THE MASK OF STOICISM: INTERSECTIONS OF MASCULINITIES AND STORYTELLING IN TRAUMA WORK WITH VETERANS

by

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Abstract

An estimated 15 to 30 percent of Canada’s approximately 811,000 Veterans and serving military personnel are expected to experience posttraumatic stress injuries either immediately or even years after their deployment (VAC, 2013; DND, 2013). When Veterans’ traumatic stress injuries are not addressed through well-integrated interventions, stress reactions can contribute to the emergence of Posttraumatic Stress Disorder and associated difficulties such as substance abuse, increased aggression, relationship problems, depression, and suicide (Herman, 1997; Westwood et al., 2012). Males, who make up 88 percent of the Veteran population, experience these difficulties at proportionally higher rates than their female compatriots, and also have significantly lower usage rates for trauma therapies, and higher relapse rates and drop-out rates when they do access treatment (Brooks, 2010; van der Kolk, 2007; Westwood et al., 2012).

While the key role of gender socialization in women’s experience and recovery from trauma has been extensively studied, there has been little attention paid to male social norms and expectations in Veterans’ psychological and physiological experience of trauma and the process of treatment and recovery (Brooks, 2010; Fox & Pease, 2012). The objective of this research was to “cast the net wide” to gain greater understanding of Veterans’ trauma experiences without reducing their uniqueness, their complexity, and their “embeddedness” and interaction with their contexts. By examining case examples from a cohort of male Veteran participants in a group trauma program, the UBC/Legion Veterans Transition Program (VTP), using interview, focus group and personal writings, and examples of cultural “master narratives”, it was hoped that a more coherent clinical picture would emerge of the relevance and impact of gender socialization on men’s trauma experience and their recovery and re-engagement in community. This research suggests that a gender informed approach to Veterans’ trauma work could contribute to more
accessible, relevant and effective trauma treatment that respects male Veterans’ existing courageous and agentic helping and healing efforts.
Preface

The research presented in this dissertation was approved by the University of British Columbia’s Behavioural Research Ethics Board. The Certificate Number of the Ethics Certificate obtained was H13-00206.

Portions of the literature review concerning masculinity and military culture were used with permission from Westwood, et al. (2012), of which I am a co-author. Chapter 3 of this material has been accepted for publication in the Psychology of Men and Masculinity as Shields, D.M., (2015), Military Masculinity, Movies and the DSM. Chapter 4 was presented at the 2013 APA National Conference and published in abstract form as Shields, D.M., (2013), Helping Veterans Come Home and is under peer review for journal publication. Chapter 3 and 4 have also been presented at the Canadian Military and Veteran Health Research forum in November 2014. I had primary responsibility for all major areas of concept formation, data collection and analysis, as well as the majority of manuscript composition. Dr. Marv Westwood, Dr. David Kuhl and Dr. William Borgen were research supervisors involved throughout the project, contributing to concept formation and to manuscript edits.
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Dedication

This dissertation is dedicated to all of the Veterans who have shared their stories with me, and particularly to those who have allowed me to include parts of their stories here and in other presentations. I hope this work adequately depicts the generosity of your service, and does justice to your compassionate and courageous struggle to help each other and yourselves stand with pride again as men, and finally and fully come home.

And to my daughter Erin, who inspires me and brings me joy, and Laura, my friend, muse and co-navigator, with whom this work could not have begun and certainly would never have been finished. There are whole worlds yet to be discovered, to love, laugh and narrate together.
The Death of Innocence

Sean was a retired Sergeant in the Canadian Forces in his late fifties who was a participant in a group program for Veterans who had experienced traumatic events. He is telling the group about a key event during his tour in Bosnia. (Identifying information modified).

Sean: One incident I can’t shake. I see it when I close my eyes. We had come to a school yard and there were kids playing on the monkey bars. We were just watching them play and it’s like, you know sometimes watching kids play is like the best thing. I love kids, I used to love to play with kids, get right down on the floor at their level you know… anyway, we went on after a while and we had gone maybe a block or so we hear this shot. We… (Clears throat. Tears in his eyes. He stops and looks down. The other participants in the room are silent. One participant has begun to rock himself in his chair. Another participant also stares at the floor).

Facilitator: Take your time Sean. You’ve been carrying this a long time.

Sean: We hauled it back there and there’s shot after shot. I can still hear them…kids… (angry). …Well it’s this blond bitch of a sniper – we had a price on her head – a case of burgundy to be flown in from France. I’d heard of her shit but I’d never seen it – wish I hadn’t… She had this MO, she would wound a kid and then wait till the other kids or adults came out to help and then pick them off one by one. The first kid was fuck’n bait, just fuck’n bait… By the time we got there it was too late. Nothing we could do for them… (pause)

They were so light… weighed like nothin’. (A long pause. Sean wipes tears from his eyes. The other participants remain silent). You go there to do something good – make a difference. We’re trained, we’re armed, we’re ready, but we’re powerless – we failed them. I failed. (pause) They got her eventually – I wish I’d got her, I dream of that sometime but usually it’s the kids faces I see. Then I wake up all fucked up – I let those kids down, I couldn’t protect them.

Facilitator: … telling this story, thinking back, something changed for you that day didn’t it.

Sean: Yeah… big time. …lost…my innocence… a piece of myself right there and then – like something leaving my body. Lost some of my belief in humanity… Lost my belief in myself too (there are murmurs of recognition and support from other participants. One of the other group members is quietly crying with his head in his hands). Whenever I hear kids playing now, it takes me right back there – I see what they’d look like dead. I just can’t handle it. I can’t play with kids now – can barely be with them at all. I just remember how I couldn’t help. Now I’m just damaged goods.

Continuing the next day:

Sean: …I’ve never told anybody that story. I didn’t want anyone else to have to carry that – people who haven’t been there just wouldn’t get it – shouldn’t have to. And I was so ashamed.

Facilitator: And what are you aware of now, having told the group this?

Sean: (pauses) I feel …lighter.
I think I am safe, yet still on constant guard. I am tired, but must not fall asleep. My dreams terrifying – I am not protected in my mind. I have lost the ability to be loved.

Veteran Participant Reflections

Chapter 1: Introduction

1.1 Background

In March of 2014, the Canadian Armed Forces ended involvement in operations in Afghanistan after more than twelve years of conflict. This ended the largest combat mission in Canadian history since World War II, but did not represent an end to operations. Currently, there are more than sixteen ongoing expeditionary operations involving land, sea or air forces. At this date, there are approximately 72,000 serving military personnel and 731,000 Veterans of past deployments posted internationally or living in communities across Canada (DND, 2013; VAC, 2013). With estimates ranging from 15 to 30 percent of these 811,000 Veterans expected to experience operational and posttraumatic stress injuries after their deployments, sometimes long after returning from service, increased understanding of how Veterans make sense of and live with their traumatic experiences post-deployment is essential (DND, 2013).

1.2 Trauma as a Uniquely Human Story

The critical theorist, Paulo Freire, in speaking about trauma and oppression, eloquently highlighted the uniquely human experience of trauma, noting that humans can be de-humanized, while we never refer to animals as being de-animalized (Freire, 2011). Response to traumatic events, although identifiable throughout the phylogenetic spectrum, has unique manifestations in humans that, so far, our shared biological heritage does not explain. The neuroscientist, Jaak
Panksepp suggests that this unique human experience is tightly linked to the nature of language and our innate ability for meaning making and the creation of personal storylines. As a “mere reflection of our brain’s linguistic abilities” – we have the ability to generate symbol systems and layers of meaning that do not exist in nature. We are above all else, “storytelling creatures whose words can easily create semblances of meaning that are purely fantasies – but powerful ones that can change the world” (Panksepp, 1998, 336-337).

1.3 Storytelling and Recovery

For the traumatized Veteran, being able to confront and tell the story of difficult life events, and have those experiences validated by witnesses, marks an important step towards changing their personal storyline, integrating their experiences and re-engaging in life and community (Becker et al., 2004; Herman, 1997; Ready et al., 2008, van der Kolk, et al., 2007). For many however, the work of remembering and talking about traumatic experiences is complicated by the nature of trauma’s impact on the body and the mind, the individual and community; and by barriers to Veterans “truth telling” imposed by professional, social, and masculine gender dynamics (Becker et al., 2004; Brooks, 2010; Foy et al., 1997; Herman, 1997).

When these multiple barriers are not addressed, and Veterans are unable to give voice to their stories, un-integrated experiences can result in ongoing stress and adjustment difficulties, including problematic substance abuse, increases in aggressive behavior, poor functioning in relationships, withdrawal, depression and suicide (van der Kolk et al., 2007; Westwood et al., 2010). There is evidence to suggest that men, who make up 88 percent of the Canadian Veteran population, experience these negative outcomes at a proportionally higher rate than their female compatriots, and yet have significantly lower usage rates for trauma related therapies (Brooks,
These numbers translate into an estimated 107,000 to 214,000 male Veterans who will struggle with posttraumatic stress disorder, and an unknown number living with related adjustment difficulties. For male Veterans who access treatment, success rates are mixed, with high relapse rates, and drop-out rates ranging from 30 to 70 percent (Westwood et al., 2012; Ready et al., 2008; Schnurr et al., 2003). Given that these Veterans are husbands, fathers and sons who belong to and affect families and communities, the social costs of poor treatment outcomes are high, and better understanding of how these Veterans make sense of and live with their traumatic experiences post-deployment is essential (Dalliare, 2011). This raises the question then, what is it about the male Veterans’ experience of trauma that contributes to their disconnection, their vulnerability and their silent stoicism?

1.4 Physiological and Psychological Barriers

Part of the complexity of telling stories about traumatic events experienced during deployment comes from changes in physiology and brain function that result from trauma, which present special challenges to remembering and “making sense” of experience. Psychologically, traumatic events are outside the norm, unexpected, subjectively unique, isolating and disempowering (Herman, 1997). Assumptions about self, safety, and trust are swept aside in the face of experiences that shatter key protective beliefs: I can affect my circumstance; I will be ok; someone will help me (Gabriel, 1988). During these traumatic experiences, the brain bypasses cortex-mediated “conscious” decision-making processes and triggers a faster responding amygdala-mediated “survival brain” to mobilize autonomic “fight, flight and freeze” responses (Ford, 2009). An integral part of this response promotes future survival by encoding a network of trauma related memories that will re-trigger autonomic response whenever similar cues are encountered (McRae et al., 2011).
This response challenges traumatized Veterans who wish to speak about their experiences, as the accompanying distressing autonomic activation sets up one of the defining psychological and biological dialectics of trauma – the conflict between the need to express and make sense of experience, and the desire to suppress and avoid triggering memories. This conflict affects the body and mind of the individual through the alternating trauma symptoms of dissociation and intrusion – numbness and re-living (Herman, 1997). As a result Veterans attempting to tell their stories often “re-live” events, which may force them to choose between remaining silent, or riding a roller coaster of experience, feeling confused, helpless and alone in their suffering.

1.5 Sociocultural Barriers

Socially, the dilemma of speaking out or remaining silent affects relationships with friends, family and community. Trauma isolates the traumatized because the experiences they carry change them and make them different from others in their community (Gabriel, 1988). The community at large can either support the storytelling of the traumatized, facilitating their re-induction into community, or stifle and marginalize their voices. Communities, unfortunately, do not always want to face the stories that need telling. As Eitinger noted in his work with survivors of concentration camps, “War and victims are something the community wants to forget; a veil of oblivion is drawn over everything painful and unpleasant” (Eitinger, 1980, p. 127).

Storytelling about traumatic events is further complicated by a society that appropriates Veterans’ stories for entertainment, presenting a dominant cultural model of self-reliant masculinity that they cannot live up to (Westwood et al., 2012). Veterans become isolated by a
mythology of hyper-masculinity that glorifies a caricature of violence cleansed of personal and social impact. As society remains ambivalent or insistently ignorant of the realities that they face in service, Veterans may become complicit with the hegemonic masculinity, put on the mask of silent stoicism, and hide personal struggles from their families, close friends, colleagues and health professionals lest they be shamed (Brooks, 2010). For Veterans and men in particular, revealing lingering effects of trauma may be seen as an admission of weakness and the taking on of what Pascoe (2007) refers to as a “failed or abject masculine identity”. This experience of failed masculinity may inadvertently contribute to the isolation and silencing of male Veterans, exacerbate their suffering, and bar the psychological and neurobiological integration necessary for neural coherence and recovery.

Alternatively, Veterans may feel that the stories of their experiences are too disturbing to share with family and friends back home. Taking a protective stance, they may decide to remain silent out of a desire to protect those whom they care about. Unfortunately, this stoic silence may also contribute to family members and others lack of understanding of the impacts of trauma and increase the Veteran’s isolation, barring their full reintegration and return back home.

1.6 Professional Practice Barriers to Storytelling

Storytelling cannot happen in isolation – it is fundamentally a relational process. Given the number of Veterans and the prevalence of expected post-deployment adjustment difficulties, individual and group therapy programs present a potential venue for Veterans to speak out about difficult deployment related experiences. Therapeutic texts, however, warn clinicians about the possibility of vicarious traumatization from witnessing the trauma stories of their clients (Arvay, 2001; Figley, 2002; Morrissette, 2004; Smith et al., 2013).
While warnings abound, there is a lack of clear guidelines regarding how to structure the retelling of specific traumatic memories in individual and group therapy to be optimally beneficial without iatrogenic reactions - to the teller, and any witnesses including professionals (Ford, Fallot and Harris, 2009). Perhaps reflecting this gap in knowledge, there remains apprehension among professionals about using trauma memory focused “exposure” approaches for operational and posttraumatic stress injuries and as a result, many approaches prioritize trauma symptom management rather than affording Veterans a venue to speak out about their traumatizing experience (Becker et al., 2004, Foy et al., 1997; van der Kolk, 2009).

1.7 Epistemology as Barrier

Despite extensive study within professional silos of psychology and psychiatric medicine, epistemological differences contribute a further barrier to an integrated understanding of the evidence with regard to storytelling around traumatic experiences. There is a seemingly unacknowledged epistemological tug of war in the literature and in practice which lines up the research on either side of a philosophical divide; objectivist, post-positivist approaches on one side, and social constructionist explanations and approaches on the other. Depending on the epistemological perspective, research selectively prioritizes or minimizes particular aspects of the trauma experience, creating further confusion in the literature, the field, and for Veterans who suffer in the clinical void.

Dominant medical models that are used to research trauma follow an objectivist epistemology that holds that meaning and meaningful reality exists apart from the operation of any consciousness (Crotty, 2011). Much of the neuropsychiatric research on PTSD follows this view with truth and reality objectified in the people being studied. The main diagnostic
codebook, the DSM 5, is informed by this view, defining disorder as situated within the individual, as if the boundaries of personhood are impermeable. Following a post-positivist theoretical perspective, neurobiological approaches assume that the disordered structures in the brain can be identified, and targeted remedies can then be used to reverse the disorder. Unfortunately, such a physiological cure has remained elusive.

One common assumption of objectivist post-positivist approaches to trauma seems to be that the personal meaning and narrative of the traumatic event, and whether that narrative is ever voiced or witnessed, is of little or no consequence in treatment. If one sees this narrative-free model as complete, then defining trauma as a medical disorder can absolve society of the need to engage in difficult reflexivity by locating the root and meanings of trauma in the (disordered) neurobiology of the individual. There is no need for society to hear and come to terms with Veterans’ stories and the personal existential price of war and conflict. Likewise, there is no need to examine whether the colonization of masculine thinking with ideals of stoic self-sacrifice and/or the appropriation of stories for entertainment may contribute to the injury and marginalization of Veterans.

Research undertaken under a social constructionist epistemology, by contrast, rejects the notion that there is objective truth waiting for us to discover it. Meaning is not discovered but constructed and co-constructed; and can be constructed differently by different people at different times (Crotty, 2011). Social constructionism brings a very different lens to the place and meaning of trauma storytelling and often de-links physiological definitions of trauma from the narrative and the context in which that narrative is constructed.
Narrative and phenomenological research that has taken place under this framework has examined the experience of Veterans in group situations and in specific aspects of group therapy that involve construction and confrontation of personal stories. Unfortunately, these have frequently not taken into consideration the larger social context of power relationships and hegemonic forces in which these stories are co-constructed, or the force of the internal physiological sequelae of trauma (Fox & Pease, 2012).

For Russian literary theorist, Mikhail Bakhtin, all narrative, whether written or spoken, reflects a two stage social construction in the sense that the storyteller is influenced by their cultural and linguistic “habitat”, as is the recipient who becomes a co-constructor of the story as it is received and understood (Wertsh, 1991). It is important to include analysis of this wider context as certain meanings, having come into being “in and out of the give-and-take of social existence”, exist to serve hegemonic interests (Crotty, 2011, p.59).

Each set of meanings supports particular power structures (Crotty, 2011), and failure to consider contextual issues, including social and internal biological context, can oversimplify the challenges facing traumatized Veterans. This can have the unintended effect of emphasizing personal responsibility for agency and meaning making, while downplaying sociocultural influences and the effects of experiences on the body and brain. When these other influences are downplayed, those who can’t “get over it” are stigmatized as malingerers, or as weak or needy personalities.

Clearly, even the epistemological stance we take can be seen to have its own meanings that are made and reinforced through institutions that precede us and in which “we are already embedded” (Fish, in Crotty, 2011, p.52). Foucault (1980) goes as far as to say that particular
institutions of power can be said to create knowledge in the sense that institutions of power determine the conditions under which scientific statements come to be counted as true or false (Hacking 1986). According to Foucault, “truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power” (Foucault, 1980, p. 131). This description suggests that the production of ‘truth’ is never entirely separable from technologies of power.

What a particular epistemological lens magnifies or minimizes has important implications for consideration of Veterans’ stories. These explicit categories of thought, objectivist biological versus socially constructed phenomenon, and the dualistic conflict that exists in professional practice between them, can be seen as embedded in social contexts and as serving social purposes.

1.8 A Critical Narrative Analysis of Trauma Narratives

Narrative Analysis as a theoretical framework has the potential to submit the complexity of how we view and understand trauma, both clinically and personally, to critical reconsideration. A critical perspective is suspicious of constructed meanings that culture bequeaths to us and explicitly works from within existing categories of thought in order to reveal internal inconsistencies, contradictions, and shortcomings and reveal unrecognized possibilities (Schwandt, 2007, p.55). When our customary ways of making sense of things fail to bring together an integrated understanding, we must adjust and go back to the phenomena to re-examine them carefully (Crotty, 2011, p. 218).
1.9 Limits of Subjective Accounts of Change

This re-examination of the subjective experience of Veterans however, is not purposed for the discovery of “authentic” lived experience in the same way that interpretivist researchers would embrace such narratives. Critical social scientists believe that it is necessary to understand the lived experience of real people in context; however they interpret those experiences as the voice of an inherited tradition and a prevailing culture - as social constructions of meaning (Crotty, 2011, p.159).

While Narrative Analysis can assess subjective responses to a given experience, and reconsider those experiences from a critical perspective, some contend that these narrative accounts may also not accurately reflect changing bodily states in a valid or reliable manner (Matousek et al., 2010; Miller, 1996; Vanman et al. 1998). Becker and Geer (1957) warn that interviewees are least able or likely to give an accurate account of process of change, such as the growth of confidence or relationship decisions, due to transformations in their own perspectives that accompany the changes. As a “collaborative experience that orders experiences and understandings of the world” (p.32) we are limited to inferences we can draw from witnessing the interviewee’s narrative of experiences now, rather than direct sense of what actually happened. We can’t know from interviews alone what actually happened in the construction of coherent storylines, only what the interviewee thought happened and how they thought about it (Kreuger et al., 2009).

Critical approaches examine these internal and social conditions in order to uncover hidden structures and understand the ways in which various social groups are oppressed. Further, critical theory teaches that knowledge is power and makes a conscious attempt to fuse
theory and action, as praxis (Schwandt, 2007, p.55). Understanding the ways one is oppressed enables one to take action to change oppressive forces (Freire, 2011). Critical theories attempt to bring about change in the conditions that affect our lives – to seek knowledge in the context of action and the search for freedom (Crotty, 2011).

1.10 Purpose of the Study

This research sought to close gaps in the research by closely following representative case examples from a cohort of male Veterans during their participation in a group trauma program, the UBC/Legion Veterans Transition Program (VTP). Since little is known about the influences of masculine socialization on Veterans’ experience of trauma and recovery, conducting a qualitative study to inform theory was important and appropriate (Crotty, 2011).

The purpose of this study was to “cast the net wide” to gain greater understanding of Veterans’ trauma experiences without reducing their uniqueness, their complexity, and their “embeddedness” and interaction with their contexts. By closely following representative case examples from a cohort of male Veterans during their participation in a group trauma program, the UBC/Legion Veterans Transition Program (VTP), the specific objectives were: (1) to inform theory and future therapeutic practice by bringing a gender lens to male Veterans subjective experience of the physiological, psychological and social impacts of service-related traumatic stress injuries; (2) to examine Veterans accounts of factors influencing access to, engagement in and impact of help-seeking as they participate in trauma exposure work in a group setting; and (3), to consider how, or if, their personal narratives changed over the course of an exposure oriented group therapy program.
Using analysis of videotaped interviews, personal reflection writings, focus group material, as well as participant observation in, and observation of videotapes of ten days of group treatment, two exploratory studies were conducted to assess access, engagement and impact of therapy. It was hoped that by bringing together and examining data across fifteen Veterans cases, a more coherent clinical picture would emerge of the relevance and impact of gender socialization on men’s trauma experience, and their recovery and re-engagement in community.

1.11 Theoretical Approach

The qualitative approach to this study was informed by Gramsci’s (Germino, 1990) ideas about “hegemony” and the process by which definitions of “normal” come to be taken for granted, by Freire’s (2011) focus on the place of dialogue in allowing subjects to become active participants in their own liberation from oppression, and by Foucault’s (1977) notions of the internalization of social controls as norms. Finally, Kristeva’s (1982) notion of the “abject” and Pascoe’s (2007) application of that work to a theory of “abject masculine identity”, inform consideration of men’s shame reactions to disempowering trauma experiences.

While Gramsci, and Connell (1987) in the related concept of “hegemonic masculinity”, emphasize the external forces of power, Foucault adds nuance and complexity by shifting locus of power to discourse and norm internalization. Freire’s work, particularly his ideas about conscientisation, are rooted in the Marxist tradition and therefore more closely aligned with Gramsci than Foucault. Nevertheless, Freire and Foucault share a conviction that questions need to be approached critically, with an eye to the terms of reference within which an issue is cast, its problematization (Bacchi, 2012).
Gramsci and Freire are rooted in a fundamentally different, and some might say opposite theoretical tradition than Foucault, however a number of researchers have argued that there is benefit in combining their different foci for analysis of a given incident (Bacchi, 2012; Cocks, 1989; Kenway, 1990; Olssen, 1999; Pringle, 2005). In particular, Olssen (1999) notes that rather than attempting to synthesize these two camps into one cohesive modernist/postmodernist metatheory, the works may be usefully deployed as complementary lenses. He writes, “Foucault’s focus on the molecular and on the micro-physics of power supplements and enriches the Gramscian focus on structures” (p. 90). In keeping with the intention to submit the complexity of how we view and understand trauma to critical reconsideration, this theoretical triangulation is useful to ensure that the paradigmatic lens does not lead the analysis, as Rowe (1998) warns, to “write the narrative in advance”.

1.12 Research Question

The overarching question that guided this research was: Given the emphasis of male socialization on stoic mastery over self and environment, and its integral place in the training of soldiers, how are male Veterans’ intrapersonal and interpersonal experiences of trauma influenced by their gender socialization, and what impact do these experiences and constructed meanings have on narratives of personal identity, and access to, engagement in, and impact of treatment?

Sub-questions explored included:

1. How do the gender narratives generated by societal institutions, such as popular culture, converge or contrast with the psychiatric discourse of PTSD, and how might these
“master” narratives relate to, colonize or complicate the narratives and subjective experiences of Veterans with PTSD?

2. In the same vein, do masculine gender role norm expectations show up, explicitly or implicitly, as important themes in Veterans personal trauma and treatment access accounts?

3. Given masculine injunctions against self-disclosure that are thought to act as barriers to treatment access and engagement, what insights are offered by the narratives told by Veterans who completed a group therapy program?

4. How, or are masculine gender identities re-interpreted, renegotiated or re-defined through group-based trauma narrative exposure work, and is there evidence of movement from abject to empowered identity formations?

1.13 Situating the Research and Researcher in Context

An existing group based trauma program called the UBC/Legion Veterans Transition Program (VTP) was used as a laboratory to investigate the trauma storytelling experiences of Veterans. As a model that gathered together a community of peers and explicitly sought to create the conditions of safety in which the work of remembrance and storytelling could occur, the VTP provided an accessible opportunity to investigate this phenomenon and reveal possible hegemonic and internalized role norm pressures on the trauma and storytelling experience.

Silverman raises the question about how far a given research setting is consequential to the data collected (Silverman, 2010). In this case the stories are often not told outside of the therapy setting and therefore the observations of how stories are told are very much influenced by the setting. The research question, however, specifically asked about how stories are told in
this setting and the impact on these participants, and therefore the question is sound. If the question were more generally about how and to what effect men tell their stories, the conclusions could be undercut by the fact that the stories only got told because of the fact of therapy (Silverman, 2010, p. 58).

On the other hand, the influences on storytelling are unlikely to be unique and discrete to this setting, but rather exist as “occasioned and contexted” ways of interpreting, representing and ordering experiences and social relations (Silverman, 2010, p.52). This means that the influences on storytelling are wound up and linked with public life and not located in one geographic place. For this reason, observation of the process of storytelling in this setting allows tentative conclusions about the broader contexts in which Veterans live with their stories.

In conducting a narrative analysis, the participants are viewed as co-researchers and therefore it is important to also declare my own context as a researcher and co-constructor of the stories in this setting. As a former infantry reservist in the Canadian Forces, I was given insider status with Veterans. In this study, I attempted to purposefully occupy space as an indigenous outsider within these Veteran groups. In order to escape negative associations attached to civilians and yet avoid hierarchical interactions typical of military culture, it was important to develop a “least-aligned” identity that straddled or defied easy civilian or military categorization.

1.14 Implications

Veterans are often marginalized and remain silent about their service related trauma experiences. There is evidence to suggest that male Veterans experience negative outcomes at a proportionally higher rate than their female compatriots, and yet have significantly lower usage rates for trauma related therapies. At the same time, a divided research literature leaves
clinicians without a coherent picture of the experiences and unique needs of this population. This research sought to reduce the gap that exists between the needs of male soldiers with posttraumatic stress injuries and current clinical knowledge around the impact of gender socialization on subjective experience and narratives about self, trauma and treatment.

The study attempted to contribute to a more integrated understanding of how the multiple aspects of trauma experience coalesce in the male Veteran, impact their lived experience, and how they relate to and co-construct their stories. This research also sought to answer questions about the unique impacts of the abject or failed masculine identity associated with trauma reactions, and to identify whether there were discernable, and replicable, pathways to access, engagement and impact that these men travelled to participate more fully in treatment, relationship or community.

It was hoped that a more thorough understanding of the place of storytelling and its relative importance or lack thereof to Veterans would be of interest to clinicians who could use this information to guide further investigation. By contributing to current trauma theory, the research has implications for training, counselling practice, supervision, and support of counsellors working with Veterans. This research also has direct applicability to the development of group programs for civilian populations exposed to traumatizing events such as armed conflicts, terrorism, and natural disaster, and to work with other populations of traumatized men who are equally challenged in accessing services, such as vulnerable youth, patients with prostate cancer and men in later life.
Chapter 2: Review of the Literature

In the following review, a sampling of the research is presented concerning the biological, social and psychological aspects of traumatic experience. These are different lenses through which to view the phenomenon of PTSD, which yield different kinds of understandings. While much research observes a divide between these three ways of framing and studying phenomenon, biology versus social processes versus intrapersonal characteristics, such “different understandings ought to be engaged with each other, not simply tolerated as different” (Schwandt, 2007, p. 197).

As noted in the introduction, Posttraumatic Stress Disorder is marked by profound changes in the body and brain. As such, this review will begin with a review of the literature from a neurobiological and physiological approach, with particular attention to impact on episodic or narrative integration of affective and cognitive aspects of traumatic experience, and on the impact of chronic dysregulation or allostatic overload. While neuropsychological research has exploded over the past decade, this review will necessarily take a generalized view of the topic, exchanging depth for breadth to inform our discussion of the subjective experiences of trauma with some understanding of the impact on body and mind.

The section following explores masculine gender role socialization, the military as a hyper-masculine culture that enforces gender role compliance, and the impact of masculine gender socialization and “abject” masculinity on the ability to relay information or narratives with high affective content or themes of powerlessness. In this section, Gramsci’s ideas about hegemony and Connell’s use of those ideas in popularizing the term “hegemonic masculinity”
will be explored in more depth, as well as Foucault’s contrasting and analytically useful ideas about the location of power.

The final section briefly explores recent literature on narrative identity construction or personal story-lines and the impact of experiences that cannot be integrated into the personal narrative, comparing these ideas with Freire’s theories on the place of conscientisation in escape from oppression, and the place of the social group in negotiating new narratives. Finally, the gap in current knowledge at the intersection of these areas of exploration is considered.

2.1 Traumatic Experience – Affliction of the Powerless

Traumatic events, by definition, change people. The experience is outside the norm, is unexpected and is subjectively disempowering, shattering key protective assumptions about self, safety, and trust (Gabriel, 1988; Herman, 1997). It is normal in the face of these events for the traumatized to stagger under the implications of experience – to question, did that happen? How could this be?

For the traumatized Veteran, being able to revisit memory and “make sense” of difficult life events is an important aspect of healing and re-engagement in life (Becker et al., 2004; Herman, 1997; Ready et al., 2008). For many, however, pulling together differentiated parts of their story is complicated by the nature of trauma’s impact on the body and the mind (Becker et al., 2004; Brooks, 2010; Foy et al., 1997; Herman, 1997).

2.1.1 The Physiology of Trauma

Changes in brain function during trauma presents special challenges to remembering and bringing a sense of meaning to traumatic experience. During trauma, the brain bypasses cortex-
mediated “conscious” decision-making processes and triggers a faster responding amygdala-mediated “survival brain” to mobilize autonomic “fight, flight and freeze” responses (Courtois et al., 2009; Ford, 2009). Part of this response also promotes future safety by encoding a network of implicit trauma related memories that will re-trigger autonomic response whenever similar cues are encountered (Herman, 1997; Lisak, 2002; McRae et al., 2011). When these triggers remain prevalent in the post-trauma environment, the body and brain return continuously to sympathetic autonomic arousal states, overriding and reducing functioning of cortical brain systems necessary for learning, managing distress, facilitating growth and self-development, and making judgments and plans (Herman, 1997, Courtois et al., 2009).

Two decades of research suggest that chronic and repeated activation of this stress response can result in permanent neuronal and functional changes (Courtois & Ford, 2009; Kolb, 1987; van der Kolk, 2007). For example, during stress, neuroimaging evidence indicates that, unlike healthy control subjects, those with PTSD do not shift neural processing activity from amygdala to prefrontal areas; areas related to the use of higher cognitive affect reappraisal functions used to reduce negative affect (McRae et al., 2011). Understanding how these changes occur provides us clues to how PTSD disrupts functioning and the integration of experiences, as well as to pathways to recovery.

2.1.2 Trauma Dialectics

Repeated distressing somatic activation sets up one of the defining dialectics of trauma – the conflict between the need to express and make sense of disjointed experience, and the desire to suppress and avoid triggering memories. This conflict plays out in the body and mind of the individual through the alternating trauma symptoms of dissociation and intrusion – numbness
and re-living (Herman, 1992). The traumatized Veteran often rides a roller coaster between these two experiential opposites: feeling confused, helpless and alone in their suffering.

These physiological responses are an important part of the subjective experience of traumatized Veterans. Symptoms are observed within the self, are interpreted within existing world views and beliefs, and may be given meanings that impact the Veteran’s sense of identity. If the constructed meanings given to physiological symptoms lead to shame, loss of self-esteem or other negative interpretations, they may promote maladaptive coping behaviour, exacerbate suffering and complicate recovery. Given that the brain and stress response system are both the sites of functional and structural changes in trauma, and the primary systems involved in mobilizing coping responses, it is important to consider how these physiological systems are impacted by trauma and posttraumatic stress in order to understand pathways to resilience and recovery.

2.1.3 Posttraumatic Stress Disorder

According to the DSM-5 diagnostic concept of posttraumatic stress disorder (PTSD), the trauma that can set these disturbing reactions in motion is defined as a person’s direct experience, witnessing, learning about, or exposure to details of an event that involves actual or threatened death or serious injury, or sexual violence. The former DSM IV criteria that the reactions of the person affected must involve intense fear, panic, helplessness or horror at the time of exposure was removed from the diagnostic criteria in this new version. Diagnosis now requires the presence of four distinct clusters of reactive symptoms, including: 1) intrusive symptoms associated with the traumatic events involving intense sensory and visual memories, dreams, dissociative symptoms, or intense and prolonged psychological or physiological distress;
2) avoidance of reminders of the trauma, either internal and/or external; 3) a pattern of negative alterations in cognition and mood; and 4) marked alterations in arousal and reactivity associated with the traumatic event(s). These symptoms must be existent for at least one month leading to clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2013a).

This presents PTSD as an atypical rather than a normative stress response, yet a significant legacy of our common evolutionary ancestry with other animals is a highly developed capacity to experience fear (Kapfhammer, 2008; Lisak, 2002). Like other animals, our survival depended on our capacity to react instantly to threat of attack from physically superior predators. Successful adaptation demanded the evolution and maintenance of a system capable of instantly altering the body’s functioning, preparing it for fight, flight, or the capacity to freeze completely to escape detection by predators (Lisak, 2002). PTSD however, lies at a critical point on a continuum of severity, where adaptive and protective experiences of fear cross a line into prolonged and severe disturbance. In order to better understand this critical point, it is necessary to understand the normal function of the brain in appraisal, memory and response to stress.

2.1.4 The Triune Brain

Unlike computers or mechanical systems that that can be built from the ground up, integrating prior learning into radically new designs, evolution does not have the luxury of starting over from scratch. Neuroscientist Paul McLean (1990), noting the preservation of primitive brain structures over the course of evolution, proposed the theory of the triune brain. Embodying an evolutionary connection to both reptiles and lower mammals, he proposed that the
modern brain is structured in three layers with each layer devoted to increasingly complex functions and abilities (Cozolino, 2010; McLean, 1990).

At the lowest level is the brainstem and reptilian brain that is responsible for basic activation, arousal, homeostasis and reproductive drives. The second level is the paleo mammalian brain or limbic brain, which wraps around this core and is central to learning, memories and emotion. At the highest level, and the latest to evolve, (and latest to develop in the child) lies the neo-mammalian brain or cerebral cortex, which organizes conscious thought, problem solving, and self-awareness (McLean, 1985).

While the low level brainstem and reptilian brain are fully formed and functional at birth, the higher levels of the brain, in particular the structures of the cerebral cortex, continue to develop throughout the first three decades of life. In interaction with our social and environmental milieu, the cortex is initially organized by, and then comes to organize, our experiences and how we interact with the world (Cozolino, 2010; van der Kolk, 2007).

2.1.5 Explicit and Implicit Memory and Learning Systems

Each of these levels of the brain are associated with different aspects of learning and memory functioning known as implicit and explicit memory (Courtois & Ford, 2009; Cozolino, 2010; van der Kolk, 2007). Implicit memory includes the genetic memories encoded in the reptilian brain that control reflexes, instincts and bodily functions, and the limbic level emotional memories and conditioned learning such as procedural memory. These include know-how memories, such as how to ride a bicycle, that are “implicit” or difficult to explain (O’Shea, 2005). These are right biased, unconscious and nonverbal, and are mediated by the more primitive structures of the brain such as the thalamus and amygdala.
As the central hub of fear processing, the amygdala plays a vital role in the integration of information coming in from the senses. Using implicit memory systems, it appraises danger and safety in approach-avoidance situations and, in conjunction with the right prefrontal cortex, connects emotional values to sensory input based on instincts and learning, and translates these into bodily states. It is the central player in unconscious and conscious indicators of danger, pre-conscious intuition, emotional bias, and preparation of the survival response (Panksepp, 1998).

By contrast, *explicit memory* involves conscious learning and memories, including semantic, sensory and motor forms (van der Kolk, 2007). This also includes declarative knowledge such as facts and figures, and episodic memory for past events or “episodes” (O’Shea, 2005). This memory system is biased toward the left hemisphere and contains networks responsible for explicit verbal or “languaged” learning and memory (Cozolino, 2010). While the amygdala plays a role in identifying what is of interest to pay attention to, processing of non-threatening experience moves into the hippocampus and upwards to the left and languaged areas of the prefrontal cortex.

The hippocampus plays a key role in the organization of spatial and temporal information and the ability to compare different memories and make inferences from prior learning in new situations (Cozolino, 2010). Damage to this sensitive region condemns a person to forgetting everything seconds after it is experienced, although the ability for new procedural learning remains intact (O’Shea, 2005). Explicit memory, mediated through the hippocampus, allows for autobiographical first-person accounts that combines episodic, semantic and emotional memories and that can be organized sequentially and narrated with self-awareness. It is the form of memory that is essential for the maintenance of emotional regulation, self-identity and the transmission of culture. This late developing explicit memory system provides for higher level,
conscious contextualized learning and narrative memory (Cozolino, 2010; van der Kolk, et al., 2007).

2.1.6 Of Two Minds – Inhibitory Functions of the Cortex

One of the essential functions of the higher cortex is development of subcortical inhibition and conscious control. Throughout development, neural networks descend from the cortex to subcortical regions and gradually inhibit primitive reflexes and drives, and bring the body and emotions under increasing conscious control. It is important to note that this inhibition, first of reflexes, then spontaneous movement, and then even later of emotions and inappropriate social behaviour, does not eliminate these reactions and reflexes. These remain embedded in the lower brain and can re-emerge as cortical release signs due to damage or disease within key areas of the cortex (Cozolino, 2010).

These subcortical reflex reactions and drives may also be inhibited or released depending on environmental influences and changing degrees of inhibitory cortical control. Because of their respective areas of advantage and functionality in managing stimuli, the top down conscious brain associated with explicit memory is often referred to as the Learning Brain, while the bottom up, reflexive subcortical areas associated with implicit memory are referred to as the Survival Brain (Courtois & Ford, 2009). Either of these two “minds” may assert executive functioning depending on circumstances and incoming stimuli, and each has evolutionary advantages and disadvantages.
2.1.7 Fast and Low, High and Slow – The Neural Pathways of Fear

LeDoux (1994) demonstrated the existence of two separate yet interrelated neural circuits that regulate fear, a low fast road, and a high and slow road that are related to our two memory systems. The first of these paths for fear, the low and fast reflexive system, is mobilized by structures within the ancient reptilian and limbic or paleo mammalian brain (Cozolino, 2010). The second, high and slow path to fear, involves the highest layers of the brain, the neo-mammalian brain or cerebral cortex, which organizes conscious thought, problem solving, and self-awareness (Cozolino, 2010). The existence of these two paths for learning and fear is critical to our understanding of both the normal response to stress and the symptoms of PTSD.

The low fast reflexive system sends incoming information directly from the sense organs through the thalamus directly to the amygdala for review in implicit memory systems within 50 milliseconds. By contrast, incoming information can take as long as 500 milliseconds to reach consciousness and the high neural structures of the cortex where it can be reviewed in explicit memory and learning systems – far slower than the reflexive system when it comes to responding to a charging predator (Panksepp, 1998).

Evolutionary selection and survival favoured a system that bypassed the explicit conscious management of the cortex – the brain’s center of higher and integrative functioning. It favoured retention of the faster responding primitive reflexive systems of the lower brain - a system that is wired directly into the implicit learning system and the brain’s “fear center”, the amygdala (Cozolino, 2010; van der Kolk, 2007).

In this lower response system, sensory input is evaluated in the amygdala, in conjunction with the thalamus, against ancient instinctual and crude representations of danger. Once the
amygdala has received the information, and where threat is determined to exist, survival action is quickly mobilized. The amygdala’s direct connectivity to the hypothalamus-pituitary-adrenal axis (HPA), limbic-motor circuits and brainstem nuclei allow it to trigger rapid and intense somatic survival responses. Within a fraction of a second, heart rate, blood pressure, breathing rate, blood distribution and pupil dilation are all fundamentally altered in a sympathetic fight or flight response. (Kapfhammer, 2008; van der Kolk, 2007). All of these functions are executed and mobilized before the sensory input reaches the cortex and is available for conscious review (Courtois & Ford, 2009).

Meanwhile, along the high slow road, sensory information is sent on to the hippocampus and cortex for further evaluation. This road allows more thorough analysis through the rich synaptic connections of the cortical circuits of explicit memory, conscious appraisal and executive functioning including inhibitions, which allow more careful and detailed comparison to prior experience. The high slow circuit aids in fear processing by contextualizing ongoing perceptions and behaviours with the input of time, space and learning. It also has the task of making sense of the behavioural, affective and visceral responses already set in motion by the amygdala and the HPA circuit – to discern why we already became anxious before we could begin to understand why. Where environmental cues are ambiguous and do not result in firing of the low amygdala circuit, the high slow road allows a more deliberate second assessment of the nature of the threat (Lisak, 2002).

2.1.8 System Integration for Optimal Performance

In the dynamic interplay of higher and lower regions within the prefrontal cortex, the right biased orbitomedial prefrontal cortex (ompfc), and the left biased dorsolateral area (dlpfc),
are the key areas in the cortex where these two pathways to fear and learning come together and are coordinated for optimal functioning. The ommpfc (right) is densely connected to the amygdala and is vital for appraisal – interpreting complex social events and linking them to information about emotional valence provided by the amygdala. While the amygdala will identify threat based on implicit learning and instinct, the ommpfc (right) will add additional environmental information based on prior explicit learning. If that additional context suggests that there is not a threat, the ommpfc can modulate the amygdala and down-regulate its response (Courtois & Ford, 2009). The more emotional the task, the more activation takes place in the ommpfc (right).

Experiencing from a first person perspective and tasks of self-regulation (which requires the down-regulation of the amygdala) activate the ommpfc regions, while more cognitive situation-focused regulation activates the dorsal and lateral (left) regions of the prefrontal cortex (Cozolino, 2010).

The dorsal and lateral regions of the left prefrontal cortex (dlpfc) are vital to attention and judgement and organizing working memory and temporal experience. This area of the cortex evolved networks with the hippocampus and performs a variety of functions relating to explicit memory encoding and cognitive tasks. The more demanding the cognitive task, the more activity there will be in the dlpfc (left) and the less activity in the ommpfc (right) and the amygdala (Cozolino, 2010). This may account for why refocusing on cognitive tasks can reduce subjective anxiety and distress.

These two areas must be integrated in a shifting dynamic balance to operate normally. If the ommpfc (right) is not doing its task of down-regulating amygdala activation, sympathetic reactions will interfere with dlpfc-directed cognitive processes (Dolcos & McCarthy, 2006). On the other hand, if the dlpfc (left) is not handling cognitive environmental demands, anxiety will
eventually disrupt emotional regulation – resulting in the common experience of losing basic problem solving skills when distressed (Cozolino, 2010).

These higher cortical areas, and their linkage to the lower hippocampus and amygdala, allow for the integration of emotional and cognitive aspects of experience. The hippocampus and the dlpfc (left) are necessary for forming new explicit memories while the amygdala organizes stressful and traumatic learning. At low levels of arousal, amygdala activation supports hippocampal learning by boosting the biological aspects of long term potentiation (LTP) or Hebbian learning (the basis of neuro-plasticity).

2.1.9 Traumatic Dis-Integration

This dual circuit human capacity to experience fear and process responses is both crucial to our species’ survival and also the cornerstone of our capacity to become traumatized (Cozolino, 2010; Lisak, 2002). A human being who has not been traumatized is capable of using both the “low” and “high” roads to fear. For the person who has been traumatized or subjected to chronic levels of stress, the low road to fear may come to predominate (Lisak, 2002). At high levels of arousal, and after chronic levels of amygdala activation, functioning of the hippocampus can be disrupted, sometimes permanently (Courtois & Ford, 2009; Cozolino, 2010; van der Kolk, 2007).

This rewiring the brain may have once ensured survival in continuously unpredictable and unsafe environments by adapting the brain for optimal processing of threats. Optimal learning and functioning in situations that do not present imminent threats to safety and survival however require a balance between the two (Cozolino, 2010). Where threats do not exist, the
hyperarousal associated with low road predominance is unnecessarily taxing on the body and brain.

This leads to an important finding that is key to understanding stress response and PTSD – that the brain, as both the site of initial stress appraisal and response, and as a target of stress and the stress hormones, can be both protected and potentially damaged (or adapted) due to the effects of the mediators of stress and adaptation. This has led to the introduction of the two terms: “allostasis,” referring to the process of maintaining stability (homeostasis) through the active release of stress hormones and other mediators; and “allostatic load or overload,” which is the wear and tear on the body and brain caused by the repeated or sustained use of allostasis, particularly when the mediators are not turned off when stress is over, or not turned on adequately when they are needed (McEwen, 2004; 2007). Understanding how these mediators function normally and can contribute to neuronal change provides us clues to how PTSD disrupts functioning as well as to pathways to recovery. These physiological changes occur outside of “conscious” explicit control, and yet form a significant aspect of the subjective experience of PTSD.

2.1.10 Allostasis

Sterling and Eyer (1988) introduced the term “allostasis” to refer to the active process by which the body responds to daily events and maintains homeostasis (allostasis literally means “achieving stability through change”). This provides a clarification and refinement of Hans Seyle’s concept of “homeostasis”, referring to the stability of physiological systems that maintain life. Allostasis distinguishes between the systems that are essential for life (which are held in homeostasis and exhibit control within narrow ranges, such as seen with pH, body
temperature, glucose levels or oxygen levels), and those that maintain these systems in balance (allostasis).

The primary mediators of allostatic adaptation to challenges of daily life, as well as major stressors, include hormones of the hypothalamic–pituitary–adrenal (HPA) axis, such as cortisol and dehydroepiandrosterone (DHEA), as well as catecholamines and cytokines (McEwen, 2004; Warnock, 2010). Whether facing a dangerous situation, a challenging social setting, or getting out of bed in the morning, the human organism expresses response through the interaction of these chemical mediators in a dynamic network of reciprocal effects (McEwen, 2004, 2007). These chemical mediators provide the energy to cope with short-term increases in demand and refuel the system in preparation for future stress.

In response to an acute stressor or encoded triggers, the catecholamine neurotransmitter, norepinephrine is released from the locus coeruleus and other regions resulting in anxiety, vigilance, symptoms of panic, and contributing to the fight-flight response. Norepinephrine also serves to enhance memory for details associated with stressful and traumatic events (van der Kolk, 2007). These “implicit” and procedural memories promote future safety by encoding a network of stress or trauma related associations that will re-trigger sympathetic response whenever similar cues are encountered (Herman, 1997; Lisak, 2002).

At the same time, the hypothalamus secretes corticotropin-releasing hormone (CRH), which travels to the anterior pituitary gland and stimulates the secretion of adrenocorticotrophic hormone (ACTH). ACTH, in turn, is released into the blood stream and eventually reaches the adrenal cortex, where it stimulates the release of the glucocorticoid, cortisol and the estrogen hormone, dehydroepiandrosterone (DHEA) (Vinson et al., 2007).
Both cortisol and DHEA are actively involved in the body’s development, growth, immune response, and cardiovascular function. They affect carbohydrate, protein, and lipid metabolism, serve as anti-inflammatory agents, modulate thyroid function, and increase resistance to stress. While cortisol has systemic catabolic properties (energy releasing), DHEA has anabolic properties (energy storage), representing the two complementary sides of the allostatic balance (Mouthaan et al., 2014).

The release of cortisol by the adrenal cortex in response to an acute stressor promotes survival functions by increasing blood pressure and blood glucose levels, and promoting analgesia. Cortisol concurrently conserves energy from non-vital functions by suppressing metabolic, reproductive, immuno- and neuro-defensive processes to adequately cope with the stressor, and triggers a negative feedback loop when sufficient circulating levels are reached (King & Hegadoren, 2002; Matousek, Dobkin & Pruessner, 2009; Mouthaan et al., 2014; Vinson et al., 2007).

The estrogen hormone, dehydroepiandrosterone (DHEA) which is released by the adrenal cortex at the same time as cortisol, functions as a cortisol antagonist (works against the effects of cortisol)(Olff, 2007; Spivak et al., 2000). DHEA is the most abundant circulating steroid hormone and functions predominantly as a metabolic intermediate in the biosynthesis of the estrogen and androgen sex steroids (such as testosterone, via androstenedione). DHEA may contribute to an up-regulation of HPA-axis responses (through anabolic processes), have neurogenerative effects in the hippocampus (Karishma & Herbert, 2002), as well as protect the brain from the neurotoxic effects of high cortisol levels (Rasmusson et al., 2003).
Every system in the body responds to acute challenge with allostasis, putting out mediators that promote adaptation (McEwen, 2007, p.3). In the neuroendocrine response, under normal conditions of allostasis, DHEA levels are closely correlated with cortisol. In response to longer periods of stress, however, imbalances of cortisol/DHEA may occur as the body attempts to continue to adapt, independent of the bodies energy requirements. In this situation, symptoms of “allostatic overload” may appear that produce wear and tear on the regulatory systems of the brain and the body (McEwen, 2007).

2.1.11 From Allostatic Load to Overload

Glucocorticoid receptor sites in the hippocampus (associated with the high road) normally provide a feedback mechanism that inhibits amygdala (low road) activity when cortisol bonds to receptor sites. However, sustained exposure to cortisol can result in allostatic overload, showing up as decreased hippocampal volume, either due to cell death or impeded neurogenesis (Cozolino, 2010; McEwen, 2007). Studies have shown, for example, that patients with PTSD due to combat stress have hippocampal cell loss (McEwen, 2007). As the hippocampus shrinks, there is a loss of the moderating glucocorticoid receptor sites in the hippocampus. This loss of modulating influence due to decreases in hippocampal function lead to increases in amygdala activity (low road) and corresponding continued release of cortisol into the system, perpetuating the cycle.

This initial hypercortisolemia has been documented in a number of animal and human trauma studies. Decreases in hippocampal volume correlate with deficits in encoding short-term into long term memory and an increased vulnerability to psychological trauma. As networks of affect and cognition become unlinked, affect regulation and reality testing are disrupted.
Cozolino (2010; Courtois & Ford, 2009). With dissociation between hippocampal and amygdala networks, there is disconnection between visceral-emotional (amygdala) and declarative-conscious (hippocampal) processing.

Cozolino (2010) speculates that this may not be an evolutionary accident. As valuable as language can be, evolution seems to have selected for the shutdown of language in the face of overwhelming threat. “Cortical networks responsible for (explicit) memory, language, and executive control become inhibited and underperform during times of overwhelming stress” (Cozolino, 2010, p.24). Being silenced in the face of danger may save your life.

Van der Kolk (2007) posited that flashbacks may be due to cortisol mediated, amygdala driven memory networks that are triggered by sensory cues which result in posttraumatic intrusions. These are usually experienced as if they are occurring in the present moment, and have the characteristic of being stereotyped and repetitive, suggesting that they are not subject to the assimilating and contextualizing properties of the hippocampus and cortex (high road explicit system) (van der Kolk, 2007).

Similarly, dissociated PTSD patients have greater activation in neural networks relating to the representation of bodily states, suggesting a lack of top-down modulation of these networks. Additionally, severity of symptoms is positively correlated to amygdala activation (Shin, Rauch, & Pitman 2006).

By contrast, although a large literature on stress induction studies in animals and humans links stress to increases in cortisol levels, numerous studies have shown PTSD symptoms to also be associated with lower cortisol (Mouthaan et al, 2014; Rasmusson, Vythilingam & Morgan, 2003; Yehuda, 2002, 2004). For example, Yehuda and colleagues (2000) showed that chronic
PTSD was associated with lowered cortisol activity compared to those without a PTSD diagnosis and suggested that chronically high stress levels may exhaust the HPA axis.

The conditions that dictate the direction of dysregulation are numerous and require additional study. Influences and potential mechanisms of bi-directional dysregulation that have been studied include timing of the trauma in relation to development, frequency or chronicity of previous trauma, and transient factors related to the assessment context (Glover, et al., 2006).

Of note, avoidance, one of the criterion symptoms of PTSD, may also play a role in the relationship between cortisol and PTSD. Engagement/non-engagement style of coping has been shown to influence cortisol levels, with non-engagement (avoidance) linked to lower cortisol levels (Mason et al., 2001; Delaney, 2010). This may explain some of the variability in cortisol studies as those participants who avoid, disengage or isolate show lower cortisol levels while those who are re-experiencing or in a hyper-arousal state have higher cortisol levels.

Mason and colleagues (2001) found that cortisol levels of Vietnam Veterans reflected the ongoing balance between the undifferentiated emotional arousal state of engagement (associated with higher cortisol levels) and opposing anti-arousal disengagement defense mechanisms (associated with lower cortisol levels). They concluded that the low cortisol levels often seen in patients with posttraumatic stress disorder are psychogenic and reflect a dominating effect of disengagement coping strategies, which represent secondary compensatory adaptations during the chronic course of PTSD to counteract primary arousal symptoms, especially those related to an intractable shame-laden depressive syndrome. The psychoendocrine findings suggested that the relatively unstudied clinical feature of shame, resulting from both the primary and secondary
traumatizations in PTSD, is a particularly powerful, preoccupying, and overwhelming source of emotional conflict.

Alternatively, some studies have linked hypocortisolism in PTSD to the presence of co-morbid depression which may also influence engagement versus disengagement and isolation (Hellhammer et al., 2009; Olff et al., 2007). Other possibilities for bi-directional dysregulation include, negative feedback regulation and genetic variations in cortisol sensitivity to corticotrophin releasing factor, ACTH or hippocampal sensitivity to heightened glucocorticoid production, as well as antiglucocorticoid activity related to endogenous steroids like DHEA. Consistent with this last hypothesis, several studies have found higher DHEA levels among study participants with PTSD (Laudenslager et al., 1998; Olff, Guzelcan, de Vries, Assies, & Gersons, 2007; Spivak et al., 2000).

Thus, PTSD symptoms appear to result in cortisol dysregulation in both directions. While these equivocal findings require substantially more study, it is clear that both inadequate and excessive adrenocortical and autonomic function has negative consequences for health and survival (McEwen, 2007). Just as normal cortical function requires a balancing of excitatory and inhibitory functioning, the chemical mediators of the stress response also function in dualistic balance. Changes in adrenal functioning can profoundly affect an individual’s energy levels, emotional state, disease resistance, and general sense of well-being. Although the Veteran experiencing PTSD may not understand the neurological and endocrinological changes going on, the “felt” impacts are part of the subjective experience and must be given meaning within the Veterans personal trauma narrative.
2.1.12 Treatment Effects on Neuroendocrine Dysregulation

Given the neuroendocrine dysregulation in those with PTSD, researchers have begun to study the impact of psychological PTSD treatments on cortisol and DHEA levels. Olff, et al., (2007) examined cortisol response to trauma-based cognitive-behavioral therapy (CBT) in 21 individuals with PTSD due to civilian traumas. They found that successful treatment, assessed by the Structured Interview for PTSD (SI-PTSD) and self-report symptom measures (i.e., Impact of Event Scale (IES), and the Beck Depression Inventory (BDI), was associated with enhanced levels of basal cortisol and DHEA at post-treatment. However, the improvements in hormonal measures were only seen when depression symptoms were included in the model.

This interplay between depression and PTSD was also found by Gill et al. (2008) in a study of cortisol and DHEA and immune function with women with PTSD. In this study, HPA axis and immune function in 26 women with PTSD with and without major depressive disorder was compared to 24 traumatized controls and also to 21 non-traumatized controls. PTSD was associated with low cortisol and higher levels of DHEA compared to traumatized and healthy controls. Women with PTSD and depression exhibited higher levels of DHEA than those with PTSD but without depression. These findings support the theory of dysregulated HPA axis in PTSD, and that co-morbid depression may contribute to these abnormalities.

Using a sample of 28 trauma survivors from the 9/11 attack of the World Trade Center, Yehuda and colleagues (2009) monitored individuals’ cortisol levels as they participated in psychological treatment. Basal cortisol and measures of PTSD severity were collected before and after treatment. At pre-treatment, cortisol indicators were lower for those who had higher avoidance scores but for no other symptom cluster (i.e., re-experiencing or hyperarousal). At
post-treatment, cortisol levels where correlated with all three PTSD symptom clusters, as well as total severity scores. Overall, these findings indicate that those who were highly avoidant showed lowered cortisol activity, and successful treatment increased cortisol levels, echoing earlier findings related to engagement/disengagement style of coping.

Yahuda and colleagues (2010), also reviewed the literature on prolonged exposure (PE) therapy with PTSD. PE therapy requires that patients confront, rather than avoid, traumatic memories, mostly by revisiting the “imagined” scene while constructing a sequential narrative in structured therapy sessions. By accessing the memory in session there is an opportunity for patients to experience abreaction in relative safety, and then to begin a process of habituation to the memory. Because the initial recounting of traumatic events is often psychologically and physiologically distressing, a patient may engage in avoidance before habituation can begin and neural re-integration of the memory through high road processing. Yahuda et al., demonstrated that augmenting cortisol levels through hydrocortisol administration increased distress tolerance. This was thought to allow for more full engagement with traumatic material during the initial phases of therapy and was related to accelerated habituation and recovery.

These clinical trials and case studies are consistent with neuroimaging and neurophysiological research and support a tentative hypothesis. It may be that PTSD initially leads to hypercortisolemia which may prompt the traumatized person to adopt an avoidant/disengaged coping style to restrict distressing physiological and psychological responses. Successful integration of trauma, however, seems to require the opposite strategy, facing and habituating to the traumatic memories and their related physiological activation.
2.1.13 The Integrating Nature of Narrative

*We live as embodied creatures who also form and retain understandings.*

*William L. Randall*

One route to the re-integration of high and low networks, and regulation of catabolic and anabolic processes is through activities and interventions that increase affect tolerance and the development of integrating narratives. In the context of safety and structure, experiencing and tolerating fear, memories and thoughts, activates previously inhibited neural networks and makes them available for inclusion into conscious processing (Cozolino, 2010; Seigel, 1995). Language and the act of creating and recalling a story require the convergence of multisensory emotional, temporal, and memory capabilities that bridge all neural networks. In this way, language integrates, organizes and regulates the brain (Cozolino, 2010). As Cozolino (2010) observes, “an inclusive narrative structure provides the executive brain with the best template and strategy for the oversight and coordination of the functions of the mind” (p.164).

This process of integrating automatic survival brain experiencing with new episodic or narrative memory is largely based on engaging self-reflectively in the observation of one’s own processes of thinking and feeling, and experimenting with conscious (versus automatic, low road) acquisition of new information and integration with old information (high road episodic memory) (Ford, 2009). It is the cultivation of the experience of self-control and integrated self-awareness that is normal when in “learning” rather than “survival” mode.

This suggests that the pathway back from PTSD and allostatic overload must be based on self-reflection and not merely on the facilitation of remembering, enhanced coping, or any other non-reflective or survival brain activity (Ford, 2009). The learning brain responds to stressors
based on reflective self-awareness rather than on purely non-self-aware automatic survival responses. No matter how adaptive the survival brain has been, with its ability to respond instantly, it cannot provide a pathway out of trauma. Exercises that build on procedural memory, rote learning, or avoidance and symptom control may lessen anxiety momentarily, but these essentially survival brain based strategies ultimately increase automaticity, and decrease self-reflective autonomy and the inhibitory functions of the cortex (Ford, 2009).

Putting feeling into words (affect labelling) correlates with decreased amygdala response and an increase in right and left prefrontal activity (Hariri et al., 2000). The creation of a coherent trauma narrative, which simultaneously activates dlpfc (left) and ompfc (right), allows cognitive processes to have a modulatory impact on emotional activation (Johnstone et al., 2007). The combination of storyline and visual imagery woven together with verbal and nonverbal expressions of emotion activates dedicated circuitry in both left and right hemispheres, cortical and subcortical networks, the various regions in the frontal lobes, and the hippocampus and amygdala, effectively integrating neural processing of experience (Cozolino, 2010, p. 164).

Writing narratives about experiences also seems to support this top-down modulation of emotion and bodily responses. For example, Pennebaker (1997) found that journaling increased well-being and decreased physical symptoms and physician visits. Later studies have provided insight into the neurological basis of this, correlating journaling with greater immune functioning including T-helper cell response, natural killer cell activity, and also lower heart rate and down-regulation of the amygdala (Dolcos & McCarthy, 2006).

According to Cozolino (2010), narratives perform an array of important functions including:

- Grounding our experience in a linear sequential framework;
• Remembering sequences of events and steps in problem solving;
• Serving as blueprints for emotion, behaviour, and identity;
• Keeping goals in mind and establishing sequences of goal attainment;
• Providing for affect regulation when under stress;
• Allowing for context for movement to self-definition.

In addition, the relating of narratives of trauma can reconnect individuals into families, communities, and societies. The stories we tell to ourselves and to others provide a means to make sense of our lives and connect us into the broader stories we are part of, and to our broader cultural group (Cappeliez & Webster, 2012). However, as Eitinger noted in his work with survivors of concentration camps, sometimes there are barriers to the creating and the sharing of narratives of trauma. “War and victims are something the community wants to forget; a veil of oblivion is drawn over everything painful and unpleasant” (Eitinger, 1980, p. 127).

Finding help to confront and integrate trauma memories is complicated in the world of the military, and in a society that appropriates the stories of soldiers for entertainment. Trauma isolates the traumatized because the experiences they carry change them and make them different from others in their community. With full knowledge of human vulnerability and the capacity to harm one another, admittance is denied into the world of polite society where the illusion of personal agency and a benign world persist. Innocence is lost; no return to Eden is possible.

For male Veterans, perhaps one of the most insidious and powerful barriers to full integration of traumatic experience and the creation of neurally integrated narratives of traumatic experience lies unnoticed and unchallenged within. The physiological changes that accompany trauma impinge on the subjective experience of traumatized Veterans and are given personal
meanings within existing world views and beliefs. For Veterans and men in particular, revealing lingering effects of trauma may be seen as an admission of weakness and the taking on of what Pascoe (2012) refers to as a “failed or abject masculine identity”. In the face of their own experience of trauma, these cultural stories may leave men unable or unequipped to narrate integrated storylines that reduce distress, and that support a life trajectory they still subjectively consider worth living.

If these constructed meanings exacerbate suffering, promote isolation or complicate recovery, the Veteran must cope with “two problems for the price of one” – the underlying distressing physiological symptoms of PTSD, plus the negative evaluations and emotions about the underlying symptoms. If these negative evaluations then prompt further stress response, or contribute to shame-laden depression or avoidance, the cycle may become self-sustaining. The evidence suggests that such shame-laden trauma and depressive states exacerbate neuroendocrine dysregulation and perpetuate avoidant strategies that preclude the integration of trauma experiences into the life story.

In order to look for pathways to resilience and recovery therefore, it is important to supplement understanding of the physiological impacts of trauma with consideration of the forces that act upon the Veterans process of meaning making, and their ability to tell their story and integrate their trauma experiences. In particular, what is it about being male that seems to exacerbate these Veterans’ suffering and isolation and bar their engagement in treatment?

2.2 Masculine Culture

The dilemma of speaking out about “unspeakable” events and subjective distress, or remaining silent, is complicated by a dominant cultural model of self-reliant masculinity that
serves as an oppressive force that marginalizes and stigmatizes Veterans who experience traumatic distress. As Veterans are confronted with a mythology of hyper-masculinity that glorifies a caricature of violence cleansed of personal and social impact, their own stories, as witnesses or victims of trauma, become colonized by negative value judgements and expectations of society at large.

Interestingly, one study demonstrated that when people make decisions that are congruent with racial and gender biases, the ompfc and amygdala (the low road) become more active. The dlpfc (the high road) shows more activity when we express beliefs that reflect tolerance and acceptance of differences (Knutson, Mah, Manly & Grafman, 2007). More primitive impulses seem to drive prejudice while expanded perspectives facilitate more integrated neural processes (Cozolino, 2010). It is unknown whether intolerance of the self follows these same neural circuits, although evidence from depression suggests that it might (Cozolino, 2010).

Where then do these Veterans turn to reconnect and co-construct new and coherent narratives of their trauma experiences in the face of cultural, racial and gender biases? As society remains ambivalent or insistently ignorant of the realities that Veterans face in service, Veterans may become complicit with the dominant societal expectations of men and “warriors”, put on the mask of stoicism, and hide personal struggles from their communities lest they be shamed. In order to better understand the influences of socialized ideals of masculinity on male Veterans as they attempt to make sense of their experiences, it is necessary to gain a better understanding of how masculinity is constructed and enacted by individuals and in society.
2.2.1 Gender and Sex

Before turning to an exploration of the relationship of gender to traumatic experience, it is important to differentiate between the categories of gender and biological sex. These categories are two of the most central components of most peoples’ identities and are frequently confused (Brown, 2008). Sex is a term that describes the biological makeup of the body while gender is a series of schemata and roles that are both internalized and enacted and that begin to be imposed on children from the moment at which the sex of the fetus is determined (Brown, 2008).

Researchers have long debated how much of what is seen as gender normative behaviour can be accounted for through biological, or “essential” differences. Essentialists argue that gender normative behaviours and attitudes are hard-wired through biology (Kilmartin, 2010). They view masculinity and femininity as “static, trans-historical, cross-cultural, and cross situational” (Kilmartin, 2010, p.20). From this perspective, change in gendered behaviour is either impossible or significantly constrained by biological differences - women are incapable of fully conforming to masculine norms and vice versa. Many writers consider the “essentialist” perspective to be limited as it does not account for the considerable variability in gendered behaviour within and between groups (Addis & Mahalik, 2003).

A contrasting model of understanding the source of gender normative roles is described as constructivist. Here, gender is posited to be represented in a series of schemas that have been created through biological maturation and social influences from conception onwards (Gergen, 2011). Schema, which will be considered in detail later, are thought to be the outcome of largely automatic processes in the brain that produce human knowledge and subsequent activity in the
social realm. In order to make sense of a complex and rapidly changing world, we automatically simplify processing of incoming information by developing categories. An individual's internal cognitive framework contains a variety of schemas, each helping to structure information into categories that are relevant to the person (Gergen, 2011).

Once formed, these schema become an automatically-functioning filter through which the world and one's self are perceived and experienced. Schemas are considered to be relatively fixed, and to play a primary role in directing one's behaviors, thoughts and feelings (Mourasund & Erskine, 2004). Many constructivists consider that, once established, gendered role schemas are extremely stable. Although behaviors, thoughts and feelings can be modified in experience, this is considered an after-effect and reflects strategic relationship maneuvering, not shifts in internal schema structure. In short, “one’s actions can be flexible; one’s mental structures are stable” (Gergen, 2011, p. 15).

From a contrasting social constructionism epistemology, gender is a constantly changing collection of meanings that we construct through our relationship with ourselves, with each other, and with our world (Kimmel & Messner, 1992). From this perspective, gender norms are socially constructed and are subject to change over time and from one situation or place to another. While some functions, particularly reproductive, are determined by biology, every culture also prescribes behaviour norms to males and females that extend into every area of work, family life and social convention (Kilmartin, 2010). As such, gender can be understood as a social organizing principle, a human invention like language, which unceasingly organizes and re-organizes life in culturally patterned ways (Barrett, 1996).
The constructivist perspective, while providing some room for interaction with social forces (particularly early in development), gives primacy to a system of stable personal constructs in the maintenance of gender identity and in the enactment of gender in social relations. By contrast, a social constructionism view of gender emphasizes the development and use of modelling and “languaging” activities in ongoing dialogical processes of sustaining a gendered self (Gergen, 2011).

The social constructionism perspective has the theoretical flexibility to encompass these different points of view: biological differences, internal constructivist processes and stable schema systems, and the influence of ongoing relational social constructions of gender. It provides a way of understanding both between and within-group differences, early category learning, and active contextual gender role renegotiations, by describing gender on a continuum, with both relatively stable and relationally negotiated features.

What gender norms happen to be “in force” and enacted will vary based on the social contexts that men and women grow up in and interact in today. Thus, as eloquently stated by Kimmel and Messner (1992), the important fact of men’s lives is not that they are biologically males, but that they become men through a process of socialization. For the purposes of this research, gender is viewed as developing and being maintained through a process of internal and external role negotiation, influenced by biological maturational and reproductive processes, early stable schema formation, and interaction in relational contexts.

2.2.2 The Unexamined Life: Gender Schemas and Unconscious Categorization

Part of the reason that gender schemas may exhibit the stability over time or even resistance to change that constructivists have noted, is that these norms do not necessarily
operate at a conscious explicit level. Instead, gender roles, at least in part, seem to function as part of our tendency to simplify our perceptual worlds by thinking in categories (Kilmartin, 2010). From the earliest developmental stages, the individual comes into contact with overwhelming numbers of objects and events and relationships that must be reduced into categories in order to reduce the incoming information to manageable amounts.

According to Bartlett’s (1932) “Learning Theory”, our understanding of the world is formed by a network of abstract mental structures called “schemas” that help organize and interpret information. Schemas allow us to take shortcuts in interpreting the vast amount of information that is available in our environment. Incoming information is quickly organized into these categorical schemas and further grouped into higher order scripts. Once formed, these scripts drive processing and behaviour “automatically” and drop from conscious mental processing space.

A popular example illustrates a very simple form of this automatic, pre-conscious pattern-recognizing (forcing) capacity of the human brain. The text proceeds as follows:

Aoccdrnig to a rscheearchr at Cmabrigde Uinervtisy, it deson't mttar waht oredr the ltteers of a wrod are in, the olny iprmoatnt tihng is taht the frist and lsat ltteer be in the rghit pclae. The rset can be a taotl mses and you can sitll raed it wouthit a porbelm. Tihs is bcuseae the huamn mnid deos not raed ervey lteter by istlef, but the wrod as a wlohe.

A child learning to read, who has not yet developed automatic reading schema, cannot make sense of the preceding passage because they still must decode and render meaning from words letter by letter. Few adults, however, are challenged by the task. Established reading schemas allow us to rapidly designate incoming information into “best-fit” categories that speed
information processing and allow us to assemble meanings with sparse or inconsistent information. As humans schemas allow us to read, drive, and live much of our lives on auto-pilot.

This economy of processing, however, also causes us to exclude or lose information in favour of things that confirm our pre-existing beliefs and ideas. As anyone who has tried to proofread text they have written can attest, knowledge of what a sentence is supposed to say can hinder our ability to read what we have “actually” written. In research we call the same mechanism confirmation bias, where we unconsciously read our data in ways that reflect our a priori biases. Schemas can contribute to stereotypes and make it difficult to process new information that does not conform to our established ideas about the world. At the level of gender roles, the formation of schemas is used to negotiate highly complex social and performance situations at a pre-conscious level.

This pre-conscious and automatic level of gender role negotiation is important to our understanding of gendered behaviour. While most people can describe some differentiating characteristics of males versus females, few might be aware of the extent to which gender schemas and scripts shape their moment by moment behaviour in social interactions. Given the importance of gender roles to personal identity, and their influence on social behaviour, a number of researchers have attempted to render these underlying schema systems explicit as gender norms or typologies.
2.2.3 Masculinity: Idea and Action

Goffman’s (1976) study, Gender Advertisements, looked at how social modelling through popular culture influences the construction of gender role norms. He differentiated gender display as a performance, from a gender ideal that one can more or less adhere to: “One might just as well say there is no gender identity. There is only a schedule for the portrayal of gender” (Goffman, 1976, p. 8). Goffman posited that people “read” images of gender based on prior learning and current contextual factors and then try to reproduce those images in a “gender performance”.

Judith Butler (2006) developed this idea arguing, "gender is always a doing, though not a doing by a subject who might be said to pre-exist the deed… …There is no gender identity behind the expressions of gender; that identity is performatively constituted by the very ‘expressions’ that are said to be its results" (p. 34). Through repeated acts within a highly rigid regulatory frame, the categories of masculine and feminine congeal over time to produce the appearance of substance and stability. Howells, (2003), notes that despite the appearance of stability and natural order, this postmodern performatve concept of identity is actually shifting, relational and subject to endless re-figurings.

Englar-Carlson (2006) further defined the relationship between these two aspects of gender, describing gender roles as behaviours that are congruent with the socially constructed ideals of masculinity and femininity that are learned over time from significant people in the social reference group. According to Cohen (2001), a gender ideal is formed by “the shared beliefs or models of gender that a majority of society accepts as appropriate masculinity or femininity,” and gender display is “the variety of ways in which we reveal, through our verbal
and nonverbal demeanor, that we fit in with masculine and feminine ideals” (p. 234). This divides the concept of gender into the domains of the cognitive, including automatic processes and schema formation, and the behavioural domain of how gender belief systems are enacted alone and in relationship. These are frequently not differentiated in the research; however they are important to distinguish because normative gender ideals are posited from observation of behaviour and may not be directly accessed or observed.

2.2.4 The Masculine Gender Role(s)

Researchers have investigated and advanced many models of masculinity based on observations of how masculinity is performed and the gender role socialization paradigm. One of the most influential typologies was identified by Brannon (1976) in his “Blueprint for Manhood”. Brannon identified four central themes for the “real man” that he labeled, No Sissy Stuff, The Big Wheel, The Sturdy Oak, and Give ’Em Hell!

Brannon noted that, first and foremost, a “real man” must never resemble women, or display “feminine” behaviours or characteristics. No Sissy Stuff means that, physically, real men exhibit strength and stamina. Emotionally, men must present themselves as invulnerable and repress expressions of affection or emotions other than anger. Behaviorally, they devalue and avoid any activities seen as traditionally female, from child care to housework.

Brannon’s second major role attribute, the Big Wheel, centered on the ability of real men to obtain wealth, fame, success, and status. Typically, the Big Wheel is determined by a man’s occupation, but it can also be achieved through other competitive endeavours. The Sturdy Oak theme conveyed the ideals of manliness, confidence, and self-reliance. A real man projects toughness and is physically a “man’s man” – epitomized perhaps in the popular culture icon John
Wayne. The fourth theme, Give ’Em Hell described the need for real men to act aggressively, take risks and seek sexual conquests – the bad-boy who emits an aura of danger and potential violence.

Since Brannon’s landmark study, numerous other versions of masculine gender norms have appeared that have added to, but also shown remarkable similarity to, his original typology (Connell, 1995; Gerzon, 1992; O’Neil, 1982). For example, Doyle (1994) listed essential “elements” of masculinity as the anti-feminine element, the success element, the self-reliant element, the aggressive element and the sexual element. Harris (1995) identified nine messages that illustrate modern expectations for men: “be like your father; be a faithful husband, Good Samaritan, law abider, nature lover, nurturer, rebel, scholar, and technician” (p. 13). The expectation to be both law abiding and rebellious at the same time highlights the often contradictory nature of gender expectations. Englar-Carlson (2006) in a review of the research on male gender norms catalogued eight prized attributes including: toughness; intensity; strength; competition; discipline; courage; sacrifice; and aggressiveness.

Westwood et al. (2012) suggested that there are seven scripts or gender roles that men adopt and frequently present. Characteristics of these scripts include projecting an image that: 1) males are stoic and in control of themselves; 2) males are able to manage emotions, especially those associated (or deemed associated) with being vulnerable; 3) males are fearless and indestructible; 4) the only acceptable male emotion is anger; 5) that males are competitive, achievement oriented, and successful; 6) that males are strong and independent, and finally; 7) that to be male is to be the opposite of any of the characteristics associated with either femininity or homosexuality.
While we can see that these role definitions have striking similarities, what can we make of the subtle differences that appear? As gender norms are socially constructed and performed in a specific historical and cultural context, how do these roles change according to social context and over time?

2.2.5 Alternative Masculinities

A number of studies have investigated how gender is actively socially constructed into a variety of “alternative “ identities based on geographic location, class, race, sexual orientation, family background, generation, and work identity (Barrett, 1996; Cockburn, 1983; Harris, 1995; Hollander, 2001; Klein, 1993; Messerschmidt, 1993; Pascoe, 2012). For example, Barrett (1996) documented how masculine gender norms differed between aviation, surface warfare and supply corps communities within the US navy.

Pascoe (2012) documented a variety of differing and interacting masculine gender norms within a typical American high school. She found that alternative masculinities were associated with particular racial and socioeconomic groups, and that these alternative norm expressions could be either actively endorsed or suppressed by school authorities.

Recognizing the way masculine role norms become renegotiated in particular places and times and by particular groups, researchers have proposed the concept of “multiple masculinities” rather than characterizing gender roles as monolithic and stable (Brooks, 2010). Hence, researchers have come to recognize that “the category of ‘masculinity’ should be seen as always ambivalent, always complicated” (Berger, Wallis & Watson, 1995), an idea that acknowledges the multifaceted, fluid, and socially marked nature of male experience.
This raises questions about how these various masculine role norms relate to each other – are they equal but different, or are there optimal or dominant forms of masculinity? How, and to what end, are various masculine role norms negotiated, defined and compared?

2.2.6 Masculine Hegemony

“When I was born, they looked at me and said: 'What a good boy, what a smart boy, what a strong boy!' And when you were born, they looked at you and said: 'What a good girl, what a smart girl, what a pretty girl!'”

Lyrics from “What a Good Boy,” The Barenaked Ladies

Most of us learn to comply with the dominant gender norms of our reference group at an early age and come to view these norms as a natural and valid set of constructs - if we examine them at all (Barrett, 1996). Gender roles serve as implicit and explicit guideposts that provide social valence to certain behaviours and attributes and influence the behaviour of men and women throughout the lifespan. They are part of the social fabric and turn up as stereotypes (commonly held overgeneralizations based on sex), myths (such as the idea that masculine and feminine traits are opposite versus different), norms (beliefs about how men should or shouldn’t be), and ideals (prized attributes) (Kilmartin, 2010).

In the opening quote to this section, for example, the gender role ideals that boys should be strong and girls pretty, are not startling, but any reversal in this order is revealing. One has a clear sense at least that boys should not be pretty, while girls being strong may be negatively or positively construed depending on the context.

These stereotypes, myths, norms and ideals have no objective validity themselves, except through the daily practices of how people “do” gender in their daily lives (Barrett, 1996; West &
Zimmerman, 1987). As agentic beings, humans support or challenge gender structures continuously through every action and reaction. Lest we overstate individual gender autonomy however, it is important to consider that this individual performance occurs within the wider context of larger social patterns. As Lorber (1994) observed, “the social reproduction of gender in individuals reproduces the gendered societal structure; as individuals act out gender norms and expectations in face-to-face interaction, they are constructing gendered systems of dominance and power” (p.6). These roles then, far from having a neutral social influence, tend to serve as a hegemonic force that is policed in relational interactions (Pascoe, 2012).

In his work on class relations, Gramsci used the term “hegemony” to refer to the process by which class groups create and sustain power, and how normal definitions and taken-for-granted expressions come to define situations (Germino, 1990; Holsti, 1985). It is about the process of how “normal” and ideal definitions emerge and shape social systems of dominance and power (Barrett, 1996).

Connell and colleagues (Carrigan, Connell, & Lee, 1985; Connell, 1990, 1995, 2005) popularizing the term “hegemonic masculinity”, referring to the idealized image of masculinity to which other images of masculinity, or femininity, are compared, marginalized or subordinated. This concept provided a robust anti-essentialist, non-reductionist, analytical framework for the understanding of the construction of subjectivities and power in gender. This paradigm explicitly recognizes that individuals and societies can simultaneously maintain multiple gender role norms that are deployed selectively depending on factors such as race, class, and social context, and that particular enactments of masculinity may be conferred special status by virtue of their closer alignment with the hegemonic ideal (Kilmartin, 2010; Pringle, 2005).
Star (1999) argued that Connell’s ideas concerning multiple masculinities and the hegemonic gender order have been hampered by a neo-Marxist perspective that views power as stemming from ruling groups and acting in a somewhat repressive manner on the ruled. Star, and Pringle (2005), suggested that Foucault’s radical re-theorizing of the location of power provides an alternative lens that is helpful in understanding the nuances of power and the often dis-empowered experience of individual men despite the existence of “patriarchal” power. While Foucault’s contrasting and analytically useful ideas will be considered more closely at a later point, the notion of hegemonic masculinity provides an important starting point with regard to the workings of masculine norms in the everyday lives of men and traumatized Veterans.

The military, as an institution, emphasizes and exaggerates hegemonic masculinity, and has historically explicitly defined and promoted the soldier as an embodiment of the traditional male sex role (Barrett, 1996; Fox & Pease, 2012; Keegan, 1994). In turn, these institutionally supported messages play a primary role in shaping the broader cultural notions of hegemonic masculine ideals, and serve as a standard against which other masculinities are compared and negotiated.

2.2.7 Hegemonic Men: The Hyper-Masculine Culture of the Military

We few, we happy few, we band of brothers;
For he today that sheds his blood with me
Shall be my brother; be he ne’er so vile,
This day shall gentle his condition.
And gentlemen in England, now abed,
Shall think themselves accursed they were not here;
And hold their manhoods cheap whiles any speaks
That fought with us upon Saint Crispin’s day.

If culture is a shared, acquired pattern of values, attitudes, beliefs and schema that consciously and unconsciously shapes peoples’ identities and behaviours (Brown 2008, p. 53), traditional male gender ideals underpin the foundation of military culture, which in turn, plays a primary role in shaping cultural ideals of masculinity in society (Barrett, 1996; Connell, 1992; Morgan, 1994). Within the context of military training, aspects of traditional masculine culture, such as stoicism, are emphasized and exaggerated in order to prepare men for combat and to inculcate values of selfless sacrifice for the group (Brooks, 1991; Morgan, 1994; Fox & Pease, 2012; Westwood et al., 2012).

Mejia (2005), discussing the positive survival functions of masculine gender ideology, describes the masculine gender precept around the need to confront particular aspects of human biology and suppress them – to override and disregard biological signals to run in fear or to cry out in grief or pain. Other key features that other researchers have emphasized include domination over one’s body and the external world, a neglect of physical needs and health, limited emotional expression, and allegiance to, and self-sacrifice for ones’ buddies (Brooks, 1991; Higate, 2000). This “hyper-masculine” cultural norm is adopted and promulgated through military training and includes a high standard of self-discipline and emotional control, a professional ethos of loyalty and self-sacrifice, an emphasis on group identity, and a strong “warrior” identity that is aggressive, dominant, and risk taking and precludes expression of “weakness” (Gabriel, 1988).

Across the globe, human history is filled with accounts of military culture and action, and the states and institutions we participate in, as well as their laws, have often been born out of military conflict and bloodshed (Keegan, 1994). As such, military training and its associated hyper-masculine socialization is a pervasive influence in larger society and culture.
2.2.8 The Pervasiveness of War and Warriors

A brief look at the last hundred years alone underscores the pervasive presence of narratives of military culture and conflict. A first glance brings a number of well-known conflicts into view including two world wars, Korea, Vietnam, Yugoslavia, Iraq, and Afghanistan. However, many other conflicts have also boiled during this time period including civil wars or revolutions in Greece, China, Indonesia, Congo (Zaire), Cuba, North Yemen, Chad, Sudan, Guatemala, Pakistan, Uganda, El Salvador, South Yemen, and Liberia.

States that have seen colonial or independence conflicts in the same period include Indonesia, Indochina, Madagascar, India and Pakistan, Algeria, Malaysia, Angola, Ethiopia, Guinea-Bissau, Guyana, Kenya Mozambique, Nigeria, Spain, Northern Ireland, Rhodesia (Zimbabwe), Morocco, Nicaragua, and Sri Lanka. Ethnic or tribal wars have occurred in Burma, Kenya, Burundi, Cambodia (Kampuchea), and Rwanda among others.

Border wars include those between India-China, India-Pakistan, Arab-Israeli, China-USSR. Invasions include the Soviet invasion of Hungary, Chinese invasion of Tibet, U.S. invasion of Dominican Republic, Soviet invasion of Czechoslovakia, Turkish invasion of Cyprus, Vietnamese invasion of Cambodia, Soviet invasion of Afghanistan, Chinese invasion of Vietnam, Tanzanian invasion of Uganda, Israel’s invasion of Lebanon, and the Iraqi invasion of Kuwait. There have been multiple other wars such as the El Salvador-Honduras Soccer war, the Arab-Israeli Six-Day and Yom Kippur Wars, the Ogaden War, Sahel War, Gulf War, and the Falkland War. This list does not include multiple more “minor” skirmishes, the conflicts associated with the Arab Spring, and the evolving conflict in the Ukraine.
According to military historian John Keegan (1994), over 50,000,000 have died in these conflicts since the First World War. Fifty million is a difficult figure to envision. Fifty million affected families, men, women and children, mothers with lost sons, missing husbands, missing fathers and brothers, civilian casualties, each leaving loved ones with their own devastating experience of emptiness and loss, expanding this number to touch nearly every person around the globe.

This cataloguing of the folly of humanity and hyper-masculine violence underscores the parallel and pervasive presence and reach of military culture. Arkin and Debrofsky (1978) contended that, “The military has socialized millions of men according to some traditional blueprint. As such the dominant adult male role model could largely be the product of the military, particularly in as much as those who are thus socialized have returned to society” (p. 167, emphasis added). These images of masculinity and the association of masculinity to power, aggression and violence have been readily translated into messages in popular culture which reinforce and further idealize military depictions of masculinity for non-military populations, and for coming generations of new Veterans.

2.2.9 Military Masculinity and Popular Culture

Starting with Goffman’s (1976) study, Gender Advertisements, multiple studies have mapped the similarities of depictions of masculinity in media to militarized or “warrior” masculine role ideals. For example, an investigation of male and female adolescents’ perceptions of the relative “virility” of men depicted in popular media revealed three vital aspects: physical strength and a muscular body; courage and the ability to protect; and a
propensity for violence (Duret, 1999). Similarly, the Media Education Foundation (1999) asserts that men wear the mask of the “Tough Guise,” where violent masculinity is the norm.

Bordo (2000) examining how male bodies are presented in popular culture, identified one of the two main messages in the presentation of men’s bodies in magazine advertisements as “face-off masculinity”. The face-off, or challenge occurs when the male model “stares coldly at the viewer, defying the observer to view them in any way other than how they present themselves as powerful, armored, emotionally impenetrable” (p. 186).

Given the celebration of these male virtues in movies about war, a query was made on Google.com about the number of movies made with war themes. The only answer found was “too many to count”. Reducing the query to the number of movies made about World War II, since 1950 did provide manageable statistics and a list of titles. The total number of movies about WWII between 1950 and 2012, in all languages, was 1348 with an additional 23 currently in production.

In order to render a full accounting of societies’ love affair with the mystique of the military and violence, one would have to add in all the other movies about conflicts listed beforehand, such as World War I, Vietnam and Afghanistan. Add popular comics, literature, drama, art, TV and radio programming and news to this barrage of social messages, and one gets the sense of the scale at which society appropriates military stories for entertainment. Unfortunately, under societies fascinated gaze, common yet simplistic narrative themes of hero and villain are perpetuated, as popular culture presents and reinforces hegemonic cultural constructions of self-reliant masculinity, that few, including soldiers themselves, can ever live up to (Westwood et al., 2012).
Under this cultural regime, Veterans become isolated by a mythology of hyper-masculinity that glorifies a caricature of violence cleansed of personal and social impact. As society remains ambivalent or insistently ignorant of the realities that they face in service, Veterans may become complicit with the hegemonic masculinity, put on the mask of silent stoicism, and hide personal struggles from their families, close friends, colleagues and health professionals lest they be shamed (Brooks, 2010). For Veterans and men in particular, revealing lingering effects of trauma may be seen as an admission of weakness – a fall from an idealized masculine military identity into, what Pascoe (2012) refers to as, a “failed or abject masculine identity”.

2.2.10 The Ideal’s Shadow: The Power and Place of the Abject

"What we call masculinity is often a hedge against being revealed as a fraud, an exaggerated set of activities that keep others from seeing through us, and a frenzied effort to keep at bay those fears within ourselves"

Michael Kimmel

Butler (1999), building on the idea of gender as a relational accomplishment, argues that gendered identity is created and maintained through repeated processes of invocation and repudiation. By referencing or invoking the gendered norm, that norm takes on the semblance of being a “timeless truth”. Similarly, the boundaries of the norm are also defined by all of the behaviours that are repudiated or cast out of the normative category and which become associated with a “constitutive outside” (Butler, 1999, p.3). This constitutive outside is inhabited by all of the “abject identities” which are unrecognizable or unacceptable within the gendered norm (Pascoe, 2012).
Kristeva (1982) writes that the “abject” is a part of self which must be denied, these denials being as important to the fashioning of a coherent identity as are one’s affirmations. The presence of the abject in the self disturbs identity and must be forcefully rejected and deposited on the other side of an imaginary border which separates the self from that which threatens the self. Gender, in this sense is constituted through the force of exclusion and abjection, which produces a constitutive outside to the subject, an abjected outside, which is also, “inside the subject as its own founding repudiation” (Butler 1993, p.3). Kristeva characterizes the condition of abjection in terms of an extreme feeling, remarking that it is above all a revolt of the person against an external menace from which one wants to keep a distance, but of which one has the impression that it may also menace us from inside (1988). It is a desire for separation and firm boundaries of identity, for becoming autonomous and also the feeling of impossibility of doing so (Kristeva, 1988, 135-36).

Butler (2006) extends these notions of definitional boundary referents, and describes the interactional accomplishment of gender as a process which involves the continual iteration and repudiation of the abject identity. In order to maintain its power, the abject must be constantly named and repudiated by individuals and groups so that they can continually affirm their identities as normal and culturally intelligible against this defined abjection (Pascoe, 2012). This repudiation creates and reaffirms a “threatening spectre” of failed gender, which must be continually guarded against through interactional processes.

Reflecting further in this vein, White (1997) observed that manhood does not appear to be self-reliant and autonomous. It depends chronically on the estimation of others, and is vulnerable to attack by ridicule, shaming, subordination and the “dishonour” of being seen to be
feminine. Kimmel (2001) also lends support to this idea, observing that masculine norms stem from the fear of being seen a sissy, feminine, or less than a man – fear, in other words, of the abject identity. This ever-present existence of the spectre of failed masculinity results in what Pascoe (2012) refers to as “compulsive” masculinity, in which role compliance must be continually proven, abject identity defended against, and success never attainable in any permanent way.

2.2.11 The Good, the Bad and the Ugly

“A man can’t go out the way he came in, Ben, a man has to add up to something.”

Arthur Miller (1949), Death of a Salesman

This, I think, is the point. Masculinity, on its face, lacks the capacity to legitimate itself. It always needs affirmation, and there, in that need lies its de-legitimating “weak point.” its confession to be less than - other than - it aspires to. No matter how complete, masculinity suspects itself of pretending.

Donald Moss, Masculinity as Masquerade

The historical emphasis of the military on hegemonic masculine ideals underscores the adaptive and functional nature of these norms within certain contexts. For example, Basham (2008) and Fowler (2010) discussed the skill of detachment that help the soldier survive in battle. Researchers have also documented how these gender norms can be adaptive in other contexts. For example, Mahalik, Good, and Englar-Carlson (2003) developed a scale to report when conformity to male role expectations results in positive outcomes for men. Kilmartin (2010) considered the adaptive aspects of traditional role norms in work contexts, reproduction, and in social conditions like the struggle for power and competition for scarce resources.
One interesting study linked gender role definitions, behaviours and expectations to the emergence of organized sport during the Victorian era (Adair et al., 1998). The authors suggest that sport emerged as a major cultural activity through which to test the physical attributes of men of different nations and regions. Sport was also vitally important as a means of demonstrating gender differences between men and women because, with few exceptions, men and women participate in sport separately. The authors observed that traditional male sports celebrated masculinity – “Body contact sports such as rugby and boxing were the preserve of men since they tested what were thought to be inherently masculine traits – notably courage, strength, fitness, and competitiveness” (Adair et al., 1998, p.51.).

However, despite the positive influences, when these socialized gender roles interfere with men behaving in adaptive or functional ways, then they can be said to be experiencing what O’Neil called, “gender role conflict” (O’Neil, Helms, Gable, & Wrightsman, 1986). O’Neil (1981; 1982) identified a set of values that he referred to as “masculine mystique”, associated with stereotypical masculinity and which produce dysfunction and distress for men in relationships with others. O’Neil posited a central unifying theme of “fear of femininity” and presented related patterns of behaviour which contribute to “gender role conflict” and which restrict a man’s ability to fully actualize personal and relationship potential (O’Neil, 1981; O’Neil et al., 1986).

Building on this work, Pleck (1995) proposed a Gender Strain Paradigm, positing that a considerable portion of men’s problems are the result of the impossibility of fully meeting the extreme demands of masculine ideology. Given the strain associated with living up to impossible ideals, most men see themselves falling short of the ideal “real man” (Pleck, 1995). Noting these pressures and the resulting impacts on men, Kimmel (1994) declared that there is “a
paradox in men’s lives in which men have all the power, yet few individual men feel powerful”. Many writers have explored how men cope with and adapt to the discrepancy between impossible masculine ideals and the realities of their own self-perceptions through adoption of a range of self-defeating “macho” behaviours.

Brooks (2010) catalogued the negative impacts of hegemonic masculinity for men and society, documenting impacts on boyhood, relationships with women and other men, fatherhood, work life and health. In boyhood, for example, he pointed to an “ordeal of emotional socialization” whereby boys are systematically taught to deny and suppress their tender and vulnerable emotions to fit in with the dominant ideas of masculinity. Mejia (2005) argued that shame was “pervasively” and traumatically used to reduce boys’ range of expression and promote conformity with traditional masculinity. Learning to comply with traditional masculine roles involves a dramatic loss or disruption of a boy’s identity, and the experience of being forced into a new and ultimately self-defeating formation, informed or influenced by the hypermasculine norms espoused by popular culture. Likewise, Pollack (1998) has called the gender rules for boys “traumatizing” noting that gender socialization for boys and men is heavily shame laden.

In relationships with women, Brooks and others (Brooks, 2010; Pascoe, 2012) point out that the anti-feminine element of masculinity, as first proposed by Brannon (1976), results in strained relationships with females throughout life. Although the dictates of masculinity may be conflicting, many developing boys have a clear idea of what they must not act like: they must not act like girls. Doyle (1995) described the proscription as “Don’t be like a girl because…. Well, girls are bad, stupid, inferior, subordinate” (p. 134). Pascoe (2012) argued that in abjectifying
anything feminine within themselves, young males implicitly learn to have lower regard for the feminine and women in general.

Tannen (1990) explored socialized differences in male and female relationship and communication styles, noting that women emphasize support and validation, while men emphasize advice giving and information sharing. These socialized differences in communication style, and masculine proscriptions against emotional content other than anger contribute to the development of what Levant (2003) called “normative male alexithymia”, where men become unable to identify internal affective states. Tannen documented the impact of this on women in relationship, noting that a chief complaint of women is that men are inadequate as emotional partners because they are so emotionally walled off and uncommunicative.

Compliance with masculine hegemonic ideals also interferes with men’s ability to connect to other men. Levy (2005) found that women’s friendships are most often marked by personal intimacy, reciprocity, and emotional closeness. In contrast to this, there is considerable evidence that most men lack emotionally close friendships and have few social supports to assist them through difficult times. Levy used the term “comradeship” to describe typical male-male relationships which appear close but lack commitment and emotional closeness. Underneath a façade of social connectedness and public camaraderie, there are considerable differences in patterns of relationship. As a result of this inability to connect emotionally, Brooks (2010) observed that most men are quite lonely and become highly dependent on at least one woman for emotional comfort and support. Despite men’s cultural advantages, men often come to feel one-down and overly dependent on women.
Susan Faludi, in her book, Stiffed (2000), coined the term, “crisis of masculinity” and suggested that men have attempted to live up to the expectations of masculinity established in post-World War II America, only to be let down by society. Economic pressures have made it difficult for men to live up to their expected roles as providers. In particular she links the problems of many men today with the rise of a corporate “organization man” culture in the 1950s and 1960s, which led to absent fathers failing to provide a positive, nurturing environment to their children, and then to failed expectations as companies laid off long-time loyal employees during the 1980s and 1990s. These kinds of disruptions to work connections result in major problems for men who have work as a central life focus (Marini 2005; Sternbach, 2001).

Masculine role socialization can also impact health. Men who adopt traditional beliefs about manhood and dominant norms of masculinity have been found to have greater health risks. Rather than this being due to inherent biological factors, researchers (Phillips, 2005) have explained differences in life expectancy data as a function of gender-related behaviour. For example, contributing factors to the statistic that men live 6-8 years less than women include, that men engage in riskier behaviours, are less likely to perform routine preventative health behaviours or maintain routine health appointments, and ask fewer question of their physicians (Courtenay 2005). Men also put themselves at great risk by feeling they have less of a need for adequate sleep, less of a need to observe safety measures, and have less prudent eating habits (Copenhaver & Eisler, 1996). Men are 4 to 5 times more likely to have problems with alcohol than women (Health Canada, 2012), and being able to “handle” drinking is frequently depicted as a badge of male pride. These findings lend support to Harrison’s (1989) contention: “Warning, the male sex role may be hazardous to your health”.

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Pope, Phillips, and Olivardia (2000) coined the term “the Adonis Complex” to describe a range of body image concerns of boys and men that included a preoccupation with building muscles, eliminating fat, using anabolic steroids, binge eating, hair loss, and penis size. These researchers concluded that the significant and growing number of boys and men suffering from body dysmorphia, is due in large part to the media-generated images of the “supermale” combined with the male body industries that seek profits built on male insecurities. Other consequences of struggling to comply with gender roles include higher psychological distress, greater depression, difficulty with interpersonal intimacy, greater biomedical concerns, and poorer health behaviours (Good et al., 2005).

Brooks (2010) also catalogued the “ugly” side of masculine role compliance in problematic behaviours and interactions that damage men, women and society. Violence perpetrated by men against women in relationships is estimated to be in the 21 to 33 percent range (Brooks, 2010; Goodman, Koss, Fitzgerald, Russo & Keita, 1993). Men are also the most likely perpetrators and victims of violent death (Stark, 1990). Estimates of serious violence against children by men are at one in five, while rates of “minor violence” are estimated at 65 percent (Lisak, 2001). Despite these costs, Fasteau (1975), in his work on the negative impact of masculinity on society, referred to violence as the “crucible of manhood”, and its centrality to the portrayal of epic men.

Men are usually the perpetrators of sexual crimes and some estimates show between 50 and 88 percent of rapes victims know their perpetrators (Koss & Cook, 1998). Fifteen to thirty percent of women are date raped at some point in their lives (White & Kowalski, 1998). One third of women report being physical or sexually abused by a partner at some point in their lives
(Katz, 1999). These figures suggest that there is something very wrong with the way masculinity is constructed and enacted in our culture (Brooks, 2010).

Faludi (2000), considering this self-defeating nature of masculine role compliance, pointed to the irony that even in the world they supposedly own and run, men are at the mercy of cultural forces that disfigure their lives and destroy their chance at happiness. Despite these negative consequences to men and society however, cultural institutions actively and explicitly promote and exploit traditional masculine role norms through the evocation of hegemonic and abject masculine identities (Barret, 1996; Pascoe, 2012). These opposite identities, and the gender role strain that results from them, are vital to our emerging understanding of male experiences of trauma and powerlessness. Despite the natural evolution and flux in role definitions, those who trespass across commonly held role boundaries or who become associated with lower status role definitions, risk social ridicule, rejection, sometimes violence, and a concomitant loss of self-regard (Pascoe (2012).

2.2.12 Gender, Attachment and Shame

Shame is the fear of disconnection. Is there something about me, that if other people know it or see it, that I won’t be worthy of connection? It’s universal - the only people who don’t experience it are incapable of empathy or connection – But nobody wants to talk about it and the more you don’t talk about it, the more you have it.

Brené Brown

Brooks (2010) catalogued the negative impacts of hegemonic masculinity and pointed to an “ordeal of emotional socialization” whereby boys are systematically taught to deny and suppress their tender and vulnerable emotions to fit in with the dominant ideas of masculinity. Mejia (2005) argued that shame was “pervasively” and traumatically used to promote conformity with traditional masculinity. Learning to comply with traditional masculine roles involves a
dramatic loss or disruption of a boy’s identity, and the experience of being forced into a new and ultimately self-defeating formation, informed or influenced by the hyper-masculine norms espoused by popular culture.

Schore and Schore (2008) posit that the “stuff of relationships” from the earliest stages of life indelibly shape our survival functions in basic ways, which in turn shape interactions for the rest of our lives (p. 1). In order to adapt and survive in a complex world, we learn to discern patterns not just in object categories, but also in the flow of social experience, making implicit pre-conscious judgements about situations and self. As we have seen, the primary adaptive mechanism for processing information from a constantly shifting social environment is the development of “schema”. Through schema formation, and the higher order organization of multiple schema into “scripts” we pre-consciously categorize our varied experiences to create a sense of order and predictability that allows us to feel sane and stable. Our schemas allow us to maintain a consistent, predictable identity in a consistent and predictable world (Moursund & Erskine, 2004).

Such beliefs and implicit judgements about ourselves and others converge to create “culture” – a kind of collective set of schema that organize our behaviour in social settings (Davis, 2009). Attachment itself is dependent on adherence to these cultural and social norms. As social animals, our contact with others is at once necessary for survival, the source of our greatest comfort and safety, and fraught with the risk of exclusion, humiliation and isolating shame. Learning to fit into our social surroundings, therefore, begins with our first contacts with caregivers and is complicated by the constant tension between asserting our needs and conforming to social demands (Moursund & Erskine, 2004). Sooner or later, pursuit of a personal need will give rise to an emotion, thought or action that conflicts with the needs and
context of some important relationship and the need must be suppressed to preserve the relationship (Moursund & Erskine, 2004, p.26).

Masculine gender norms play an important role in demarking acceptable from unacceptable behaviour and emotion, with those labelled as weak being stigmatized (Karen, 1992). Shame emerges as an internal governor, limiting expression of dangerous stigmatizing behaviour. Rather than a feeling/need-for-acceptance conflict being expressed explicitly, a negative self-evaluation related to the need becomes introjected to limit any outward display (Schore & Schore, 2008). Shame is the emotion that protects us from disconnection (Brown, 2012). Aspects of the self that others will not accept, and that render the self abject and unworthy of connection, are forcefully submerged in order to not threaten attachment and connection with others in the social group. The most effective means to stifle all feeling that has been labeled as weak or shameful is to stifle the voice, withdraw from relationship, and not tell our stories.

A schema pattern that emerges in this way may begin as a chosen and conscious suppression, but if maintained it will eventually become so automatic that it is no longer noticed (Moursund & Erskine, 2004). When consciousness disappears, suppression becomes repression and the ability to exercise choice is lost. Whether through denial of thought, disavowal of emotion or desensitization from physical sensation, repression becomes the adaptive mechanism that allows contact to be maintained with significant others (Moursund & Erskine, 2004).

Repression, however, carries a price. Shame results in a “self divided against itself”, and is consciously experienced as an incessant internal dialogue. Introjected self-depletion is marked by continuous self-criticism, second guessing and self-restraining. Self-worth is eroded by the
internal dialogue, by the behaviours that result from it, and even by the effort required to maintain the whole pattern (Moursund & Erskine, 2004). By far the most pervasive consequence of shaming schema, and the defences that maintain it, is the loss of full contact and connection with others. The focus of attention is pulled to the inner dialogue and away from mindful attunement with others, effectively disrupting contact (Siegel, 2007).

Evidence from neuroscience suggests that these relational schema patterns involve key areas in the right hemisphere – circuits that are laid down before the development of verbal explicit systems related to the left hemisphere. Throughout the lifespan, the right hemisphere holds representations of the emotional states associated with events we have experienced. When we encounter a familiar scenario, representations of past emotional experiences in the form of schemas are retrieved by the right hemisphere and are incorporated into the reasoning process as part of our implicit pre-conscious categorical meaning making processes (Schore & Schore, 2008, p.15).

The substrate of affective cues that underlies most relational transactions, and which give a valence to communication, occur at an implicit pre-rational level of rapid cueing and response that occurs too rapidly for simultaneous verbal transaction and conscious reflection (Schore & Schore, 2008, p.13). These implicit, and non-verbal processes analyze, regulate and communicate an individual’s relationship with the environment – they are bidirectional and intersubjective. Expectation causes interactions to be played out in ways that feel safe but elicit the same old unwanted reactions in others. This creates a sequence of “repetitive relational experiences” and the whole system becomes self-perpetuating, with each element reinforcing the next.
Personal understandings of hegemonic gender norms are encoded at this level of automatic pre-conscious processing and thus are not always available to critical consideration and reflection. Yet these norms play out in these repetitive relational experiences and serve to stratify males (and females) into hierarchies. From a place of hiding beneath explicit consciousness, hegemonic norms mete out stark judgements about men’s relative success or failure as men.

Under a societal and military cultural regime that glorifies a mythology of hyper-masculine stoicism and unassailable agency in the face of violence and horror, Veterans may become complicit with the hegemonic masculinity, put on the mask of silent stoicism, and hide personal struggles from their families, close friends, colleagues and health professionals lest they be shamed (Brooks, 2010). This trauma, then, is both social and internalized, as the man’s identity is formed and practiced with others who share the same expectations and the same language, and policed internally and relationally through the processes of shame (Fox & Pease, 2012). Shame is a potent and yet innocuous sociopolitical force that disempowers people – those judged as inferior or unworthy are often driven into silence and isolation, and this isolation, as Laing (1998), notes “is the glue that holds oppression in place”.

Reflecting back on our review of the endocrinological research findings, Mason and colleagues (2001) concluded that the low cortisol levels often seen in patients with posttraumatic stress disorder are psychogenic and reflect a dominating effect of disengagement coping strategies, which represent secondary compensatory adaptations to counteract primary arousal symptoms, especially those related to an intractable shame-laden depressive syndrome. Thus, while hypercortisolemia may be the initial body adaptation response to chronic trauma and
allostatic overload, shame, perhaps contributed to by gender role strain, drives opposing anti-
arousal disengagement defense mechanisms (associated with lower cortisol levels). These
avoidance strategies, in turn, although effective in reducing immediate arousal, ultimately
increase automaticity, and decrease self-reflective autonomy and the inhibitory functions of the
cortex (Ford, 2009) creating a vicious cycle of avoidance, shame and suffering, and further
avoidance.

2.2.13 Internalized Oppression

Foucault, in his influential work, *Discipline and Punish*, studied the practices of
discipline and training associated with institutions of power and social control. He posited that
disciplinary practices subject bodily activities to a process of constant surveillance and
examination that enables a continuous and pervasive control of individual conduct. The aim of
these practices is to both optimize the body’s capacities, skills and productivity and to foster its
usefulness and docility: to produce “subjected and practiced bodies, ‘docile’ bodies” (Foucault
1977, pp. 138-9). Foucault suggested that these practices were first cultivated in isolated
institutional settings such as prisons, military establishments, hospitals, factories and schools but
were gradually applied more broadly as techniques of social regulation and control.

Foucault describes the way in which the central technique of disciplinary power –
constant surveillance – which is initially directed toward disciplining the body, takes hold of the
mind as well to induce a psychological state of ‘conscious and permanent visibility’ (Foucault
1977, p. 201). In other words, perpetual surveillance comes to be internalized by individuals to
produce the kind of self-awareness that defines the modern subject. Foucault challenges the
notion of power as simply externally imposed constraint or repression (such as would be
understood by a strict reading of Gramsci’s ideas of hegemonic power) and argues that in the transition to modernity, the law has been replaced by the norm as the primary instrument of social control (Foucault, 1977).

Thus, Foucault suggests that in modern society the behavior of individuals and groups is increasingly and pervasively controlled through standards of normality that are disseminated by social institutions such as we have examined through popular culture and the military, and also through the sciences such as psychology and psychiatry. Eventually, individuals become the agents of their own ‘normalization’ to the extent that they are subjected to, and become invested in, the categories, classifications and norms propagated by these institutions. Modern disciplinary society can, therefore, dispense with direct forms of repression and constraint because social control is achieved by means of subtler strategies of normalization, strategies which produce self-regulating, ‘normalized’ individuals.

For traumatized Veterans, grappling with a sense of failure and abjection, the self, self-regulates by withdrawing from relationship in anticipation of rejection and shame. Having been steeped in a culture that glorifies agentic and unaffected masculinity, and which actively abhors and rejects spectres of the abject, there is little room for healthy self-definition that includes the experiences of trauma symptoms. Since gender is performative and reliant on social interaction for affirmation, the isolation that is sought in response to shame also robs the Veteran of the opportunities and experiences that could support healthy redefinition of gendered identity.

2.2.14 A Fall from Grace: Trauma, Moral Ambiguity and the Abject

“War has become an activity that has surpassed the ability of human beings to endure”.

Richard Gabriel, No More Heroes

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“Discipline keeps enemies face to face a little longer, but it cannot supplant the instinct of self-preservation and the sense of fear that goes with it. Fear! There are officers and soldiers who do not know (fear), but they are people of rare grit. The mass shudders because you cannot suppress the flesh”.

Ardant Du Picq, 1872

Military training, in emphasizing and exaggerating hegemonic masculinity, invokes both masculine ideals and abjections in order to define military cultural norms (Fox & Pease, 2012). According to Whitehead and Barrett (2001), masculine performance is central to achieving entry into, and being accepted within, any particular community of men. “Belonging” is not an automatic process, and military identity and belonging, like any gender or social identity, is an achievement that is dependent upon ongoing conformity to others’ expectations and their acknowledgement (Fox & Pease, 2012).

The centrality of performance testing in the military, and the need to “measure up,” heightens this dependence on the esteem and estimation of others. It also heightens the vulnerability to and influence of shame (Barrett, 1996, p. 141). From early training, recruits who cannot keep up with others or who exhibit sensitivity to the harsh demands, environments or treatment are subjected to a variety of shaming, feminizing gendered insults such as faggot, pussy, or wimp (Fox & Pease, 2012).

This compulsive invocation of the abject, and the military cultural identification with hegemonic masculine ideals, may, ironically, not only contribute to soldiers strength, but also create vulnerability to shame in the face of overwhelming circumstance – even if that experience “has surpassed the ability of human beings to endure” (Gabriel, 1988). While part of Veteran’s stories include identification with an internalized and hegemonic masculine role ideal of the
warrior, and engagement in “ultimate tests” of manhood such as combat or other extreme risk activities, the nature of those experiences and the sequelae of trauma may also bely the absence of these qualities (Fox & Pease, 2012).

Mejia (2005), as discussed previously, pointed to the masculine gender precept around the need to confront particular aspects of human biology and suppress them - to override and disregard biological signals regarded as “weak”. Brooks and others highlighted the military cultural emphasis on domination over one’s body and the external world, stoicism, a neglect of physical needs and health, limited emotional expression, and an emphasis on group identity and self-sacrifice for ones’ buddies. A strong “warrior” identity is aggressive, dominant, and risk taking and precludes experience or expression of “weakness” (Brooks, 1991; Gabriel, 1988; Higate, 2006). The soldiers’ role is to protect the weak, not to be weak or require assistance themselves – these are abjected feminized roles that cannot be accepted as part of the self.

By contrast, trauma tends to shatter ones sense of competency and mastery over the self, the body and the environment (Gabriel, 1988; Herman, 1997). Posttraumatic Stress Disorder as a diagnostic category emphasizes this loss of agency by cataloguing the reactive symptoms of trauma, and the presence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2013a). For men who comply with hegemonic masculine ideals, this loss of functioning, and the physiological “highjacking” of the body from conscious control, confronts the self with evidence of the loss of mastery over one’s body and experiences – a source and reason for shame, and evidence of a fall from masculine grace. The emphasis in training on hegemonic ideals, and the frequent invocation and repudiation of abject masculinity, push men to hide and suppress these “dishonourable” self-definitions, reinforcing a code of silent stoicism and, paradoxically, the hegemonic norm (Fox & Pease, 2012).
While military training attempts to prepare soldiers for combat, the realities of war and conflict are also often morally ambiguous and contradictory. Rather than calm and rational leadership, confident application of training, and an identifiable and unambiguous (and deserving) enemy, Veterans report confusion, uncertainty, vulnerability, capricious or cavalier leadership, and ambiguous and confusing scenarios such as women and children as enemies. Exposure to the worst of humanities’ inhumanity to other humans results in a dialectic of helplessness and rage, and the disconcerting and morally confusing experience of pleasure when the opportunity to strike back is seized with extreme and sometimes, in retrospect, excessive and troubling violence (Gabriel, 1988; Grossman, 1996). These experiences may undermine the protective effects of feeling that one’s actions are morally justified and necessary.

Having been tested, lingering symptoms of trauma may be interpreted by self or others to suggest that a man has been found wanting. They have failed to perform or live with their experiences as a hegemonic man is expected to. For Veterans and men in particular, revealing lingering effects of trauma may be seen as an admission of weakness – a collapse into the ever threatening abject identity. As Oliffe and Philips (2008) note, symptoms signal vulnerability, attract stigma, and directly threaten hegemonic masculine ideals. From many military personnel’s perspective, admission of, or diagnosis with PTSD is akin to career suicide (Linford, 2013). Confronted with their symptoms or their perceived shortfalls as men, they may be left with a sense of failure and a lack of confidence in their ability to control their lives (Fox & Pease, 2012; Gabriel, 1988). Unable to fulfil the expectations of himself as a man, the Veteran may no longer feel he can hold himself out as complying with the accepted military or social norms of manhood (Karner, 1994, in Fox & Pease, 2012; Mejia, 2005).
Karner (1994, in Fox & Pease, 2012) posited that it was the combination of these contradictions of vulnerability and moral ambiguity that produced a rupture in the Veterans’ sense of masculine self. Hegemonic masculine ideals demand that soldiers master potentially overwhelming personal threats as well as protect the weak and innocent (which women and children were expected to be). In her work with Veterans, Karner found that it was the experience of the failure to conform to their understanding of masculinity that constituted the Veterans’ trauma, rather than the traumatic events themselves. Karner also found that their experience of the symptoms of PTSD, such as intrusions, also “appeared to be more about ruptured images of self than the horror of the event” (In Fox & Pease, 2012). “For those Veterans, their contradictory experiences of their selves, as young men, as soldiers, and as Veterans in civilian life, rendered their claims on masculinity suspect. Their experience had not given them any resources to narrate a ‘good man’ view of themselves” (Karner, in Fox & Pease, 2012, p. 26). Their response was one of shame associated with their fall into socially driven, but personally held, narratives of abject masculine identity.

2.3 Conscientisation: From Testimony to Transformation

*The biographical side of human life is as complicated and critical to fathom as the biological.*

(Kenyon et al., 2011)

We have seen that the construction of narratives is a necessary activity to achieve neural integration and continuity in one’s senses and in one’s sense of self. We also, however, are confronted with the reality that we are not autonomous in our meaning making enterprise. As Zilber et al. (2008) observed, “people construct their stories in relation to their social sphere and
their position in it and in light of the “social stock of stories” and local social conventions available to them (p.1048).

In our social sphere, our personal storylines are densely colonized by the messages of our culture – and our gender, and concomitant socialization, is one of the most basic defining characteristics of our identity and our stories. Gender, de Lange writes (2011) is one of the most important criterions in the creation of identity within the community. The stories we tell, composed of events and experiences we select and order, are integral pieces of our identities, yet are shaped in dialogic processes (Bakhtim, 1986; de Medeiros, 2011).

When this interplay between personal and cultural stories results in the generation of integrating and coherent life stories, these can enable self-understanding, facilitate growth and affective resilience, and support the pursuit of meaning across the life course (Cappeliez and Webster, 2011). The stories we tell ourselves and others provide a means to make sense of our lives within the broader stories and cultures we are part of.

These co-constructed stories, however, can also serve to oppress and to generate wounds of their own (Freeman, 2011). While unaware of the cultural forces that shape and contain them, human beings remain ‘submerged’ in their circumstance and cannot reflect upon them critically (Freire, 2011). When male Veterans experience themselves as failed men, it is a difficult task to emerge and critically reflect through “high road” processes on the cultural programming that defines and delimits these value systems. Thus, when the narrative view of self sees certain features of the past, helplessness, the moral depravity and animality of one’s own or others behaviour, or perceives meaninglessness in prior sacrifice, this can bring shame, loathing, deep pain and regret (Freeman, 2011). In the face of this breakdown in the personal story, the narrator
can suffer what Ehrenberg (1995) referred to as ‘la fatigue d’être soi’ – the depression that comes when one is tired of being themselves, and the continuing creation of a narrative trajectory is foreclosed (de Lange, 2011).

As Freeman (2011) notes, in some cases the weight of the personal narrative can become so oppressively burdensome and the resultant immobility so seemingly irrevocable that, on the face of it, there seems no way of revitalizing one’s story. “For these people it was too late, or so it felt; the ending was a foregone conclusion – there would be, there could be, no moving on. For this reason, suicide might seem like the only viable option: if it is impossible to imagine a future that is any different from the present, the conviction may emerge that the ending is to be hastened, seized ahead of time” (in Kenyon et al, 2011, p. 4). Alternatively, paradoxically, suicide may be the only agentic response that can be mustered in the face of depression – a last desperate stand. Under these circumstances and frames of viewing the self and the challenges to be faced, how can the necessary work of critical re-examination and integration of trauma experience proceed?

2.3.1 Narrative Foreclosure

"Being a traumatized soldier means being somebody in earlier days, and a nobody today.

Afghanistan Veteran

Freeman (2011) asserts that individuals can experience a sense of “narrative foreclosure” in that the types of stories that the individual can tell become severely limited by the dominant messages of culture. For military populations who promote ideals of honour, agency and corporal control, loss of standing, agency or control can interfere with one’s ability to perceive and live (and continue to narrate) one’s life meaningfully and productively. In this sense,
narrative foreclosure denotes a loss of narrative vision, a failure to continue working on, expanding, and finding meaning in one’s story and life trajectory going forward (Phoenix, 2011).

Marks (2011) wrote about the negative impact of the loss of congruence between individual and dominant societal stories for returning Vietnam Veterans. Public opinion shifted against the war, and news of war crimes meant that many Veterans returned home to face taunts of “Baby Killer”. The congruence between individuals’ stories and the larger cultural story was lost. As a result, Veterans were left alone with their trauma and their shame with no larger protective story to give meaning to their suffering and losses. In the years that followed, more than twice the number of Vietnam Veterans have died by suicide than had been killed in combat. This example helps to illustrate how crucial the interplay is between individual’s stories and societal stories, and underscores what war historian, Michael Stephenson (2012) calls the “last clause” of the contract each soldier makes with his country – that his suffering or death have meaning and purpose.

Whether due to changes in societal views on the “rightness” of a particular conflict, or due to cultural and military injunctions against voicing experiences deemed weak and unfitting, the loss of congruence between the individual narrative and the dominant narratives of one’s culture can result in a sense of profound ‘lonesomeness’ in one’s internal representation (Marks, 2011). In the face of this narrative isolation, the despair to communicate with others diminishes the person’s ability to be in contact and in tune with themselves, to be able to register, to reflect to themselves about their own experiences (Laub, 2000).

In writing about the silence imposed by isolation and oppression, Freire declares that, as essentially languaged creatures, women and men cannot be truly human apart from
communication. To impede communication is to reduce men to the status of “things” (Freire, 2011, p.128). When the narrative of life is foreclosed, we lose some of our humanity. Indeed, where low road processing of trauma experiencing remains unintegrated into the cortical re-appraisal systems of the learning brain, we lose some of the essential humanity that comes from that higher processing and languaging of experience through the learning brain.

2.3.2 Reconnection

Dialogue is the encounter between men, mediated by the world, in order to name the world. Those who have been denied or who have lost their right to speak their “word” must first reclaim this right and prevent the continuation of this dehumanizing aggression.

To exist, humanly is to name the world, to change it. Once named the world in its turn reappears to the namers as a problem and requires of them a new naming. Human beings are not built in silence, but in word, in work, in action.

Paulo Freire

Personal narratives, we see, are shaped by broader societal narratives, and individuals are therefore not completely free of their social sphere to express a self-narrative that is based solely on a unique and private self. The narrative foreclosure that may accompany trauma is, in this way, a social phenomenon connected to the reification of cultural storylines and the tendency to uncritically internalize these storylines in a manner that severely constricts the ability to re-narrate in an integrated and integrating way.

Coming together in community, however, offers an opportunity to counteract the impact of shame and disrespected vulnerability for male Veterans. In this respect, the community can do what the individual cannot – negotiate new cultural norms that counter the myth of heroic, disconnected and stoic men, and support a model of courage based on connection and critical
self-reflection. The creation of the conditions of safety in which the work of remembrance and repair can occur, however, requires a careful and fragile collaboration between the traumatized and those who seek to assist them.

For Veterans, group therapy offers a direct antidote to the isolation and social disengagement that often accompanies trauma, by building a safe community to witness and reconnect the traumatized into a sense of belonging (Westwood et al., 2012). Such work requires responding strategically to the tendency to avoid distressing memories, which may be accentuated by the shaming that comes through masculine socialization, by naming the dominant values, and seeing them as merely one version of reality. Contextual awareness and questioning the dominant myths are essential to resisting and countering what sociologist Patricia Hill Collins refers to as controlling images (1999).

Chandler and Ray (2002) note that the experience of telling part of our story to a compassionate listener can serve to awaken us to new ways of framing old experiences. The telling allows the teller to distance themselves a little from their own life story, to identify themes and patterns within it that escaped their attention before and to move toward a larger, healthier, more self-affirming story instead. In a therapy group, others can also assume a role as co-authors of the affected person’s narrative. As witnesses they serve as keepers of the story that the affected individual is unable to articulate in clear coherent fashion – in essence, responsibility partly shifts to others for the meaning making process and for re-negotiating the social norms that have foreclosed the ability of the traumatized Veteran to escape an abject identity and “narrate a ‘good man’ view of themselves” (Fox & Pease, 2012).
From a neurobiological perspective, talking through trauma with supportive others creates the conditions for the reestablishment of neural coherence. Narratives drive the integration of cognition, affect, sensation and behaviours, which can remain dissociated in trauma (Cozolino, 2010). A supportive community, willing to hear and give witness to trauma stories, can undo the neurological, political and gender dynamics that silence Veterans in a private suffering.

2.3.3 Restorying

*Autobiographical activities that force us to turn over our stories in our minds, serve a metaphorical function. They take us from the Known (from the seemingly settled past) to novel ways of seeing things: the Unknown. They serve as an antidote to narrative foreclosure by helping us re-genre-ate our past, to “restory it”, to rewrite it.*

Randall, 2011, p.28.

Polkinghorne says, “We are in the middle of our stories and cannot be sure how they will end”; as a result, “we are constantly having to revise the plot as new events are added to our lives” (1988, p.150). This process of “re-storying” does not follow a one way track that permanently marks certain events as significant in never changing ways. “Memories are not straight recordings of actual occurrences, devoid of bias or interpretation and with all the details intact” notes Randall (2011, p.22). They are not events themselves but narrated summaries of them that are woven and re-woven into tapestries of personal meaning and affective valence.

These narratives reflect the narrative environments we have lived in through the years that contribute to the socially constructed nature of meaning. They are constructed in part through our relationships with others and are thus open to rewriting and the influence of new social environments. No reading of any part is therefore ever final, impervious to further
reinterpretation. There is literally no end of meaning to be gleaned from it. Polkinghorne says “the realm of meaning has great plasticity” (1988, p. 16), despite our tendency to perceive it as finished and settled.

Freeman notes that, given this great plasticity, the process of autobiographical reflection is fundamentally a metaphorical one: a new relationship is being created between the past and the present and thus, the text of the self is being rewritten (Freeman, 1994, p.30). For Randall (2011) there is no continuous, defined self within us but, depending on the context or the people we are interacting with, only a great array of possible ones: failure, survivor, hero, loner, success. Therapy exploits such multiple possible storylines to confront limiting stories and to envision healthier self-narratives instead, including narratives that create the conditions for the critical emergence from traumatic experience and the integration of dissociated cognition, affect, sensation and behaviours. In this way, therapeutic dialogue becomes a strategy for developing a critical consciousness – a pedagogical practice that disrupts taken-for-granted “truths” (Bacchi, 2012).

2.3.4 Re-Integration

Freire used the term conscientisation to describe the process of becoming more critically conscious. Human beings can only do this if they “emerge” from their situation, reflect upon it, and intervene in it. They are able to do this only if they perceive their state not as an outcome of unalterable fate, but merely as limiting and therefore challenging (Freire, 2011, p.57). This is a call to constantly transform the narrative and Freire argued that humans can do this by entering into dialogue with their circumstance, posing the limits of their situation as problems to be worked out – as problematizations. In many ways this critical emergence from the flow of
experience is reminiscent of the cultivation of self-control and integrated self-awareness that is normal when in “learning” rather than “survival” mode. Certainly, conscientisation would enlist high road dorsolateral prefrontal cortex integrating functions.

Freire referred to this process as *critical self-insertion* into the reality of one’s situation. Human beings are called upon to be re-creators, not just spectators of the world (2011, p.49). They are meant to be Subjects and not merely Objects of their history. For them, the world is to be seen not as some kind of static reality but as a reality in process. They are called to transform it – and thereby transform themselves. In and through this kind of action, people cease to see their situation as a “dense, enveloping reality or a tormenting blind alley”. Instead it emerges as “an historical reality susceptible to transformation” (2011, p.58). When people come together to confront their situation, they discover in it the obstacles to their humanization and are called to struggle against them (Freire, 2011, p.90).

Freire felt that the central task of human beings is to become more fully human. No one escapes this “ontological and historical vocation” of becoming more fully human (2011, p. 45). Freire sees dehumanization as both a possibility and an historical reality. Unlike other animals, which cannot be de-animalized, humans can be de-humanized. They can fail to become human or become less human (Freire 2011, p.52).

Freire felt that it is in speaking their word that people, by naming the world, transform it. Dialogue imposes itself as the way by which they achieve significance as human beings. Dialogue is thus an existential necessity. And since dialogue is the encounter in which the combined reflection and action of the dialoguers are addressed to the world which is to be
transformed and humanized, it must be an act of creation and re-creation in community; it can only take place in fellowship.

This requires placing those who have been silenced, shamed, or who’s narratives have been foreclosed, in a consciously critical confrontation with their trauma experiences. The problem posing approach requires them to emerge from their situation and reflect on it. They have a “focalized” view of their own reality that the culture of silence has imposed upon them and they must move from this to a view that sees their reality as a totality – with all its causes and consequences. This is critical thinking, and is, in essence, the function of the critical languaging and inhibitory functions of the higher cortex – the uniquely human neo-mammalian portions of the triune brain.

2.4 Convergence and Discovery

_memory does not repeat experience but traces a parallel path in order to find meaning in experience”_

_Goertz_

Therapists, who work with military personnel, know the burden that these clients carry from their military service. They rarely share their experiences with others. We also see the toll that personal difficulties take on careers and on relationships with spouses/partners, parents, children and siblings. To optimize their effectiveness, counsellors need to understand the important issues, concepts and approaches that impact their work with traumatized male clients who are part of the military.

A number of key ideas underpin our emerging understanding of masculine socialization and its impact on Veterans, and point the way for further inquiry. These ideas include:
1. Kimmel and Messner’s (1992) contention that, the important fact of men’s lives is not that they are biologically males, but that they become men through a process of socialization.

2. The idea that masculinity is “a constantly changing collection of meanings that we construct (or perform) through our relationships with ourselves, with each other, and with our world” (Kimmel, 2001).

3. Characteristics of normative masculinity include projecting an image that males:
   1) are stoic and in control of themselves; 2) are able to manage emotions 3) are fearless and indestructible; 4) only express anger; 5) are competitive, achievement oriented, and successful; 6) are strong and independent, and finally; 7) are defined as the opposite of femininity or homosexuality.

4. Lorber’s (1994) observation that, “as individuals act out gender norms and expectations in face-to-face interaction, they are constructing gendered systems of dominance and power” (p.6).

5. Connell’s (1995) concept of hegemonic masculine role norms which serve to stratify males (and females) into hierarchies that are policed in interactions. Those who trespass across commonly held role boundaries, or who become associated with lower status role definitions, risk social ridicule, rejection, sometimes violence, and a concomitant loss of self-regard (Pascoe, 2012).

6. White’s (1997) observation that manhood does not appear to be self-reliant and autonomous. It depends chronically on the estimation of others, and is vulnerable to attack by ridicule, shaming, subordination and “dishonourable” feminine-like behaviour.
7. The military represents an idealized form of hegemonic masculinity, and that this model is further supported and exaggerated by popular culture depictions of warrior masculinity.

8. That compliance with masculine role norms can produce both positive and deeply negative consequences for men, women and society (Brooks, 2010).

9. That gender role strain, the effort to comply with impossible internalized masculine role norms, can escalate and exacerbate emotional and relational functioning problems.

10. That men are constantly threatened by the spectre of failed masculinity – the abject – and that assumption of this failed masculine identity can result in shame, silence and isolation.

We have also seen that the defining characteristics of trauma are:

1. The experience is subjectively unique, isolating and disempowering.

2. Assumptions about self, safety, and trust are swept aside in the face of experiences that shatter one’s sense of competency and mastery over the environment (Gabriel, 1988; Herman, 1997).

3. During trauma, the brain bypasses cortex-mediated “conscious” decision-making processes and triggers a faster responding amygdala-mediated “survival brain” to mobilize autonomic “fight, flight and freeze” responses (Courtois et al., 2009).

4. Part of this response also promotes future safety by encoding a network of trauma related memories that will re-trigger autonomic response whenever similar cues are encountered (Herman, 1997; Lisak, 2002).
5. When these triggers remain prevalent in the post-trauma environment, the body and brain return continuously to autonomic arousal states, overriding and reducing functioning of cortical brain systems necessary for learning, managing distress, facilitating growth and self-development, and making judgments and plans (Herman, 1997, Courtois et al., 2009).

6. The physiological dialectics of intrusion and numbing are experienced as loss of control over the body.

7. Posttraumatic Stress Disorder involves the loss of regulation of the neurobiological processes responsible for appraising and responding to threat (Cozolino, 2010).

8. Engagement/non-engagement style of coping, especially relating to intractable shame-laden depression, has been shown to have psychogenic impacts on adrenal function as marked by cortisol and DHEA levels (Mason et al., 2001; Delaney, 2010).

9. The process of integrating automatic survival brain experiencing with new episodic or narrative memory is largely based on engaging self-reflectively in the observation of one’s own processes of thinking and feeling, and experimenting with conscious (versus automatic, low road) acquisition of new information and integration with old information (high road episodic memory) (Ford, 2009).

10. We have also seen that the process of conscientisation, requires critical emergence from the flow of experience and that this process is easiest to engage in a community of supportive peers. Relating this concept to oppressive gender norms, suggests that talking through men’s trauma in a community of supportive others may create the social
conditions necessary for the reestablishment of neural integration, revitalized personal storylines and reconnection to community.

While the key role of gender socialization in women’s experience and recovery from trauma has been extensively studied, there has been little attention paid to male social norms and expectations in Veterans’ psychological and physiological experience of trauma and the process of treatment and recovery (Brooks, 2010; Fox & Pease, 2012). Given the military’s historically explicit emphasis on the soldier as the ideal of the stoic male, the disempowering nature of trauma and its symptoms may undermine a Veteran’s identity as a male and be experienced as “failure” as a man (Fox & Pease, 2012). This experience of failed masculinity may inadvertently contribute to the shaming, isolation and silencing of male Veterans, exacerbate their suffering, and bar the psychological and neurobiological integration necessary for neural coherence.

Despite this, how male Veterans’ intrapersonal, interpersonal, and physiological experiences of trauma are influenced by their gender socialization, and what impact these experiences have on access, engagement and outcomes of treatment have received little attention in the literature (Brooks, 2010; Fox & Pease, 2012; Westwood et al., 2012).

2.5 The Current Project

The purpose of this project was to examine Veterans trauma experiences, with a view to understanding how narrative processes of meaning making are influenced by their gender socialization, and whether these narratives are “re-written” or re-negotiated through the course of a group therapy program. Since little is known about the influences of masculine socialization on Veterans’ experience of trauma and recovery, conducting an exploratory qualitative study to inform theory was important and appropriate (Crotty, 2011).
A primary consideration in overall design was to “cast the net wide” to gain greater understanding of Veterans’ trauma experiences without reducing their uniqueness, their complexity, and their “embeddedness” and interaction with their contexts. By closely following case examples from a cohort of male Veterans during their participation in a group trauma program, the UBC/Legion Veterans Transition Program (VTP), the specific objectives were: (1) to inform future therapeutic practice by bringing a gender lens to male Veterans’ subjective experience of the physiological, psychological and social impacts of service-related traumatic stress injuries; (2) to examine Veterans’ accounts of factors influencing access to, engagement in and impact of help-seeking as they participate in trauma exposure work in a group setting; and (3), to consider how, or if, their personal narratives changed over the course of an exposure oriented group therapy program.

2.5.1 Research Question

The overarching questions that guided this research were: *Given the emphasis of male socialization on stoic mastery over self and environment, and its integral place in the training of soldiers, how are male Veterans’ intrapersonal and interpersonal experiences of trauma influenced by their gender socialization, and what impact do these experiences and constructed meanings have on narratives of personal identity, and access to, engagement in, and impact of treatment?*

These overarching questions were explored in two related studies designed to tease out specific aspects of interest, including:

1. How do gender narratives generated by societal institutions, such as popular culture, converge or contrast with the psychiatric discourse of PTSD, and how might these
“master” narratives relate to, colonize or complicate the narratives and subjective experiences of Veterans with PTSD?

2. In the same vein, do masculine gender role norm expectations show up, explicitly or implicitly, as important themes in Veterans’ personal trauma and treatment access accounts?

3. Given masculine injunctions against self-disclosure, that are thought to act as barriers to treatment access and engagement, what insights are offered by the narratives told by Veterans who completed a group therapy program?

4. How, or are masculine gender identities re-negotiated or re-defined through group-based trauma narrative exposure work, and is there evidence of movement from abject to empowered identity formations?

2.5.2 Research Venue

The studies that formed this project set out to explore and examine the experiences of a cohort of male military Veterans who attended the UBC/Legion Veterans Transition Program (VTP), a ten day residential treatment program for Veterans that has demonstrated clinically and statistically significant outcomes for trauma symptoms and depression, and has an unusually high completion rate by Veteran participants (Cox et al., 2014). The VTP is a group-based intervention designed to reduce posttraumatic stress symptoms and promote adjustment to civilian life in military Veterans (Westwood et al., 2012). Each cohort program is run by two leaders and by two para-professional Veterans with a cohort of six to eight Veteran participants. The VTP uses a multi-day residential retreat format, divided into three phases; two four day weekends and one two day weekend separated by approximately four weeks each.
The VTP was ideally suited for the investigation of Veterans’ gendered narratives as the program is organized around two explicitly narrative-based exposure interventions; autobiographical life review; and therapeutic enactment. These exposure based interventions place participants in an engagement stance relative to their trauma stories and therefore could be expected to be rich sources of information about how narratives are re-constructed when confronted rather than avoided.

2.5.3 Life Review

The first exposure intervention, occurring in phase one of the program, is called Autobiographical Life Review. Life review is a form of guided autobiography narrative that consists of theme-based autobiographical writing and the sharing of one’s stories within the group (Birren, 2001). It is thought that the process of writing out the story and then sharing it in a group allows opportunity for social re-construction of those stories – making intentional and explicit a usually implicit process of social co-construction of personal narrative (Ochberg, 1994). In the process, participants have the opportunity to gain clarity and meaning from accumulated life experiences, resolve issues, and uncover hidden pressures and influences on the construction of their stories (resembling Freire’s concept of conscientisation), and learn to accept themselves and others (Birren, et al., 2001). The interventions put participants in an engagement stance towards their trauma, which may be expected to have implications for neuroendocrine function. The VTP employs two distinct Life Review exercises, one for pivotal life moments before service and one targeting military service experiences. For this research, and particularly in the research study presented in Chapter 4, military service experiences and reflections that were written out by participants were used as a data source.
2.5.4 Therapeutic Enactment

Therapeutic Enactment (TE) is a group based therapeutic intervention that uses action-based techniques to help individuals resolve personal issues. As deployed in the VTP, it organizes Veterans in the strategic embodied recreation of disturbing events from each other’s lives in a safe, supportive environment, and allows for “exposure to” and “working through” of those scenes to more integrated and adaptable ends. The TE works as an essential act of posing the unintegrated narrative as an unfinished gestalt. Like Freire’s problem posing dialogic, the personal narrative becomes a problem or puzzle that the Veteran can hold out from the body, to be turned and manipulated, entered and exited, in order to see it anew, and from that new externalized vantage point enter into a new, “critical” relationship with it. Following the TE, which takes place in the second or third phase of the program, a group debrief occurs which gives participants the opportunity to reflect on their experiences and articulate changes in framing, identity and relationship. Participants are encouraged to write about their personal reflections through the course of the program and these personal reflection documents were used extensively to inform the project detailed in Chapter 4.

2.5.5 Participants

The studies included Veterans who are referred to the VTP from a number of sources, including word of mouth, other healthcare providers, and Veterans Affairs Canada. A criterion for inclusion in this program is that Veterans have a military-related trauma that is negatively impacting their lives. It is not necessary for trauma symptoms to reach the diagnostic threshold for PTSD or other disorders such as Depression. Veteran participants in the VTP are screened and excluded if active psychotic, suicidal, or addictions issues are present (Westwood et al.,
2012). Each of the individual studies to follow present the specifics of the participants involved in more detail.

2.5.6 Triangulation

Plausible understandings of phenomena are best constructed through several levels of evidence. Triangulation is a technique that allows researchers to construct more meaningful propositions about the social world by gathering data from a variety of sources that reflect different ways of understanding phenomenon. By gathering information in a variety of ways, the researcher can establish links and eventually create a more complete picture of phenomena supported by multiple data sources (Mathison, 1988).

Denzin, in writing about the use of triangulation as a strategy to provide researchers with a rich picture of social phenomenon, suggested triangulation in the areas of data, investigator, theory and methodology (1978). Although, he then suggested that theoretical triangulation is likely to be unfeasible in most cases, he points to this as most likely to be important for analysis of areas characterized by high theoretical incoherence. Certainly, trauma studies are one such area.

Drawing on the experiences of Veterans who have lived through disturbing or unusual life events, the goal of this research was to assemble a critical understanding about how these men construct gendered narratives of those experiences, and how gendered themes relate to access, engagement and impact of therapy. The studies compiled multiple forms of data, including an example of a popular “warrior” genre movie, text of the Diagnostic and Statistical Manual for Mental Disorders (DSM), videotaped interviews, personal reflection writings, focus group material and videotapes of ten days of group treatment. Using these multiple data sources,
the studies attempted to identify points of convergence to contribute to a more integrated understanding of how the multiple aspects of trauma experience coalesce in the male Veteran, impact their lived experience, and the way that they relate to and co-construct their stories.

2.5.7 The Studies

Two related exploratory studies were conducted to drive theory development regarding gender socialization effects on Male Veterans trauma experience, and to identify whether there were discernable, and replicable, pathways that these men travelled to participate more fully in treatment, relationship or community. The studies are presented in the following chapters as separate manuscripts for publication in peer reviewed journals. This presentation format requires some repetition of the reference literature to establish the context for stand-alone publications. The studies are logically linked, with the first providing a foundation for the second, and each building on the subject of inquiry. The studies are presented as follows.


Chapter 4. The Heroes Path: Veterans’ Narratives of Therapeutic Engagement.

The research question began, “Given the emphasis of male socialization on stoic mastery over self and environment, and its integral place in the training of soldiers, how are male Veterans’ experiences of trauma influenced by their gender socialization”. The theory and research reviewed suggests that the starting “given” is valid, and that this emphasis contributes to a fundamental disconnect between hegemonic masculine role norms and the “disordered” or “abjected” identity associated with a diagnosis of PTSD. That this is true is a fundamental assumption underlying the research question, however the existing literature has not illustrated
how conflicting theoretical cultural “master” narratives (such as movies, military training and the DSM diagnostic system) might colonize and create conflict in the narratives of Veterans with PTSD. The first case study attempts to explore this assumption by considering how messages from popular culture and a PTSD diagnosis might intersect in one individual’s subjective account of trauma, with a view to how macro level workings of masculine socialization appear at this micro level.

The second study builds on this groundwork but narrows the focus of inquiry from the larger cultural milieu to the interactions and self-reflections of a group of Veterans in a group-based treatment program. While the first study explicitly explores the nature of conflicting messages that might come from cultural institutions, the second study is more concerned with implicit and explicit examples of how these conflicts are negotiated and renegotiated intra and interpersonally. It was hoped that by bringing together and examining data across multiple Veteran’s cases, a more coherent clinical picture of the relevance and impact of gender socialization on men’s trauma experience and recovery, and re-engagement in community would emerge.
Chapter 3: Access – Military Masculinity, Movies and the DSM: Veterans’ Narratives of Institutionally (En)Gendered Trauma

3.1 Section Synopsis

During consultations regarding revisions to Posttraumatic Stress Disorder as a classification in the DSM 5, some military leaders expressed concern that the word “disorder” may make soldiers with PTSD symptoms reluctant to ask for help. Despite this recognition of the linkage between military masculine gender norms, language, and male help-seeking behaviour, the way that conflicting military masculine norms and psychiatric discourses of “disorder” play out in the experience of individual traumatized male Veterans remains largely unarticulated. This chapter of the dissertation seeks to contextualize and complicate discussions about men and trauma; to examine and make explicit the masculine gender role norms of stoicism and agency across three domains including popular culture, psychiatric discourse, and one Veteran’s trauma narrative. I argue that any representation of men’s trauma within a singular narrative of disorder “of the individual”, situated “within the individual”, misses key aspects, and potentially drivers of the male experience of trauma and recovery. To articulate this conceptual argument, I interrogate three narrative sources that appear in the life of Jack, an Afghanistan Veteran. These include: (1) the first seven minutes of a popular warrior genre movie, 300; (2) the diagnostic category for Posttraumatic Stress Disorder in the Diagnostic and Statistical Manual (DSM versions IV and V); and (3) Jack’s personal account of his trauma and its aftermath. These examples illustrate how masculine role discourses, embedded in cultural institutions, colonize and complicate the personal trauma stories of affected male Veterans, and may inadvertently contribute to their isolation and their suffering, complicating their recovery.
3.2 Military Masculinity, Movies and the DSM: Narratives of Institutionally (En)Gendered Trauma

Jack is a young, good looking Veteran who prides himself on his athletic ability. As a military sapper he received elite training to defuse improvised explosive devices (IEDs). He is being interviewed about his experiences in Afghanistan and about the events that triggered his PTSD. He looks to the floor as he recounts one pivotal event, and for a moment seems transported back in time and place. With pressured speech he tells the interviewer about having to sit helplessly by as a friend burns to death in a vehicle after hitting an IED, and how he is haunted by the fact that he was not able to help. “I just remember thinking, we’ve got to do something, like, we’ve got to do something. Because it just felt, it felt so horrible just to be standing there watching that. And instantly I just felt myself die. That’s when everything changed big time for me”.

When Jack came home from Afghanistan he had initially felt a heightened sense of appreciation for everything he had in his life. Within a few short months, however, overwhelmed, angry, guilty, and frustrated, he began drinking and using drugs to avoid recurring intrusive memories of watching his friend burn to death, and to escape his own sense of failure over not having been able to save him. An estimated 15 to 30 percent of Veterans and serving military personnel are expected to experience such posttraumatic stress injuries either immediately or even years after their deployment (VAC, 2013; DND, 2013).

When service related trauma experiences are not treated successfully, they can result in ongoing stress and adjustment difficulties, including problematic substance abuse, increases in aggressive behavior, poor functioning in relationships, withdrawal, depression and suicide (van der Kolk et al., 2007; Westwood et al., 2010). There is evidence to suggest that men, who make
up 88 percent of the Veteran population (VAC, 2013), experience these difficulties at proportionally higher rates than their female compatriots, and also have significantly lower usage rates for trauma therapies (Brooks, 2010; Westwood et al., 2012). For male Veterans who access treatment, success rates are mixed, with high relapse rates, and drop-out rates ranging from 30 to 70 percent (Westwood et al., 2012; Ready et al., 2008; Schnurr et al., 2003). Given that these Veterans are husbands, fathers and sons who belong to and affect families and communities, the social costs of poor treatment outcomes are high, and better understanding of how these Veterans make sense of and live with their traumatic experiences post-deployment is essential (Dalliare, 2011). This raises the question then – What is it about the male experience of trauma that contributes to these Veterans’ vulnerability and their silent stoicism?

Unlike research concerning women’s gender socialization and trauma, relatively little attention has been paid to the influence of gender socialization in the male experience of trauma, and on the experiences of male Veterans like Jack (Brooks, 2010; Fox & Pease, 2012). Despite this lack of attention, historically hyper-masculine gender norms have been explicitly used by the military to socialize soldiers into an idealized culture of “warrior masculinity”; presenting the soldier as the ideal of the strong and stoic male (Barrett, 1996; Fox & Pease, 2012; Keegan, 1994).

3.2.1 Military as Referent of High Status Masculinity

If culture is a shared, acquired pattern of values, attitudes, beliefs and schema that consciously and unconsciously shapes peoples’ identities and behaviours (Brown 2008, p. 53), traditional male gender ideals underpin the foundation of military culture, and in turn, play a primary role in shaping cultural ideals of masculinity in society (Barrett, 1996; Connell, 1992; Morgan, 1994). Arkin and Debrofsky (1978) went as far as to contend that, “The military has
socialized millions of men according to some traditional blueprint. As such the dominant adult male role model could largely be the product of the military, particularly in as much as those who are thus socialized have returned to society” (p. 167).

Within the context of military training, aspects of traditional masculine culture are emphasized and exaggerated in order to prepare men for combat and to inculcate values of selfless sacrifice for the group (Brooks, 1991; Morgan, 1994; Fox & Pease, 2012; Westwood et al., 2012). Mejia (2005), discussing the positive survival functions of masculine gender ideology generally, describes the masculine gender precept around the need to confront particular aspects of human biology and suppress them - to override and disregard biological signals to run in fear or to cry in grief or pain. Other researchers have emphasized domination over one’s body and the external world, a neglect of physical needs, limited emotional expression, and allegiance to, and self-sacrifice for ones’ buddies (Brooks, 2010; Higate, 2006). The “hyper-masculine” cultural norm of the military emphasizes such values and includes a high standard of self-discipline and emotional control, a professional ethos of loyalty and self-sacrifice, an emphasis on group identity, and a strong masculine “warrior” identity that is aggressive, dominant and risk taking, and precludes experience or expression of “weakness” (Gabriel, 1988).

In the wider societal context, popular culture has also participated in the perpetuation of these normative ideas of military masculinity by appropriating Veterans’ stories for entertainment and rewriting them into an extreme model of stoic and unfailingly agentic masculinity (Fox & Pease, 2012; Gabriel, 1988; Westwood et al., 2012). These images of masculinity, and the association of masculinity to power, aggression and violence have been readily translated into messages in popular culture which reinforce and further idealize military
depictions of masculinity for non-military populations, and for coming generations of new soldiers.

Belkin (2012) explored how “military masculinity” receives high status in society at large, resulting in attempts by political leaders to associate themselves with the military as a means of claiming high masculine status and legitimizing their claims to authority. Belkin also notes that this high status given to military masculinity is both attractive to, and influential on military members who often explain their willingness to risk their lives in terms of a desire to cement their masculine status. In this way, military masculinity influences societal norms for men, which in turn influence norms of military masculinity in an iterative cycle.

3.2.2 Fall from Masculine Grace

While military and popular-cultural institutions help mold and perpetuate ideals of the military masculine for men, institutional psychiatry articulates the boundaries of an opposite, “disordered” side of the functional spectrum. Rather than offering a counter-argument to the pervasive influence of military masculine norms, institutional psychiatry inadvertently reinforces these norms for men by grasping together the symptoms of PTSD and defining them as disordered. Facing a popular culture and psychiatric discourse, unified in their assignment of those who lose external or internal agency into a lower status and stigmatized position, male Veterans experiencing lingering effects of trauma may begin to narrate their symptoms and diagnosis as “failure” or weakness - a fall from masculine grace (Fox & Pease, 2012).

Having been steeped in a culture that glorifies agentic and unaffected masculinity, and actively rejects any sign of “weakness”, there may be little room for a Veteran to develop a healthy self-definition that includes the experiences of trauma symptoms. Instead, symptoms signal a fall from the previously held idealized masculine military identity into, what Pascoe
refers to as, a “failed or abject masculine identity” (Pascoe, 2012). To avoid this identification, Veterans may become complicit with the norms of masculinity; put on the mask of silent stoicism, and hide personal struggles from their families, close friends, colleagues and health professionals lest they be shamed (Brooks, 2010).

In her work with Vietnam Veterans, Karner found that it was the experience of failing to conform to their own understanding of masculinity that constituted the Veterans’ trauma, rather than the traumatic events themselves (In Fox & Pease, 2012). She noted, “For those Veterans, their contradictory experiences of their selves, as young men, as soldiers, and as Veterans in civilian life, rendered their claims on masculinity suspect. Their experience had not given them any resources to narrate a ‘good man’ view of themselves” (Karner, in Fox & Pease, 2012, p. 26). Previously granted membership among those associated with a masculine ideal, these soldiers experienced their trauma as a collapse “from hero to zero”, into the abject identity of “disordered” and “abnormal”.

This paper seeks to contextualize and complicate the discourse about men and trauma; to re-examine whether masculine gender norms of stoicism and agency are relevant to consider in the psychological treatment of male Veterans trauma. Gender socialization is recognized as an important aspect of women’s subjective experience of trauma and an important consideration for treatment and recovery (Jordan, 2004). Can it be similarly argued that masculine “cultural competence” is necessary for psychologists treating male Veteran’s PTSD?

3.3 Methods

To explore whether masculine themes are present, or relevant in the male Veteran’s experience of PTSD, I interrogate a single case study, in which three narrative sources cohere. These narratives include: (1) a popular warrior genre movie, “300”, with emphasis of the first
seven minutes which set the scene; (2) the diagnostic category for Posttraumatic Stress Disorder in the Diagnostic and Statistical Manual; and (3) the personal trauma account of Jack, an Afghanistan Veteran.

3.3.1 Choice of Narratives

Jack was part of a larger study of ten Veteran participants in a residential trauma program, who agreed to be interviewed for this study. At the time of intake, Jack had been diagnosed with PTSD and was experiencing significant distress. He had been suicidal before admission and initially spent most of his group sessions rocking himself and avoiding eye contact. As treatment progressed, and Jack became more socially involved and communicative, he would occasionally quote parts of the movie “300”. Near the end of the residential program, Jack at one point led the other Veteran participants in a “closing call” at the end of group session, “We are Spartan”, referencing a line in the movie.

Jack provided an opportunity to consider how messages from popular culture and a PTSD diagnosis, might cohere in one individual’s subjective account of trauma, with a view to how macro level workings of masculine socialization appear at this micro level. This assumes that these narratives are neither innocent nor trivial. As Berger (1996) observes, narratives hold power “to dramatize and give concrete form to a society’s attitudes and beliefs”.

Narrative analysis is grounded in the study of the particular and cannot be generalized to populations in the same way that other statistical methods might. Instead, case study research aims to inform theoretical propositions that can then be tested through other methods. With this in mind, we can explore our three examples from this case and look to discover how, within these texts, societal conflicts and beliefs about masculinity are given form and resolution, and
consider the way that masculine role discourses, embedded in cultural institutions, might
colonize and complicate the personal trauma stories of affected Veterans.

3.3.2 Theoretical Approach

Umberto Eco noted that there are two ways to walk through a wood. One can try to get through as quickly as possible, or one can walk so as to discover what the wood is like and why some paths are accessible and others are not. Similarly, the reader or viewer can approach a text in two ways – to read as a first level reader, interested in the obvious content of the narrative, or at a second level that inquires about what sort of reader the author is asking one to be, what assumptions are embedded in the text, and how the author is subtly guiding the reader and for what purposes (Eco, 1994). At this second level of analysis, attention shifts back and forth from context to details; how and why a particular event is storied, who elicits the story and for what reason, and the effects on the reader or viewer. The power of narrative analysis lies here; that within particularities and context, varied and potential meanings can be brought to the forefront, interrogated and made explicit (Reissman, 2008).

There are, of course, a range of definitions of narrative in practice and the three narratives presented here are, admittedly, disparate in form and content. Narrative analysis, however, affords the opportunity to consider these cases as a coherent set, despite their heterogeneity, and to assemble them into a rich new constitutive whole worthy of exploration. This bringing together relies on their shared nature as narratives, and the narrative structures that each, therefore, contain.

Salmon suggests that a fundamental criterion for judging a text to be a narrative rests in the consequential linking of events or ideas (Reissman, 2008). Whatever the form or content, a narrative imposes a meaningful pattern on what would otherwise be random and disconnected
events. Within each of the three examples considered here, an organizing theme or “narrative plot” weaves together a complex set of events into single stories (Polkinghorne, 1988). The plot configures episodes into wholes and thus, translates each of the stories into one “thought”. The task in this paper is not only to understand how the elements within each of the three narratives are grasped together into meaningful wholes, but also to see how these three, disparate examples, grasped together, create a larger meaning whole across these domains. Within this new larger cohesive narrative, what novel understandings emerge regarding male Veterans’ trauma, as each narrative reflexively informs and is informed by the others?

Narrative analysis offers a framework and terminology that researchers can use to deconstruct texts in order to compare their meanings independent of their specific form (Holley, 2009). Building on foundational work in narratology by such authors as Freytag (In Griffith, 2006), Propp (1968), and Labov (1972), methods have been refined for the systematic analysis of texts through the use of formalized, semiotic categories (Bal, 1985; Bruner, 2002; Gergen & Gergen, 1986; Polkinghorne, 1988). Although the narratives examined here are a distinctly different “genre” in comparison with works of fiction, the basic components of literary analysis are similar, and the division of the narratives into elements of emplotment allows for clearer comparison between the rich yet diverse narrative examples. Borrowing from this work, for each of the three narratives here, plot is analyzed according to initial situation, conflict and suspense, climax and denouement (from Freytag’s plot pyramid).

By identifying protagonist and antagonist, action and resolution in these “stories”, and by examining language use and metaphor, these stories can be examined as either “progressive” narratives, that lead to increasing mastery over self and world, or “regressive” narratives with the protagonist experiencing a loss of mastery over self and world (Gergen & Gergen, 1986).
Arguably, the progressive narrative of mastery and power align more closely with ideas about successful masculinity. As the purpose of this analysis is to bring a gender lens to the three domains, the analysis highlights explicit and implicit references to masculinity themes such as agency and emotion in the face of crisis. Through consideration of plot, discourse, and metaphor, potential masculine role pressures and messages in and across the texts are brought to light.

3.3.3 Credibility or Trustworthiness

In narrative research, the trustworthiness of the findings refers to well-grounded and supportable (Polkinghorne, 1988). The researcher must present evidence to support the conclusions they make and present the reasoning that led to their conclusions. Polkinghorne, however, notes that the argument presented does not result in certainty; it produces likelihood (1988). He goes on to observe that, although the methods are quite different than quantitative research, Karl Popper proposed that verisimilitude is the limit of all scientific inquiry, and we therefore limit our claims to the demonstration of the falsity of null hypotheses rather than “truth”. The conclusions presented here, likewise, remain tentative, and are open to scholarly critique and consensus as the ultimate test of verisimilitude and therefore trustworthiness (Polkinghorne, 1988, p.177-178).

3.4 Case 1: The Movie “300” – The warrior male in popular culture

The first case to be considered provides an example of how popular culture represents the “Warrior Male” through movies. The 2006 American action film “300”, based on a 1998 comic series by Frank Miller, is a fictionalized retelling of the battle of Thermopylae in which King Leonidas led 300 Spartan soldiers against an overwhelming Persian army of 300,000. The film received mixed reviews and raised controversy over its negative depiction of the Persian people;
however it was also a box office success, grossing over $450 million, and has since developed a cult following. The film is a particularly interesting exemplar of the “Warrior Male” action genre as it begins with a seven minute narrated exposition that explicitly articulates the socialization of the Spartan warrior male.

In the opening scenes a Spartan soldier delivers a voice-over narrative against the backdrop of a progression of vignettes from King Leonidas’ (the protagonist), childhood. Each vignette informs the audience about important details of Leonidas’ back-story and the Spartan cultural setting, moving through King Leonidas’ birth and an emotionally detached inspection of his body for flaws, an early brutal training in swordsmanship, his abduction and violent initiation into the Agoge, the Spartan school system for boys, his solitary wilderness trial and confrontation with a giant wolf, and finally his return to his people as King. In particular, these first seven minutes ensure that the viewer is informed about the training and rites of passage for males transmitted through the Agoge, and the implicit and explicit cultural ideas around “successful” expressions of masculinity.

In terms of the overall narrative, the meaning of these vignettes is not located within the individual events themselves, although each has a protagonist, an antagonist, and a crisis of their own. Rather, the larger meaning of the vignettes, and the function they fulfill in the opening sequences of the movie, is produced by the recognition of how these events interact and provide form for each other. By inclusion in a narratively generated exposition, the uniting theme or plot of the opening sequences governs and gives significance to the succession of its events, and the simple chronicle of scenes is transformed into a larger cohesive whole (Polkinghorne, 1988). Considering the chronicle in terms of the larger unifying plot, with initial situation, conflict, suspense, crisis and denouement explicitly articulated, makes the overarching meaning apparent.
3.4.1 Initial Situation

The future King Leonidas, is introduced in the first scene as a naked baby being inspected for flaws, any discovery of which would result in him being discarded. This initial situation is one of complete vulnerability, dependence and weakness in a harsh and emotionally disconnected world. Without any concerned adult or caregiver, survival for such a child is only ensured by quickly growing to independence. He has been born into the world of Sparta where strength, fearlessness, and honour are dominant values, and where violence is depicted as both the nurturing process for the formation of these characteristics, and the highest expression of them. There is no choice in this world (for a man) but to become strong, or die.

3.4.2 Conflict

There are a variety of conflicts depicted in the first seven minutes of the film. They include images of the protagonist pitted against other characters, the weather and a giant wolf. Despite the varying external guise of these conflicts, each is represented by the narrator as a conflict of character versus self, with the suggestion that the self should be impermeable and unaffected by external circumstance. The emerging narrative discourse or plot syntax, within which one can view the characters and events of the movie, is that the (male) self in its natural state is weak and needs to be toughened to withstand the demands of life in a harsh world.

Developing mastery over self, including hiding pain and distress while increasing agency, puts the protagonist in conflict with his own natural form. In this sense, the basic conflict expressed throughout is internal, in that the protagonist carries the antagonist within, as abjected aspects of the natural self (Kristeva, 1982). These images call to mind Theweleit’s analysis of the Freikorps, the German paramilitary mercenary units of the period 1918-1923, in which he
suggested that the hard leather armour of these “soldierly men” served as defence not just to external threat, but also against weakness and disorder within (Amidon, 2009; Bogdal, 2001).

The metaphors used by the narrator reveal how we are being asked to conceptualize things. Bruner’s and Gotschall’s suggest that we fundamentally think through stories, while Lakoff and Johnson contend that not only do we think through stories but that those stories are riddled with metaphors and are also metaphoric in themselves (Bruner, 2002; Gotschall; 2012; Lakoff and Johnson; 1980). Combining these ideas, we can see how the metaphors used in the story reflect how the broader concept of masculinity is constructed, and in turn, reflexively reinforces these constructions of masculinity.

The narrator tells us that from the time the boy can stand, he is *baptised in the fire* of combat. At age seven, he is taken from his mother and *plunged into a world of violence*. The hardening process of the Agoge is *manufactured* by 300 years of Spartan society, to *create* (versus train) the finest soldiers the world has ever known. These metaphors cohere around an industrial metaphor and specifically around the process of strengthening, tempering and hardening steel. This root metaphor about the hardening of steel helps us to understand what the conflict in the story is about. The boy must become hardened to be strong. This metaphor also foreshadows the downfall of the hero as the hardest steel is also brittle and will break before it bends.

### 3.4.3 Suspense

As the vignettes unfold in the first seven minutes of the film, the protagonist is subjugated repeatedly and denied personal agency. He is dependent on others and suffers or is threatened by that status. This effectively builds suspense and the desire for the protagonist to overcome this dependency. In the third scene, as the protagonist finally bludgeons an opponent,
the movie uses slow motion to slow down narrative time and emphasize the release after the buildup of pressure (Eco; 1994).

3.4.4 Climax

The progression of scenes present Leonidas at different ages and show a gradual move from the vulnerability of the baby first introduced, to the third scene where he finally bludgeons another boy into submission (or death). It is here that the plot reaches a visible emotional peak for the protagonist Leonidas; however it is also the point where there is a disconnection between the emotional climax of the protagonist and the apparent action climax which comes later in a scene with a giant wolf. While the emotion shown by the protagonist Leonidas begins to diminish with each successive vignette, the observed severity of conflict with antagonists continues to build. Likewise, the exultant emotional pitch of the narration continues to rise.

The wolf that is stalking the young man, Leonidas, in the final scene of the introductory exposition is described as follows: “claws of black steel, fur as dark as night, eyes glowing red – jewels from the pits of hell itself, ...anticipating the coming meal”. By contrast, about Leonidas, bare foot and armed with a stick in the middle of a snowstorm, the narrator remarks, “It’s not fear that grips him, only a heightened sense of things – cold air in his lungs, windswept pines moving against the coming night”. While the protagonist’s life is in danger, the narrator emphasizes his absence of fear. As Leonidas impassively kills the lunging wolf, the narrator declares, “his aim is true, his form perfect”. His agency is unquestionable, and he shows no emotion whatsoever to either the threat to his life or his victory despite uneven odds.

3.4.5 Denouement and Resolution

When Leonidas makes his way back from the wilderness to Sparta, he is greeted as King. Consistent with the emotional trajectory he has been following, he shows no sign of pleasure or
any relief at the end of his trials or his return home to his people. He has shown that he neither shows nor even feels distress or fear, and here, he shows no pleasure either. In this narrative close to the series of vignettes, a sense of an ending has been created and reached. Out of the ongoing succession of instants that a life contains, the narrative plot has imposed an end point on this part of Leonidas’ story that brackets the central “thought” of the narrative (Polkinghorne, 1988). The boy has overcome the inner conflict, suppressed or banished his own inner weakness and vulnerability, and has been “forged” into the Spartan ideal of masculinity.

The machine-like unemotional responses of the protagonist Leonidas create a sense of hyper-agentic masculinity that has unfailing mastery over both the external world and the internal world of emotion. These implicit and explicit cultural ideas around “successful” expressions of masculinity are referenced repeatedly throughout the film and are essential to the logic of the story. For example, when parting from his wife for war, Leonidas turns away from her without a word. The narrator speaks the expected sentiment for the protagonist saying, “Goodbye my love. He doesn’t say it. There is no room for softness. Not in Sparta. No place for weakness. Only the hard and strong may call themselves Spartan. Only the hard. Only the strong.”

Cultural texts always have more than one possible meaning and this opening narrative sequence from 300 is no exception. 300’s presentation (and promotion) of idealized military masculinity, to the exclusion or explicit derogation of other forms of masculinity, is highlighted here as an example of how popular culture participates in the perpetuation of idealized norms of masculinity with their emphasis on stoicism and agency. Films like 300 appropriate real soldiers’ stories for entertainment, rewriting them into an extreme model of stoic and unfailingly agentic masculinity that few, if any men can actually live up to.
While popular-cultural institutions such as Hollywood help mold and perpetuate an ideal military masculinity for men in society, the next case, taken directly from institutional psychiatry, articulates the opposite side of the functional and emotional spectrum; “abnormal”, “disordered”, and “ill”.

3.5 Case 2: DSM and Posttraumatic Stress Disorder – Instituting Abnormal

Jurisdiction over establishing and elaborating criteria for what constitutes normal and abnormal behaviour in contemporary western society has been delegated to (or claimed by) the allied professions of psychiatry and psychology. The primary text of this cultural authority, which speaks to current consensus on the constitutive elements of mental disorder, is the Diagnostic and Statistical Manual for Mental Disorders (DSM) (APA, 2013a). This text has recently undergone a complete revision process, with extensive stakeholder consultations, replacing the former DSM-IV TR with the new DSM-5 as the primary authority on mental illness as of May 2013.

The periodic revision of, and consultation around, DSM definitions and criteria suggests that these professional discourses do not simply describe meaning structures that have prior independent existence; they are also integral to and active in constituting those meaning structures. From this view, psychiatric “disorder” is not something that “just exists” or “just is” independent of social and cultural processes (Crowe, 2000). Instead, “disorder, illness and abnormal” are “meaning” products established by discourse and reflect the workings of power and the value systems of a dominant social group (Gordon, 1980). The DSM-5, as a voice of “global expertise”, “supported by scientific evidence”, encodes a socially constructed classificatory system that aims to isolate features defined as “disordered, deviant, or abnormal”, grasp them together into groups of symptoms, and classify them into species or families.
Under the new DSM-5, the diagnostic category for Posttraumatic Stress Disorder is laid out as a chronicle of seven events or experiences (criteria) that are “grasped together” to cohere in the larger meaning expression of PTSD (APA, 2013a). The elements included are as follows:

1. Exposure to a traumatic event, which:
   2. is persistently re-experienced;
   3. is persistently avoided or numbed out;
   4. is followed by significant negative cognitions and mood;
   5. is accompanied by physiological arousal;
   6. lasts more than a month; and,
   7. causes significant distress or impairment.

When contrasted with the narrative of the first case example, this is clearly a very different master narrative than the one embedded in King Leonidas’ story. As in the previous case example, re-presenting these events according to components of plot assists in the consideration of embedded norms regarding internal and external agency within the tight and closed text of the DSM.

### 3.5.1 Initial Situation

The initial situation presupposes the existence of a certain norm of acceptable behaviour within the culture. Psychiatric discourse categorizes behavior as within or outside these norms, and tends to do this by situating the individual as the “site” of disorder if they do not adhere to these norms. Hence, disorders such as PTSD are seen as disorders “in” the individual despite being precipitated by social or other external circumstances (APA, 2013a, p.20). There is no consideration given in the DSM text to the influence of gender norms in the experience of the
individual. The individual, pre-trauma and pre-diagnosis, is seen through the lens of relational attachment, productivity, rationality and independent self-control.

3.5.2 Conflict

The new DSM identifies the trigger for PTSD as exposure to actual or threatened death, serious injury or sexual violation. The previous DSM-IV diagnostic category stipulated that reactions of the person affected must involve intense fear, panic, helplessness or horror. The DSM-5 removes this criterion as it proved to have no utility in predicting the onset of PTSD. Despite the removal of this explicit reference to the emotional sequelae and loss of agency at the moment of trauma, the triggering situation remains the cause of later emotional distress and cognitive and behavioural impairment – a loss of agency over self and world.

The potential trigger conflicts outlined in the DSM-5 would be inclusive of the types of conflicts presented in the first case example, 300, including character vs. character or character vs. nature conflicts. The difference in these narratives, however, emerges in the individual’s response to the conflict. While Leonidas follows a “progressive” narrative that leads to increasing mastery over self and world, the conflict presented in PTSD results in a “regressive” narrative with the protagonist experiencing a loss of mastery over self and world (Gergen & Gergen, 1986).

3.5.3 (Anti)Climax

As a diagnostic manual rather than a treatment manual, the PTSD narrative does not culminate in a climax that releases the tension generated by the conflict. There is no victory articulated for the hypothetical patient protagonist. Instead, the diagnostic master narrative for PTSD details the presence of four distinct clusters of reactive symptoms, including: 1) the repeated reliving of distressing memories of the traumatic experiences, recurrent dreams related
to it or flashbacks; 2) avoidance of distressing memories, thoughts, feelings or external reminders of the event, as well as emotional numbing; 3) a pattern of negative cognitions and mood, from a persistent and distorted sense of blame of self or others, estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event; and 4) increased autonomic arousal such as aggressive, reckless or self-destructive behavior, sleep disturbances, hyper-vigilance or exaggerated startle response. The DSM notes that the disturbance causes clinically significant distress or impairment in the individual’s social interactions, capacity to work or other important areas of functioning, and the symptoms must exist for at least one month and lead to major personal suffering and social disability (APA, 2013a, pp. 271-280).

The DSMs categorization of the individuals’ loss of control over external (trigger) and then internal (symptom) worlds as, “disordered”, has distinct parallels with the messages of the opening narrative of 300. A key premise in the definition of mental disorder is that a syndrome occurs in an individual, and rests on some disturbance within the individual. Much like the first case study, 300, these conflicts are represented primarily as conflicts of character versus self, with the implicit assumption that “normal” would entail a self impermeable to, or at least less affected by external circumstance.

The emerging narrative discourse or plot syntax within which one can view the characters and events of PTSD is that a “normal” person is able to withstand the demands of life in a harsh world. This implies, then, that recovery from trauma involves developing mastery over self, including hiding pain and distress while increasing agency. In this sense, the basic conflict expressed is again, internal, in that the protagonist with PTSD carries the antagonist within, as unacceptable, “disordered”, and therefore abjected aspects of the self.
3.5.4 Denouement

The diagnostic criteria for PTSD spell out the master narrative against which the diagnostician must carefully compare and match the story of the individual being assessed. Only by doing so can the clinician claim legitimacy of diagnosis because the individual’s story “fits” the precedent. Like the dialectic process of matching current case to precedent and corpus juris in law, the successful ritual of assessment, creates an “emotional state that makes the message uncontestable because it is framed in such a way as to be seen as inherent in the way things are… beyond debate” (Bruner, 2002, p. 45). In this way clinical practice and discourse both construct and undergird normative ideas about disorder, while the influences of cultural authority and power remain largely hidden from view.

In the previous case, 300 presents (and promotes) an idealized warrior masculinity, while excluding and derogating other forms of masculinity. In doing so, it participates in the perpetuation of norms of stoic and agentic warrior masculinity in the larger society for a modern audience. Institutional psychiatry, explored in the present case, articulates the opposite side of the functional and emotional spectrum in defining the boundaries of “abnormal”, “disordered”, and “ill”. In the next and final case example to be explored, the trauma experience of an Afghanistan Veteran is examined to consider how these ideal and abject hegemonic masculine role discourses, embedded in cultural institutions of popular culture and psychiatry, colonize the personal trauma stories of an affected male Veteran.

3.6 Case 3: Jack’s Story – Unpopular Culture (or the Effects of War on the Warrior)

Jack is a 24 year old Canadian Sapper (explosives expert) who served in Afghanistan in 2007, the year after the movie 300 became a blockbuster hit. He is a young, good looking Veteran who prides himself on his athletic ability – his personal physical agency. As a Sapper he
has received elite training to clear minefields and IEDs which is considered to be a very
dangerous job. He is being interviewed about his experiences in Afghanistan, the troubles that
have plagued him since coming home, his PTSD diagnosis and his later treatment in a group
therapy program (Judyfilms, 2011).

3.6.1 Initial Situation

Jack describes the everyday life of a soldier and the way that they enjoyed playing
practical jokes on each other. In one particular incident, a friend unexpectedly slapped him hard
across the face with a sandal. Of the incident, he says smiling, “Yeah, he got me good!” This
stoic play reflects the masculine privileging of emotional toughness and the ability to “take it”
without expressing emotions regarded as weak.

This cultural norm also applies to the work of being a soldier. Jack relates that he
“learned to shut down” early in his tour of duty because “there’s just too much going on”.
“There’s too much going on psychologically and emotionally so you just got to turn the button
off and just be numb, numb, numb”.

3.6.2 Conflict

Jack talks specifically about the experience of conflict. “Being a human being conflicts
with being a soldier sometimes – you know what, as a human being you should be doing. But as
a soldier it may be different so there’s a lot of inner conflict”. The incidents where this conflict
is most apparent in Jack’s story are those that call on the soldier to stand down, to witness things
while not being allowed, or not being able to intervene. The loss of agency in the face of crisis
has no place in the internalized military masculine identity of the soldier.

One incident that Jack describes highlights the unfolding of this conflict. A light
armoured vehicle driven by three colleagues hit an IED and caught fire. Two of the men were
killed instantly but the driver, Jack’s friend, was caught in the vehicle. While Jack and his companions attempted a rescue, ammunition began to “cook off” in the fire, firing off in random directions, making it necessary for the rescuers to pull back. Unable to rescue the driver, the soldiers had to watch their colleague burn to death. Jack describes the experience of being helpless in the face of his friend’s death.

So basically we just had to sit there and watch a friend burn to death and not be able to do anything. I just remember thinking, we’ve got to do something, like, we’ve got to do something. Because it just felt so horrible just to be standing there watching that. And instantly I just felt myself die. That’s when everything changed big time for me.

Although this is a conflict that Jack could have narrated between himself and a variety of external antagonists such as people (insurgents), technology (IED, ammo), or nature (fire), the greatest conflict related by Jack is internal – He has to do something but he cannot and this reversal is depicted as a death. Later he repeats this sentiment saying, “Yeah I had to stand there and watch that happen, I died instantly, right there”.

With Jack’s experience of helplessness, there is a shift in the internal experience he reports. It is here that he begins to describe a new and unwanted emotional life, previously absent. He describes the personal aftermath of the experience, “And that’s where a lot of my anger came from as well; I was so angry that I couldn’t, that that happened to them”. He continues, “I carry a lot of guilt and anger around because I don’t feel that I personally did all that I could have in that situation. I didn’t 100 percent do everything I could have”.

The metaphors change as Jack struggles with his reactions to his experiences. After the death of his friend and, arguably, the death of his personal sense of agency, he shifts from talking about controlling his emotions in machine-like terms such as shutting down, or turning off the
button, to metaphors that suggest a burden to be carried, hidden, contained. Unwilling to share his inner conflict with others at home he says, “I didn’t want to burden them, just kind of keep it to myself”. Jack tries to stuff it down, hold it inside, and suck it up. “I just pushed everything inside of me, I held it down”.

According to Jack, this tendency to see emotions as objects to be contained or kept locked away is the norm (the soldiers’ “hurt-locker”). He says, “Most people keep it inside and they’re dying inside”. In order to not feel or remember he starts using alcohol and drugs (like a tool) and says, “that’s going along; it’s great; it’s doing what you want it to”, until “then it stops working, then you start getting into rages when you’re drunk and doing things you regret in the morning”. Containment has failed and unwanted emotions are leaking out. “Then you’re having meltdowns”. First the external world has escaped control, now emotions can no longer be shut off or mastered.

As Bruner notes, narratives (and the metaphors contained therein) model not only a world “but the minds seeking to give it its meaning” (Bruner, 2002, p. 27). As in the preceding movie plot, the Jack’s self is presented as something that should be rendered impermeable and unaffected by external circumstance. Mastery over self, including hiding pain and distress while increasing agency, puts the protagonist in conflict with his own natural reactions which are considered weak. Coming home, Jack finds himself unable to contain his emotions and feels he no longer fits in his society. He describes it, “Like a square being rammed in a round hole”. He can no longer live up to his own or others expectations.

3.6.3 Suspense

From the point of the inciting incident of the vehicle fire and death of his friend, Jack struggles with a new unwanted emotional life. He describes himself in the interview as numb
while in Afghanistan, and later when he comes home as, overwhelmed, angry, guilty, and frustrated. He begins drinking and using drugs to numb the memories of watching a friend burning to death in an IED attack, and is haunted by the memory of his own helplessness and fears that he didn’t do absolutely everything he could have to rescue his friend.

The emergence of troubling emotions and the sense of lack of control over them contribute to a building suspense. What will he do with his unwanted reactions? Jack speaks directly about the seriousness of the struggle. “I’ve thought about suicide- even almost tried it a few times”. However, “I always got interrupted somehow”.

By contrast, the men who died are remembered as being untouched by the shame of this struggle. Jack comments, “They were spectacular men; couldn’t have lost any better men than that because they were people everyone looked up to and strived to be. They were honestly the best of the best. They were great”. In the movie 300, the narrator comments that death in battle in service of Sparta is the highest glory and honour that a man can achieve. Here, the images of the dead are not tainted by a future where they are burdened by endless guilt and questioning. They remain forever heroic - their superior stoic masculinity ensured by the silencing of their voices. Barry (2010) observes that the messages of masculinity require that men’s lives be expendable; here however they are not just expendable but receive their ultimate value in their sacrifice. Jack, however, does not have a certainty of returning to the place of the heroic. There is suspense here that hinges on whether he will survive his inner death.

3.6.4 Climax

According to Nietzsche, the self is not a constant, stable entity. Rather, it is something one becomes, something one constructs (Polkinghorne, 1988, p. 154). Polkinghorne observes that we are in the middle of our stories and “cannot be sure how they will end; we are constantly
having to revise the plot as new events are added to our lives” (Polkinghorne, 1988, p. 150). Self is not static but a constantly shifting configuration of personal events that is woven into a historical unity that includes not only what one has been but also anticipations of what one will be.

If we consider that there is no stable substance to self, there is a danger that a story can be disrupted by experiences that cannot or will not be integrated into a coherent self story. Freeman (2011) asserts that when this happens, individuals can experience a sense of “narrative foreclosure” in that the types of stories that the individual can tell about themselves become limited by the dominant messages of culture. For males who subscribe to military masculine norms promoting ideals of honour, agency and corporal control, the loss of standing, agency or control that accompanies traumatic experience can interfere with the ability to perceive, to live, and continue to narrate a meaningful life going forward. The “precarious social state” of masculinity (Vandello & Bosson, 2013) is imbued with heightened threat and urgent need to regain, buttress, and defend lost status or isolate and die (Meija 2005; Fox & Pease, 2012; Westwood et al., 2012).

For Jack, the climax of his narrative comes after he finds a group of fellow soldiers who are able to tell each other their stories, and provide witness to each other’s experiences. In this environment, he receives permission from other men to put words to his experience and to integrate his reactions into his self-story. He says, “This gets rid of the thought that men can’t have emotions; that men aren’t allowed to feel.” “We have to suck it up and soldier on”. Rather than “a square being rammed into a round hole”, here, Jack discovers he can finally come home; “sharing stories... you notice how much you have in common”. Within a social context
of narrative co-(and re)construction, he receives permission to feel, without seeing that feeling as evidence of his own failings as a man and as a soldier.

Expressing feelings and supporting others in the expression of their feelings, becomes redefined as “courageous”, the “hard thing to do”, as “men’s work”. Paradoxically, the very expression of emotional life that was previously stigmatized becomes construed as a form of agency. Finally, there is something that can be done - courageously, and in bold self-assertion against the dominant military masculine norms, Jack can participate in building a parallel meaning structure in which the strongest men are able to feel and speak their truths (Michaels, 2011).

3.6.5 Denouement

Polkinghorne suggests that the concept of self is not a discovery or release of some innate “I”; it is a construction built on other people’s responses and attitudes toward a person and is subject to reorganization with changes in the social milieu. In order to narrate a coherent self-story, the person needs to synthesize and integrate the experiences they have with the diverse social responses he or she experiences (Polkinghorne, 1988). The relief that Jack feels at the discovery of a social context in which he can accept and be accepted with previously abjected parts of his self-story, is palpable. He says, “This group is the light at the end of the tunnel”. The effect on Jack is visible to others. Jack says, “I was starting to live again. People saw me and they could instantly see life in my face; joy”. Later he declares, “I can see the future again and it has promise in it and life”.

3.7 Conclusion

In early 2013, the American Psychiatric Association published a fact sheet on changes to the classification for PTSD in the new DSM-5, noting that the diagnosis had sparked debate
during public consultations. “Certain military leaders, both active and retired, believe the word “disorder” makes many soldiers who are experiencing PTSD symptoms reluctant to ask for help. They have urged a change to rename the disorder posttraumatic stress injury, a description that they say is more in line with the language of troops and would reduce stigma” (APA, 2013b). The simple logic was that an injury implies a cause coming from outside, while a disorder is situated within. The fact sheet goes on to say, “But others believe it is the military environment that needs to change, not the name of the disorder, so that mental health care is more accessible and soldiers are encouraged to seek it in a timely fashion”. Accordingly, consistent with the definitions of a disorder as residing “in” the individual, the new DSM-5 continues to list PTSD as a “disorder”.

This framing of the debate as a problem situated “within” the military follows the same logical pathways that underpin the concept of disorder as situated “in” the individual – it pulls the subject out of context and assumes its independent autonomy. Individuals, or individual institutions, are expected to be able to assert autonomous agency in correcting the “problem”, independent of social contextual forces. Likewise, institutional psychiatry, perhaps retaining ties with its Freudian roots, assumes its own "analytic neutrality", to objectively stand “outside” of society to define the boundaries of normal and abnormal without influencing the cultural gender discourse. The three narratives presented here suggest the situation may be more complex.

Despite the call for the military to make their culture more mental health “friendly” for men, the grasping together of symptoms into the PTSD diagnosis, and the labelling of them as disordered, closely resembles the masculine norms portrayed in the movie 300. The redefinition of symptoms, from weak to disordered, does little to reduce the stigma connected with the socially and subjectively abject state narrated in PTSD. Jack’s story provides a poignant
example of how the subjective experience of the traumatized Veteran is colonized by concerns about agency, and how the inability to remain stoically unaffected in the face of horror is a significant source of the distress he experiences.

Judith Jordan, in her writing about the politics of oppression in women’s trauma, noted that the societal emphasis on the autonomy of the disordered individual, independent of social forces, creates isolation and disempowerment at the personal level and preserves the politics of dominance. In this way the personal is political, the political is personal, and the rewriting of a psychological paradigm becomes an act of social justice (Jordon, 2004). Extending these insights, the goal of assistance for male Veterans ought not to be to help them “adjust” despite disempowering or stigmatizing social circumstances. Rather, by naming destructive social practices embedded in military or other masculine ideals, the goal could be to destabilize the notion that the problem is “in the individual” and emphasize the critical need to create alternate ways of understanding masculinity, and to redefine successful masculinity in society.

This analysis suggests that, while the DSM language of posttraumatic stress disorder may be helpful to clinicians, it is incomplete and potentially problematic for male Veterans. Failure to take into account social influences on gender may contribute to the isolation, stigmatization and suffering of male Veterans. Against the backdrop of aligned scientific and popular cultural institutions, congruent in their “abjectification” of trauma symptoms, individual Veterans experiencing trauma are caught in a confining and stigmatizing gender discourse that colonizes their experiences and expectations with unattainable ideals of stoic agency. In light of this larger context, Jack was perhaps fortunate to be able to come together with other Veterans to reconnect and co-construct new and coherent narratives of his gendered trauma experiences – to redefine the precarious state of manhood. Other Veterans need the opportunity to do the same, to
renegotiate successful visions of themselves as men who have experienced trauma, so that they, like Jack, can finally fully come home.

3.8 Bridge between the Studies

The purpose of the study just presented was to provide an opportunity for consideration of the assumption that a fundamental disconnect exists for male Veterans between hegemonic masculine role norms and the “disordered” or “abjected” identity associated with a diagnosis of PTSD. By exploring how messages from popular culture and a PTSD diagnosis might intersect in one individual’s subjective account of trauma, it was hoped that a better understanding would emerge of the how macro level masculine socialization might appear at this micro level of the individual.

The second study builds on this groundwork but narrows the focus of inquiry from the larger cultural milieu to the interactions and self-reflections of a group of Veterans in a group-based treatment program. While the first study explicitly explored the nature of conflicting messages that might come from cultural institutions, the second study takes this conflict as a given, and is more concerned with implicit and explicit information about how these conflicts are negotiated and renegotiated intra and interpersonally.
Chapter 4: Engagement – The Heroes Path: Veterans’ Narratives of Therapeutic Engagement

4.1 Section Synopsis

This chapter examines how male Veteran’s accounts of why they completed a group-based trauma program, and the personal impact of that participation, reflect larger socio-cultural contexts and pressures of hegemonic masculinity. Males, who make up the majority of the military population, experience negative outcomes from Posttraumatic Stress Disorder (PTSD) at proportionally higher rates than their female compatriots, and also have significantly lower usage rates for therapies, and higher relapse rates and drop-out rates when they do access treatment (Westwood et al., 2012). The Canadian Veterans Transition Program (VTP) is a group-based treatment for Veterans who suffer from posttraumatic stress symptoms that has demonstrated clinically and statistically significant outcomes for trauma symptoms and depression, and has an unusually high completion rate by Veteran participants (Cox et al., 2014). Of the approximately 340 Veterans who have entered the VTP, only two have dropped out before completion (a 99.4% completion rate). As this completion rate is unusually high for PTSD work with Veterans (Jetly, 2011; Schottenbauer, et al., 2008), examining Veterans’ narratives about their reasons for engagement may hold keys to understanding how to develop other programs that engage male Veterans in therapy, and shed light on the unique ways that programs can be made more gender/culturally sensitive and relevant for male Veterans. This chapter examines Veterans’ narratives about their program involvement through a gender socialization lens, and highlights evolving relational constructions of meaning around personal trauma, treatment, and engagement within cultural frames of masculinity.
4.2 The Heroes Path: Veterans’ Narratives of Therapeutic Engagement

Males, who make up the majority of the military population, experience negative outcomes from Posttraumatic Stress Disorder (PTSD), including problematic substance abuse, relationship problems, depression and suicide, at proportionally higher rates than their female compatriots. They also have significantly lower usage rates for therapies, and higher relapse rates and drop-out rates when they do access treatment (Brooks, 2010; van der Kolk et al., 2007; Westwood et al., 2012). In Canada, these numbers translate into an estimated 107,000 to 214,000 male Veterans who will struggle with PTSD, and an unknown number living with trauma symptoms below diagnostic thresholds and with other adjustment difficulties (VAC, 2012). The evidence suggests that the majority of these Veterans will either not seek, or will disengage prematurely from treatment services (Brooks, 2012; Westwood et al., 2012).

Against the backdrop of this evidence, the Canadian Veterans Transition Program (VTP) is a group-based treatment for military Veterans who suffer from PTSD that has demonstrated clinically and statistically significant outcomes for trauma symptoms and depression, and has an unusually high completion rate by Veteran participants (Cox et al., 2014). Of the approximately 340 Veterans who have entered the VTP, only two have dropped out before completion (a 99.4% completion rate). As this completion rate is unusually high for PTSD work with Veterans (Jetly, 2011; Ready et al., 2008; Schnurr et al., 2003; Schottenbauer, et al., 2008; Westwood et al., 2012), examining Veterans’ narratives about their reasons for engagement may hold keys to understanding how to develop other programs that engage male Veterans in therapy.

While the key role of gender in women’s trauma has been extensively studied, there has been less attention paid to male social norms and expectations in Veterans’ psychological and
physiological experience of trauma and engagement in treatment (Brooks, 2010; Fox & Pease, 2012). Given the military’s historically explicit emphasis in training on the military man as the ideal of the stoic male, the disempowering nature of trauma and its symptoms may undermine a Veterans identity and be experienced as “failure” as a man (Fox & Pease, 2012; Keegan, 1994). This may contribute to low treatment usage and high drop-out rates as male Veterans isolate and hide personal struggles lest they be shamed (Brooks, 2010; Westwood et al., 2012 ). The relevance and impact of this gender-related shame and loss of identity on the social, psychological and physiological aspects of traumatic stress, has received little attention in the literature. Similarly, the possibility that shifts in gender-norm induced (influenced) narratives of failure and shame, towards ones of mastery and pride may contribute to engagement and treatment outcomes has received little attention in the literature (Brooks, 2010; Fox & Pease, 2012; Westwood et al., 2012).

Given that these Veterans are husbands, fathers and sons who belong to and affect families and communities, the social costs of poor treatment access and outcomes are high, and better understanding of barriers to treatment and how these male Veterans make sense of and live with their traumatic experiences post-deployment is essential (Dallaire, 2011). This paper seeks to close gaps in the literature by following male Veterans taking part in a group transition program. Examining Veterans’ narratives about their reasons for engagement in treatment may hold keys to understanding how to develop other programs that engage male Veterans in therapy, and shed light on gender specific barriers and potential aids to treatment access and engagement for male Veterans.
4.2.1 A Gender Lens

It has been frequently observed in the men’s health research literature that males in general have lower service usage, and that this lack of access has negative short and long term health consequences (Brooks, 2010). This raises the question then, what is it about being male, the male experience of trauma, or male perceptions of treatment services that contribute to this lack of engagement in treatment and the resulting epidemic of silent stoicism?

Most of us learn to comply with the dominant gender norms of our reference group at an early age and come to view these norms as a natural and valid set of constructs - if we examine them at all. Gender roles serve as implicit and explicit guideposts that provide social valence to certain behaviours and attributes and influence the behaviour of men and women throughout the lifespan (Kilmartin, 2010). They are part of the social fabric.

Various researchers have attempted to articulate and make explicit the norms that are enacted and enforced for masculinity. Englar-Carlson (2006) detailed eight “prized attributes” that describe the hegemonic male. These include: toughness, intensity, strength, competition, discipline, courage, sacrifice and aggressiveness. Similarly, Westwood et al., (2010) suggested that there are seven central gender roles that men frequently adopt and present. Characteristics of these scripts include projecting an image that: 1) males are stoic and in control of themselves; 2) males are able to manage emotions, especially those associated (or deemed associated) with being vulnerable; 3) males are fearless and indestructible; 4) the only acceptable male emotion is anger; 5) males are competitive, achievement oriented, successful; 6) males are strong and independent; and finally; 7) to be male is to be the opposite of any of the characteristics associated with either femininity or homosexuality.
For military personnel, these kinds of traditional masculine gender roles are extended or emphasized in a hyper-masculine hegemonic cultural norm that includes a high standard of self-discipline and emotional control, a professional ethos of loyalty and self-sacrifice, an emphasis on group identity, and a strong “warrior” persona that is aggressive, dominant and risk taking, and precludes experience or expression of “weakness” (Gabriel, 1988). Within the context of military training, aspects of traditional masculine culture, such as stoicism, are emphasized and exaggerated in order to prepare men for combat and to inculcate values of selfless sacrifice for the group (Brooks, 1991; Morgan, 1994; Fox & Pease, 2012; Westwood et al., 2012).

4.2.2 Military Masculinity and PTSD

While military training and cultural gender norms help mold and perpetuate a hegemonic ideal of the stoic, hyper-agentic warrior masculine for men, discourse from institutional psychiatry articulates the boundaries of an opposite, “disordered” side of the functional spectrum. Under the new DSM-5, the diagnostic category for PTSD is laid out as a chronicle of seven events or experiences (criteria) that are “grasped together” to cohere in the larger meaning expression or master narrative of PTSD (Polkinghorne, 1988, p. 168). The elements included are as follows:

1. Exposure to a traumatic event, which:
   2. is persistently re-experienced;
   3. is persistently avoided or numbed out;
   4. is followed by significant negative cognitions and mood;
   5. is accompanied by physiological arousal;
   6. lasts more than a month; and,
7. causes significant distress or impairment.

When contrasted with the hegemonic masculine ideals of the military culture, the person described in the PTSD master narrative is quite profoundly different. Considered side by side, the contrast between the identity characteristics of the hegemonic male and the identity characteristics of a person diagnosed with PTSD, can be seen below in Table 1.

**Table 1. Military Masculinity and PTSD**

<table>
<thead>
<tr>
<th>Hegemonic Masculine Gender Norms</th>
<th>Posttraumatic Stress Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mastery over environment</td>
<td>Helplessness of witnessed or experiencing trauma</td>
</tr>
<tr>
<td>2. Mastery over thoughts</td>
<td>Re-experiencing of trauma and intrusive thoughts</td>
</tr>
<tr>
<td>3. Mastery over the emotions</td>
<td>Numbness, emotional hijacking or negative mood</td>
</tr>
<tr>
<td>4. Mastery over body</td>
<td>Physiological hyper or hypo arousal</td>
</tr>
<tr>
<td>5. Powerful and stoic</td>
<td>Distressed, impaired and in an abject state</td>
</tr>
</tbody>
</table>

Against the backdrop of masculine hegemonic norms, reinforced by society and by military training, veterans who experience lingering effects of trauma may begin to narrate their symptoms and PTSD diagnosis as “failure” or weakness – a fall from masculine grace. Previously granted membership among “warriors”, those considered the hegemonic masculine ideal, these Veterans may experience their trauma as a collapse “from hero to zero”, into the abject identity of “unfit”, “disordered” and “abnormal”.

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Thus, the very qualities which are highly valued within the military context, and which may aid in the performance of tasks in times of conflict, may exacerbate and exaggerate emotional, behavioral and relational difficulties after deployment, and when interacting with family and in civilian environments. The need to maintain the appearance of stoic competence makes it more difficult for these clients to admit they have problems, seek professional help, or have faith in the efficacy of treatment (Brooks, 2012). A PTSD diagnosis, and the gendered stigma it brings, may itself become a central barrier to treatment access and engagement. The resulting “code of silent stoicism” isolates military personnel during times of distress and perpetuates a myth that real men neither ask for nor need help.

4.2.3 From Flak Jacket to Emotional Straight Jacket

For military personnel who conform to these hegemonic norms seeking help may be seen as an admission of weakness, and experienced as a source of shame and identity loss. The dilemma of speaking out about “unspeakable” events and subjective distress or remaining silent, or of engaging in treatment or suffering silently, is therefore complicated by a dominant cultural model of self-reliant masculinity that may serve as an oppressive force that marginalizes and stigmatizes Veterans who experience traumatic distress. Under these conditions, suicide may present as the last and final act available to demonstrate personal agency.

This context is further complicated by a society that appropriates Veterans’ stories for entertainment, presenting and reinforcing a dominant cultural model of self-reliant warrior masculinity that they cannot live up to (Westwood et al., 2012). As soldiers are confronted with a mythology of hyper-masculinity that glorifies a caricature of violence cleansed of personal and social impact, their own stories, as witnesses or victims of trauma, become colonized by negative
value judgements and expectations of society at large. Under this regime, Veterans may become complicit with the hegemonic masculine norms, put on the mask of silent stoicism, and hide their personal struggles (Brooks, 2010).

Numerous studies and surveys show that clients with high conformity to masculine gender norms are less likely to seek therapy, and/or drop out early. Some researchers have suggested that this is in part due to a conflict between masculine and therapeutic norms (Brooks, 2009; Englar-Carlson & Stevens, 2006; Addis & Mahalik 2003). For instance, Brooks (2009) argues that traditional male socialization predisposes these clients to hide private experience, maintain personal control, appear stoic, present the self as invincible, and value action over introspection. In contrast to these norms, traditional therapy approaches tend to favour clients who self-disclose, relinquish control, recognize and express emotion, introspect, experience vulnerability and admit failure and/or ignorance.

In the face of these larger hegemonic masculine socio-cultural contexts and pressures, how do programs successfully engage Veterans? If PTSD disrupts the ability of the individual to form safe social attachments (Herman, 1997), and masculine socialization may engender shame reactions that exacerbate this shift towards isolation (Brooks, 2010), how do male Veterans negotiate culturally-safe spaces to form therapeutic alliances, establish group cohesion and reparative peer attachments? Examining Veterans’ narratives about their reasons for engagement in programs with high completion rates may hold keys to understanding how hegemonic masculine barriers to treatment can be successfully negotiated.
4.3 Methodology

As Polkinghorne observes, we only have direct access to one realm of meaning; our own (1988, p.7). For this reason, although the program completion rate of 99.4 percent may be unusual with this population, or even theoretically improbable, as a statistic it also lacks meaning. At face value, it is unclear whether it is a reflection of mere attendance or meaningful participant engagement. Engagement is an artifact of personal meaning, as in, “this activity has meaning for me because…” There may be significant reasons for attendance and program completion that have little to do with the programs relevance or efficacy for the Veteran participants (such as serving military personnel being ordered into the program).

To understand others’ processes of meaning making, and therefore to understand whether or why these Veterans engaged in the therapy they attended, it is helpful to move from the population variable (a 99.4% completion rate) to case-based research that can restore individual agency, respecting these Veterans as subjects with both histories and intentions (Mishler, 1979). Framed within a social constructionist epistemology, this chapter examines Veterans’ narratives about their PTSD and their program involvement through a gender socialization lens, and focuses on evolving relational constructions of meaning around trauma treatment and engagement within cultural frames of masculinity. The overarching research questions that guided this narrative analysis were as follows:

1. Given masculine injunctions against self-disclosure, that are thought to act as barriers to treatment access and engagement, what do Veterans identify as influencing them to complete their trauma program?
2. Are there explicit references in Veterans’ narratives as to what differentiates a program worth engaging in from others not seen as relevant?

3. Do masculine gender role themes show up, either explicitly or implicitly, in Veterans’ narratives about program completion?

4. How, or are masculine gender identities re-negotiated or re-defined through group-based trauma narrative exposure work, and is there evidence of movement from abject to empowered identity formations?

4.3.1 The Research Venue

The Canadian Veterans Transition Program (VTP) is a group-based treatment for military Veterans who suffer from posttraumatic stress symptoms that has demonstrated promising outcomes, and has an unusually high completion rate by Veteran participants (Cox et al., 2014). This program has been evaluated extensively, shown to produce clinically and statistically significant reductions in depression and trauma symptoms, and has recently been expanded across Canada for access to all Veterans (Cox et al., 2014; Westwood et al., 2012).

Each group is run by two professional therapists and two paraprofessionals (Veterans who have previously completed the program and who have also completed a 20-hour certificate program in basic helping skills). Participants consist of six to eight Veterans who meet at a residential retreat centre for three multi-day residential retreats, spaced approximately four weeks apart for a total of approximately 80 hours of therapeutic work.

Silverman raises the question about how far a given research setting is consequential to the data collected (Silverman, 2010). In this case the narratives collected are told by participants
in a particular therapy setting and therefore the observations about engagement will be very much influenced by that setting. On the other hand, the influences on Veteran engagement are unlikely to be unique and discrete to this setting, but rather exist as “occasioned and contexted” ways of interpreting, representing and ordering experiences and social relations (Silverman, 2010, p.52). This means that the influences on engagement are wound up and linked with public life and not located in one geographic place. For this reason, observation about engagement in this setting can allow us to make tentative theoretical conclusions about the broader contexts in which Veterans live with their trauma experiences and shed light on the way that hegemonic masculine role discourses, colonize and complicate the personal trauma stories of affected male Veterans.

4.3.2 The Program

During the first phase (four days), forming and building a strong group is emphasized. Members learn active listening skills such as paraphrasing, reflecting empathically, and about the importance of advice-free listening. They are educated on trauma, and symptom management skills such as diaphragmatic breathing and cognitive reframing. During this phase, writing activities are used to solicit Veterans’ military and non-military traumatic experiences, which are then read into the group for shared reflection and co-learning. At the end of the four days participants set short-term personal goals for career, relationships and self-care (Cox et al., 2014).

Four weeks following the first phase, participants meet again for a second four day retreat. Participants report to the group on their goal accomplishments and insights about barriers. During the second phase each participant can select a traumatic index event and
participate in group-based, titrated, in-vivo desensitization and reprocessing intervention if they choose. During these interventions group members function as trusted witnesses, supports, and also work vicariously on their own index events. The high-ratio of four facilitators to six to eight participants ensures safety for this work. At the end of this phase short-term goals are again set for the intervening time before Phase 3 (Cox et al., 2013).

The third and final phase (two days) focuses on clarifying the goals that participants identified in the first two phases, making lessons learned explicit, consolidating new knowledge and skills, and planning for transition to other services and supports (Cox at al., 2013). This three phase delivery model affords ample opportunity for participants to drop out of treatment, making the 99.4 percent completion rate particularly worthy of note.

### 4.3.3 Sources

Plausible understandings of phenomena are best constructed through several levels of evidence. Triangulation is a technique that allows researchers to construct more meaningful propositions about the social world by gathering data from a variety of sources that reflect different ways of understanding phenomenon. By gathering information in a variety of ways, the researcher can establish links and eventually create a more complete picture of phenomena supported by multiple data sources (Mathison, 1988). To gain a more complete understanding of the process and influences on treatment engagement in Veterans’ groups, case data collection took place from three sources.

The first dataset included in this study were transcriptions and unedited footage of four videotaped interviews of Veteran graduates of the VTP. These interviews were conducted by a documentary filmmaker, Judy Jackson, as part of the raw footage for the 2011 documentary,
“War in the Mind”. Given that these interviews were conducted by a journalist, independent of, and blind to the research purposes of this analysis, this footage provided a rich source of data that was unlikely to be influenced by researcher bias.

The second dataset consisted of a transcribed, one and a half hour focus group session with six Veteran participants during the final phase of a VTP. The focus group followed recommendations made by Kreuger (2002), and discussion was started with the question, “what influenced you to complete this program? The in-depth, semi-structured discussions that followed, elicited rich descriptions of the participants’ lived experience with PTSD, as well as their prior access attempts and eventual engagement in trauma treatment.

The third dataset consisted of four written personal reflections by Veteran participants on “the journey so far”. As mentioned previously, in phase one of the VTP curriculum, Veterans are encouraged to write two autobiographical reflections, one for pivotal life moments before service and one targeting military service and traumatic experiences. For this research, four written narratives of military service experiences were used as the data source. The explicit themes that participants were to write about were their experiences with traumatic, unusual or abnormal events during their military service and the personal impact of those events since they had transpired.

As a participant observer during the VTPs of all of the Veteran participants, I was present as they entered into the group program for the first time and able to observe their evolution, shifting from cautious observer to fully engaged participant, as it occurred. I was able to develop relationships with these Veterans that allowed opportunities to query emerging themes or clarify issues both immediately after the sessions and also after review of the session videotapes. In this
way, data collection began by observing how group members made “experiences” and “motives” publicly available within the group context (Becker & Geer, 1957; Silverman, 2011).

Combining these three data sources resulted in master dataset of fourteen “cases”, reflecting the experiences of Veterans across three settings of interview, peer group and solitary reflection. Observation of narratives across these three settings provides a system of data source triangulation that can allow us to construct more meaningful propositions about the broader contexts in which Veterans live with their trauma. By identifying themes that emerge in all three data settings we can establish with more credence whether the themes are active and carry across different circumstances and settings in Veterans’ lives. The decision to focus on points of convergence is a strategic one that reflects the research goals of identifying a community of experience. The places where data do not converge across the settings are equally important and relevant for future study.

Veteran participants ranged in age from 24 to 52 and had served in Afghanistan, Bosnia, or Somalia. Several participants had served on multiple missions. Cases were chosen to maximize what we can learn and because they may contain important information about socio-cultural influences; hegemonic contributors to the Veterans (co)constructed experience of PTSD and possible barriers or aids to engaging in treatment.

The purpose of this kind of research is to inform theoretical propositions, rather than to generalize to populations. More traditional comparative and correlational studies will establish generalizable findings more effectively. Through qualitative work, we seek greater understanding of cases through their uniqueness and complexity, their embeddedness and
interaction with their contexts. As Stake notes, the function of this kind of research is not necessarily to map and conquer the world but to sophisticate the beholding of it (1995, p.43).

4.3.4 Researcher Context

In conducting a narrative analysis, the participants are viewed as co-researchers and therefore it is important to also declare my own context as a researcher and co-constructor of meaning in this setting. As a former infantry reservist in the Canadian Forces, Veterans often honour me with “insider status”, making explicit gestures of inclusion into their ranks. As a therapist, however, I am also regarded with initial caution by this population. In this study, I attempted to purposefully occupy space as an indigenous outsider within these Veteran groups. In order to escape negative associations attached to civilian therapists and yet avoid hierarchical interactions typical of military culture, it was important to develop a “least-aligned” identity that straddled or defied easy civilian or military categorization.

Berger (2013) warns against the dangers of researching the familiar, with its inherent risk of fusing personal experience with participants’ stories and “pushing” the stories in certain directions, or of inadvertently falling into power dynamics of competition and comparison. Exercising researcher reflexivity was critical at every stage of this research project, taking the form of written diaries, and extensive consultation with both military and research peers.

4.3.5 Analytic Process

In analysing this data, my first basic unit of analysis was the transcript of each single case and of the focus group discussion as a whole. Following Ryan and Bernard’s (2003) recommendations, I started with what they describe as “scrutiny techniques”, looking over the
whole of each narrative sample, first for repeated topics and any identifiable networks of ideas within each transcript. Using Stake’s notion of categorical aggregation and direct interpretation, case narratives were analysed for implicit and explicit categories, as well as what might be one-off but important anomalies (Stake, 1995). I paid particular attention to the dynamics of hegemonic masculinity and explicit statements about engagement, agency and emotion. Analysis continued across cases and settings to identify themes that were present in multiple cases and in all three settings. For the purposes of this study, in order for themes to be considered, they had to appear in all three settings.

The task in this paper however, is not just to understand what themes operate across these three narrative settings, but also to see how themes, grasped together, create a larger meaning whole across these settings. Within this new larger cohesive narrative trajectory or plot, what novel understandings emerge as Veterans seek to narrate a coherent self-story of their trauma?

Integrating thematic and structural approaches to narrative analysis, both the “what” and “how” of these narratives are examined. Analysing plot across the themes leads to identification of initial situation, conflict and suspense, climax and denouement. Through consideration of plot and thematic discourse, potential hegemonic meaning and messages in and across the texts are brought to light.

In order to document the main themes for the reader, I selected details from a few of the cases to highlight commonalities. Direct quotes are given to ground the findings in the data. In each of these cases, confidentiality was promised. For this reason, names are severed and identifying military service details are eliminated from examples that appear in this chapter.
These quotes enable the reader to gain a concrete understanding of the themes and how they play out in Veterans personal narratives relating to their trauma and engagement in services.

4.4 Narrative Themes

Analysis suggests the presence of four intersecting themes that are woven throughout these Veterans’ narratives of trauma and engagement. These include:

1. A struggle against an abject identity;

2. The quest for affirmation of “fitness” and “belonging” by a community of peers;

3. The colonization of the therapy space with masculine “culturally-safe” metaphors; and,

4. The re-affirmation of personal agency.

These points of reference concentrate the complexity of hegemonic pressures around the need to re-affirm their “belongingness” in the world of men despite trauma, and reaffirm themselves as having mastery or agency in the world. Turning now to the case data, I will explore the specifics of these four central themes through examples from the focus group (FG), interviews (Int) and personal reflection writings (WPR).

4.4.1 Abject Identities – From Hero to Zero (and Back)

Theme description: Participants describe a sense of personal failure, weakness, or loss of agency associated with their PTSD diagnosis or symptoms and their own failure to comply with hegemonic norms of independent mastery and emotional stoicism. The norms that they compare themselves to may be expressed implicitly or explicitly, and reference internal or external sources. They also describe incidents of being treated as “less than” or in ways that make them feel inadequate and stigmatized.
This theme emerged in all fourteen Veteran narratives in one form or another, across all three narrative settings of written personal reflection, interview and focus group. One participant explicitly referenced the group norms and stigma and sense of weakness associated with admitting to trauma symptoms and seeking help. In the focus group he observes:

...at my work, psychologist is a dirty word. Nobody wants to see the psychologist... like if you have to see the psychologist then you’re weak, broken.

(FG – P6:8)

In the written personal reflections, a participant elaborates on this theme and reveals an interesting “indigenous category or typology” that reflects the operationalized hegemonic norms around stoicism and independent self-mastery. He writes:

There had always been stigma around this throughout my life and career. It was hard for me to reconcile that who I thought was as a strong man had these problems and needed the help of someone else.

(WPR – A1:52)

This statement, that being “a strong man” is hard to “reconcile” with having “these problems” (PTSD), and needing “the help of someone else”, is revealing. Ryan and Bernard (2003) write about the use of missing data and recommend that you pretend you’re translating the material for a foreign audience. Where you find yourself filling the gaps, there may be fundamental themes hiding. The idea that “who I thought was a strong man had these problems and needed help” is a kind of abbreviation – there is an assumption about what “everybody knows”. There may be a hidden category here that there are strong men and weak men and having problems will categorize you as one or the other. It is assumed that it is not possible to be strong and yet be faced with certain problems. These categories are instead mutually exclusive.
In the preceding quote, the characterization of those who seek help as “weak… broken” also reflects this categorization. In this way it appears that people are slotted into black and white categories – weak and strong, hero or zero.

This categorization, reflecting hegemonic masculine gender norms of stoicism and mastery, is elaborated by one of the interviewees. Interviewee 3, speaking about the conflict between his reactions to his experiences and the “code” of expected military emotional expression and behaviour, says:

*There is the acceptable emotion for a man, sort of anger; you can express that by fighting or by yelling and that’s about it. The rest of the emotions, they say to you in the military context again, it’s your personal problem; bottle that up inside.*

*Don’t go telling other people about it because you are weak if you do.*

(*Int – P3*)

Speaking later in the interview about the internal struggle and stigma surrounding his emotions relating to his PTSD, and his fears about how those emotions will make him lose control over himself, he reveals:

*I was worrying about all the social pressures; the externals; what people think of me. You’re not really conditioned to embrace those sorts of feelings as a guy, especially in the military. So I had all those worries going on… there was just the dark feeling within me, the fear of the amount of control that my emotions had over my actions.*

(*Int – P3*)
All of the Veterans in this study referenced similar feelings of shame and lost standing when reflecting on their PTSD symptoms and need for assistance. In many cases, this shame and loss of self-regard seemed to be the most disturbing residual impact of their trauma – they could no longer narrate a “successful man” image of themselves. This echoes findings in other research with Veteran populations in trauma treatment (Fox & Pease, 2012).

Consistent with this, the participants in the focus group also referenced shame and loss of pride as central aspects of their trauma experience. Here however, the discussion touched on shifts in the opposite direction as well – that the movement from shame back to pride was also an integral part of the perceived benefits of engaging in the program.

**Participant 1:** All of the values, pride, honour, I had lost all that, it was gone.

Through sitting in a group of my peers I was able to get that back. I was able to be proud again of what I did, and proud of my job and proud of what I went through. So instead of feeling shame about it I was able to be proud of myself again. About what I did and who I am.

**Participant 4:** Recovered pride and values.

**Participant 1:** It’s huge.

In the face of dominant hegemonic social norms linking PTSD to a loss of competence and worth, this participant says “sitting in a group of my peers I was able to get that back”. That a sense of shame accompanied their trauma is clear. The question remains, how did these Veterans come to negotiate a gender-safe space to form therapeutic alliances, establish group cohesion and reparative peer attachments? What account do they give of the narrative co-(and
construction of gender norms needed to have permission to feel difficult emotions like grief, guilt, fear, or depression, without seeing those feeling as evidence of their own failings as men and as soldiers? How did coming together restore these Veterans’ sense of pride?

4.4.2 Safe Social Bonds – A Band of Brothers

Theme description: Participants rediscover a sense of camaraderie with their peers and gain support and pride of “belonging” with men whom they respect. They move from isolation and back into relationship with others for whom they express trust, attachment, loyalty and care.

In the focus group session, the Veterans responded directly to the initial question, what influenced you to complete this program? The ensuing discussion emphasized their appreciation for the rediscovery of a close-knit bond with military peers. Of note, there seemed to be a clear distinction made between mixed civilian groups that they had attended and this group of all military participants, who they grew to trust implicitly. Participant 2 in the focus group states the distinction in this way:

*It’s not only the power of group therapy because lots of organizations offer the same service. What draws me is the band of brothers. What keeps us here and keeps us together is the brotherhood.*

*(FG – P2)*

One of the interviewees also expressed a similar sentiment saying:
... at first I was really hesitant. But then I found out it’s a peer-supported program. There’s going to be other soldiers there. And then I was just like “Yeah this sounds good.” Because I’ve told that to people before, the only people that can help me are the people that have been there; the people that know.

(Int – P2)

Yet all of the Veteran participants had had opportunities to connect with military peers in other settings, however a similar level of safety had not emerged and they had remained isolated behind the mask of their own perceived need to be stoic. Here, something else had happened to allow the formation of safe social bonds with their peers – the creation of a cohesive band of brothers. One of the Veterans wrote:

Here, there were no judgements but a real sense of connection. It was the first time that I had felt camaraderie, a sense of belonging, a deep understanding and connection in over ten years. I felt that we were a troop who was facing our fears and all standing beside each other against a common enemy. My sense of despair left and was replaced with hope.

(WPR – A6)

“No judgements” and “a real sense of connection”. If participants were busy defending against being seen by the others as abject, weak and failed men, would “deep understanding and connection” emerge? Would receiving sympathy translate into mutual respect, belonging and the sense of “standing together against a common enemy”? This question is considered in the next theme; however, a contextual note may help understand these statements.

The VTP program commences with the Veterans learning active listening skills, which they then practice, interviewing each other in pairs about their “proudest moment”. The full
group then reconvenes and each Veteran “introduces” their partner by talking about that person’s proudest moment. Perhaps as an artefact of this exercise, midway through the first day, the participants seem to have an appreciation for each other as agentic, masterful men who are accomplished in the world, rather than as broken, weak and out of control. Perhaps as a result, from the first interactions it becomes a group that the participants want to be identified with, not a group that is seen as stigmatizing to be identified with. One participant supported this hypothesis in his writing:

Having us introduce our partner to the group was also a perfect way to be able to sit back and observe reactions and start to feel a connection to the group. ...by the end of that, I was fully immersed in the group and felt a true sense of connection and brotherhood with all involved. It was at this point that I knew I had to stay.  

(WPR – A)

This is a group of men who have come to respect and admire each other, although they did not know each other before the program. One focus group participant explained the impact of identifying with, but not respecting other participants in a different group program that he had attended.

If it was a group of people that you saw as weak, who were having problems, then you would associate with being a weak person too.

The focus group discussion reflected the importance of respect as well.
I think the difference here is that you’re not just sitting here with a therapist; you’re sitting here with other people that you respect and admire. And you are invested as much in them as they are in you.  

(FG – P4)

Notwithstanding the humorous (and humbling) implication that the therapist isn’t a person to be respected and admired, this is an important statement as it hints at where the roots of safety and (perhaps) engagement lie. The previous quote ends, “…you are invested as much in them as they are in you”. With the emergence of respect for the other participants, and in the absence of perceived judgement from them, there seems to be a shift in Veterans’ stated purposes for attendance. Rather than engaging in the therapy setting because they see the value to themselves, these participants invest as a way of “doing something” to stand by their buddies.

If any one of the people in this group left, you would feel the hole. ...I still didn’t want to come back this time, but I came back because I felt a need to be here for everyone else.  

(FG – P3)

Attendance and engagement have become reframed as agency, loyalty, and selfless service to others – values that are consistent with dominant hegemonic masculine ideals, yet which now support engagement rather than disengagement and isolation. Just like in military training, the focus is no longer on self, but on others. Another participant reiterates this commitment to the group and also hints at some of the benefits that accrue to him.

I had to stay but more out of a sense of wanting the best for the other participants than myself. This was really freeing because I didn’t focus on how crazy I thought I was.  

(WPR – A6)
The focus on the “other” allows for a safe and acceptable reason for being in the group – I’m here for my buddies. From this safe ground, initial sorties can be made into the threatening territory of therapy. One of the interviewees articulates a kind of trajectory; from coming together, to building trust and ultimately to an opening up.

…it’s getting together; earning trust with them, and then sharing stories. And you notice how much you have in common. And there’s no better help then talking to another soldier that you trust, that can understand what you’re going through; rather than a professional. Although they’re trained, it doesn’t give the same therapeutic effect as talking with another soldier who understands what you’re going through. (Int – P1)

In this atmosphere of mutual regard, safety and support, among peers who are seen as men to be admired and respected, tentative steps are made to renegotiate the rules of hegemonic masculinity – subverting the cultural imperatives of stoicism. Here, men can speak about their “truths” about their inner emotional life without losing face.

It’s soldiers helping soldiers. That’s what made it. This group is like the light at the end of the tunnel. It’s the best kept secret. That’s for sure. We don’t want it to be a secret because this, this gets rid of the thought that men can’t have emotions; that men aren’t allowed to feel. And we have to suck it up and soldier on. This is a bunch of soldiers who have different stories but the theme is all the same. (Int - P1)
4.4.3 Cultural Appropriateness – Treatment Through a Warrior Male Gender Lens

Theme description: Participants begin to colonize the therapy process with their own metaphors and language, making it their own through culturally appropriate hegemonic masculine language of hard work and struggle.

In the previous theme discussion, examples were given of the change in the permissibility of openness and emotional expression within this now close-knit group of Veterans. In this theme analysis it can be seen that this does not necessarily reflect an abandonment of hegemonic norms, but rather a redefinition of emotional expression and engagement in therapy itself as a new standard of agentic hyper-masculinity. In the focus group an animated discussion centered on how “tough” therapy really is. One participant emphatically describes therapy as follows:

*It’s war. War is hell. It’s hard. It’s not something that’s easy. You don’t take it for granted. The outcome is not assured. You have to f***’n work hard at it. You’re going to suffer. It means pain. No pain, no gain. Okay, so you have to feel the f***’n pain.*

*(FG – P4)*

This is not typically how we, as therapists, would present our treatment services. However, this provides an interesting contrast with other programs participants talked about that they had dropped out of. Attempts to create an atmosphere in which Veterans could talk about experiences and emotions sometimes inadvertently further undermined the participants’ sense of mastery and masculinity. The following exchange, about his experiences at a stress clinic, was animated by Participant 5 in a feigned soft, melodic and babyish tone.
Participant 5: On the base they would treat you as a baby. ...they would say, “Sometimes people suffer from this and this is normal... You guys have been through some terrible things, poor you”. And you feel kind of emasculated...

Participant 3: You feel coddled, don't you?

Participant 5: Yeah!

At this exchange, the other participants became more engaged and animated, sitting forward in their chairs, and the energy in the room changed dramatically. This direct reference to emasculation by a Veteran participant surprised the facilitators and seemed to jolt the other participants with a sudden, common recognition of something experienced but not quite articulated before this point. This showed up in the written personal reflections as well with one participant remembering:

*I felt I was being treated very softly and gently. I began to wonder if this was because of other people in the room and began to wonder if they had some sort of rage issues.* (WPR - M7)

Here, a “soft and gentle” approach seems to inadvertently communicate that Veterans may not be fully masters of themselves, not really men. Participants felt disoriented and alienated by these experiences.

*Going to his office and this sterile environment was unnerving and then the way I was treated was foreign to me. I had been used to taking orders and to working amongst other "strong" men. I was not used to talking about my feelings and certainly did not even understand them.* (WPR - M7)
For military populations, or men who subscribe to hegemonic ideals of stoicism, agency and corporal control, the loss of agency or control that accompanies traumatic experience brings a concomitant loss of standing “as a man”. To be “coddled” or treated “softly” appears to exacerbate this loss of standing for these men. To feel the symptoms of PTSD and need the assistance of others to resolve emotional needs is experienced as “emasculating”, and the manner in which care is given appears to be critical to engagement. The “soft” approach contrasts sharply with the way that these participants begin to represent the therapy process themselves.

*Only the toughest belong here. We’re in a battle. That battle is not done alone. You never go to battle alone.*

(FF – P5)

The hegemonic masculine norms, metaphors and language are clear. Only the toughest belong here. The reader might well question whether this therapy-as-battle metaphor could lead to a “safe” therapy environment for the expression and processing of traumatic experience and emotion. For these Veterans, the answer seems to be, yes. The distinction seems to not lie in the “what” of therapy as much as the “how”. The participants do talk about their emotions and speak about difficult experiences, however rather than adopting the foreign language and culture of therapy, the participants seem to have co-opted and colonized therapy for themselves with their own gender-appropriate, and culturally-safe language and metaphors.

Interestingly, the therapists are also gathered up in these redefinitions – like the Veterans themselves, they are allowed, and even expected to express emotion under the “new rules of engagement” as price of admission to this group. Speaking about the therapists, an interviewee says:
They are real men, especially when you can see their emotion, like when they’re working with us and they get emotional, and you can see that emotion in them, even when we talk about certain things, you can see their emotion. You can’t fake, you can’t fake that. And it just, yeah it just, I just hold them in high regard.  
(Int-1)

Emotions are present, but they’ve been reframed. To be a real man, is to not shrink from the hard work of expressing difficult emotions. PTSD is not about being weak, it is about the tough battle that you must stand and fight – and fight together, backing each other on a new battlefield of the heart and mind. To be called to such a battle is a new badge of pride for these Veterans. One interviewee, wanting to get the message out to other Veterans suffering silently and alone, says:

_I’ll tell you right now it’s going to be hard but we’ve been in harder situations._

_I’ve been in harder situations. I’m not afraid of hard work. And I’m pretty sure if you’re on the fence about PTSD or if you need help I know you are not afraid of hard work._  
(Int – P2)

And again, later in the interview, he reiterates this same message about hard work and the need for courage.

_Don’t be afraid of hard work. Don’t be, don’t be. Pull up your socks and get ready to rock. Get ready to. Even though it’s painful it’s worth the struggle._

(Int – P2)
“Get ready to rock”. Here, therapy is redefined by these participant Veterans as a call-to-arms. The cultural divide between masculine and therapeutic norms has been crossed and, one might say, “conquered”. In one particularly moving and elegant piece of poetry written by one of the Veterans about his challenges and the VTP experience, this call to the brotherhood of arms is explicit and passionate. In the final stanza of his poem, he writes:

Together we shall stand, face to face with our demons
With battle cry and drawn sword we protect our feelings
In the ranks with my Brothers I stand tall, true and brave
To the evil we have faced never again be we slaves (WPR – P2)

4.4.4 Taking Control – From Passive Recipient to Personal Responsibility

Theme description: Participants begin to move from seeing themselves as passive recipients of care, to motivated, agentic men engaging with the challenges presented to them.

The final theme of this analysis captures threads that have already appeared, woven throughout the first three theme examples. The fall into an abject un-agentic state results in a broken, weak victim stance, which begins to shift with the non-judgemental acceptance of respected peers. From this place of supported safety, therapy becomes recast as battle or as hard work for tough men; framed in familiar, culturally-safe hegemonic language and metaphors, the work begins. This shift in perspective, both of the self and of the “work”, appears throughout the narrative samples. For example, writing of his lowest point struggling with PTSD symptoms, a participant reflects:
I think at this point I started to see myself as a child. I had already lost my sense of competence and now felt I needed to rely on someone else's strategy to pull me out of my dark place. (WPR – P1)

Child-like and lacking competence, his sense of needing someone else persisted, and each successive therapist and program failed him.

I started with another psychologist and once again I believed this was the person who would "save me." Again I was disappointed.

Eventually, however, and often without explicit statement of an understanding of why, locus-of-control shifts back into the Veterans themselves. In the focus group, this shift gets articulated this way:

...the therapist they’re analyzing you and looking at you like you’re not strong. It sort of takes the power away from you, whereas I think here you work as a unit for a common goal and you feel strong together. But even when you leave you feel strong like that you worked through this and you were taking charge of your scenarios and such. (FG – 1)

This sense of “taking charge” versus taking direction was repeated in a number of ways. About the therapists, one focus group participant went as far as to say:

You may be facilitating our care but we’re doing the therapy. But you go to the therapist and they’re doing the therapy and we’re listening. (FG -9)
Taking control, they have moved from passive recipient to taking personal responsibility.

This last sample raises an interesting issue regarding treatment engagement. Here, the participant is engaged with the work to the point that he has downplayed the importance of the therapist’s presence. But this is not the complete story either. In reframing the therapy setting as a battlefield where only the best and toughest belong, the therapists have also been included in that esteemed group of “real” men. For example:

*These doctors that we’ve been working with, I see them more as men now and not as doctors. When I leave here I’ll probably compare every doctor I see from now on to them. And that’s not fair but they, just like the men in this group, the cream of the crop, the best; they’re the best too.* (Int – P2)

So the therapists (doctors) have a place, but the participants are nonetheless articulating their experience of a different relationship to the professionals involved in their treatment.

This different and more autonomous relationship is not without its risks. When a client “takes control” it can take many forms, even forms that we wouldn’t predict and would never endorse or advise. One participant being interviewed about the changes he had seen in himself since starting the program revealed:

*I have seen changes in myself. The biggest one, I got back and I took myself off of almost all but one of my medications; almost every one. I have one left that I’m on. So I don’t need sleeping pills to get to sleep now. I don’t need to take them every night or every couple of nights. And I completely took myself off one of the other antidepressant medications so it’s a big difference.* (Int – P1)
Agency means that Veterans will start making decision about their own care, and as therapists we are well advised to watch for the places that this may cause them risk of harm. Ultimately however, Veterans hold responsibility for their own lives. Is a shift from a passive state, towards taking control and personal responsibility, re-establishing their place as motivated, agentic men, engaging with the challenges presented to them, not a valid outcome? Perhaps this shift reflects the emergence of one of the most powerful buffers against despair and suicide - hope. One participant expressed it this way:

*The course of my life has changed because I didn’t really, I didn’t know about the future. I didn’t feel like I had one before. But now it is kind of like the world is my oyster, like I have a pretty set goal and I’m determined to make something, make the best of it.*

(WPR -)

With hope for the future, a new course can be set and energy applied.

*Well it’s just a sense of desperation. You’re desperate to, you see yourself, the person you were, the person you’ve slowly become over the last couple of years or however long it’s been, because of all the things you’re holding on inside. One day you just, you just see it. You just see that you need to take control of it.*

(Int – P2)

And ultimately, taking control for themselves is the only viable long-term option. As eruditely stated by one of the interviewees:

*You’ve only got one life so take charge of it because no one else is going to do it for you.*

(Int – P3)
4.5 Narratives of Engagement

In focusing on how hegemonic masculine themes cut through private written narratives as well as the public spaces of interview and focus group, I have attempted to shed light on the way that hegemonic masculine role discourses, colonize and complicate the personal trauma stories of affected male Veterans and their relationship to treatment services. However, the task in this paper is not only to identify repeating themes across the narrative settings, but also to see how these themes, grasped together, create a larger meaning whole. Narrative analysis affords the opportunity to step back and critically examine these cases and the themes that they contain as a larger, coherent set. Within this new larger cohesive narrative, what novel understandings emerge about how Veterans make sense of trauma and help-seeking, as each theme reflexively informs and is informed by the others?

Within each of the cases considered, Veterans have assembled personal narratives that weave together complex sets of life events into single stories. Each configures episodes into wholes and thus, translates their stories into one “thought”. Salmon suggests that a fundamental criterion for judging a text to be a narrative rests in the consequential linking of events or ideas (Reissman, 2008).Whatever the form or content, a narrative imposes a meaningful pattern on what would otherwise be random and disconnected events. Polkinghorne (1988) refers to this overarching organizing theme, which identifies the significance of individual events and transforms them into a schematic whole, as the “plot”.

According to Ricoeur, plot works to “grasp” events together into a cohesive, coherent and meaningful “storied” whole. Within that story, the meaning and identity of the component events are not merely inherent to those events themselves, but rather produced by recognition of
how each event and the plot interact, each providing form for the other. By “pulling events out of a mere succession” and grasping them into “an adventure with a beginning, middle and an end”, the viewer can reflect back and reach new understandings of the beginning in light of the end, parts in light of the whole (Crotty, 2011).

Considering plot across the Veterans’ themes leads to identification of a narrative trajectory moving from initial situation, to conflict and suspense, to climax and denouement - the plot following the archetypal narrative of the hero’s journey (Propp, 1968; Labov, 1973). There is a trajectory that can be seen, not causal but suggestive. From the excavation of these narratives themes, what emerges is an account of men wrestling with the pressures of negotiating a “competent man” version of themselves in the face of PTSD and the hegemonic norms of masculinity.

Seen in these narrative terms, for these Veterans, the initial situation in this plot is one in which they identify with the hegemonic norms of masculinity. Molded by military and popular-cultural institutions that explicitly promote hyper-masculine norms, they enjoy membership among those considered a masculine ideal, warriors. Against the backdrop of these hegemonic norms, conflict emerges.

PTSD assaults their taken-for-granted world and disrupts their vision of themselves as men (The Abject Identity theme). Having been steeped in a culture that both glorifies agentic and unaffected masculinity, and which actively rejects spectres of the abject, there is little room for them to develop a healthy self-definition that includes the experiences of trauma symptoms. Instead, symptoms signal a fall from the previously held idealized masculine military identity
into, what Pascoe refers to as, a “failed or abject masculine identity” (2012). As one participant wrote, “If you have to see the psychologist then you’re weak, broken”.

According to Nietzsche, the self is not a constant, stable entity. Rather, it is something one becomes, something one constructs. Polkinghorne observes that we are in the middle of our stories and “cannot be sure how they will end; we are constantly having to revise the plot as new events are added to our lives” (1998, p. 154). Self is not static but a constantly shifting configuration of personal events that is woven into a historical unity which includes not only what one has been but also anticipations of what one will be. For these Veterans, trauma has disrupted the unity of the self-story. These episodes and experiences cannot or will not be integrated into a coherent self story of the competent man and so suspense emerges. “It was hard for me to reconcile that who I thought was as a strong man had these problems”. How will this resolve?

The narrative gerontologist, Mark Freeman (2011) asserts that when experiences cannot be integrated into a coherent self-story, individuals can experience a sense of “narrative foreclosure” in that the types of stories that the individual can tell about themselves become limited by the dominant messages of culture. For military populations, or hegemonic men generally, promoting ideals of honour, agency and corporal control, the loss of standing, agency or control that accompanies traumatic experience can interfere with the ability to perceive, to live, and continue to narrate a meaningful and productive life going forward.

In the plot of the archetypal hero’s journey narrative, it is at this point that action will either turn towards climax or anticlimax, the resolution of the tension and conflict or the demise of the hero. Which direction it takes will also mark the story as either a “progressive” narrative
that leads to increasing mastery over self and world, or a “regressive” narrative with the protagonist experiencing a loss of mastery over self and world (Gergen & Gergen, 1986). Following an archetypal hero’s journey narrative, treatment marks a turning point which sees either the rise or fall of the protagonist.

Against the backdrop of confining and stigmatizing hegemonic discourse that colonizes their experiences and expectations with unattainable ideals of stoic agency, medical and psychological explanations of PTSD do not seem to provide a viable defense against shame. To avoid this identification, Veterans may become complicit with the hegemonic masculinity; put on the mask of silent stoicism, and hide personal struggles from their families, close friends, colleagues and health professionals, and the regressive narrative begins. It seems traditional approaches to therapy can compound the difficulties, may fail to provide a reliable path toward a “progressive narrative” for these Veterans, and drive the action inexorably towards the anticlimax. As participant 1 put it, “...the therapist they’re analyzing you and looking at you like you’re not strong”. Or as participant 5 said, “...you feel kind of emasculated”.

Within the context of this group of peers however, Veterans seem to have engaged in a process of social-reconstruction of the meaning of PTSD, elaborating reconstructions of their experience in such a way that PTSD could be given a comprehensible place alongside pride, honour and a sense of competence. These reconstructions bridge the gap between the clinical reductions of disorder lying “within” the individual, and the larger pressures of hegemonic social norms. Perhaps as evidence for the socially-constructed nature of hegemonic norms, and the force and influence of these norms in the reasoning and meaning making processes of the individual, it was not alone that these self-identities were renegotiated, but within the “Band of Brothers”. As one participant wrote, “I felt that we were a troop who was facing our fears and
all standing beside each other against a common enemy. My sense of despair left and was replaced with hope”. Or as Participant 1 in the focus group said, “Through sitting in a group of my peers... ...I was able to be proud again of what I did, and proud of my job and proud of what I went through. So instead of feeling shame about it I was able to be proud of myself again”.

In a group of respected peers, social renegotiation of the story begins to take place. It seems that it was difficult for these Veterans to “step back” and create a coherent narrative that included PTSD and being a competent man, except through safe and cohesive social dialogic relationships, Freire’s process of conscientisation, with respected peers.

Expressing feelings and supporting others in the expression of their feelings, becomes redefined as “courageous”, the “hard thing to do”, as “men’s work”. “I’m not afraid of hard work”, says one Veteran in his interview. Paradoxically, the very expression of emotional life that was previously stigmatized becomes construed as a form of agency – the hero’s path. Finally, there is something that can be done – courageously, and in bold self-assertion against the judgement of others, these Veterans could collaborate in building a parallel meaning structure in which the strongest men are able to feel and speak their truths. “Only the toughest belong here. We’re in a battle. That battle is not done alone. You never go to battle alone”. The climax has been reached and the hero returns to mastery over self and world.

4.6 Conclusion

This paper sought to close gaps in the literature by following male Veterans taking part in a group transition program that has an unusually high completion rate, coupled with clinically and statistically significant outcomes. Examining their narratives for thematic content, function and structure allows us to make several theoretical assertions examined in the following sections.
4.6.1 Gender Ideals that Oppress

As has been documented in other studies (Fox & Pease, 2012, for example) the disempowering nature of trauma and its symptoms appears to undermine a Veterans identity and may be experienced as “failure” as a man. The relevance and impact of these gender-narratives of failure and loss of standing on the social, psychological and physiological aspects of traumatic stress are not trivial. As Berger observes, narratives hold power “to dramatize and give concrete form to a society’s attitudes and beliefs”. Though narratives may be simple, their influence and impact are often quite profound. This research suggests that the dynamic between trauma and gender socialization may contribute to low treatment usage and high drop-out rates as male Veterans isolate and hide personal struggles lest they be shamed (Brooks, 2010; Westwood et al., 2012). Given that these Veterans are husbands, fathers and sons who belong to and affect families and communities, the social costs of poor treatment access and outcomes are high, and the rewriting of a gender paradigm that creates barriers to access becomes an act of social justice. In this way theory must be translated into action, as praxis, to rewrite the politics of hegemonic power and dominance (Jordan et al., 2004).

4.6.2 Necessary Conflict or an Issue of Framing

Several researchers have suggested that there is a conflict between masculine and therapeutic norms (Brooks, 2009; Englar-Carlson & Stevens, 2006; Addis & Mahalik 2003), and linked high conformity to masculine gender norms with the reduced likelihood of an individual seeking therapy, and/or dropping out early. The narratives examined in this study support this theoretical assertion, but suggests that the disconnect lies not so much in the “what” of therapy, but in the “how”. These Veterans’ narratives suggest that therapy can be made culturally-safe
for men who conform to hegemonic norms, through changes in framing, language and metaphor. Thus, while Brooks (2010) argues that traditional male socialization creates a barrier to therapy, by predisposing clients to hide private experience, maintain personal control, appear stoic, present the self as invincible, and value action over introspection, this study suggests another possibility. Instead, here, self-disclosure, recognition and expression of emotion, introspection, openness to vulnerability and struggle become redefined as evidence of masculinity, in a helpful parallel meaning structure, under specific conditions.

4.6.3 Healing from a Position of Strength

Insight into the creation of these conditions is also found in the Veterans’ narratives. For these clients to engage in therapy, clinicians need to attend to issues of cultural “safety” and appropriateness in order for safe social bonds to develop. In this study, identification with respected peers was an important distinction, versus association with processes or people seen to be abject, weak or failures. This is likely an issue of framing the therapeutic environment in ways that recognize and support notions of competence and skill first. By creating conditions of safety and recognizing resources and strength, capacity is created to explore vulnerability and emotional content. Explicitly recasting therapeutic activities as within masculine role norms, or even as proof of compliance to hegemonic norms, appears to have been a critical aspect of the formation of a therapeutic alliance, establishing group cohesion, and facilitating reparative peer attachments.

4.6.4 Social Reconstruction of Norms

Safe social bonds, whether through group membership or as a therapeutic alliance, are widely regarded as a prerequisite to engagement in the “tough” work of PTSD (Herman, 1997).
As therapists, the Veterans’ narratives presented here suggest further nuance to this therapeutic factor, and challenge our notions of what leads to change. Given statistically and clinically significant change on outcome measures of depression and trauma symptomology, we started with the notion that veterans stayed because the program was effective. These narratives suggest that we may need to consider the equally viable proposition that the Veterans made the program effective because the conditions were right for them to develop loyalty and care for each other. It is possible that the Veterans made this program “work” because the fundamental conditions were met for them to have a “felt sense” of safety and to attach to each other – their safe attachment not just a prerequisite for work, but the key ingredient of it.

4.7 Final Word

Polkinghorne (1988) observes that the goal of research into the production and impact of personal meaning sets is to produce clear and accurate descriptions of the structures and forms of the various meaning systems that are active. This does not provide information for prediction and control of behaviour, but rather, “knowledge that individuals and groups can use to increase the power and control they have over their own actions” (Polkinghorne, 1988, p. 10). By naming possibly destructive social practices embedded in hegemonic masculine ideals, the goal of such knowledge is to destabilize “socially sedimented agreements” about masculinity and assist Veterans in redefining successful masculinity for themselves after service and after traumatic exposure (Polkinghorne, 1988).

Critical approaches examine these internal and social conditions in order to uncover hidden structures and understand the ways in which various social groups are oppressed. Further, critical theory teaches that knowledge is power and makes a conscious attempt to fuse
theory and action, as praxis (Schwandt, 2007, p.55). Understanding the ways one is oppressed enables one to take action to change oppressive forces (Freire, 2011). Critical theories attempt to bring about change in the conditions that affect our lives – to seek knowledge in the context of action and the search for freedom (Crotty, 2011).

Judith Jordan, in her writing about the politics of oppression in women’s trauma, noted that the societal emphasis on the autonomy of the disordered individual, independent of social forces, creates isolation and disempowerment at the personal level and preserves the politics of dominance (2004). This study suggests that a similar destructive dynamic between individual and hegemonic social forces is at play for men struggling with trauma. In the face of masculine socio-cultural pressures, the path to successfully engaging these Veterans in treatment, and to creating culturally/gender safe spaces for them to form therapeutic alliances, group cohesion and reparative peer attachments, is fraught with challenges for Veterans and the professionals who work with them. This research suggests that to successfully negotiate these challenges, therapists need to have a strong understanding of the dominant influence of traditional masculine gender roles in the military culture in order to successfully engage and work with this at-risk population.
Chapter 5: Discussion

5.1 Synthesis of the Findings

Evidence suggests that Veterans who face service-related stress injuries are often marginalized and remain silent about their trauma. Male Veterans, in particular, experience negative outcomes at a proportionally higher rate than their female compatriots, and have significantly lower usage rates for trauma related therapies. This project attempted to contribute to a more integrated understanding of how the multiple aspects of trauma experience coalesce in the male Veteran, impact their lived experience, and how they relate to and co-construct their stories. This research also sought to answer questions about the unique impacts of the abject or failed masculine identity associated with trauma reactions, and to identify whether there were discernable, and replicable, pathways to access, engagement and impact that these men travelled to participate more fully in treatment, relationship or community.

The overarching question that guided this research was: *Given the emphasis of male socialization on stoic mastery over self and environment, and its integral place in the training of soldiers, how are male Veterans’ intrapersonal and interpersonal experiences of trauma influenced by their gender socialization, and what impact do these experiences and constructed meanings have on narratives of personal identity, and access to, engagement in, and impact of treatment?* The two studies conducted, teased out specific aspects of interest in this overarching question.
5.1.1 Masculine Hegemony, Cultural Discourse and the Experience of Trauma

In the first study, which considered the intersection of psychiatric discourse and popular culture, it could be seen that these two social institutions paradoxically shared a common pathologizing stance towards a person’s loss of agency over self and world. While the military and popular-culture help mold and perpetuate ideals of an unflinching and unfailing agentic military masculinity for men, institutional psychiatry articulates the boundaries of an opposite, “disordered” side of the functional spectrum. Although the language differs, rather than offering a counter-argument to the pervasive influence of military masculine norms, institutional psychiatry inadvertently reinforces these norms for men by grasping together the symptoms of PTSD and defining them as disordered, abnormal and somehow inadequate.

Veterans like Jack, then, face a popular culture and psychiatric discourse unified in their assignment of those who lose external or internal agency into a lower status and stigmatized position. In the second study, participants amplified this concern, describing a sense of personal failure, weakness, or loss of agency associated with their PTSD symptoms and their inability to exhibit independent mastery and emotional stoicism. Supporting the notion that these “failings”, were socially constructed and not simply self-judgements against internally held values, they also described incidents of being treated by others as “less than” or in ways that suggested that they were inadequate and stigmatized; owning up to their symptoms would be “career suicide”.

This theme emerged in all fifteen Veteran cases in one form or another, across all three narrative settings of written personal reflection, interview and focus group. Far from being an innocuous side effect of PTSD, the fall into abject identity was a significant source of distress for these Veterans, and also a significant barrier to accessing treatment. This supports the
observations of Mason and colleagues (2001), who linked shame-laden depression to low cortisol levels of some Vietnam Veterans and the chronic, avoidant/disengaged coping strategies that showed up as dominant secondary compensatory adaptations to traumatic distress. Their psychoendocrine findings suggested that the relatively unstudied clinical feature of shame in PTSD is a particularly powerful, preoccupying, and overwhelming source of emotional conflict.

The depiction of PTSD as a masculine “fall from grace” that emerged from these studies is also consistent with the findings of Fox and Pease (2012) and several others. For example, Brooks (1990, 1991), considering the role of traditional masculinity in men's experience of trauma, called for greater attention to masculinity in regards to the mental health of Veterans and of their responses to deployment trauma.

Karner (1994, in Fox & Pease, 2012) appears to be the only researcher who has focussed explicitly on the relationship between combat trauma and masculinity in terms of a self/social-narrative. She found that traditional masculinity was the “master identity” by which the Veterans navigated their lives, and that it was the experience of failure to conform to their understanding of masculinity that resulted in their distress and their narrative foreclosure; their inability to continue to narrate a 'good man' view of themselves” (Karner, 1994, in Fox & Pease, 2012).

Strikingly, few other researchers have investigated this particular aspect of male Veterans experience of PTSD. This has not been true in research concerning women’s trauma. For feminist researchers, the development of new understandings of femininity has been a central feature of responses to women traumatized by rape, abuse and domestic violence. There, a rich research literature demonstrates the importance of social constructions of gender on both
women’s experience of trauma, and in developing gender-sensitive approaches to respond to it (Burstow, 2003; Butler, 2006; Harvey et al., 2000; Herman, 1998).

Despite the contributions of feminist researchers, contemporary approaches to military deployment trauma continue to focus on resiliency and risk factors – exceptional characteristics of external events or the individual, with little consideration given to broader social influences, and to masculine hegemony in particular (Fox & Pease, 2012; Hourani et al., 2003 and Schnurr et al., 2004). This is not surprising, perhaps, given that a key premise in the definition of mental disorder is that a syndrome occurs in an individual, and rests on some disturbance within the individual. Much like the first case study of the movie 300, the index event in trauma may be external, however the conflicts are represented primarily as conflicts of character versus self, with the implicit assumption that “normal” would entail a self, impermeable to, or at least less affected by external circumstance.

In this search for extraordinary influences that disrupt the integrity and functioning of the self, we may fail to perceive the importance of the everyday. The studies conducted here suggest that representation of trauma within a singular narrative of disorder “of the individual”, situated “within the individual”, misses key aspects, and potentially drivers of the male experience of trauma and recovery. Isolated and silenced in their shame, Veterans became barred from the very resources that could help them resolve these feelings and losses. As one focus group participant said, “Nobody wants to see the psychologist... like if you have to see the psychologist then you’re weak, broken”.
5.1.2 New Rules of Engagement

Both studies have highlighted how for males who subscribe to hegemonic and military masculine norms, the loss of standing, agency or control that accompanies traumatic experience can interfere with the ability to perceive, to live, and continue to narrate a meaningful life going forward. The self has been disrupted by experiences that cannot or will not be integrated into a coherent self story as a man. Into this “precarious social state” of masculinity (Vandello & Bosson, 2013), trauma brings heightened threat and an urgent need to regain, buttress, and defend lost status, or isolate and die (Meija, 2005; Fox & Pease, 2012; Westwood et al., 2012).

Consistent with Pleck’s (1995) assertion, seeing themselves falling short of the ideal “real man”, these men begin to exhibit a range of self-defeating behaviours to cope with the discrepancy between gender ideals and the realities of their own self-perceptions. Jack resorted to alcohol and drugs to try and contain unwanted emotional states, “I just pushed everything inside of me, I held it down”.

Mimicking Bordo’s (2000) observations about the presentation of strong men in popular culture, the Veterans entered the group program exhibited a kind of “face-off masculinity”. With cold stares they initially seemed to defy the other participants to view them in any way other than how they presented themselves as “powerful, armored, emotionally impenetrable” (Bordo, 2000, p. 186). As one participant put it, “everyone was holding back to see who’s who in the zoo”. 

Brooks (2010) documented how men adopt stereotyped responses of denial and suppression of tender and vulnerable emotions to fit in with the dominant ideas of masculinity. To feel the physiological symptoms of PTSD and need the assistance of others to resolve emotional needs is experienced as “emasculating”, and the manner in which care is given
appears to be critical to engagement. To be “coddled” or treated “softly” in the therapy setting appears to exacerbate the loss of standing for these men, and perhaps, inadvertently, amplify these coping styles. Participants in the focus group derided the way some clinicians had approached them in the past, referring to being treated as a “baby”, but also to being “emasculated”.

This is consistent with Brooks (2010, p. 34) contention that, “While the creation and the development of the psychotherapy establishment has been historically dominated by men, it has largely failed to develop models of therapy that are more harmonious with unique masculine ways of experiencing emotional pain and coping with distress.” Hoge and colleagues noted that there exists a stigma associated with seeking psychological care and the fear of stigmatization is particularly present in the early stages of contact with the mental health system (2004).

The VTP program, by contrast, commences with the Veterans interviewing each other in pairs about their “proudest moment” and then introducing each other, and that person’s proudest moment, to the group. Perhaps as an artefact of this exercise, midway through the first day, the participants seem to have an appreciation for each other as agentic, masterful men who are accomplished in the world, rather than as broken, weak and out of control. Perhaps as a result, from the first interactions it becomes a group that the participants want to be identified with, not a group that is seen as stigmatizing to belong to. In the focus group, identification with respected peers was an important and explicit distinction made between their engaged involvement in the transition program and past experiences in programs associated with processes or people seen to be abject, weak or failures.
The centrality of performance testing in the military, and the need to “measure up,” heightens dependence on the esteem and estimation of others while also heightening the vulnerability to and influence of shame (Barrett, 1996, p. 141). For these clients to engage in therapy, therefore, clinicians needed to attend to issues of cultural “safety” and appropriateness in order for safe social bonds to develop. This is likely an issue of framing the therapeutic environment in ways that recognize and support notions of competence and skill first. As noted earlier, by creating conditions of safety and recognizing resources and strength, capacity is created to explore vulnerability and emotional content. Explicitly recasting therapeutic activities as within masculine role norms, or even as proof of compliance to hegemonic norms, appears to have been a critical aspect of the formation of a therapeutic alliance, establishing group cohesion, and facilitating reparative peer attachments.

5.1.3 Conscientisation and the Re-Negotiation of Masculine Norms

Within the context of this group of peers, Veterans seem to have engaged in a process of social-reconstruction of the meaning of PTSD, elaborating new narratives of their experience in such a way that PTSD could be given a comprehensible place alongside pride, honour and a sense of competence. These reconstructions bridge the gap between the clinical reductions of disorder lying “within” the individual, and the larger pressures of hegemonic social norms. Perhaps as evidence for the socially-constructed nature of hegemonic norms, and the force and influence of these norms in the reasoning and meaning making processes of the individual, it was not alone that these self-identities were renegotiated, but within the “Band of Brothers”.

For Jack, the climax of his narrative comes after he finds a group of fellow soldiers who are able to tell each other their stories, and provide witness to each other’s experiences. In this
environment, he receives permission from other men to put words to his experience and to integrate his reactions into his self-story. He says, “This gets rid of the thought that men can’t have emotions; that men aren’t allowed to feel.” We have to suck it up and soldier on”. Here, Jack discovers he can finally come home; “sharing stories… you notice how much you have in common”. Within a social context of narrative co-(and re) construction, he receives permission to feel, without seeing that feeling as evidence of his own failings as a man and as a soldier.

As another participant wrote, “I felt that we were a troop who was facing our fears and all standing beside each other against a common enemy. My sense of despair left and was replaced with hope”. Or as Participant 1 in the focus group said, “Through sitting in a group of my peers… ...I was able to be proud again of what I did, and proud of my job and proud of what I went through. So instead of feeling shame about it I was able to be proud of myself again”.

In a group of respected peers, social renegotiation of personal storylines begins to take place. It seems that it was difficult for these Veterans to “step back” and create a coherent narrative that included PTSD and being a competent man, except through safe and cohesive social dialogic relationships, Freire’s process of conscientisation, with respected peers.

Expressing feelings and supporting others in the expression of their feelings, becomes redefined as “courageous”, the “hard thing to do”, as “men’s work”. “I’m not afraid of hard work”, says one Veteran in his interview. Paradoxically, the very expression of emotional life that was previously stigmatized becomes construed as a form of agency – the hero’s path. Finally, there is something that can be done – courageously, and in bold self-assertion against the hegemonic masculine norms, these Veterans could collaborate in building a parallel meaning structure in which the strongest men are able to feel and speak their truths (Michaels, 2011).
5.2 Novel Contributions

Stake (1995) noted that seldom through research is a completely new understanding reached, but refinement of understanding is. The goal of this research has not been to map and define the world of Veterans trauma but to “elaborate the beholding of it” and several unique findings have emerged that offer refinements to our understanding. The research studies tapped into participants’ perspectives about their trauma and about what worked and didn’t work to engage them in therapy. As experts in their own experiences, these perspectives were crucial to these refinements.

5.2.1 Not the What, the How

Tannen (1990) noted men’s inadequacy as partners because they are so “emotionally walled off and uncommunicative”, and Levant (2003) coined the term “normative male alexithymia” to describe men’s inability to identify internal affective states as a result of complying with masculine proscriptions against emotional content other than anger. Noting men’s apparent preference for advice giving and information sharing rather than emotional support and sharing, several researchers have suggested that there is a conflict between masculine and therapeutic norms (Brooks, 2010; Englar-Carlson & Stevens, 2006; Addis & Mahalik, 2003).

What emerges from the narrative of these Veterans as they engage in therapy, however, runs counter to the popularized notion of emotionless and unsupportive “walled-off” men. While Brooks (2010) argues that traditional male socialization creates a barrier to therapy by predisposing clients to hide private experience, maintain personal control, appear stoic, present the self as invincible, and value action over introspection, this study suggests another possibility. Instead, here, self-disclosure, recognition and expression of emotion, introspection, openness to
vulnerability and struggle, and mutual support become redefined as evidence of masculinity, in a helpful parallel meaning structure.

Shelley Taylor and colleagues (2000) work on female trauma promotes the idea that women’s response to trauma involves a “tend and befriend” instinct that is fundamentally different than the typical “every man for himself” response of men. The research presented here raises the question, if men did not rise from boyhoods in which shame was “pervasively” and traumatically used to reduce their range of expression and promote conformity with traditional masculinity (Mejia, 2005), would their responses still be fundamentally different? Once an atmosphere of non-judgement among respected peers was achieved, Jack expressed relief at the opportunity to connect and to share emotions. Similarly, the participants in the second study spoke at length about their care and concern for one another.

The narratives examined in these studies suggests that the disconnect between men and therapy lies not so much in the “what” of therapy, but in the “how”. These Veterans’ narratives suggest that therapy can be made culturally-safe for men who conform to hegemonic norms, through changes in framing, language and metaphor, and that when these conditions are met, Veterans are highly capable of emotional sharing and support. This raises the question as to whether Levant’s (2003) “normative male alexithymia” is a “real” male incapacity or the artefact and iatrogenic effect of culturally unsafe therapeutic environments.

5.2.2 The Colonization and Displacement of Personal Meaning Spaces

Shearer-Creeman and Winkleman (2004) examined the impact of public rhetoric around “survivorship” on narratives of women who had been abused. They noted that while notions of “survivor” provide abused women with an abstract sense of companionship with “like” others,
the concept also colonizes and displaces their own meaning making around the trauma they have faced, and their conceptions of healing. In this way, the language of survivorship constrains the client and limits her ability to have her own experience, in her own language. Yet the need to fit in society precludes rejection of these “recipes”, denies personal authorship of meaning, and forces them to accept societally mediated definitions.

While such feminist writers have wrestled with these cultural dilemmas and searched for ways that women can inject their own stories and meaning into socially prescribed models, this scholarship and clinical research appears largely absent from study of men’s trauma. While Karner (In Fox & Pease, 2012) documented the influence of ideas of masculinity on the experience of combat trauma, and on Veterans ability to narrate successful self-stories, her work stopped short of proposing pathways to more life embracing storylines.

The colonization of male Veterans experience of their trauma with hegemonic masculine role norms, and the problems that ensue, shows a parallel need for such scholarship. The work presented here, suggesting culturally safe and relevant approaches to engaging male Veterans in therapy, is an initial contribution to research in this much needed area.

5.2.3 Diagnosis as Iatrogenic

Taken together, these studies suggest that the hegemonic masculine ideals of the military culture and the master narrative of PTSD, may present the male Veteran diagnosed with PTSD with a binding contradiction of master narratives that leave little space for them to inject their own meaning into forcefully prescribed social models. Against the backdrop of masculine hegemonic norms, reinforced by society and by military training, Veterans who experience
lingering effects of trauma may begin to narrate their symptoms and PTSD diagnosis as “failure” or weakness - a fall from masculine grace.

The APA task group working on the updated DSM 5 noted that “certain military leaders” urged a change to rename the disorder posttraumatic stress injury, believing that the word “disorder” makes soldiers who are experiencing PTSD symptoms reluctant to ask for help. The simple logic was that an injury implies a cause coming from outside, while a disorder is situated within. The APA responded, however, by urging the military to make changes so that mental health care is more accessible and soldiers are encouraged to seek it in a timely fashion.

This position presumes that the diagnostic system stands outside of the social discourse. This analysis suggests that this is not the case. While the DSM language of posttraumatic stress disorder may be helpful to clinicians, it is incomplete and potentially problematic for male Veterans. Failure to take into account social influences on gender may contribute to the isolation, stigmatization and suffering of male Veterans, and in extreme cases, may contribute to the desperate final stand taken in suicide.

5.2.4 Trauma Therapy as Liberation from Oppression

To my knowledge, the application of revolutionary theory to the oppressive effects of gender hegemony in male Veteran trauma has not been ventured in the literature before this point. By contrast, feminist literature has extensively explored the oppressive nature of societal expectations on women, and the complex interplay between these norms and women’s experience of trauma (For example, Butler, 2006; Jordan, 2004; Shearer-Creeman and Winkleman, 2004).
Although our review of the state of knowledge around the neurological and endocrinological impacts of PTSD demonstrates the very real physiological impacts of this disorder, viewing the related suffering and negative outcomes as secondary psychogenic effects of oppression related to gendered meaning making, affords critical insights into Veterans access engagement and the impact of treatment. Critically, the neurophysiological evidence offers some tentative support for such a contention (For example, Gill et al., 2008; Hellhammer et al., 2009; Mason et al., 2001; Olff et al., 2007; Yehuda et al., 2009).

While unaware of the cultural forces that shape and contain them, human beings remain ‘submerged’ in their circumstance and cannot reflect upon them critically (Freire, 2011). When male Veterans experience themselves as failed men, it is a difficult task to emerge and critically reflect through “high road” processes on the cultural programming that defines and delimits these value systems. Thus, when the narrative view of self sees certain features of the past, helplessness, the moral depravity and animalistic nature of one’s own or others behaviour, or perceives meaninglessness in prior sacrifice, this can bring shame, loathing, deep pain and regret (Freeman, 2011). Understanding the ways one’s socialization can bind and constrain personal narrativity enables one to take action to change oppressive forces (Freire, 2011).

Freire’s concept of conscientisation, becoming more critically conscious, is reminiscent of the cultivation of self-control and integrated self-awareness that is normal when in “learning” rather than “survival” mode. Like Freire’s problem posing dialogic, the personal narrative becomes a problem or puzzle that the Veteran can hold out from the body, to be turned and manipulated, entered and exited, in order to see it anew, and from that new externalized vantage point enter into a new, “critical” relationship with it.
5.3 Cultural Safety in Trauma Work with Male Veterans

Safe social bonds, whether through group membership or as a therapeutic alliance, are widely regarded as a prerequisite to engagement in the “tough” work of PTSD (Herman, 1997). For male Veterans to engage in therapy, clinicians need to attend to issues of cultural “safety” and appropriateness in order for safe social bonds to develop. This requires that clinicians have a strong understanding of the military culture and the dominant influence of traditional masculine gender roles.

Consideration of the basic assumptions underlying the diagnostic system of the DSM suggests that the conditions for cultural safety, and its impact on Veterans engagement, may also be affected by counsellors’ attributions regarding the etiology of trauma and its psychosocial sequelae. A number of researchers have noted that, although the professional counselling relationship may be supportive, to the degree that it focuses exclusively on inner processes and sources, the therapeutic relationship can easily provide the meta-message that the problems in play are the result of inadequacies, damage, or deficit within the client (Fincham, Bradbury, Arias, Byrne, & Karney, 1997; Rempel, Ross, & Homes, 2001). Gergen (1991, 1998), McKnight (1995), and Duncan and Miller (2001) have all pointed out that therapy clients are exquisitely vulnerable to this kind of influence on their sense of self and social identity. Although these researchers have not explicitly implicated men’s trauma in these arguments, the studies conducted here suggest that such a caveat is pertinent to this population.

The results of the present studies showed that the basic assumptions associated with the PTSD diagnosis can imply or overemphasize internal causes of psychological distress. In some ways, the diagnostic framework may influence psychotherapy to be differentially oriented
toward attribution of dispositional as opposed to contextual causes to human distress. Whereas an individual therapist and an individual Veteran client may be able to do little about systemic hegemonic masculine gender ideals, they can address the issue of how a person caught up in the influence of these forces can bring about an optimal adaptation at a personal level.

McKnight’s (1995) critique of professional service provision is that, at minimum, it tends to identify people with problems, to displace political action, and to lead to systemic aggregations of services that, while individually benign, are collectively harmful. In short, psychotherapy that does not include an emphasis on context may, intentionally or not, subtly reinforce the very conditions that contribute to Veterans’ suffering and which are, ultimately, maladaptive.

5.4 Implications for Exposure Work

Brown (2012) argues that shame is the emotion that protects us from disconnection. Aspects of the self that others will not accept, and that render the self abject and unworthy of connection, are forcefully submerged in order to not threaten attachment and connection with others in the social group. Because it brings the expectation of negative evaluations by others, shame is, understandably, accompanied by a desire to hide or withdraw. However, if this withdrawal is extensive, it can exacerbate shame by denying exposure to countervailing experiences that could reduce expectations of censure, ridicule and rejection.

Most theories of PTSD attempt to explain the long-term sequelae of PTSD as an individual response to external events that involve actual or threatened death or serious injury, or violence (APA, 2013; Litz et al., 2009). As a result, most current evidence-based models of treatment emphasize the management or extinction of fear memories and do not consider the role
that shame could play as an internal perpetuating factor. However, for the Veteran who has fallen into an abjected self-story, repeated exposure to their trauma experiences without additional components that address the experience of shame, could lead to iatrogenic effects. Repeated remembrance of trauma experiences would simply be re-exposures to evidence of personal failing, which, without targeted corrective therapeutic strategies, would be counterproductive and potentially harmful.

Litz et al., (2009) note in their research on moral injury, that while fear extinction and loss recovery seem to be hard wired and occur spontaneously (after unreinforced exposure to conditioned cues, or reengagement and reattachment in relationships, respectively), there seem to be fewer spontaneous opportunities for correction of beliefs about personal defects and shortcomings. This research suggests that targeted strategies for shame are a necessary adjunct to exposure therapies, and that lack of such strategies could inadvertently allow exposure work to become a secondary traumatization that propels Veterans into increasing avoidance responses, exacerbating and complicating the course of trauma and future treatment.

5.5 Clinical Care Model

This research suggests that trauma treatment for male Veterans who identify with hegemonic masculine norms, needs to be deployed with specific cultural modifications that orient male values and norms to align, rather than conflict with therapeutic goals. For the purposes of stimulating discussion, and as a working model of clinical care, treatment should be reworked to build opportunity to directly address the issue of gender norm driven shame, and to build more nuanced definitions of successful masculinity. The model of care proposed by Litz et al., (2009) for addressing moral injury has points of convergence with what is proposed here as their model is also directed at the issue of shame, though related to perpetration of immoral acts
rather than from gender role strain. I propose that treatment should include the following intersecting and iterative (non-sequential) elements that, combined, create the conditions and cultural milieu for connection, and courageous conversations about consciousness and commitment:

(1) **Cultural Relevance** – create the space that welcomes the warrior into therapy by creating an environment that calls for the strength of the stereotypical male role in a different kind of battle, a “battle for the mind”. This careful attendance to issues of cultural “safety” during the initial connection and attachment phase of therapy includes the opportunity to connect through mutual regard. These men, who have “fallen from grace”, yearn for inclusion by respected peers, however their symptoms, and the meanings that they have given them, bar their transparent or authentic self-insertion back into community. In group therapy, there is opportunity for introductions to be focussed on agency, acknowledgement of accomplishments, courage of attendance and capacity, as a prelude to responsibility, self-reflection and the hard work of self-disclosure and action-based return to health. This acknowledgement of strength as a starting point can help establish the resilience needed to explore more difficult aspects of experience. In individual therapy, exploration and acknowledgement of capacity will look different, but is equally important and possible.

(2) **Courageous Conversations** – direct, courageous, emotional-focused exposure-based processing of experience related to shame laden beliefs. It is important, perhaps, to emphasize that starting with acknowledgement of strengths is not a dismissal of the Veterans self-critical and shame-laden reactions. Platitudes and pat reassurances of worth will not shake these feelings, and at worst, may drive them underground. Instead, this is a beginning of co-construction of a more nuanced vision of masculinity – one that embraces complexity and the
possibility that struggle and even defeat can co-exist with strength, honour and courage. We have seen that avoidance-focused coping strategies preclude the conditions for high road integration and extinction of fear experiences. Similarly, avoidance of issues of shame associated with abject gender identities will bar the kind of transparent, authentic self-insertion in groups of peers that could create countervailing experiences.

(3) **Connection/Standing Together** – carefully mediated real-time countervailing experiences with peer acceptance, or even pride, that combat isolation through mutual resourcing. As Litz et al. (2009) note, and as also found here, service members tend to be good leaders and, given the opportunity, offer habilitative and encouraging advice to peers. Their thinking, as with most of us, tends to be more accepting and less black and white when applied to others than themselves. Creating culturally safe opportunities for connection uses this inherent strength to create corrective experiences of inclusion, acceptance and mutual pride. Where Veterans are able to first give the very thing that they yearn to receive, their self-worth is paradoxically re-established through their contribution to others. Whether by working to create cohesive attachments in a group therapy setting or by maximizing connection to community outside of the individual therapy room, the active strategic work to connect men to each other and to their community is key to ensuring they remain resourced and resilient.

(4) **Critical Consciousness** – education to align treatment goals with personally held and performative norms of masculinity, including the re-languaging of therapy processes and goals. The place for ideals is as aspiration, as inspiration. When ideals serve as a beacon that, through resolute action, draw one forward and help give direction to life decisions, they can be positive and life affirming. We have also seen, however, how hegemonic ideals can slip down to serve as harsh and judgemental comparatives, as sources of shame that bind, silence and isolate.
Therapy, therefore, must create opportunities for cognitive re-structuring and reframing of key identity and experience narratives. In order to not remain “submerged” in the automaticity of self-judgement and foreclosed self-narratives, frank discussion of the damaging and self-defeating norms of hegemonic masculinity, and active re-definition of the meaning of trauma experiences, and of therapy, is essential for movement from a stance of abjected passive recipient of treatment, to active agentic responsibility for self.

(5) Commitment and Accountability – establishing personal and interpersonal accountability to values and goals. Trauma has disrupted the trajectory of the personal narrative, shifting from the “progressive” narrative of ever increasing mastery over self and world, to a “regressive” narrative marked by loss of mastery over self and world. With the non-judgemental acceptance of respected peers, a shift from a passive state begins to emerge, towards taking control and personal responsibility, re-establishing their place as motivated, agentic men, engaging with the challenges presented to them. This shift reflects the emergence of one of the most powerful buffers against despair and suicide, hope; an essential ingredient of change. For many men, who are more comfortable orienting to “doing” than “expressing”, hope may be best preserved by its translation into committed aspirational action – into a deeply “felt” sense of what needs to be done. These goals, and engaging in the associated “hard work” to move towards them, can be sources of pride for men. These goals can also be supported by the accountability created by disclosure of intention to respected others, as this taps into deeply held needs to be regarded as competent. This use of hegemonic gender norms to drive healthy behaviour must, in turn, be tempered by courageous conversation about context, struggle, setback and defeat, highlighting the continuous and iterative nature of this work.
The foundation for effective work with Veterans, who identify with hegemonic norms, as with work across all cultural boundaries, is high regard and profound respect for the “other.” Through culturally relevant, courageous conversations that provide opportunity for connection and critical consideration of experience and meaning, these men can move back into committed and accountable engagement in life and community. Mental health professionals can embrace the strengths present in the traditional male client and build on those strengths, while helping them break free of the need to project a competent, unemotional image. These men can then start to take responsibility for their lives and move toward healthier, more productive behaviour and relationships. When these Veterans, who are our fathers, brothers, sons or partners, are better served by culturally appropriate mental health services, we all stand to gain.

5.6 **Future Directions**

Future research will be important to replicate the findings in other populations of Veterans, and with civilian men, to further develop the conceptual model and applications. As noted in the literature review, there are multiple masculinities that differ over place, culture and time, and further study is needed to better understand whether these gender impacts are held in common or are unique to male Veterans.

The literature review also noted the physiological impacts of trauma on the HPA and neuroendocrine function. Future work could measure Cortisol and DHEA directly through salivary cortisol to look at whether changes in biological markers of stress-related hypothalamic–pituitary–adrenal (HPA) axis activity are correlated to narrative shifts into agency and accountability. As cortisol and DHEA levels are also suggestive of systemic load and neural integration of trauma memories, that is, whether memories are physiologically processed as events “remembered”, rather than as moments “relived” in the present, these measures could also
be used to consider the effects of recounting trauma narratives on physiological stress response and would bring additional lenses or “ways of knowing” to the complex terrain of masculinity and Veterans’ PTSD.

Although the primary lens applied in this research has been on the Veterans’ narratives, and the intersection of masculine role norms and their treatment experiences, group-counselling theory provides an additional lens through which to view the trajectory of change as it occurred in the Veterans Transition Program. The context of group therapy has many implications for what has been observed in these studies including but not limited to the creation of safety, the emergence of group cohesion, and the shift from “norming” to “performing” stages of group development. The research presented here focused on the participants narrative accounts of what had transpired during the group process. These accounts tended to downplay the importance of the facilitators specific interventions or skill, which undoubtedly played an important role in creating the conditions for the Veterans to colonize the space with their own metaphors and language and create cohesive social bonds. Rather than focusing on the agency and mastery of the “helper”, participants’ narratives tended to be focused on the mastery and agency of the self and other participants. Future research could reverse this figure/ground and focus on the helper interventions and interactions that were the fulcrum of change, and which likely contributed to the conditions that “allowed” the Veterans to colonize the therapy space.

Research may also explore whether the hegemonic masculine influence on access and engagement has relevance to the development of group programs for civilian populations exposed to traumatizing events such as armed conflicts, terrorism, and natural disaster, and to work with other populations of traumatized men who are equally challenged in accessing services, such as vulnerable youth, patients with prostate cancer and men in later life. Further
investigations could enhance our understandings of the reach of masculine hegemony and perhaps reveal the sequence in which facilitative factors interact during the group re-negotiation of masculine norms.

5.7 Limitations

As noted in the introduction, Silverman raises the question about how far a given research setting is consequential to the data collected (Silverman, 2010). In these studies, the narratives are told by participants in a particular therapy setting and therefore the observations will be very much influenced by that setting. On the other hand, the influences on Veteran experiences, and their access and engagement in therapy are unlikely to be unique and discrete to this setting, but rather exist as “occasioned and contextualized” ways of interpreting, representing and ordering experiences and social relations (Silverman, 2010, p.52). This means that the influences on access and engagement are wound up and linked with public life and not located in one geographic place.

Nevertheless, from the cases analyzed, I have proposed that the complexities of male Veterans’ trauma experiences, and their access and engagement in treatment, are impacted by an interplay of a ubiquitous gender socialization and the physiological sequelae of trauma, and yet I have not provided any empirical proof in support of that claim. Rather, I have mined a small number of illustrative cases from one Veterans’ program. Additionally, this research was confined to participants who fit specific program inclusion criteria and random sampling was not employed. Results were therefore derived from the experiences of a small, homogenous group of individuals, and generalization to the larger Veteran population is neither advised nor intended. Instead, observations in this setting allow us to make tentative theoretical assertions about the broader contexts in which Veterans live with their trauma experiences, and the ways
that hegemonic masculine role discourses, colonize and complicate the personal trauma stories of affected male Veterans.

Further, Nietzsche’s dictum that “to perceive resemblances everywhere, making everything alike, is a sign of weak eyesight” (1974, p.74), reminds us that the very process of identifying themes leads to the loss of detail about differences. Moving from stories, to thematic concepts, to emplotment, to theory, is an exercise that allows the complex and unfamiliar to seem more familiar and navigable, but it is just a “seeming”, not reality itself which retains all of its complexity. For this reason, consideration of the themes presented should be a dialectic that preserves the distinction between map and territory.

A number of questions can be asked about why these particular cases were selected. Even if the importance of weaving together the narratives from different sites is appreciated, why, for example, was the film 300 chosen and not other warrior films? Why the first seven minutes and not a different part of the film? Why use Jack’s story and not others? Why this particular program? It cannot be avoided that the answer is at least in part that I have found resonance and opposition within these texts which helps the analysis. The reader is right to remember that I have inevitably interpreted the examples and could have unintentionally biased the representation of the individuals and their circumstances to support my claims. The studies are therefore open to the criticism that they are overly subjective, that cases have been chosen to fit with a particular reading of an important area of analysis, and as such are reification of an academic position rather than an empirical account of the social world; confirmation bias writ large, if you will.
I have attempted to limit the influence of this bias through the use of “validity” or trustworthiness strategies recommended by Creswell (2009). Specifically, these studies employed triangulation of theory and data sources, bringing preliminary findings back to participants to check accuracy and fit, using “thick description” to convey the results directly to the reader for their own judgement, clarifying researcher biases up front, spending prolonged time in the field with these Veterans, and using peer debriefings to check process and tentative conclusions. Nevertheless, it has not been possible to make completely objective observations and conclusions, and therefore this remains a major limitation of the studies.

In narrative research, trustworthiness refers to well-grounded and supportable (Polkinghorne, 1988). The researcher must present evidence to support the conclusions they make and present the reasoning that led to their conclusions. Polkinghorne, however, notes that the argument presented does not result in certainty; it produces likelihood (1988). He goes on to observe that, although the methods are quite different than quantitative research, Karl Popper proposed that verisimilitude is the limit of all scientific inquiry, and we therefore limit our claims to the demonstration of the falsity of null hypotheses rather than “truth”. The conclusions presented here, likewise, remain tentative, and are open to scholarly critique and consensus as the ultimate test of verisimilitude and therefore credibility and trustworthiness (Polkinghorne, 1988, p.177-178).

Finally, the studies here ventured from theme identification to interconnection of themes in narrative storylines that were suggestive of causal trajectories. Based on the participants reported experience it was possible to speculate on the mechanisms and process of changes in masculine norm definitions as Veterans became engaged in therapy. Experimental design that specifically manipulates variables while holding other dimensions unchanged, however, is what
is needed to isolate cause and effect relationships. In terms of scientific method this is a serious limitation because it does not allow for the validation of a given theory (Popper, 1958).

However, in terms of social action and examining cultural sensitivities for clinical practice, the issue is more about the ability to grasp the complexity of a given situation, and this kind of result is valuable.
Chapter 6: Conclusion

This research sought to reduce the gap that exists between the needs of male soldiers with posttraumatic stress injuries and current clinical knowledge around the impact of gender socialization on subjective experience and narratives about self, trauma and treatment. The studies conducted attempted to answer questions about how the broader social and cultural milieu shapes and colonizes Veterans’ personal experiences and complicates their recovery. This research project also looked to identify whether there were discernable, and replicable, pathways to access, engagement and impact that these men travelled to participate more fully in treatment, relationship or community.

The cases explored in this research project suggest that oppressive hegemonic masculine norms have undeniable impact on the trauma experiences of male Veterans. Veterans are often marginalized and remain silent about their service related trauma experiences; however, the findings of this research are hopeful. Under the right conditions, a culturally safe, gender-informed approach to Veterans’ trauma work can contribute to more accessible, relevant and effective trauma treatment that respects male Veterans’ existing courageous and agentic helping and healing efforts.

Therapists are in an ideal position to contest and subvert these hegemonic impacts and to propose, and help Veteran clients negotiate, contrasting and more life-embracing narrative accounts. Rewriting the rules of masculinity to recognize the battle for the heart and mind as valid, courageous and a sign of strength, restores dignity to the individual and brings to light inherent capacities and convictions that enhance their ability to resolve whatever difficulties they face. The following poem written by Tim, a participant in the transition program, attests to the
impact and importance of creating culturally safe spaces for these men to come together, to “tend and befriend” one another as men, so that finally they no longer have to face their traumas alone.

In the Company of Men

In the company of men I am never alone
For they understand me, I am no longer a drone
All the weight that I carried bore me into the earth
But they have since dug me out with shovels, smiles, and mirth

The connection we share is more valued than gold
We united souls stand on guard. To have is to hold
In our lives we have faced demons, all-encompassing black
But this light to which we cling illuminates our track

Together we shall stand, face to face with our demons
With battle cry and drawn sword we protect our feelings
In the ranks with my Brothers I stand tall, true and brave
To the evil we have faced never again be we slaves

Tim G.
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Appendix A: Consent Form

OUTCOME RESEARCH ON THE GROUP-BASED VETERANS TRANSITION PROGRAM
CONSENT FOR RESEARCH PARTICIPATION
Delivered through the University of British Columbia

Principal Investigators:

Dr. Marv Westwood, Department of Educational and Counselling Psychology, the University of British Columbia. Dr. Westwood can be contacted at:

Co-Investigator:

Stu Hoover, doctoral student in the Department of Educational and Counselling Psychology, the University of British Columbia. Stu can be contacted at:

Duncan Shields, doctoral candidate in the Interdisciplinary Studies Graduate Program, the University of British Columbia. Duncan can be contacted at:

Overview of the Program

The Veterans Transition Program is a 10-day group-based program designed to assist the transition of military personnel back into Canadian society by aiding with their personal and career readjustment. Participants in the program are veterans who have experienced varying degrees of combat-related trauma.

Led by trained psychologists, the program takes place in three stages, with a month between each stage. Stage one occurs over four days at a residential centre. Stage two begins a month after Stage one and is also four days long at a residential centre. Stage three begins a month after Stage two, and is two days long at a residential centre.
Confidentiality

Your participation in the VTP will be held in strict confidence, unless you provide written consent stating otherwise. Limits to confidentiality include the following:
- Harm to self or others
- Harm to children or vulnerable populations
- Court ordered subpoena
- Research study (your identifying information is made anonymous)

Risks and Benefits

Because of the in-depth, experiential nature of trauma repair work, there is potential risk of elevated levels of psychological arousal. Veterans may access and relive stressful memories and thus may experience intense cognitive, emotional, and physiological reactions. This risk is addressed and contained by a highly structured environment that employs trained psychologists who focus on the development of group-based safety and support. In addition, you as the participant are always in control of the process. This is ensured by group norms that allow you to question or refuse any intervention suggested.

Benefits of participating in the program may include reduced trauma-related symptoms, increased self-reflection, self-acceptance, expression and release of negative emotionality, member-to-member personal validation, and social support (for more examples, please see Westwood, McLean, Cave, Borgen, & Slakov, 2010).

Exclusion Criteria for the Therapeutic Program

Veterans are not eligible for participation if they currently have psychotic symptoms; severe alcohol or other drug dependence; unwillingness to refrain from substance use during the treatment program; significant cognitive impairment; current planful suicidal ideation; and/or a severe cardiovascular disorder.

Brief Overview of our Research

The research component evaluates the outcomes and change processes within the Veterans Transition Program (VTP). This consists of several questionnaires (e.g., measuring traumatic stress symptoms) that will be administered prior-to and after treatment, along with participant interviews. Measurements will occur before, immediately after, three months, one year, and 18 months post-program.
Parts of the group programs will be audio/video recorded. These recordings are for part of the evaluation of how therapeutic change occurs through the VTP program. During research interviews, parts of these audio/video recording will be used to cue your memory and explore your experiences during particular moments during the therapy program. You will never be recorded without your knowledge and the cameras may be switched off at any time during the program if you wish. If you wish to have cameras switched off at any point during the program you may ask any of the facilitators privately or in the group. Additionally, you will have the opportunity to view these recordings before confirming you consent.

Three times each day during the residential portion of the program, saliva samples will be collected to study the levels of a stress hormones, cortisol and DHEA, which is an indicator of how the body is responding to trauma and stress. Collection will involve holding a specially designed swab in the mouth for one minute and transferring (spitting) the swab into a plastic test-tube (called a salivette). These samples will only be used to consider how stress response varies through the program. There is no way to identify any sort of medical concerns from a single cortisol sample and the samples will not be used for DNA or any other diagnostic testing. Researchers will wear latex (or latex-free) gloves when handling containers before and after collection for hygiene reasons and to avoid sample contamination.

**Research Confidentiality**

Paper copies of consent forms, digital video recordings, transcriptions, and analyses will be retained in a locked file cabinet in the principle investigator’s locked office. The consent form will be stored separately from the demographics and transcriptions. Additionally, all digital files and backups will be password protected and encrypted. Only people directly involved in the research will see or hear the audio/video recordings. The tapes will be erased as soon as practicable after the research, and in any event within 5 years.

Saliva samples will be given a participant code to ensure anonymity before leaving the research site and being transferred to the lab for assessment. Samples will be disposed as soon as measurement has occurred according to guidelines for disposal of human bio waste.

**Risks and Benefits of the Research Study**

While all the risks of participating in the VTP may also occur during the research component, the level of potential risk is reduced, as the questionnaires are less intensive than the treatment program itself. Audio/video recordings will be securely stored and not accessible to anyone outside of the research team. There is some risk that you may experience a negative reaction to seeing yourself on the tapes when viewing them with the researchers.
Benefits of participating in the research component extend to a greater understanding of the transition process for veterans returning to civilian life. These additional benefits include an increased integration of the above (e.g., increased self-reflection) as a result of further processing during in-depth interviews. For instance, previous research participants have reported re-experiencing or experiencing new insights during interviews. By completing the questionnaires and interviews, participants may also gain further insight into their own psychological well-being and trauma related symptoms. In addition, results generated from the research component may benefit future treatment methods and may help benefit future veterans.

Let it be clear that your participation in research is not necessary to be involved in the VTP. Your decision to not participate in our study will in no way affect your involvement in the program or any future related events. Further, you are free to withdraw at any time you wish without question.

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the UBC Office of Research Services (604.822.8598) or if long distance (RSIL@ors.ubc.ca).
Consent Form

Title: Veterans Transition Program

I have read and fully understand the information contained in this document. Any and all questions I have regarding the contents of this document have been answered to my satisfaction and I would like to participate in this research study examining the Veterans Transition Program. I have been given a copy of this form for my own records.

Name: __________________________ (please print)

Signature: __________________________

Date: __________________________

Home Telephone Number: __________________________

E-mail: __________________________

Mailing Address (include city and postal code) __________________________

☐ Yes You may contact me in the future in the event that Dr. Westwood’s lab receives additional funding for research on veterans.

☐ No

Keep this form for own records.

*All responses will be held confidential*
Appendix B: Praxis

Paulo Freire (2011) defines praxis as "reflection and action upon the world in order to transform it". Through critical awareness of limiting conditions, those who are marginalized and their allies, can struggle for liberation. This research project highlighted the ways in which social discourse around masculine gender norms can isolate, silence and exacerbate the suffering of male Veterans with PTSD. The overarching aim of this research project was not simply to follow the knowledge journey from case into theory through research. Theory must be translated into action, as praxis, to rewrite the politics of hegemonic power and dominance (Jordan et al., 2004).

To this end, opportunities were sought to disseminate the research in scholarly forums as well as translate the research for non-academic audiences, both military and civilian. Consistent with that aim, aspects of the project were presented in the following forums:


In addition, the following articles were written for a general readership, to: 1) introduce the ideas to a military and Veteran population; and 2) translate the lessons learned from this research for a general population and civilian men. The first article was written for a military audience and published in the Guard Star: The Newsletter of the Governor Generals’ Foot Guard Regimental Association, Fall, 2014. The second article was published in Visions: BC’s Mental Health and Addictions Journal, 2014, 9(4). Both articles are included here in full.
The Guard Star – Never Alone: Supporting Veterans with PTSD

Between ten to thirty percent of our 811,000 Veterans and serving military personnel are expected to experience operational and posttraumatic stress injuries (PTSD) after their deployments, and sometimes not until long after. This translates into an estimated 81,000 to 214,000 Canadian Veterans who will struggle with PTSD, and an unknown number living with other difficulties after their service. Exposure to operational stressors can rewire the brain to adapt to the up-tempo of deployment, and this response doesn’t necessarily “unwire” itself after coming home. This neural groundwork can then trigger a rollercoaster of intrusive reliving and physiological activation, and a desire to suppress and avoid triggering memories.

Males, who make up the majority of the military population, experience negative outcomes from PTSD at proportionally higher rates than their female compatriots, and also have significantly lower usage rates for treatment. Research suggests that valued “male” qualities, such as a high standard of self-discipline and emotional control over fear, and a strong “warrior” identity that is aggressive, dominant, and risk taking, can make admitting to difficulties and seeking assistance post deployment more difficult. These qualities, which can aid task performance in times of conflict, can contribute to a tendency to hide personal struggles and interpret trauma symptoms as weakness post-deployment. Operational stress injuries are not weaknesses, however, they are normal responses to abnormal events and the stigma and silence around stress injuries is continuing to isolate and kill good soldiers.

Isolation is the single most dangerous contributor to Veteran suicide, and Reservists, who often lose the company of comrades who they served beside in theatre, are sometimes hardest hit. Isolation is not only about being alone, but is sometimes about being with friends and yet unable to talk about what’s happening. One Veteran of four deployments put the importance of
talking about his experiences with other soldiers when he came home this way, “There is another battle when you come home – one for the mind. It takes every bit as much courage, and that battle is not done alone. You never go to battle alone”.

Keeping connected to each other is one of the best ways that soldiers can help each other. You can “bust” a buddy who is isolating, take them for coffee and talk frankly about the challenges they face coming home. There is a time and place to be stoic, and a time to take off the armour, to rest and heal the body and brain in readiness for challenges to come. The discipline of keeping personally fit includes care for the mind. As one Veteran put it, “anyone can go get drunk, but sitting down sober and talking about what’s really going on takes real courage”.

As soldiers and as citizens we have a vital role to play, not just in bringing Veterans home, but creating the conditions for them to finally and fully feel at home. We honour the service of our Veterans not just by hearing the stories they are proud to tell, but also by standing shoulder to shoulder with them as they speak courageously about the experiences they would rather forget, but cannot. Those who have served should never have to stand alone.
Visions – Culturally Competent Care for Men

Mental health professionals are becoming increasingly aware that a persons’ culture shapes their identity, values, attitudes and beliefs in key ways. These cultural differences can also shape how people experience mental health challenges, what they believe about the meaning of the challenges they face, and what they feel would be helpful for them as treatment or healing.

While mental health counsellors and clients may not share the same cultural background, it’s important that counsellors respect the cultural background of the clients they work with, and be open to discussing how care can best “fit” the client. Counsellors need to be “culturally competent”; that is, speak and work with their clients in ways that make sense to the client and that don’t alienate them.

Feminist theorists have suggested that – in addition to what we normally think of as cultures, such as South East Asian or White Anglo-Saxon and so on – female gender (femininity) can also be understood as a kind of culture. This culture shapes societies’ expectations for females and can affect attitudes, opportunities, power in relationships and identity. For decades, university counsellor training programs have prepared mental health professionals to consider these kinds of impacts when working with female clients.

The mental health profession, however, has been slow to consider what effect male gender (masculinity) has on attitudes, opportunities and power in relationships when men experience mental health challenges.

It’s important to be clear about the differences between the terms, gender and sex, two central parts of our identity that are frequently confused. Sex describes the biological makeup of
the male and female body, while gender refers to a series of social roles and behaviours we begin to learn as children and are exposed to throughout our lives (e.g., masculinity or femininity).

While some functions, particularly reproductive, are determined by biology, all cultures have behaviour norms for males and females. These behaviour norms extend into every area of work, family life and social convention (Kilmartin, 2010). Each culture or social group may have slightly different expectations for the masculine and feminine role, but they are usually significant parts of how individuals in that social group understand themselves and their role in the world.

Most of us learn to comply with the dominant gender expectations of our social group at an early age and, if we examine them at all, come to view these norms as natural and normal (Barrett, 1996). However, within each male or female social group, individuals may identify very closely with gender expectations, or they may not feel the need to conform. We refer to those who conform closely to gender expectations as “traditional.”

“Traditional” men:

Traditional men have not been served well by our mental health system. In part, this is because we’ve been slow to recognize masculinity as “culture” and to consider that culture respectfully. Two decades of clinical work with men, and my recent research and work in developing the curriculum for a national program for male Veterans returning from service, have given me insights into how viewing these clients through a lens of “cultural competence” can help us understand how to adapt our services to better meet the needs of male clients.

Over the years, researchers have proposed many models of ideal masculinity. In 2006, a review of the research on male gender norms noted eight prized attributes that define the ideal of
masculinity in many cultures. These include: toughness, intensity, strength, competition, discipline, courage, sacrifice and aggressiveness (Englar-Carlson, 2006). Such ideals are often emphasized and exaggerated in settings where men take on demanding work in dangerous or difficult environments such as the military, policing or other traditionally male-dominated work environments.

These masculine ideals, although useful in some situations, do not serve men well in relationships, in caring for their health, in admitting to difficulties, or in seeking assistance. The traditional man has a need to maintain the appearance of stoic competence (not showing feelings, appearing to be in control, etc.) when faced with experiences that overwhelm or bring into question their personal sense of control.

This may make it more difficult for these clients to admit they have a problem, let alone ask for help. To avoid feeling shame, traditional men may continue to comply with masculine ideals of being tough and unemotional on the surface by hiding personal struggles from their families, close friends, work colleagues and mental health professionals. These men may remain silent rather than seek help through therapy.

Research has suggested that across the globe, most cultures tend to idealize a tough, strong and unemotional image of masculinity; therefore, asking for help is often seen as an expression of weakness and frowned upon by those who seek to conform to this strong male role model (Brooks, 2010).

Despite the many advances we’ve made toward equality between men and women, the fact remains that there is a large population of traditional men who view having mental health issues as weakness, failure and a loss of control. So, the challenge for mental health professionals
is to find a way to bridge the gap between men’s need for help and the cultural pressures to stay silent.

**Strategies to help the traditional man seek help:**

Multicultural theories and approaches can be helpful to create trust and reduce a client’s fear of the stigma associated with seeking help. Therefore, it’s important for mental health professionals to become culturally competent. This means that, regardless of their own cultural background and gender roles, mental health professionals must strive to communicate and practise in ways that respect and take into account the language and cultural realities of the people they are working with (Brown, 2008).

In my research and work with male military personnel and men in other traditionally male-dominated professions, I’ve found that the following changes to how I practise can make therapy more culturally appropriate:

- **Start with strengths.** For example, in the Veterans groups we start the program with an exercise that focuses on their “proudest moment,” rather than having them reveal the details of their trauma. Starting with a strength-based conversation rather than focusing on a deficit or weakness allows the men to get comfortable in the group and build cohesive respect-based relationships. This provides a solid foundation for later discussions about their trauma.
- **Make space for male language and metaphors.** For example, the men in our Veterans program are often more comfortable referring to the program as a “course” rather than “group therapy.” Similarly, one Veteran talked about his trauma work this way: “Only the toughest belong here. We’re in a battle. That battle is not done alone. You never go to battle alone”. Adopting the language that men are more comfortable with, and using examples
based on challenges they face, helps to engage men and move them to action. Metaphors based in work, sports, conflict and so on can be helpful.

- Recognize men’s preference for doing rather than talking as a starting point. Traditional men are often initially less comfortable than women when it comes to discussing their feelings or even admitting they have a problem. So, focusing on behavioural or “how-to” strategies can provide a familiar starting place to build confidence and demonstrate value in the therapy process. Self-regulation strategies (e.g., body and breath awareness) and self-coaching (cognitive therapy) exercises, which have a strong “how-to” component, can be high-value techniques in that they can be quickly mastered, so “fit” men well.

The foundation for effective work with traditional men, as with work across all cultural boundaries, is high regard and profound respect for the “other.” Mental health professionals can embrace the strengths present in the traditional male client and build on those strengths, while helping them break free of the need to project a competent, unemotional image. These men can then start to take responsibility for their lives and move toward healthier, more productive behaviour and relationships. When these clients – who are our fathers, brothers, sons or partners – are better served by culturally appropriate mental health services, we all stand to gain.