

# Field Notes: A Journal of Collegiate Anthropology

---

Volume 4 | Issue 1

Article 4

---

2012

## Going AWOL: Alternative Responses to PTSD Stigma in the U.S. Military

Katinka Hooyer

Follow this and additional works at: <https://dc.uwm.edu/fieldnotes>

---

### Recommended Citation

Hooyer, Katinka (2012) "Going AWOL: Alternative Responses to PTSD Stigma in the U.S. Military," *Field Notes: A Journal of Collegiate Anthropology*. Vol. 4 : Iss. 1 , Article 4.  
Available at: <https://dc.uwm.edu/fieldnotes/vol4/iss1/4>

This Article is brought to you for free and open access by UWM Digital Commons. It has been accepted for inclusion in Field Notes: A Journal of Collegiate Anthropology by an authorized administrator of UWM Digital Commons. For more information, please contact [open-access@uwm.edu](mailto:open-access@uwm.edu).

## Going AWOL: Alternative Responses to PTSD Stigma in the U.S. Military

Katinka Hooyer

---

*Abstract:* The psychiatric costs of war have contributed to an ‘epidemic of suicide’ linked to PTSD among United States military service personnel. Current research identifies ‘self-stigma as the barrier to care’ and dominant thinking surrounding interventions focuses on overcoming self-stigma to obtain mental health services. The research and programming is grounded in leading social- cognitive and behavioral models that focus on individual interactions. This descriptive analysis of high-profile AWOL cases provides a counter-narrative to this predominant biomedical discourse. In these cases, soldiers chance increased stigmatization through risking dishonorable discharge in their pursuit of care. The question emerges, is lack of help-seeking taking place due to self-stigmatizing or due to broader structural elements that restrict choices? And more critically, are dominant theories of health behavior that focus on individual choice relevant in contexts where there is limited autonomy? Preliminary ethnographic research with veterans and active duty soldiers in addition to content analysis of online military blogs and investigative news reports explore these questions. Anthropological models are introduced to provide a more fixed consideration of structural influences on individuals’ actions and to offer an alternative approach to intervention.

**Key words:** PTSD, OIF/OEF, veterans, stigma

---

### *Introduction*

When I read the headline I thought it was about the story I posted yesterday and then the shock hit that this was another story. Six more deaths tied to combat and four of them never went. Two children dead. Two Moms dead. Two National Guardsmen dead. Yesterday it was a Wisconsin National Guard soldier and today it is a post about a Hawaii National Guards soldier. Both of them were tied to PTSD and I sit here in total disbelief. So many still falling into the abyss when so many others have come out of the darkness into healing and I wonder why it is still happening.

August 21st, 2010 Wounded Times Blog<sup>1</sup>

An ‘epidemic’ of tragic deaths such as these have prompted a number of investigations into the psychiatric costs of war. Multiple deployments during almost ten years of war in Afghanistan and Iraq have intensified the emotional strains put on soldiers and their families. A military commissioned report entitled *Army: Health Promotion, Risk Reduction, Suicide Prevention* (2010) showed that the number of newly diagnosed cases of post-traumatic stress disorder (PTSD) increased from 2931 to 10,137 between 2004 and 2007, with the percentage of suicide deaths among soldiers with PTSD rising from 4.6 percent in 2005 to 14.1 percent in 2009. Additionally, soldiers diagnosed with PTSD were four times more likely to endorse suicidal ideation than those who were not diagnosed (Jakupak 2009). Despite this high prevalence of mental health issues, 87 percent of active duty and 73 percent National Guard soldiers *did not seek care* at 12 months after returning from war (Kim et al. 2010). Mental illness stigma was

Field Notes: A Journal of Collegiate Anthropology 4(1): 106-128. (May 2012)

Copyright ©2012 by Field Notes: A Journal of Collegiate Anthropology

identified as the *main barrier* to care: those scoring positive for a mental disorder were twice as likely to be concerned with being stigmatized than those who did not. Disturbingly, soldiers and National Guardspeople exhibiting the most severe symptoms were the least likely to seek treatment for fear their peers would lose confidence in them, leadership would view them as weak and careers would be jeopardized (Hoge et al. 2004). The study of stigma, in respect to PTSD, is of particular significance and urgency considering this grave problem.

The psychiatric costs of war might be quantified through recent longitudinal studies and cross-sectional anonymous surveys but the statistics become qualified through the personal blogs, illness narratives, investigative reporting and documentaries that give these numbers names. In an attempt to better understand and personalize these statistics, through a collection of ethnographic data, a counter-narrative emerges. It is a counter-narrative that on one level challenges the 'stigma barrier' story and on another embraces it through its very resistance. I am referring in part to the high profile cases of soldiers who have gone AWOL (at risk of being court-martialed and imprisoned) to seek out mental health treatment, but also to those who are discharged from service and denied PTSD claims. The class action suit *Sabo vs. United States* illustrates the gravity of the problem. The question is, does stigma play the dominant role in these heated issues?

In the first part of this paper I will review leading concepts in stigma science and briefly touch on how these frameworks are presented in the military. In the second section I will provide a more detailed application of these concepts through an analysis of cases of service members who went AWOL (absent without leave) to attain care for their PTSD. The intention is to explore the contradictions between the categorical divisions found in leading conceptual models and the everyday experiences of soldiers and vets. Mainly, how do such theoretical abstractions as self-stigma and public-stigma translate in the real lives of those suffering with PTSD? I will conclude with some anthropological approaches to stigma and how these understandings might contribute to successful health care policy and intervention.

### *Methodology*

The data collected for the case studies presented in this paper are from secondary sources starting with investigative journalistic reports obtained through an online news source. These high profile news stories of servicemembers who were AWOL, due to their PTSD, were located on both independent and mainstream websites, *Truthout* and *CBS Evening News with Scott Pelley Online* (dated June 2010 - January 2011). The actual narratives provided in the case studies were adopted from these investigative reports. To gain a better understanding of the public stigma surrounding these cases and PTSD in general, I combined preliminary fieldwork with online content analysis. I followed discussions on *Home Post: The Military in San Diego* and this online community's response to the controversial AWOL cases that made national news. This blog is underwritten by KPBS, the national public radio, television and web source in San Diego, California. The blog explores 'military life and military families': <http://homepost.kpbs.org/> but is not exclusive to servicemembers. *Wounded Times*, a weblog from the National Veteran's News Service was also used as a source. This blog focuses specifically on issues surrounding PTSD: <http://woundedtimes.blogspot.com>.

Additionally, I began preliminary fieldwork with ex-military mental health providers, veterans of Vietnam, Iraq and Afghanistan and active duty soldiers in the National Guard. This included semi-structured interviews with 12 individuals and attendance at two mental health conferences for veterans. My aim here was to explore the different experiences and understandings of stigma, PTSD, and help seeking between: (1) veterans and mental health providers; (2) veterans of different generations, and; (3) veterans/soldiers and the military (as presented in health reports, government mandates and anti-stigma strategies). This data is presented in the first part of the paper to illustrate conceptual frameworks but also begins to hint at the contradictions between stigma theory and veterans' experiences that are further developed in the case studies.

### *What is stigma?*

That's me. I'm in those statistics. I would never admit to PTSD because all this time I've been told [by the Army] that I'm mentally tough.

T. – National Guard Active Duty

Many receive medical discharges for mental illness. Those rumors spread and other soldiers get afraid to express their problems. It becomes an unwritten rule... everyone pretends to be strong. They want to keep their careers in line.

A. – National Guard Active Duty/mental health provider

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

This “spoiled identity” clearly emerges in the Military's understanding of stigma: “Stigma as defined by the Red Book is ‘the perception among Leaders and Soldiers that help-seeking behavior will either be detrimental to their career or that it will reduce their social status among their peers’” (*Army 2020* 2012:69). Military research identifies servicemembers' own perceptions, that depression, anxiety, and PTSD are signs of psychological weakness, as the main barrier to attaining care (i.e., Hoge et al. 2004). The fear is that one will be viewed as weak of character.

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

Since the 1960s stigma has transformed from a theoretical interest of the social sciences into a major public health issue. New conceptualizations of stigma in social psychology, anthropology and sociology have expanded Goffman's framework, with considerable variations on his definition, to be more practical in its application to health services research. These reformulations retain Goffman's ideas of "spoiled identity" and social exclusion but are more centered on health-related stigma with broader implications for identifying areas for intervention. Two leading concepts, as put forward by Corrigan (2000) in social psychology and Link and colleagues in sociology (2001), are presented below.

### *Cognitive behavioral model of stigma*

Corrigan et al. focus on individuals' psychological processes of stereotyping, prejudice, and discrimination in their model. Stereotypes refer to cognitive knowledge structures, prejudice to the emotional reactions to those stereotypes, and discrimination to the behavioral results of prejudice. Focusing on the psychological processes of individuals through these three core components allows for an analysis of various stigmatizing attitudes and behaviors. For example, stereotypes are distinguished from prejudice and discrimination in that they are "social" (collectively agreed upon ideas of groups or types of persons) and quickly generate impressions: "All vets are crazy". But awareness of this stereotype is not equivalent to endorsing the stereotype: "Yes, all vets are crazy!" or having an emotional reaction, "Vets are ticking time bombs, ready to blow up at any minute!" which shows prejudice. Discrimination occurs when the person doing the stereotyping acts on the stereotype: "I would never hire a vet!" It is the 'hot' emotional response of prejudice, not the 'cold' cognitive knowledge structure of stereotyping, that causes the discriminatory behaviors and stigmatization (Corrigan et al. 2001). In this way, people may have stereotypes about others, but if they are not reacting to them and engaging in discriminatory behavior, stigmatization does not unfold. This model and the research of Corrigan et al. focus on the behavior of the public on an individual psychological level.

The 'hot' emotional response of prejudice can further be illustrated through the undermining and teasing that goes on when soldiers seek mental or physical medical care. A common response to help-seeking in the military is: "What, you got sand in your vagina?" While this type of berating contributes to stigma processes it is also intertwined with military cultural practices that deliberately nurture self-reliance, mental/physical toughness and group loyalty in order to ensure combat survival. Yet, as recent anthropological research suggests (Finley 2011), mental health messaging that help-seeking is "not a sign of weakness" (i.e. the US Department of Defense's *Real Warriors* campaign) is in direct opposition to the psychological resilience essential and highly valued in military training. When this toughness cracks, the situation is often viewed as cowardice or a character flaw resulting in social exclusion.

While mental health providers say, 'We can help', the military community proclaims 'If you are broke, we'll kick you to the curb.

An Army chaplain (Finley 2010:110)

Military health researchers frame the situation slightly differently, acknowledging that stigma is "...especially pronounced in the military, where the pervasive culture is one of mental and physical toughness, 'pushing through the pain'" (*Army 2020* 2012:69).

### *Sociological model of stigma*

They [the military] cut funding for therapy and drugs took their place. You know Ambien? It's used for insomnia but causes sleep-walking, [sleep] driving, and [sleep]cooking. Sure, that's bad if you are on a diet and wake up in the morning with half the refrigerator empty... even more dangerous if you walk around the FOB [forward operating base] all night in your underwear without your weapon.

L. – ex-military psychiatrist/ Iraq veteran

Sociologists Link and Phelan (2006) view stigma as the result of the interaction of five interrelated components. In the first, differences are identified and labeled; some are socially selected as significant while others remain irrelevant. Mental disorders, for example, vary in how they are viewed as different, with schizophrenia carrying more stigma than depression (Schnittker 2008). We see this with medical conditions in general - consider diabetes in comparison to AIDS. The second component involves stereotyping where the labeled person is associated with undesirable characteristics. In the third component, the group doing the labeling separate themselves from those with the undesirable characteristics. In the fourth component, the labeled group experiences discrimination and loss of status as a result of this separation. Link and Phelan postulate that the labeling, association with negative traits, and separation of “us” from “them” creates a rationale for rejection and exclusion. The fifth component of stigma is exercise of power. Stigmatization cannot take place without the social power necessary to translate all these components into negative consequences.

For example, some soldiers with PTSD may label their doctors as a pill pushing, oblivious, uncaring lot to be avoided at all costs. In theory the doctors are discriminated against but because the soldiers lack the political power to transform their dislike into any serious consequences for the doctors stigmatization does not result. On the other hand, doctors have the political power, through diagnoses, to stigmatize. For example, veteran Chuck Luther, in the service for 12 years, was diagnosed with a personality disorder, rather than PTSD, in the military's effort to discharge him without medical assistance (Jamail 2010). Recent ethnographies (Gutmann and Lutz 2010; Caplan 2011) illustrate that the military has been controversially discharging troops under the claims of “preexisting conditions” (such as personality disorder and anxiety disorder) that predate military service in order to deny benefits. From 2001 to 2007, 22,500 individuals were discharged without benefits in this manner (Gutmann and Lutz 2010:159). Some suggest that this was a strategy to save on funding while Glantz (2009) points out that the pressures put on military therapists to assign personality disorder over PTSD was a way to discharge “undesirables” and replace them with “fresh bodies” (Caplan 2011:143). It should be noted that one of the challenges of diagnosing PTSD, besides a lack of clear biological markers, is that the symptoms overlap with other psychiatric disorders. This shared symptomology creates much controversy over accurate diagnosis – especially in a setting where this diagnosis is needed to get disability compensation.

Interestingly, in an effort to reduce stigma and *increase* diagnoses through improving treatment-seeking, military leaders are currently advocating to change the “D” for disorder in PTSD to “I” for injury (*Army 2020* 2012). This name change is being pitched to the American Psychiatric Association as a military specific sub-category of PTSD for the new edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The new PTISI category would acknowledge that the mental ‘injury’ was sustained while serving. As one of my informants

stated “Words are powerful...changing it to injury, that’s admitting that the problem happened in combat. With ‘disorder’, when did it happen? It could have happened before. It’s all about money” (personal communication, November 23, 2011).

In summary, Link and Phelan stress that the components of identifying difference, stereotyping, separating “us” from “them” and social exclusion must co-occur in a power situation for stigma to develop. They emphasize that no definition of stigma can be universally applied. Their work concentrates on the effects of stigma on self-esteem and coping strategies, or self-stigma (i.e., Link et al. 1991). This self-stigma framework is especially apparent in the military’s understanding of stigma where “Acknowledging a problem, particularly anything associated with an individual’s mental health, is frequently perceived as admitting weakness or failure” (*Army 2020* 2012:69).

In comparison to the cognitive behavioral model of Corrigan and colleagues, Link and Phelan’s model focuses on these necessary social aspects: the differences between persons must be noticeable for the labeling process to occur and the stigmatizing group must be in a more powerful social position for stigma to unfold. This does not contradict Corrigan et al.’s model, but rather links the psychological processes of the individual to broader societal features (Rusch et al. 2005).

### *Public Stigma*

Here I’m testifying in court [for better healthcare for women vets] and this guy says “You don’t look like a soldier.”

C. – female Iraq war Air Force veteran

Now society is embracing vets... when it comes out what happened in Iraq and Afghanistan it’s going to be Viet Nam all over – baby killers and all.

H. – female Army veteran, psychiatric nurse

These images aren’t changing... all you have to do is turn on the TV. I just saw on CSI (a primetime television series)... the guy who cracks and is the killer is an Iraq vet now.

V. – male Gulf War veteran

Public stigma refers to the actual experience of rejection and social exclusion that persons experience from the general public. As mentioned earlier, it involves a process where the stigmatizer labels difference, attaches meaning through stereotyping, and denies opportunities through exertion of power. With the media having such a huge influence over public attitudes, it is not surprising that a majority of mental illness stereotypes are rooted in television and film representations (Benkert et al. 1997). For example, media analyses of mental illness stereotypes illustrate that accounts that instill fear have a greater influence on public opinion than direct contact (Rosen et al. 1997). Additionally, media portrayals of mental illness almost exclusively take place in the context of unmotivated crimes and police reporting (Schulze and Angermeyer 2003) and negative images are more commonly recalled than positive ones (Benkert et al. 1997). As a result, the public image of people with mental illness is dominated by views of violence and danger. Public stigma is often expressed through social distancing and avoidance, especially when it comes to forming and maintaining relationships, whether professional or personal (Angel

et al. 2005). This severely affects opportunities for employment, housing, healthcare, and friendship.

*Self-Stigma*

PTSD is scary, like addiction there is a lot of denial surrounding it.

K. – male Vietnam veteran, peer mentor

I just feel like my brain is broken. I missed a test at school... I didn't call the professor because I didn't want to use it [PTSD] as the excuse, because it's always the excuse... it's always something.

Z. – female Iraq War veteran, student

Stigma operates not only through discriminatory individuals and broad power structures but also through the stigmatized person (Link and Phelan 2001). Self-stigma can be understood through utilizing the same conceptual framework applied to public stigma: stereotypes, prejudice and discrimination (see Table 1). People with mental illness, for example, may develop or adopt stereotypical understandings of themselves through their membership in society (i.e. through role models or peers' attitudes). The stereotypes attached to mental illness might lead persons to believe they will be devalued and ostracized by others, creating low self-esteem and causing them to withdraw from society. This marginalization perpetuates the cycle of stigma through strained personal relationships, smaller social networks, reduced life chances, unemployment and loss of income (Link and Phelan 2006). The cycle is especially insidious when ill persons avoid accessible and desired medical services, thus exacerbating the symptoms that contributed to the stigma in the first place. Table 1 illustrates different behavioral responses to prejudice in the public and self-stigma categories, yet the result remains the same: the person goes without care.

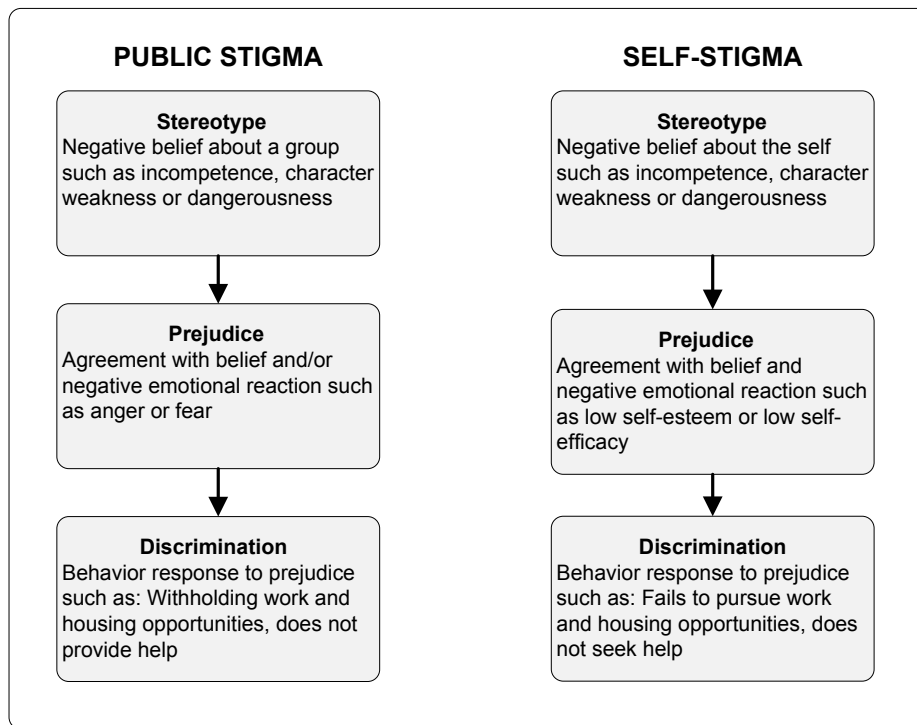


Figure 1. The components of public stigma and self-stigma. Adopted from Rusch et al. 2005.



What I want to highlight at this point is that in the category of self-stigma the individual is held responsible for his/her behaviors, in this case seeking help, and stereotypes and prejudice must occur for this behavior to take place in both categories. In this socio-cognitive model, within the parameters of public stigma, the person withholding care is to blame but with self-stigma the person being stigmatized is to blame. The assumption is that stigmatizers and the stigmatized are autonomous agents in control of their help seeking/providing behaviors. However, as mentioned above, policy mandates might constrain physicians in their diagnoses, pressuring them to discharge ‘undesirables’. In a rank and command setting, a doctor may have to follow the orders of a soldier’s commanding officer and send that soldier back to combat despite a psychiatric diagnosis. In either case, behavior may have nothing to do with individual stigmatizing and more to do with institutional procedures.

Also, most people are aware of group stereotypes that exist in society but not everyone internalizes them and self-stigmatizes. Some react with indifference or even more surprisingly, with increased self-esteem (Crocker and Lawrence 1999). The paradox of mental illness stigma is that some remain totally oblivious to stigma while others suffer it terribly. Then there are those that react with righteous anger.

### *Alternative Responses to Stigma*

NO VETERAN SHOULD EVER HAVE TO FIGHT THEIR COUNTRY TO OBTAIN CARE!!! All the army cares about are warm bodies... I will not stop the fight and I have made it my mission to educate the public about PTSD, how the military treats their soldiers and most of all to advocate on behalf of all veterans and to be their voice.

Staff Sgt. Francisco Carillo<sup>2</sup>

All they [the government] care about are boots on the ground. They don’t give a shit about us. Most don’t trust the VA, I don’t. That’s why I work here. We need places like this.

D. – Vietnam vet, staff at non-governmental organization

Many people who experience public stigma do not self-stigmatize. It is the paradox of self-stigma and mental illness that certain people react to stigma with increased self-esteem and righteous anger while others suffer diminished confidence. To complicate matters more, there are those that neither express anger nor experience decreased self-esteem but completely ignore public prejudices altogether (Corrigan and Watson 2002). According to Corrigan and colleagues, people who have a stigmatized health condition and do not identify with the stigmatized group remain unresponsive to stigma because they do not feel the prejudice applies to them (Corrigan and Watson 2002). On the other hand, those that identify with the group end up applying those prejudices to themselves. If there is agreement with the stigmatizing attitudes and the attitudes are perceived to be legitimate, self-esteem is decreased. In contrast, if those attitudes are perceived as unjust and illegitimate, the reaction is righteous anger (see Figure 1). The people who react with indignation to public stigma often become advocates who actively challenge discrimination through targeting misdirected policies and the quality of health care services. Identification with the broader group is the key variable that determines whether or not a person will respond with indifference or resistance. Evidence from gender, race and gay/lesbian studies suggests that high group identification creates a protective factor against the damaging effects of stigma (Watson and River 2005).

While this social psychological conceptualization of self-stigma helps us to understand the various ways people react to stigma, mental illness presents a special case. First of all, decreased self-esteem may be brought on by depressive syndromes and therefore need to be distinguished from decreased self-esteem brought on by self-stigma. Secondly, response to stigmatizing situations depends upon awareness of having a mental disorder, which may be temporarily affected in the case of a psychotic episode. Lastly, peoples' reactions to stigma depend on their perceptions of the subtle messages others send (Rusch et al. 2005).

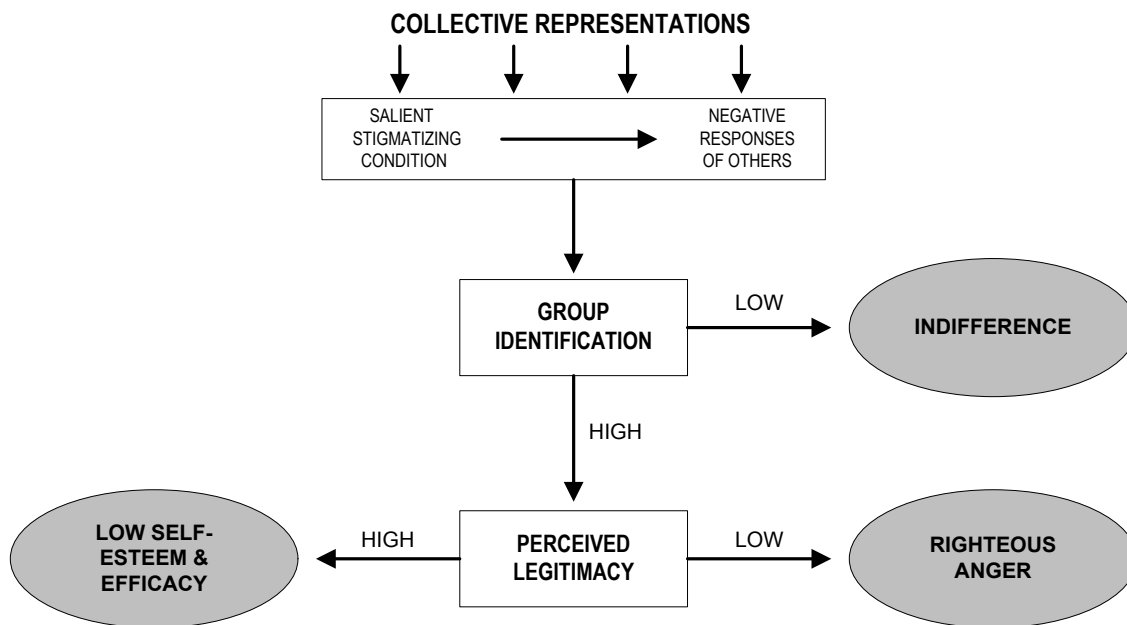


Figure 2. Alternative responses to stigma emerge through perceived legitimacy of stereotypes. Adopted from Corrigan and Watson (Rusch et al. 2005).

### *PTSD and Stigma*

There's the idea that 'Whoa, that guy's a veteran', idea that if you've been deployed you have PTSD.  
X. – Iraq War veteran/student

Anti-stigma campaigns are bullshit because you have to go back to your squadron. If something happened on deployment, everyone knows how you fucked up. People will hate you. But things [problems] happen, some people have been deployed 10 times... But try and get help and you get deployed, traumatized or not. 20% get deployed on pharmaceuticals.

C. – female Iraq War Air Force veteran

Going AWOL will hopefully haunt him more than the fake PTSD he claims and one day he will have to explain this to his kids. Hanks never heard the screams of wounded soldiers because he didn't really do anything but sit in a gunner seat.

Comment left on CBS News online regarding Jeff Hank's PTSD claim<sup>3</sup>

The stigma surrounding traumatic stress is culturally and temporally specific and contemporary attitudes towards PTSD vary significantly between civilian and military culture. The diagnosis has its roots in the Vietnam War and the highly publicized atrocities that occurred

there. Upon returning home, soldiers found themselves labeled “babykiller” and “psychopath”, essentially being blamed for the war itself. The anti-social behavior that resulted from this reception resulted in psychiatric diagnoses spanning anxiety, personality disorder, depression, schizophrenia and substance abuse. Antiwar proponents angry that military psychiatrists were using their skills for military operatives rather than clinical directives, lobbied for specialized medical care for veterans. PTSD, as a “new” disorder eventually replaced older diagnoses of battle fatigue and war neuroses from previous wars.

The new diagnostic label was as much a socio-political construction as it was a psychiatric one. Attention shifted from the soldier’s psyche to the trauma of war (Young 1995). The intended transformation of stigma, through creating this clinical category, had powerful aims: no longer were Vietnam veterans to be seen as perpetrators of heinous crimes, but as “victims” of the trauma they experienced in combat - trauma that was a result of the roles forced on them by the US military. The PTSD diagnosis was thus used as a tool by veterans’ advocates to morally excuse soldiers but also to ensure medical and disability benefits (see Breslau 2004 for a discussion on PTSD as a form of activism). This history is significant in that the medicalization of distress is purported to have removed the *public* stigma attached to the Vietnam veteran and also to have paved the way for other non-war-related trauma. According to Summerfield, PTSD legitimizes “victimhood” and “...has become the means by which people seek victim status – and its associated moral high ground – in pursuit of recognition and compensation” (2001:96). For Summerfield, victimhood gains more social utility than “survivorhood” in contemporary society. As a result, PTSD is a psychiatric diagnosis that people actually like to receive (Andreasen 1995, cited in Summerfield 2001:96). The implication is that there is no stigma attached. If employment and wage earnings are any indication, then the usefulness of the psychiatric label for Vietnam veterans is questionable: PTSD diagnosis significantly lowered the probability of working and, for veterans who were working, their hourly wages (Savoca and Rosenheck 2000). The fact that military leaders are taking steps to change the diagnostic label from PTSD to PTSI (“I” for injury), in the creation of a military specific sub-category for the DSM-V, illustrates that the experience of being diagnosed with PTSD is associated with stigma. The military believes that changing the diagnostic label to PTSI could “...reverse over 40 years (since Vietnam) of stigma associated with combat-related PTS “I” [PTSD] among America’s veteran population,” (*Army 2020* 2012:25). This suggests the failure of the PTSD label as an anti-stigma tool, not only for recent war veterans but also for those of the Vietnam era.

More importantly, this policy change suggests what shapes and signifies stigma for military veterans, compared to civilians, is more complicated. Victim status is not socially useful in the military where values of resilience, strength, selfless service, duty and respect prevail. In fact, victimhood is despised in a setting where the larger mission takes precedent over the individual. In an institution based on rank and command, in the business of war, people depend on each other for survival. While veterans *need* the PTSD diagnosis to claim benefits, the claiming of victimhood conflicts with values that the military intentionally fosters: values such as self-reliance, psychological toughness, collective responsibility and group loyalty. Beyond the intense loyalties that help individuals survive in combat situations, the rank and command institution of the military instills a very real fear of being demoted, discharged and losing benefits if given a diagnosis (Gutmann and Lutz 2010). There also exists the possibility, mentioned earlier, that Army doctors will connect symptoms to pre-existing conditions resulting

in discharge without benefits (Gutmann and Lutz 2010). These stories travel through units affecting help-seeking behavior.

Understandably, soldiers are concerned about how they will be perceived by peers and leadership. They fear being viewed weak by commanders or unreliable by peers (Hoge et. al. 2004), making ‘getting help’ all that much more conflicting. Yet alternative responses to stigma occur even as the stereotype of the strong selfless soldier conflicts with the negative stereotype of the victimized soldier, the coward. These case studies of resistance presented below illustrate how multilayered stigma is and how these soldiers’ experiences blur the categories and processes of public and self-stigma.

### *AWOL*

I am just trying to get help. My goal in this situation [absent without leave] is simply to heal. And they wonder why there are so many suicides

Jeff Hanks, quoted by Sarah Lazare (2010)<sup>4</sup>

During his leave from his second tour of duty, Jeff Hanks<sup>5</sup> of the 101<sup>st</sup> Airborne Division, sought mental health services from military doctors for PTSD. His decision was prompted by his trouble being in large crowds, his fear of attacking his wife while sharing a bed, and bouts of uncontrollable anger. He believes these behaviors are brought on by the mental wounds sustained in battle. Jeff describes his deployment to Afghanistan as defined by constant mortar attacks, mass casualties, and a lack of leadership: “We had no clear mission and nothing got done. We basically just sat in a valley waiting to get hit”. Jeff tried to get mental health care during his first tour but mental health care is scarce and inadequate on overseas bases. Professionals only come once a month for a short period. He describes his appointment with a provider in Iraq as a “total joke” – much note-taking but no action. In Afghanistan, medical treatment was just as limited. Added to the lack of resources is the context of the ‘psychological conditioning’ (or therapy): “Combat stress people hardly ever came to the base. And it is hard to talk in a situation like that, since you are still in the war and on edge all the time.” To add to the limited care available, Jeff recounts the undermining and teasing that occurred when soldiers would seek mental or physical medical care. Jeff describes the unfortunate experience of one Private who was dealing with headaches after being blown backwards into a building during a mortar attack: “He was made fun of by the command in front of everybody. There is a saying in the military: ‘What, you got sand in your vagina?’ It keeps you from seeking help. I didn’t seek help. I wanted to, but I would be ostracized.” Jeff is convinced that he is not the only one avoiding care because of this hazing. On leave from tour Jeff took the opportunity to seek mental and physical healthcare from doctors in Fort Bragg and Fort Campbell. As soon as treatment commenced his command insisted the military doctors grant him clearance for immediate deployment, even though he had not completed preliminary testing. The doctors granted the clearance. Jeff felt his only choice was to go AWOL. After turning himself in on Veteran’s Day, with supporters of Iraq Veteran’s Against the War, Hanks may face a dishonorable discharge (no healthcare benefits or pension) or jail.

There are multiple levels of stigma operating in this scenario. Mental health is stigmatized in general, with a lack of adequate resources for care. Commanders stigmatize troops who ask for medical services, contributing to the process of self-stigmatization that keeps soldiers from

seeking health services. This lack of seeking help can be attributed to high group identification and high perceived legitimacy of the commander's remarks. However, things become blurry when Jeff's stigma avoidance reverses: he seeks care on leave. Corrigan and colleagues would conclude that the perceived legitimacy of earlier remarks decreased and the resulting "righteous anger" led to the AWOL (Corrigan and Watson 2002). The consideration is, to which group is Jeff now identified with, civilian or military? Has he completely *dis-identified* with the Army? (AWOL is a highly stigmatizing experience in the military considering the gravity of the punishment, loss of integrity and loss of financial benefits.) Essentially Jeff has traded one stigma in for another.

The question emerges, is lack of help-seeking taking place due to self-stigmatizing (agreement in stereotypes of weak and feminine) or due to exertion of social power in the domain of public stigma? According to the model presented earlier, avoidance of medical help is a result of self-stigma. When Jeff was on leave the degrading remarks of the commander were back in Iraq (although his power was everywhere), he had the autonomy to seek care and when it was interrupted and negated by his commander he had the agency to go AWOL. In other words, it is quite possible that Jeff did not agree with the belittling or internalize it, due to his help-seeking on leave. Is it possible he was merely fearful of the instituted punishment (hazing) for an infraction coded as un-masculine? What this narrative suggests is that negative beliefs (stereotypes) and agreement of those beliefs (prejudice) about the self do not have to be in line with public stigma for discriminatory behaviors (not seeking help) to unfold. The power exerted by the stigmatizers is what kept Jeff from seeking care, not his agreement with their negative stereotypes, as the model suggests. To illustrate further, did the doctors provide clearance mid-testing because of prejudice or because of their lower rank? The question then becomes, what is contributing to those discriminatory behaviors if it is not the individual's own beliefs?

Jeff seeking help on leave and then going AWOL to pursue treatment suggests that, in addition to public stigma, broader forces may be shaping the issue of PTSD and suicide in the military. Social exclusion is detrimental in the very dependent setting of a war, where soldiers rely on each other for survival. Might avoiding care, to avoid being labeled and 'ostracized' from one's unit, be a matter of life or death in this context, or a 'choice'?

### *Stop-lossed and Jailed*

After a 14-month deployment to Iraq, Army intelligence analyst Eric Jasinski<sup>6</sup> suffered severe PTSD. Eric created strike packets (military offensive strategies involving air force bombing plans, justifying where the benefits outweigh the harm – civilians can be unintentionally wounded and killed in these airstrikes). He suffers regret and guilt from his role in contributing to loss of life in Iraq. After returning to the U.S. Eric attempted to receive treatment for his PTSD, he describes the experience as follows:

I went to get help... But after several attempts, finally I got a periodic check up and I told that counselor what was happening, and he said they'd help me... but I ended up getting a letter that instructed me to go see a civilian doctor, and she diagnosed me with PTSD. Then, I was taking the medications and they were helping me, because I thought I was to get out

of the Army in February 2009 when my contract expired.<sup>7</sup>

As Eric's discharge date approached he was stop-lossed – the involuntary extension of a service member's active duty service. This was the last straw for Jasinski, who in a final counseling session in predeployment processing told his provider, "I don't know what I'm going to do if I go back to Iraq." The mental health counselor asked if he was suicidal and Eric responded that he was not, at that moment. "Well, you're good to go then." As his paperwork was being finalized and he received a 90-day supply of meds to "get him over to Iraq", he decided he could not go back with untreated PTSD. He went AWOL for almost 10 months. Upon turning himself in he was court-martialled and then sentenced to 30 days in jail, despite his severe PTSD diagnosis. In a letter from jail he writes:

When I am taken out of jail back to Fort Hood for any appointments I am led around in handcuffs and ankle shackles in front of crowds of soldiers... which is overwhelming on my mind. My guilt from treating prisoners in Iraq sub-human and I did things to them and watched my unit do cruel actions against prisoners, so being humiliated like that forces me to fall into the dark spiral of guilt. I now know what it feels like to have no rights and have people stare and judge based on your shackles and I feel even more like a monster cause I used to do this to Iraqi people.

Even worse is the fact that this boils down to the military failing to treat my PTSD but I am being punished for it... I feel as if I am being a threat to others or myself and still the Army mental health professional blow me off just like in 2009 when I felt like I had no choice but to go AWOL, since I received a 5 minute mental evaluation and was stop-lossed despite my PTSD, and was told that they could do nothing for me. The insufficient mental evaluation from a doctor I had never seen before, combined with the insufficient actions by the doctor on 9 April show the Army is not trying to make progress.

Eric was released after 25 days in jail and will receive an other-than-honorable discharge. This means he will not have full health benefits and little to no assistance from the VA for his PTSD treatment. Eric's experience has inspired him to counsel soldiers going through the same problems of not receiving necessary treatment.

Like Jeff, Eric had difficulty accessing treatment. The fact he pursued treatment assumes he overcame the military stigma attached to seeking mental health care. However, he continued to be stigmatized when upon turning himself in, he was sent to jail, with a full PTSD diagnosis, instead of a psych unit. It is clear that Eric resisted stigma on the public level of the military and did not agree with the negative responses of his commanders and doctors. However, self-stigmatizing re-emerges in a different light as he is reminded of the "sub-human" actions he committed against the Iraqi people. The "dark spiral of guilt" is brought on by his humiliation in prison being led around in shackles in front of other soldiers. The guilt and shame Eric experiences is multi-layered: there is the social opprobrium of others for his PTSD and his AWOL and the subjective feelings of punishment for his previous actions. The question remains, are these feelings of remorse and low self-esteem brought on through stigma processes or symptomatic of PTSD? PTSD includes symptoms of intrusive recollections, recollections that bring on psychological distress at the exposure to cues that resemble an aspect of the traumatic event.

Eric's negligent military treatment consisting of the five minute mental evaluation, his prognosis that he was "good to go", the stop-loss despite his diagnosis, and lastly the other than honorable discharge, can all be considered stigmatizing acts. Yet again, can the behaviors of the stigmatizers be individualized to fit neatly in a socio-cognitive model of stereotypes, prejudice and discrimination? A military culture where commands must be followed and room for individual agency is very narrow, suggests no. As veteran Chuck Luther of two deployments and 12 years service explains (quoted in Jamail 2010):

The way things are set up right now in the military is that if a soldier gets a chance to go to mental health, which is something military commanders try and prevent from happening in the first place... psychiatrists address and diagnose their PTSD and write it up, but this does not mean they will get treatment. The doctors need to send it to command... the soldier can push it up to the commander, but the commander can deny it and that's as high as it gets. Soldiers are listed as not being able to serve by a military doctor but they are nonetheless medicated and sent out into combat anyway.

Stigma may be operating on various levels in the public and private sphere, but it is assumptive to maintain, in this military setting, that people are in *control* of those stigma processes. As Chuck describes, there are the structural forces of the military industrial complex that relies on a chain of command that directs individual's actions. The doctor was acting on orders, this does not automatically indicate that he was prejudiced as the public stigma presupposes.

### *Faking it*

Staff Sergeant Francisco Carillo is a decorated soldier with 19 years service whose PTSD claim is being denied by the military. His military doctors have claimed he is Fit for Duty (denied his PTSD diagnosis) but multiple civilian doctors, his former platoon leader and other military officials support the PTSD claim. From the *Homepost: The Military in San Diego*<sup>8</sup>, a post titled Consensus: Decorated Soldier Didn't Lie About PTSD? states: "Discussion online seems to be in virtual unanimous favor for Staff Sergeant Francisco Carillo whose claim continues to be denied by the Army."<sup>9</sup> Some military folks respond in support of Carillo:

Candycane3482 writes:

I know there are people who fake it but saying that just because someone completed a master's degree and has a successful marriage means they can't possibly have PTSD... Having PTSD doesn't mean your life completely falls apart.<sup>10</sup>

Joylisten responds:

This is exactly why so many veterans are committing suicide and are homeless. It is doctors like Dr. Diana Repke who claim soldiers are Fit for Duty and send them back to the "line of duty" when in fact they are suffering from PTSD and mental health diagnoses.

What she did is very similar to what the documentary HBO Wartorn captured. The situation where the father spoke about his son who committed suicide after having his depression and suicidal ideation symptoms ignored and then he was called a FAKE. This young man was sent back to the line of duty and killed himself... thanks for giving a voice, Mr. Carillo, to all those who cannot speak for themselves.<sup>11</sup>

Carillo has made his experience public through his blog and has online supporters who identify with his suffering. He has opted to leave the Army in order to receive treatment and advocate for veterans with PTSD. He writes on his blog (reprinted in Home Post: The Military in San Diego)<sup>12</sup>:

I am a 19-year Veteran. I was deployed as a combat engineer to Iraq in 2004-2005. Eight doctors including the Veterans Administration (VA) have diagnosed me with PTSD. However, army doctors at called me a “malingerer” and diagnosed me with factitious disorder. They never talked to my current psychologist of two years who I see on a weekly, sometimes more, basis or any soldiers who were in my platoon with me in Iraq. I have had to make the choice to leave the military rather than risk more harm to my mental health. The army hospital reported I was fit for duty with no restrictions even though my current psychologist reports that if I am to be deployed or even in combat simulated training, I am at risk of mental health decompensation to the point I could harm myself (commit suicide) or harm others due to not being able to act in combat situations which require full use of self. On November 24, I will be discharged, lose my retirement, as well as my full-time job, and be unemployed. After 19 years of service, I must leave the military because recovering from my PTSD is a priority. The doctors at the army hospital are maintaining that I am a liar and that I never experienced trauma while serving our country in Iraq. These doctors are denying me the respect that I deserve for serving my country as well as continuing the cycle of denying soldiers the treatment they should be receiving for PTSD.

Carillo writes on another post:

If I knew 19 years ago that the military would be treating me with disrespect after serving faithfully, I would never have served. All the Army cares about are warm bodies and the leadership only cares about numbers. That what we are to the leadership just a number to fill a slot in a unit...I will not stop the fight and I have made it my mission to educate the public about PTSD.

The stereotype attached to PTSD itself is of a disease that wreaks havoc in one's daily life and turns competent soldiers into completely disabled and unproductive persons. If that representation is not visible or does not occur, or the trauma was not publicly witnessed by others, the experience is “faked”. This stereotype of the “liar” who is trying to get out of duty and collect compensation adds yet another layer of stigmatization. First the soldier must overcome the stigma in seeking help and then the soldier must ‘prove’ the disorder exists *beyond* the diagnostic label, through *publicly* displaying radical behavior and the deleterious consequences of that behavior. If this performance succeeds, the soldier is interpreted as a coward or unfit by the leadership, if it fails, as a fake by his or her peers.



In this manner, the discrimination soldiers with PTSD endure is multivocal. Doctors and commanders deny soldiers' subjective experiences but on another level refuse to acknowledge their service through dishonorable discharges. Soldiers are experiencing a public stigma that transcends simple discriminatory responses such as withholding benefits to negating entire personal histories, "These doctors are denying me the respect I deserve for serving my country". In other words, soldiers are not only liars but are rendered invisible, as if their service never happened nor meant anything. After 19 years of service, Carillo is losing everything to pursue treatment. Veteran Chuck Luther, in the service for 12 years has a similar story: the military tried to discharge him without medical assistance for his PTSD by diagnosing him with a personality disorder (Jamail 2010). The moral choice soldiers make to pursue a PTSD diagnosis, and then prove the diagnosis, is about competing goods. These goods involve employment, rank, pension, and health care benefits, but also less tangible commodities like respect and integrity that are so inevitably wrapped up in stigma processes. To pursue mental health services or not, whichever choice is made, the soldier is viewed as morally corrupt. Stigma becomes a barrier that cannot be overcome because it exists on both sides of the wall, cowards on the left, fakers on the right. The assumption is that the stigma stems from within the individual.

*Anthropological Alternatives to Stigma: A new geography of blame*

The general critique I am making through the counter-narratives presented above, is that stigma cannot be reduced to individual psychology. This is not a novel concept. Central to the mission of anthropology is to make connections between the macro-world of politico-economics and the micro-world of patient beliefs and experience. The stigma research in anthropology has accomplished this through a number of theoretical approaches. Das and Addlakha (2001) suggest a notion of "domestic citizenship" as a useful tool for moving the focus away from individual agency to the broader social sphere (kinship or community). Domestic citizenship relates to how the family, embedded in the broader kinship or community, ends up confronting the stigma, making it difficult to assume stability between the two in the case of a stigmatizing illness. Relations between those persons with stigmas and their immediate family can be broken as a result of the family trying to fit in with the norms of the wider community. What this reveals is that stigma associated with disease and disability "...is located not in (or only in) individual bodies but rather as "off" the body of the individual within a network of family and kin relations" (Das 2001:2). In this manner one is able to think about the different types of stigmas that exist in relation to one's domestic citizenship.

For example, in Weiss's (1998) study of "appearance impaired" newborn infants in Israel, she found that children with facial defects were abandoned to the state or hidden to "protect" other siblings from stigma processes. The rationale behind this is to save face in the social lives of families and as a result, these infants lose their domestic citizenship due to a "tyranny of norms of appearance" (Das 2001:2). In the same respect the military family abandons soldiers with mental health issues by denying treatment, PTSD diagnosis and benefits. Soldiers lose their domestic citizenship not because the military needs to "save face" but because of the political and economic reasons tied up in national defense management. In other words, the military needs more bodies and for bureaucratic reasons cannot allocate funds to bodies that are not productive. Stigma is thus located "off" the body. It is not a "mark" or characteristic of the individual, but a

consequence of military business strategy, to keep an organization sustainable. In other words, stigma processes are *outside* the personal control of individuals and are part and parcel of the broader management system that keeps the military operating.

For the soldier with PTSD, variations of stigma that occur “off” the body across various “domesticities” include: coward in the commander’s office, liar in the physician’s clinic, faker in his peer group of service colleagues (depending on what level of “proof” of suffering can be made public), and lastly, disposable warrior in the VA administration. Each domestic domain in which the post-traumatic stressed soldier is embedded creates a different stigmatizing experience. In the cases of Jeff, Eric and Francisco, this clearly illustrates how the suffering of disease is impossible to differentiate from the stigma of PTSD and its consequence, professional annulment.

In another example of “off” the body readings of stigma, Paul Farmer (1999) has illustrated that the overriding propensity in medical discourses of tuberculosis is to blame the patient and their “beliefs” for not complying to treatment. He found that patients often fail to follow medical regimes or seek help due to inadequate supplies, inability to reach providers, and severe time and money constraints. In making links between the micro-level experiences of patients and the macro-world of politics and economics, Farmer exposes the “structural violences” that influence peoples’ behaviors. These findings echo in the cases presented above, where soldiers were unable to access combat stress counseling due to minimal staff visits to war zones, receive adequate evaluations due to staff deficiencies or “get a chance to go to mental health (care)” since it was something commanders “try and prevent in the first place” (personal communication, January 12 2011). Farmer shows how the biomedical discourse surrounding tuberculosis creates a “geography of blame” where patients’ failure to comply is ascribed to their own beliefs and argues that the agency of the patient is highly overstated. Similarly, research findings show that in military culture, mental health noncompliance indicates that “succumbing” to PTSD is perceived as a personal failure, character weakness and as “evidence of the innate deficiency of the right stuff” (Hoge et al. 2004:77). These predominant readings of patient agency are reflected in the cognitive-behavioral model of self-stigma presented earlier, where discriminatory actions of medical care avoidance are attributed to one’s internalized beliefs.

Like Farmer and Das, Weiss et al. (2005) argue that the revisionist concept of stigma that is based in social interactions is limiting and that sufficient attention must be given to the structural features that dictate those interactions. On an applied level, Weiss et al. suggest that approaches to studying health-related stigma need to be disease and culture specific. Studies need to consider, in addition to the psychological processes of individuals, social dynamics of institutions and the various social and economic processes that impact policy. Through clarifying stereotypical attitudes and discriminatory behaviors (as the cognitive models do) and pushing that analysis to address manifestations of stigma in health services and military policy (i.e., addressing where in addition to how stigma unfolds) we can reveal how stigma is embedded in systems. In tandem with identifying the ways domestic citizenship is appropriated, this approach can identify the structural violences that influence discriminatory practices and untangle them from individual expressions of stigma.

### *Conclusion*

These case studies provide compelling evidence of alternative responses to stigma and yet do not neatly fit into the categories of public stigma and self-stigma. According to the models presented, the very fact that resistance occurs assumes that a type of stigma exists. Those models reviewed in the beginning of the paper are helpful in identifying and disentangling stigmatizing beliefs and behaviors for empirical research and interventions, however may not be applicable in settings where personal autonomy is limited. The cases presented show how individuals overcame the stigmas of coward, faker and “pussy” in pursuing mental health in the military, and reveal multiple layers of discrimination. In all the examples, the individuals moved through various stigmatizing experiences depending on the context: from wimp to morally corrupt to “subhuman” and eventually, disposable.

Through these case studies I suggest that avoidance of individual help-seeking may not be due to self-stigmatizing processes (i.e., internalized negative stereotypes) but instead are brought on by public stigma (fear of the social power of commanders) and structural forces outside individual beliefs and actions. The power exerted by the stigmatizers is what kept Jeff from seeking care, not his agreement with their negative stereotypes as the model suggests (i.e. he wanted care but did not want to be “ostracized”, he did not say he believed this to be a sign of weakness and pursuit of care on leave support this). To clarify further, both Jeff and Eric’s AWOL illustrate how discriminatory actions are a consequence of a rank and command organization. Doctors followed commanders’ orders despite clinical imperatives and commanders deployed despite PTSD diagnoses. Bureaucracy and the political economy of the military industrial complex are a strong determinant of discriminatory practices that place stigma processes outside the individual. The stigma process fragments in this setting: directives are followed, with discriminatory results, *leap-frogging the stereotype and prejudice components* (e.g. autonomous actions) altogether. On the surface this paints a bleak picture of stigma in the military, where individuals close their moral compasses and just follow orders. Looking deeper, it implies that a broader framework that moves beyond social interactions is necessary.

I have also illustrated how those who resist orders and go AWOL or fight the system, provide a counter-narrative to the predominant biomedical discourse of “self-stigma as the barrier” to care. Using stigma concepts such as the ones presented above provides results that assume and favor the autonomy of the individual, as recent studies show. This limits its application in settings like the military or prison where self-sufficiency is limited and a rank and command power structure exists. This could be the reason behind why “anti-stigma campaigns are bullshit”. The social-cognitive/cognitive-behavioral models focus on dyadic interactions between individuals without more fixed considerations of the social structural elements that influence or control those interactions.

Understanding where the stigmatizing behaviors are rooted, whether it is in the “numbers” the commanders need to keep their units full or the 50 soldier-a-day patient load that forces a five minute psychiatric evaluation, is essential in unpacking stigma processes and identifying spaces for interventions. However, using these stigma models without going beyond the individual to access the social structural elements exaggerates the agency of the soldiers, doctors and possibly even the commanders. In cultures and settings where autonomy is limited, it may be

more useful to include broader analyses of the structural forces.

To further illustrate, what is paradoxical about the cases presented here is not only the extremes soldiers will go to attain care and face further stigma (AWOL, prison, dishonorable discharge) but that the military wants to *keep* these “weak”, substandard, morally corrupt soldiers. In their eyes these men and women are the antithesis of LDRSHIP, the acronym for the Army’s values of Loyalty, Duty, Selfless Service, Honor, Integrity, and Personal Courage. The command stop-losses them, denies their claims, and court-martials them. Why? Pragmatically, the military’s job is to keep “boots on the ground” or as Carillo maintains, fill the slots in the units with “warm bodies”. This contradiction further supports the idea that discriminatory behavior is influenced by broader structural dynamics of the military institution. In fact, the system ends up reproducing the stigma it is trying to eradicate through punishing those that seek help.

The punishment of soldiers seeking health care is also in contradiction to the new intervention strategy promoted by the *Real Warriors* program, a campaign that promotes “the processes of building resilience, facilitating recovery and supporting reintegration of returning service members, veterans and their families.” The website advertises that “Reaching Out is a Sign of Strength” and offers “Tools for maintaining peak psychological functioning are immediately available to service members who are *willing* to ask” (emphasis added, Real Warriors 2010). All the responsibility to act is put on the soldier, yet the vignettes above illustrate that in the system of rank and command, the PTSD diagnoses can get buried at the command level no matter how *willing* soldiers are to pursue care. Autonomy, expressed through the “peak psychological functioning” for those “willing to ask”, is grossly exaggerated. If it is structural forces that are shaping the discriminatory practices then interventions should not be directed at individuals to change their beliefs but to policies upstream that, for example, do not punish those seeking care or deploy traumatized soldiers with 90-day supplies of meds. Anthropology is strategically positioned to divulge these structural forces and inform successful interventions and policy, if the government is *willing*.

### References

- Angell, Beth, with Andrea Cooke and Kelly Kovac.  
2005 First Person Accounts of Stigma. *In* On the Stigma of Mental Illness. Patrick Corrigan, ed. Pp. 69-78. Washington, D.C.: American Psychological Association.
- Benkert, Otto with Mechtild Graf-Morgenstern, Andreas Hillert, Jurgen Sandman, Simone Ehmig, Hans Kepplinger, Helga Weissbecker and Katarina Sobota  
1997 Public Opinion on Psychotropic Drugs: An Analysis of the Factors Influencing Acceptance or Rejection. *Journal of Nervous and Mental Disease* 185:151-158.
- Breslau, Joshua  
2004 Culture of Trauma: Anthropological Views of Posttraumatic Stress Disorder in *International Health. Culture, Medicine and Psychiatry* 28: 113-126.
- Caplan, Paula  
2011 *When Johnny and Jane Come Marching Home*. Cambridge, MA: The MIT Press.

Corrigan, Patrick with Annette Backs-Edwards, Amy Green, Sarah Lickey-Diwan and David Penn

2001 Prejudice Social Distance, and Familiarity with Mental Illness. *Schizophrenia Bulletin* 27(2): 219–225.

Corrigan, Patrick

2000 Mental Health Stigma as Attribution: Implications for Research Methods and Attitude Change. *Clinical Psychology: Science and Practice* 7(1): 48–67.

Corrigan, Patrick and Amy Watson

2002 The Paradox of Self-stigma and Mental Illness. *Clinical Psychology: Science and Practice* 9(1): 35–53 .

Crocker, Jennifer and Jason Lawrence

1999 Social Stigma and Self Esteem: The Role of Contingencies of Worth. *In Cultural Divides: Understanding and Overcoming Group Conflict*. Deborah Prentice and Dale Miller, eds. Pp. 364–392. New York: Russel Sage Foundation.

Das, Veena

2001 Stigma, Contagion, Defect: Issues in the Anthropology of Public Health. Paper presented at the Stigma and Global Health Conference, Bethesda, September 5–7.

Das, Veena and Renu Addlakha

2001 Disability and Domestic Citizenship: Voice, Gender, and the Making of the Subject. *Public Culture* 13(3): 511–531.

Farmer, Paul

1999 *Infections and Inequalities: The Modern Plagues*. Berkeley: University of California Press.

Finley, Erin

2011 *Fields of Combat: Understanding PTSD Among Veterans of Iraq and Afghanistan*: Cornell University Press.

Goffman, Erving

1963 *Stigma: Notes on the Management of Spoiled Identity*. Upper Saddle River: Prentice Hall.

Gutmann, Matthew and Catherine Lutz

2010 *Breaking Ranks: Iraq Veterans Speak Out Against the War*. Berkeley: University of California Press.

Hoge, Charles with Carl Castro, Stephen Messer, Dennis McGurk, Dave Cotting and Robert Koffman

2004 Combat Duty in Iraq and Afghanistan, Mental Health Problems and Barriers to Care. *The New England Journal of Medicine* 351(1):13–22.

Jakupak, Matthew with Jessica Cook, Zac Imel, Alan Fontana, Robert Rosenheck, and Miles McFall

2009 Posttraumatic Stress Disorder as a Risk Factor for Suicidal Ideation in Iraq and Afghanistan War Veterans. *Journal of Traumatic Stress* 22(4):303–306.

Jamail, Dahr

2010 “PTSD Soldier Punished by Army.” ZNET A Community of People Committed to Social Change. June 5, 2010. <http://www.zcommunications.org/ptsd-soldier-punished-by-army-by-dahr-jamail>. Accessed December 12, 2010.

Keyleyan, Armen

2010 “Soldier Takes Huge Risk to Get PTSD Help.” CBS Evening News with Scott Pelley online. November 13, 2010.

<http://www.cbsnews.com/stories/2010/11/12/eveningnews/main7049595.shtml>

Keusch, Gerald T. with Joan Wilentz and Arthur Kleinman

2006 Stigma and Global Health: Developing a Research Agenda. *The Lancet* 367:525– 527.

Kim, Paul with Jeffrey Thomas, Joshua Wilk, Carl Castro and Charles Hoge

2010 Stigma, Barriers to Care, and Use of Mental Health Services Among Active Duty and National Guard Soldiers After Combat. *Psychiatric Services* 61(6):582–588.

Lazare, Sarah

2010 “AWOL Soldier Refusing Deployment Because of Severe PTSD.” Truthout.

November 5, 2010. <http://www.truth-out.org/awol-soldier-refusing-deployment-because-severe-ptsd64831>. Accessed December 12, 2010.

Link, Bruce G. with Francis T. Cullen, James Frank and John F. Wozniak

1987 The Social Rejection of Former Mental Patients: Understanding Why Labels Matter. *American Journal of Sociology* 92(6):1461–1500.

Link, Bruce G. with Jerrold Mirotznik and Francis T. Cullen

1991 The Effects of Stigma Coping Orientations: Can Negative Consequences of Mental Illness Labeling be Avoided? *Journal of Health and Social Behavior* 32:302–320.

Link, Bruce G. and Jo C. Phelan

2001 Conceptualizing Stigma. *Annual Review of Sociology* 27:363–385.

Link, Bruce G. with Lawrence Yang, Jo C. Phelan and Pamela Collins

2004 Measuring Mental Illness Stigma. *Schizophrenia Bulletin* 30(3):511–541.

Link, Bruce G. and Jo C. Phelan

2006 Stigma and Public Health Implications. *The Lancet* 367:528–529.

Real Warriors

2010 November 8 <http://www.realwarriors.net/>

Reno, Jamie

2010 Home Post: The Military in San Diego. November 24, 2010.

<http://homepost.kpbs.org/tag/staff-sgt-francisco-carillo/>

Rosen, Alan with Garry Walter, Tom Politis and Michael Shortland

1997 From Shunned to Shining: Doctors, Madness and Psychiatry in Australian and New Zealand Cinema. *Medical Journal of Australia* 167:640–644.

Rusch, Nicolas with Matthias Angermeyer and Patrick Corrigan

2005 Mental Illness and Stigma: Concepts, Consequences, and Initiatives to Reduce Stigma. *European Psychiatry* 20(8):529–539.

Savoca, Elizabeth and Robert Rosenheck

2000 The Civilian Labor Market Experiences of Vietnam-era Veterans: The Influence of Psychiatric Disorders. *The Journal of Mental Health Policy and Economics* 3(4):199–207.

Summerfield, Derek

2001 The invention of Post Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category. *British Medical Journal* 322:95–98.

Schnittker, Jason

2008 An Uncertain Revolution: Why the Rise of a Genetic Model of Mental Illness has not Increased Tolerance. *Social Science and Medicine* 67(9):1370–1381.

Schulze, Beate and Matthius Angermeyer

2003 Subjective Experiences of Stigma: A Focus Group Study of Schizophrenic Patients, their Relatives and Mental Health Professionals. *Social Science and Medicine* 56(2):299–312.

United States Army

2010 Army Health Promotion, Risk Reduction and Suicide Prevention Report. Washington, D.C.: United States Army.

United States Army

2012 Army 2020: Generating Health and Discipline in the Force, Ahead of the Strategic Reset. Health Report. Washington, D.C.: United States Army.

Watson, Amy and Philip River

2004 A Social – Cognitive Model of Personal Responses to Stigma. *In On the Stigma of Mental Illness*. Patrick Corrigan, ed. Pp. 145–164. Washington, D.C.: American Psychological Association.

Weiss, Mitchell with Jayashree Ramakrishna and Daryl Somma

2006 Health-related Stigma: Rethinking Concepts and Interventions. Theme issue, “Perspectives in Health-related Stigma,” *Psychology, Health and Medicine* 11(3):277–287.

Weiss, Meira

1998 Ethical Reflections: Taking a Walk on the Wild Side. *In Small Wars: The Cultural Politics of Childhood*. Nancy Scheper-Hughes and Carolyn Sargent, eds. Pp. 149–162. Berkeley: University of California Press.

Wounded Times Blog

2010 August 21

<http://woundedtimes.blogspot.com/search?q=When+I+read+the+headline+I+thought+it+was+about+the+story+I+posted+yesterday+and+then+the+%09shock+%09hit+that+this+was+another+story>

Young, Allan

1995 *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton: Princeton University Press.

## Notes

<sup>1</sup> A weblog from the National Veteran’s News Service that focuses on PTSD:

<sup>2</sup> Blog entry from November 24, 2010 on *Home Post: The Military in San Diego* by Jamie Reno:

<http://homepost.kpbs.org/tag/staff-sgt-francisco-carillo/>

<sup>3</sup> Comment left by ‘deitrick05’ on November 13, 2010 regarding article *Soldier Takes Huge Risk to Get PTSD Help* by Armen Keleylan, CBS Evening News with Scott Pelley online:

<http://www.cbsnews.com/stories/2010/11/12/eveningnews/main7049595.shtml>

<sup>4</sup> Sarah Lazare’s investigative report on Truth Out. See: <http://www.truth-out.org/awol-soldier-refusing-deployment-because-severe-ptsd64831>

<sup>5</sup> Narrative adopted from Sarah Lazare’s investigative report on Truth Out. See: <http://www.truth-out.org/awol-soldier-refusing-deployment-because-severe-ptsd64831>

<sup>6</sup> Narrative adopted from Dahr Jamail's investigative report for Truth Out, an independent news source: <http://www.zcommunications.org/ptsd-soldier-punished-by-army-by-dahr-jamail>

<sup>7</sup> From Dahr Jamail's investigative report for Truth Out, an independent news source: <http://www.zcommunications.org/ptsd-soldier-punished-by-army-by-dahr-jamail>

<sup>8</sup> A blog underwritten by KPBS, the national public radio, television and web source in San Diego, California. The blog explores 'military life and military families': <http://homepost.kpbs.org/>

<sup>9</sup> For full thread of online responses go to <http://homepost.kpbs.org/2010/12/consensus-decorated-soldier-didnt-lie-about-ptsd/> and for back story go to <http://homepost.kpbs.org/2010/11/iraq-war-veteran-diagnosed-with-ptsd-called-liar-by-army/>

<sup>10</sup> Comment from Military Times blog printed in *Consensus: Decorated Soldier Didn't Lie About PTSD* by Jamie Reno in Home Post: The Military in San Diego. <http://homepost.kpbs.org/tag/staff-sgt-francisco-carillo/>

<sup>11</sup> Comment from Military Times blog printed in *Consensus: Decorated Soldier Didn't Lie About PTSD* by Jamie Reno in Home Post: The Military in San Diego. <http://homepost.kpbs.org/tag/staff-sgt-francisco-carillo/>

<sup>12</sup> Home Post: The Military in San Diego. <http://homepost.kpbs.org/tag/staff-sgt-francisco-carillo/>