Caitlin-Jo Lewin

Initially joining the BSc Critical Approaches to Counselling and Psychotherapy programme, I had a general idea of mental health and the importance of increasing the awareness around this topic. However, over the past three years this programme has brought light to my own personal struggle with Posttruamtic Stress Disorder (PTSD) and anxiety. Exploring mental health in further detail in regards to its social and political aspects has allowed me to encounter the compelling impacts of PTSD, which enabled my own self development and empathy skills, not only for myself but in my personal and professional relationships too. As well as gaining skills to emotionally attend and actively listen to others in helping relationships. Completing this degree has amplified my concerns for other children and young people experiencing PTSD in today's society, with the contribution of overwhelming technology and the aftermath of COVID-19. As a result of this, my hope is to allow my own understanding of trauma play a part in supporting others experiencing similar issues.

Why understanding PTSD and men is important?

'Post-traumatic stress disorder' (PTSD) is a psychiatric disorder which sometimes develops when someone has experienced or witnessed a traumatic event, series of events or circumstances that presents threats to the individuals mental, physical, social, and spiritual well-being (APA, 2022). The earliest detection of PTSD can be seen through different times in history, but arguably, the first signs of PTSD as it is considered today, and attempts at trying to understand and diagnose PTSD, began during the American Civil War (1861-1865). This sparked concerns for military-exposed veterans who displayed signs of concerning psychological symptoms (Friedman, 2013). Indeed, the pathologising of PTSD became more apparent not long after as seen during World War One (WW1), where many thousands of soldiers who came back from the war experienced 'shell-shock' (Garrison, 1922). The psychological consequences of war resulted in medical personnel intervening to help cope with the heightened confusion surrounding the experiences of soldiers and to get to a better understanding of PTSD (Gerson and Carlier, 1993). But is it straightforward to consider PTSD as a medical condition? We know that soldiers (mostly people who identitied as men) faced stigma and were labelled as emotionally weak and cowardly if they did not engage with war (see Muldoon et al, 2021), which can only have exasperated the emotional impact on the soldiers facing PTSD symptoms. The medicalised view of PTSD also implied that the psychological consequences the soliders faced during warefare stemmed from preexisting weaknesses within the individual and not from external forces, reinforcing Szasz's view of mental health disorders late in the century to be 'myths' or 'social constructions'.

There is an argument according to Foucault (1977), that the explosion of psychiatric disorders was due to a panoptic view of treating mental illness in hospitals, like a prison guard watching inmates. This idea arguably led to the consolidation of symptoms in soldiers as a consequence of disappearing into psychiatric institutions (Gerson and Carlier, 1993). The development of psychiatric wards for veterans was not meant to be like 'ordinary lunatics', but many men felt punished and incarcerated within these psychiatric hospitals (Shepard, 2000). Soldiers who were considered 'lucky' experienced hypnosis, massage, and rest treatments (Neilson et al, 2020). However, this was not the case for many other soldiers, and with males more likely to 'externalise' their troubles through aggression and substance misuse, this could have provoked a view that they were 'unstable' and 'crazy' (Smith, Mouzon, and Elliott, 2018). Moreover, the view that PTSD stemmed from pre-existing weaknesses within the individual and not from external forces, reinforces Szasz's view that mental health disorders are 'social constructions' claimed they were instead related to the way the individual is living (also see Muldoon, 2021). Supporting Bentham's (1791) panoptic approach within mental health hospitals as a 'great confinement' of mass controlling 'undesirable people' lead to a moral panic to some degree, possibly giving reason for the heightened amount of soldiers suffering from PTSD (Foucault, 1977). The feeling of constantly being observed with the social stigma attached to mental disorders might have fuelled 'shameful' associations with PTSD and was seen as a sign of 'inherent deficiency' for shell-shocked men (Barham, 2004).

Barham (2004) points out that men's gender power exempts veterans from the traditional stigma attached to 'lunatics', and instead created the 'service patient' as classification for better treatment. This masculinity in Western countries spotlights men to be virile and tough, placing pressure on the male gender to express their vulnerability (Neilson et al, 2020). Although, the contribution of 'misconduct' on psychiatrists' part generated tighter control over the mentally ill and reigned in expenditure (Barham, 2004), for men experiencing this kind of strain, it associated PTSD and emotional stoicism with the stigmatisation of ones' difficulty in healthy

functioning (Tucker, 2008). Nevertheless, this maltreatment towards patients arguably contributed to some de-stigmatization of mental illness with military psychiatry moving towards the interest of diagnosis and psychopathology (Gerson and Carlier, 1993). Yet this sparked debates in regards to the word 'disorder', as it can discourage men from seeking care, and for 'shell-shocked' soldiers this could be damaging to their pride and honour of 'being a man' and 'serving their country' (Bryant et al, 2019). Although, todays' diagnosis of PTSD in the DSM-5 reflects a more compassionate understanding of the mental health condition, moving away from the focus of short-term prevention and more healthy long-term impacts (Kuester et al, 2017), there still remain concerns in regards to diagnosing traumatised patients (Pai, Sursis and North, 2017). As men frozen in trauma may still fear the view of receiving mental health support and possible misjudgement in diagnosis may be apparent with a large inclusion criteria for PTSD (Pai, Sursis, and North, 2017; Horwitz, 2018).

This change was certainly needed when reviewing healthcare for patients with mental health problems, as values were far from consideration when first treating PTSD (Kristotaki, Long and Smith, 2019). Although the 'service patient' treatment was slightly more ethical when caring for traumatised soldiers during the war, men's stigma was an occurring theme that seemed to repeat itself still to this day (Barham, 2004). Women's 'hysteria' became apparent in early 1900s, that fuelled the stigma of displaying mental illness to be seen as 'weak' and 'loony', not only with women's lack of power this then created pressure for men to disclose their own psychological troubles and remain the 'strong, silent man' (Barham, 2004; Haggett, 2015). This stigma plays a huge role in how men are treated within the healthcare system, the rooted social norms and self-perception of mental health being 'women's issues' pushed values to attend to men's psychological issues further away (Hagget, 2015). Some professionals maybelieve men are 'simply less likely to be affected', for example, as women are twice as likely to display mood disorders (Freeman and Freeman, 2013; Salk, Hyde and Abramson, 2017). However, since the mid-1990s men have accounted for three quarters of suicide deaths registered in the UK, presenting the complexity of support and treatment for males psychological well-being (ONS, 2019). Although, more attention was gained for the 'heroic' soldiers that are 'allowed a reason' for their psychological disorders, whereas 'ordinary' men may still experience invaluable and heartless treatment (Haggett, 2015).

So you could say that things have got better in certain ways for men and PTSD, and in other ways, things have arguably not changed much. For example, well into the 21st century, there are major issues relating to trauma that men experience that are not a lot different than they were 100 years ago. For instance, males who experience suicidal ideation are less likely to seek mental health services that may reduce the opportunity for prevention and intervention (Sagar-Ouriaghli et al, 2019). The self-stigmatizing beliefs that men face further discourage men from help seeking, alongside poor mental health literacy may contribute to issues with diagnosis and identifying psychological problems (Cotton et al, 2014). It seems to me that more work is needed to better understand men's health particularly in relation to PTSD and other related disorders that consider trauma, trauma that can emerge in many different ways, and ways that are still not properly understood. Whilst the focus is on men and PTSD, it also implies that with so many gender identities exisiting and be celebrated today, understanding PTSD in the context of gender is important and could go a long way to helping many more people.

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