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Conceptualizing Service-Related Trauma: Controversies, Challenges, and Opportunities in the Canadian Context
Conceptualiser le traumatisme lié au service : controverses, défis, et possibilités dans le contexte canadien

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ABSTRACT
This article considers three perspectives that have figured prominently in the conceptualization of psychological trauma related to military service in the Canadian context—that of military institutions, that of military members, and that of counselling psychologists. A closer examination of these views reveals points of contention regarding the origins, terminology, and cultural relevance of conceptualizations of service-related trauma, such as post-traumatic stress disorder. By drawing from theoretical, empirical, critical, and anecdotal literature, this article highlights the need for counselling psychologists to continually evolve their understanding of the broader contexts in which service-related trauma occurs and to honour military members' knowledge of diverse sources of traumatic suffering.

RÉSUMÉ
Dans cet article, les auteurs abordent trois des perspectives les plus fréquemment utilisées pour conceptualiser le traumatisme psychologique lié au service militaire dans le contexte canadien, soit le point de vue de l'institution militaire, celui des membres des forces armées, et celui des psychologues en counseling. En examinant de plus près ces points de vue, on constate des points de discorde en ce qui concerne les origines, la terminologie, et la pertinence culturelle des conceptualisations du traumatisme lié au service, par exemple lorsqu'il est question des troubles de stress post-traumatique. En s'inspirant de la documentation théorique, empirique, critique, et anecdotique, le présent article souligne qu'il faut que les psychologues en counseling fassent évoluer

constamment leur compréhension des contextes plus larges dans lesquels survient le traumatisme lié au service et qu'ils reconnaissent que ce sont les militaires qui savent quelles sont les multiples sources de souffrance traumatique.

Throughout history, efforts to conceptualize war-related psychological distress have been somewhat of an elusive and impractical task (Molendijk et al., 2016). Indeed, historical documents and classic literature have revealed that the terminology and understandings ascribed to post-war psychological suffering have varied considerably over time and alongside changing social, cultural, economic, and political conditions (Paulson & Krippner, 2010). Although post-traumatic stress disorder (PTSD) remains the current dominant model for conceptualizing the psychological effects of exposure to extreme violence and stress, research reveals that military institutions, military members, and professional psychologists may have conflicting notions as to what constitutes psychological trauma in the context of military service (Molendijk et al., 2016; Stewart, 2016). Hence, the purpose of this article is to examine multiple perspectives on military psychological trauma within the Canadian context and to generate dialogue surrounding broader, more contextualized understandings of human suffering in the context of military service. This article begins with a brief explanation of important concepts and terms, followed by a rationale for examining disparate perspectives on military psychological trauma. Following a brief outline of the social and political events that enabled PTSD to earn a position in societal discourse, this article will consider three perspectives that have figured prominently in conceptualizing service-related trauma in the Canadian context—that of military institutions, that of military members, and that of counselling psychologists. Subsequently, the tensions that exist both within and between these perspectives are examined. The final section discusses how an understanding of these varied notions may inform counselling and psychotherapy practice.

Concepts and Terms

Given the diversity of viewpoints, conceptualizations, and discourses surrounding military psychological trauma (Molendijk et al., 2016), clarifying the terms and concepts used throughout this article is warranted. The current article broaches the topic of psychological trauma in the Canadian military through the lens of trauma theory, which takes into account broader socio-political contexts and circumstances when considering the source of human suffering and distress (Tseris, 2019). While the term *trauma* is one way to conceptualize human suffering (Young, 1995), it is used herein as an attempt to be inclusive of prominent literature and to facilitate meaningful dialogue on issues of relevance to the Canadian military, its members, and psychology professionals. In addition, the term

service-related traumatic experience (STE) refers to a violent, life-threatening, or extremely stressful event that occurs within the context of military service (Molendijk et al., 2016). Moreover, *military service* denotes both domestic and international operations that occur within the boundaries of the military profession. Finally, and with respect to the centrality of the PTSD model in this article, it is worth noting that STEs have been linked to a range of psychological conditions (e.g., depression, anxiety, and substance abuse; Arditte Hall et al., 2017; Asselmann et al., 2018). However, this article focuses exclusively on PTSD due to its significance in the Canadian military context as well as to its historical role in legitimizing the psychological after-effects of STEs and providing a gateway for military members to access treatment (Montgomery, 2017).

A Rationale for Examining Multiple Perspectives

The importance of examining multiple perspectives on STEs is informed by both research and counselling practice. With regards to research, increased Canadian military involvement in international conflict and peacekeeping efforts, not to mention the physical and psychological demands of these missions, has attracted considerable attention from clinical researchers, health professionals, military members, and broader society since the 1990s (Litz et al., 2009; Montgomery, 2017; Watkins et al., 2016). Specifically, there appears to be general agreement in Western societies that STEs can lead to extreme cases of psychological suffering among military members (Molendijk et al., 2016). In response, Western forces and governments, including the Canadian military, have designed and implemented interventions to alleviate psychological distress stemming from STEs (Molendijk et al., 2016). At the same time, the Canadian military has been criticized by its members and by related advocacy groups for responding inappropriately to traumatized military members (e.g., discrimination, stigma, accusations of malingering, inadequate support from units and chains of command, involuntary discharge, and confidentiality breaches; Freyd & Birrell, 2013; G. Jones et al., 2003; Marin, 2001; McCristall, 2016) or for failing to recognize diverse forms of distress reported by military members (e.g., dismissal or minimization of psychological suffering, betrayal by leadership, and loss of identity and culture following release from service; Dallaire, 2016; Grenier, 2018; Ray, 2009; Stewart, 2016). These findings suggest that military institutions, military members, and professional psychologists may have disparate notions of what constitutes psychological trauma within the service context as well as of what comprises an effective response to psychological distress associated with an STE (Molendijk et al., 2016; R. T. Smith & Whooley, 2015; Stewart, 2016).

With respect to practice, the field of counselling psychology has increasingly promoted a pluralistic framework that emphasizes integrative and client-oriented understandings of psychological suffering (Finnerty et al., 2018; Marsella, 2010).

A pluralistic framework acknowledges that psychological suffering may have manifold origins and solutions and that client perspectives are particularly valuable for informing effective service delivery (Finnerty et al., 2018; Marsella, 2010). However, in the context of understanding STEs, several authors have indicated that disparate understandings between helping professionals and military members have generated significant challenges to providing effective support (Spring, 2015; Stewart, 2016; Weiss & Coll, 2011; Westwood & Black, 2012). Stewart (2016) maintains that these polarized discourses, compounded by the tendency to overlook social, moral, political, and cultural contexts when designing services, have resulted in iatrogenic effects and in an inadequate response to military members' suffering by relevant stakeholders. Hence, not only is there a need to examine multiple perspectives on STEs to understand better the tensions that exist, but also, it is critical that military members' views are upheld in developing a nuanced and coordinated response to STEs.

PTSD in the Canadian Context

As noted previously, terminologies and conceptualizations surrounding post-war psychological suffering have changed over time and contexts (Montgomery, 2017; Paulson & Krippner, 2010). According to E. Jones (2006), in the twentieth century alone, explanatory models for post-war suffering and their associated labels revealed paradigmatic shifts, from causes of a biological nature (e.g., soldier's heart, irritable heart) to neurasthenia (e.g., shell shock) to toxic exposure (e.g., Agent Orange) to psychological attributions (e.g., Gulf War Syndrome). Importantly, E. Jones (2006) points out that shifts in explanatory models for post-war suffering are dynamically intertwined with current health priorities, advances in medical knowledge, the changing nature of war itself, and cultural and political forces. With respect to PTSD, clinical and medical historians have consistently traced how the diagnostic category was born primarily out of social and political pressures brought about by the Vietnam veteran advocate movement (Lifton, 2011; Scott, 1990; Shatan, 1972; Shephard, 2000/2001). While recounting the historical development of the PTSD diagnosis is beyond the scope of this article and is reported elsewhere (see E. Jones & Wessely, 2007), this article outlines briefly the political and socio-historical forces that led to the eventual adoption of the PTSD model in order to provide context for examining diverse perspectives on STEs (for a more detailed historical account, see Montgomery, 2017).

Although the term PTSD officially entered U.S. society with the publication of the DSM-III (American Psychiatric Association [APA], 1980), PTSD did not appear in the Canadian military consciousness until the mid-1990s for several reasons (Montgomery, 2017). Chiefly, the Canadian socio-political milieu was characterized by a strong anti-war position and Canadian participation in the Vietnam War was largely concealed (Gaffen, 1990). Despite evidence that

Canadian veterans of the Vietnam War were also experiencing post-war psychological, social, and economic difficulties (Clark, 1984; Wren, 1985), many Canadian professionals and researchers dismissed the notion of post-Vietnam syndrome because it was considered a phenomenon restricted to U.S. soldiers (Gaffen, 1990). Interestingly, a changing political climate in the United Kingdom advanced the issue of the psychological impact of conflict in Canada. Following the Falklands War, media outlets began describing British soldiers' psychological difficulties in ways that fit with PTSD diagnostic criteria (Shephard, 2000/2001). However, the British Ministry of Defence (MOD) was reluctant to accept the diagnosis of PTSD and consequently was sued by several veterans for failing to provide adequate treatment (Shephard, 2000/2001). While the court rejected veterans' claims, the judge ruled that the MOD could no longer deny the existence of PTSD (Shephard, 2000/2001). Although this event did not involve Canadians, historians consider it the catalyst that prompted the Canadian military and health field to view PTSD as a condition that was not exclusive to U.S. soldiers (Montgomery, 2017).

While the Canadian military became increasingly accepting of PTSD as a war-related phenomenon, misperceptions surrounding the level of violence and stress encountered during peacekeeping missions and the effects of violence and stress on mental health remained a significant barrier to adopting PTSD into military and societal discourse (Montgomery, 2017). Due to the role and the vision of Lester Pearson, who was then secretary of state for external affairs, Canada and its military became known after the Korean War for its Pearsonian peacekeeping model (Coulon, 1998). Increased involvement in United Nations (UN) missions provided a foundation for forging the Canadian identity of a peaceful nation (Coulon, 1998). However, by the 1990s, with international conflicts emerging and UN missions increasing in tempo, numerous incidents began to challenge the Pearsonian peacekeeping model (Montgomery, 2017). As details of Canadian troops' brutal torture and murder of Somalian teenager Shidane Arone in 1993 came to light, the nation faced a harrowing contradiction in their national peacekeeping identity, and civilian trust in the military reached a historical low (Montgomery, 2017). While Canadian Armed Forces (CAF) and the Department of National Defence (DND) focused on the events that transpired in Somalia, Canadian soldiers were returning from former Yugoslavia having encountered genocide, civilian atrocities, and combat, all of which deviated largely from their deployment expectations and training (Off, 2004). Although Canadian soldiers experienced significant mental and physical difficulties following these tours, CAF and DND leaders viewed peacekeeping as less stressful than combat and were initially reluctant to conceptualize peacekeeping-related suffering as PTSD (English, 2012). Yet, during this period, numerous reports of suicides among Canadian peacekeepers surfaced (English, 2012; Off, 2004). As the Canadian public placed increasing pressure on the military to address

these suicides, the CAF and the DND began to investigate the stressors facing Canadian peacekeepers (English, 2012). Notably, Greg Passey, a naval lieutenant commander and a psychiatric resident, launched a research study and found that PTSD could develop from operations other than combat (Birenbaum, 1994). Passey's work established the notion of *peacekeeping trauma* and thus served as a powerful motivator for the CAF and the DND to take concrete steps toward recognizing PTSD in the Canadian military context (Birenbaum, 1994; Brock & Passey, 2013; Grenier, 2018). As a result, in July 1995, Passey and a team of mental health professionals introduced an educational program on PTSD to Canadian military members, representing the first organized effort created specifically to acknowledge PTSD in the Canadian military (Brock & Passey, 2013). Shortly thereafter, Lieutenant General Roméo Dallaire also began openly discussing his struggle with PTSD in the aftermath of the Rwandan genocide (Montgomery, 2017). Through his public interviews, speaking engagements, influential writing, and advocacy, Dallaire (2016) alerted Canadians to the morally complex circumstances surrounding peacekeeping trauma and its adverse impacts on the health and well-being of military members. While the Canadian military conceptualization of PTSD has undergone significant transformation since this time, the intersection of Canada's historical peacekeeping identity and the challenging deployments endured by Canadian military members provides a unique context for examining diverse perspectives on STEs.

Perspectives on Service-Related Psychological Trauma

Professional Psychology

Psychological theories and practices exert a profound influence on professional and broader societal understandings of human experience (Prilleltensky & Nelson, 2002). To a large extent, psychology training and practice have allied themselves with the medical-psychiatric paradigm, which in turn influences how professional psychologists understand, talk about, and relate to human suffering (Prilleltensky & Nelson, 2002). Although the medical-psychiatric paradigm has held a dominant position in professional psychology, alternative frameworks and orientations toward human suffering have been taken up within the field (Jaimes et al., 2015). Hence, a review of the range of perspectives among professional psychologists and among counselling psychology professionals specifically is warranted.

Diagnostic Systems and PTSD

In North America, the APA model of PTSD is the dominant approach to conceptualizing service-related trauma within professional psychology (Carrola & Corbin-Burdick, 2015; Weiss & Coll, 2011). According to the DSM-5, a PTSD diagnosis first requires that an individual meet Criterion A, which is defined as direct or vicarious exposure to a traumatic event that involved actual

or threatened death, serious injury, or sexual violence (APA, 2013). In addition to the traumatic event, the core symptom clusters of re-experiencing (Criterion B), avoidance (Criterion C), negative mood or cognitions (Criterion D), and hyperarousal (Criterion E) must be present to meet the full criteria for PTSD. Furthermore, symptoms from Criteria B through E must be present for more than one month (Criterion F), produce clinically significant distress or impairment in functioning (Criterion G), and cannot be attributed to the physiological effects of a substance or a medical condition (Criterion H).

Counselling Psychologists

Several studies have revealed that Canadian counselling psychologists tend to identify with either one or an integration of the following orientations: psychodynamic, cognitive behavioural, existential–humanistic, feminist, postmodern, multicultural, and social justice (Gazzola et al., 2010; Jaimes et al., 2015; Ogunfowora & Drapeau, 2008; Sinacore et al., 2011). These differences may be attributed to multiple factors, including differences in graduate training and supervision, differences in workplace settings, and differences in context-bound views on psychological distress (Gazzola et al., 2010; Ogunfowora & Drapeau, 2008). Within the field of traumatic stress specifically, points of contention among professional psychologists persist. Critics of diagnostic-driven models argue that an overemphasis on fear-based conceptualizations of trauma overlooks the importance of clients' perspectives, the meanings ascribed to trauma, and the socio-cultural context surrounding traumatic experiences (Sijbrandij & Olff, 2016; Yehuda et al., 2016). In contrast, some advocates of the medical-psychiatric position argue that extreme postmodern positions, such as the notion that any life event can qualify as traumatic so long as it is personally distressing and viewed as traumatic by the individual, may dilute the original significance and distinctiveness of psychological trauma (McNally, 2010). This concern has led several scholars and practitioners to warn against broadening the definition of trauma, stressing the necessity to draw a line between what is and what is not traumatic (McNally, 2010). However, tensions exist even among those who share medical orientations. For instance, Brewin et al. (2009) have argued that the subjective experience of PTSD is more important in diagnosing than the clinician's objective analysis of the presence and severity of symptoms. Given differences in theoretical orientations among Canadian counselling psychologists, it is not surprising that competing discourses exist regarding trauma-related psychological distress and its appropriate treatment (Cusack et al., 2016; Duncan et al., 2014; Markowitz et al., 2015).

To date, research has not examined the dominant theoretical orientations taken up by counselling psychologists who work specifically with military members. While research on this topic would be informative, some speculations can be made based on the tensions that exist in broader debates on what constitutes

psychological trauma and its appropriate treatment. In addition to the controversies mentioned above surrounding the conceptualization of psychological trauma in professional psychology, counselling psychologists' responses to service-related trauma are also subject to external forces that may dictate the orientation they take toward treating trauma (Gazzola et al., 2010). For example, the Canadian military system and its intersection with the public mental health system are influenced primarily by insurance companies and by third-party payer requisites for professional practice, which stipulates that a provider must make a formal diagnosis of the client's concern, usually consistent with the DSM-5 (APA, 2013), and deliver empirically supported therapies (ESTs) to address said concerns (Jaimes et al., 2015). Consequently, there is an increasing demand for service providers who adhere to diagnostic models and provide ESTs (Ogunfowora & Drapeau, 2008). Veterans Affairs Canada (VAC, 2019c) supports this conjecture in the agency's public fact sheet on evidence-based treatments for PTSD, which lists cognitive behavioural (i.e., cognitive processing and prolonged exposure therapies) and psychoactive medications as gold-standard treatments. Furthermore, a growing body of literature on these therapies demonstrates effectiveness in treating PTSD-affected military members (Steenkamp et al., 2015).

While counselling psychologists' theoretical orientations are an important issue that influences how human distress is conceptualized and treated, the extent to which psychologists honour military members' perspectives remains a central concern in the therapeutic context. Numerous psychological professionals and clinical researchers have discussed the importance of cultural competence when working with military members, a position that emphasizes the role of psychologists' implicit assumptions and biases, as well as their awareness of others' cultural world views, in delivering effective clinical services (Carrola & Corbin-Burdick, 2015; Hoge, 2011; Shay, 2012). Proponents of this view argue that it is an ethical responsibility of service providers to understand the limitations of current, medically oriented practices that pervade the mental health field (Carrola & Corbin-Burdick, 2015). In addition, it is important for professional psychologists to recognize that helpful elements from a range of approaches may be integrated to meet the needs of a specific client and situation (Finnerty et al., 2018). Furthermore, professional psychologists should balance their understanding of the individual client with an understanding of military culture and service, not only to connect with military members but also to avoid stereotyping them (Carrola & Corbin-Burdick, 2015). This stance signifies a movement toward culturally sensitive approaches for addressing psychological distress associated with STEs among military members, as opposed to a "myopic" view of their experiences that is often limited to diagnostic criteria (Carrola & Corbin-Burdick, 2015, p. 1). Indeed, some scholars have argued that the intersection of military culture with trauma leads to a distinct expression of trauma-related suffering among military members, one that goes beyond what is described in the DSM (Beks, 2016; Hoge,

2011; Shay, 2012; R. T. Smith & Whooley, 2015). As it stands, the importance of cultural competence in working with military members, including those who have encountered service-related trauma, cannot be understated.

Canadian Military Institutional Conceptualizations of Service-Related Trauma

Historically, military institutional conceptualizations of service-related trauma have been subject to paradigm shifts (Montgomery, 2017). At present, the dominant view espoused by the Canadian military is that service-related PTSD is a common and normal reaction to extreme violence, human atrocities, and life-threatening circumstances (VAC, 2019c). This perspective aligns with the DSM-5 model. However, the emergence of the overarching concept of *operational stress injuries* (OSIs) demarcates yet another paradigm shift, one that challenges psychiatric language. Interestingly, several prominent U.S. military mental health providers argue that the framework taken up by the Canadian military is an effective model for responding to service-related trauma (PBS News Hour, 2011). However, to appreciate fully why some prominent figures in the U.S. military have turned to Canada as a model for approaching STEs, a closer examination of the socio-historical context of the OSI framework is warranted.

Although the Canadian military acknowledged the diagnosis of PTSD in the 1990s, military members have continued to experience significant challenges in obtaining adequate treatment and support, even after receiving an official diagnosis of PTSD (Day & Olsen, 2015; McCristall, 2016). Collectively, the CAF, the DND, and government officials responded in 1998 by establishing five operational trauma and stress support centres (OTSSCs), each with a professional military mental health team (Montgomery, 2017). The objective of OTSSCs is to provide diagnostic assessment, treatment, and various therapeutic modalities to military members and their families suffering from psychological distress resulting from STEs, including PTSD. At the same time that OTSSCs were being built across the country, Major Stéphane Grenier, who had been diagnosed with PTSD following his 1994–1995 deployment to Rwanda, was charged with the task of addressing mental health stigma in the Canadian military (Grenier, 2018). In his memoir, *After the War*, Grenier (2018) recalls the events and the rationale behind his endeavours to begin challenging military mental health culture in the late 1990s. Drawing upon his personal and professional experiences working with CAF members diagnosed with PTSD, Grenier refused to accept the idea that PTSD is an illness. According to Grenier, the term *disorder* was at odds with how soldiers conceived of their challenges. Instead, Grenier committed himself to reframe psychological distress as an *injury*, maintaining his stance that psychological wounds from military service deserved the same regard as physical wounds. As a result, Grenier proposed the use of the term *operational stress injury*, which signified his intention to embody the broad scope of psychological injuries that

could result from military service. Despite some initial opposition from mental health professionals and military leaders, Grenier conceived of the OSI label as a culturally relevant term that validated and legitimized the psychological impact military members encountered in service. Indeed, Nash et al. (2009) point out that the OSI framework is an inclusive and effective model for conceptualizing service-related mental health challenges in that it considers a broader range of injuries in discussions of service-related stressors and employs language that destigmatizes distress and psychological suffering.

Due largely to Grenier's work, OSI remains the official term used by VAC since 2001 (Richardson et al., 2008) and has become a way of conceptualizing psychological difficulties among military members that is uniquely Canadian. A closer examination of the Canadian military framework reveals that the VAC defines an OSI as "any persistent psychological difficulty resulting from an operational duty performed while serving in the Canadian Armed Forces or as a member of the Royal Canadian Mounted Police" (Sareen, 2014, as cited in Day & Olsen, 2015, p. 1). Under the term's umbrella, OSIs include conditions such as anxiety disorders, depression, and PTSD (VAC, 2021). While the concept of OSI acknowledges that traumatic experiences can lead to a range of mental health concerns, the APA-derived PTSD diagnosis remains the prevailing model for capturing trauma-specific responses among military members (VAC, 2019b). In the VAC official publication on PTSD, the following description is provided as to what constitutes a traumatic event:

> Trauma is a very personal thing. What traumatizes one person can be of less significance to others. This variation in peoples' [*sic*] reactions occurs because of their personality, beliefs, personal values, and previous experiences (especially of other traumatic events in their life). It also occurs because each person's experience of the incident is unique. However, in all cases the individual has experienced a threatening event that has caused him or her to respond with intense fear, helplessness, or horror.
>
> For military Veterans, the trauma may relate to direct combat duties, being in a dangerous war zone, or taking part in peacekeeping missions under difficult and stressful conditions. (VAC, 2019c)

This description aligns with the psychiatric model in its emphases on intra-individual factors and on the notion of a universal response to threatening events (Molendijk et al., 2016). The model is based on the premise that stressful or traumatic events can disturb military members' cognitive processes and systems (Molendijk et al., 2016). Similarly, this definition also emphasizes the impact of one's subjective experience of an event. Hence, the Canadian military conceptualization of STEs is one that simultaneously employs culturally relevant

language (i.e., use of the term OSI) while retaining the diagnostic notion of PTSD (Montgomery, 2017). The contradiction inherent in this conceptualization is illustrated well in several debates that have emerged among clinicians, politicians, and veteran advocacy groups (PBS News Hour, 2012). While a discussion of these debates is beyond the scope of this article and is discussed elsewhere (see R. T. Smith & Whooley, 2015), the controversy surrounding terminology highlights how language reflects and shapes conceptual frameworks that in turn influence institutional responses to service-related psychological suffering (Molendijk et al., 2016). Despite the Canadian military's attempt to appeal to members' understandings of STEs, the medical conceptualization of PTSD remains at the centre of the military's treatment philosophy, a model that Molendijk et al. (2016) refer to as a "PTSD-infrastructure" (p. 345). As such, treatment approaches within the Canadian military are dominated by the individually focused cognitive and behavioural paradigm, where cognitive behavioural, cognitive processing, and prolonged exposure therapies are the most prominent interventions used by mental health providers (Molendijk et al., 2016; Stewart, 2016).

From this review, it is evident that the military's current conceptualization of service-related trauma has undergone changes that were set in motion by social and political pressures from multiple stakeholders, including military members. In addition, this conceptualization is one that appeals to both military and medical-psychiatric perspectives, but concerns have been raised about whether this narrative fully captures service-related trauma among military members at an experiential level (Spring, 2015; Stewart, 2016). As will be discussed in the next section, military members have played a central role in promoting non-dominant and culturally relevant conceptualizations of STE-related psychological distress—perspectives that are influential in shaping institutional and provider responses.

Military Members' Perspectives

A broader, contextualized understanding of military members' perspectives on service-related trauma remains a critical component of strengthening a coordinated response to STEs among relevant stakeholders (Spring, 2015; Stewart, 2016; Weiss & Coll, 2011; Westwood & Black, 2012). As such, the following section draws from sources of knowledge that foreground military members' subjective experiences (e.g., qualitative research studies and autobiographical accounts). Although limited, this body of literature has focused largely on the nature of moral injury as well as on military members' views on experiences that constitute trauma and the extent to which trauma fits within the PTSD model (Dallaire, 2016; Grenier, 2018; Litz et al., 2009; Ray, 2009; Stewart, 2016; Thompson, 2015; Watkins et al., 2016). To a lesser extent, experiences of loss and betrayal have also been identified by military members as an important aspect of STEs and related psychological suffering (Dallaire, 2016; Grenier, 2018; Ray,

2009; Stewart, 2016). Hence, the literature on loss and betrayal is examined in light of its relevance to the broader context of service-related trauma.

Moral Injury

In memoirs written by PTSD-affected Canadian veterans, the aftermath of traumatic experiences has been described in ways that go beyond the PTSD diagnostic criteria (Dallaire, 2016; Grenier, 2018; Whelan, 2014). Prominent among these departures is the phenomenon known as *moral injury*, a concept that evolved largely from U.S. soldiers' self-reported experiences in therapy (Shay, 1994). Broadly defined, moral injury refers to long-lasting emotional and psychological distress following an act of transgression or an event that conflicts with one's moral and ethical expectations (Litz et al., 2009).

The concept of moral injury is particularly relevant to understanding STEs, given that Canadian military members frequently encounter situations fraught with ethical and moral dilemmas (Thompson, 2015). Research conducted on Canadian military members deployed to Afghanistan revealed that combat experiences that involved members perpetrating an act or failing to prevent an act that violated their morals were most strongly associated with a PTSD diagnosis (Watkins et al., 2016). Moreover, Ray (2009) found that Canadian peacekeepers cited the inability to prevent harm to civilians (due to rules of engagement) and the subsequent witnessing of civilian atrocities as the primary traumatic events implicated in their experience of PTSD—findings that are echoed throughout Canadian veterans' memoirs. For instance, Grenier (2018) described the psychological trauma of serving in Rwanda as a "very slow, methodical de-calibration of [his] moral compass" (p. 61). Relatedly, Grenier (2018) indicated that the mental health professionals he worked with not only misunderstood but also minimized "the moral conflict that lies at the centre of traumatic events" (p. 61). Grenier argued further that grappling with a sense of disillusionment regarding the goodness of humanity was more challenging to deal with than the forms of trauma that fit with the PTSD model (i.e., life-threatening/violent events).

According to Litz et al. (2009) and Shay (2012), the concept of moral injury more adequately depicts military members' perceptions of the conditions that lead to traumatic suffering than does the current PTSD model. Interestingly, a closer examination of moral injury and PTSD models reveals both overlapping and distinguishing features. Specifically, whereas re-experiencing, avoidance, and numbing symptoms are constitutive of both PTSD and moral injury, physiological arousal remains a criterion exclusive to PTSD (Shay, 2012). Furthermore, the meaning of the traumatic event in PTSD is a loss of safety for the individual, whereas in moral injury, it is a violation of the individual's moral code (Shay, 2012). As such, Shay (2012), as do Litz et al. (2009), maintains that moral injury differs from the PTSD diagnostic entity in that it accounts for social, cultural, and moral dimensions of suffering.

Loss

In recent years, researchers have become increasingly interested in military members' experiences of loss as it relates to traumatic suffering (Ray, 2009; Smith-MacDonald et al., 2020; Stewart, 2016). Although in its infancy, the literature in this area reveals that loss may be an immediate aspect of STEs and/or an outcome of events that follows trauma-related psychological distress (Ray, 2009; Smith-MacDonald et al., 2020). With respect to the former, an experience of loss may constitute the traumatic event itself, such as in the case of witnessing the death of a fellow military member (Dallaire, 2016; Stewart, 2016). In the latter case, loss of identity, culture, and community may be experienced contemporaneously with the exit from military service among members who suffer from enduring trauma-related conditions such as PTSD (Dallaire, 2016; Grenier, 2018; Ray, 2009; Smith-MacDonald et al., 2020). To understand this relationship better, several studies have examined the experience of loss among trauma-affected military members. For instance, Ray (2009) conducted a phenomenological exploration of Canadian peacekeepers who served in Somalia, Rwanda, and the former Yugoslavia and their experiences of healing from the psychological effects of STEs. She found that peacekeepers described grieving the loss of their military identity, comradeship, and career following medical release and viewed these events as discrete forms of trauma. Moreover, Stewart (2016) found that PTSD-affected Canadian veterans cited identity loss and alienation from society among the most salient experiences that contributed to their suffering. In a later study, Smith-MacDonald et al. (2020) found that PTSD- and OSI-affected military members described their release from military service as "injurious" and as a major source of psychological, social, and spiritual distress (p. 239). Collectively, these studies show that the nature of the relationship between loss and service-related trauma may be aptly characterized as compounding and interwoven (Smith-MacDonald et al., 2020). While the combined effect of STEs with the subsequent loss of identity, culture, and community is cited frequently in autobiographies and in qualitative research, additional research on this topic and on its role in service-related traumatic suffering is sorely needed (Dallaire, 2016; Grenier, 2018; Smith-MacDonald et al., 2020; Whelan, 2014).

Betrayal and Organization Trauma

An emerging body of empirical and anecdotal literature has turned its attention to the role of military institutions in generating and/or compounding distress among military personnel (C. P. Smith & Freyd, 2014). It is worth noting that since the late 1990s, the DND and VAC have taken a number of steps to strengthen the institutional response to the varied impacts of service-related trauma (Government of Canada, 2019; Montgomery, 2017; VAC, 2019a). For instance, the creation of a CAF/DND official ombudsman position in 1998, along with its ensuing investigations into the systemic treatment of PTSD-affected

military members, signified efforts to enhance institutional transparency and accountability (G. Jones et al., 2003; Marin, 2001; McCristall, 2016). At the same time, OTSSCs were established across the country to provide assessment, treatment, and outreach for psychological injuries, including PTSD (Government of Canada, 2019; Montgomery, 2017). Moreover, the CAF, the DND, and VAC have taken measures to destigmatize mental health conditions in the military through psychoeducational and outreach initiatives and through the development of the Operational Stress Injury Social Support program (OSISS), a peer support program for military members suffering from OSIs (Grenier, 2018; VAC, 2019a). Finally, and through the Veteran Family Community Covenant, the DND and VAC extended their recognition of the effects of service-related stress to family members and pledged to provide psychosocial services to meet the needs of family members (Government of Canada, 2013; VAC, 2013). While the aforementioned initiatives do not represent an exhaustive list of the measures taken by the CAF, the DND, and VAC, such actions represent tangible efforts to respond to the concerns of military members affected by service-related trauma as well as to its systemic impact on families. Nevertheless, even with such initiatives, military members continue to report institutional failures to understand service-related psychological trauma and to respond in ways that prioritize the safety and well-being of those affected (Freyd & Birrell, 2013; G. Jones et al., 2003; MacLeod & Leduc, 2019; Marin, 2001; McCristall, 2016; Montgomery, 2017; Smith-MacDonald et al., 2020; Stewart, 2016). Indeed, research suggests that there remains a disconnect between the perspectives of Canadian military members and military institutions as to whether the DND and VAC are upholding their pledge to protect and prioritize the well-being of military members affected by service-related trauma (Beks, 2017; MacLeod & Leduc, 2019; McCristall, 2016; Montgomery, 2017; Ray, 2009; Stewart, 2016). This divergence between military members and military institutions provides a strong impetus for examining military members' perspectives more closely.

Although limited, a small body of literature comprised of research and autobiographical accounts has explored the institutional response to military members who endure psychological suffering following traumatic events that took place within the context of service. In discussing the factors that contributed to their distress and suffering following STEs, Dallaire (2016) and Grenier (2018) describe the role of the Canadian military's actions and inactions, including (a) the failure to prevent traumatic, unethical, and life-threatening experiences among peacekeepers, (b) inadequate handling and involuntary discharge of traumatized members in the aftermath of such events, and (c) attempts to conceal or feign responsibility for civilian suffering and for members' post-conflict suffering, including psychological conditions and suicide. With respect to research on Canadian military members, an early study on PTSD-affected peacekeepers revealed instances of betrayal by the military in the form of inadequate or disrespectful

responses to members' disclosures of STEs, including stigma and discrimination as well as involuntary medical release (Ray, 2009). Peacekeepers in this study described the betrayal as complicating their healing and affecting them more negatively than the original life-threatening or violent experience that led to a PTSD diagnosis (Ray, 2009). In a separate study, Stewart (2016) cited several factors that intensified veterans' PTSD symptoms, including (a) a violation of interpersonal loyalty and trust within the military community, (b) betrayal or inadequate support by trusted leadership and the military establishment, (c) rejection by the military community in the form of involuntary medical release, and (d) stigma and discrimination by military peers or leadership. More recently, Beks (2017) explored barriers to help-seeking among Canadian spouses of PTSD-affected Canadian veterans. This study revealed that issues related to military institutional actions and inactions (e.g., withholding information and access to support, a lack of response to inquiries and family needs, and failures to deliver promised supports) were cited as factors that not only hindered help-seeking but also exacerbated spouses' and veterans' psychological distress.

Collectively, the above-mentioned literature suggests that there may be a larger, systemic issue at play concerning psychological suffering associated with STEs. Several phrases have been offered to name this issue (e.g., organization trauma, secondary wounding, sanctuary trauma), but among these terms, the concept of *institutional betrayal* (IB) has received increased attention from scholars, clinicians, and social advocates in recent years (Grenier, 2018; Hope & Eriksen, 2009; Smidt & Freyd, 2018). A term coined by C. P. Smith and Freyd (2014), institutional betrayal refers to the failure of a trusted and depended-upon institution (e.g., the military, a place of worship, or a medical establishment) to protect and support its members within the context of traumatic experiences. Specifically, harmful institutional behaviours and responses that lead to IB can be categorized as acts of omission or of commission or as a combination of the two (C. P. Smith & Freyd, 2014). Acts of omission involve failures to respond to victims in ways that have been promised by institutions, such as guarding against or preventing harms or providing support to victims (C. P. Smith & Freyd, 2014). In contrast, acts of commission involve institutional responses that downplay, conceal, dismiss, punish, or further traumatize victims (C. P. Smith & Freyd, 2014). Importantly, research has consistently found that IB may exacerbate and compound service members' psychological distress in the aftermath of trauma (Freyd & Birrell, 2013). Indeed, recent studies have found that military members who experience IB following a traumatic event such as military sexual trauma report more severe, complex forms of PTSD and heightened suicidal ideation (Monteith et al., 2016; C. P. Smith & Freyd, 2013). Although research in the area of IB does bring into question the potentially harmful role of institutions, additional research is needed to understand the compounding effect of institutional actions and inactions on the distress experienced by trauma-affected Canadian military members.

Discursive Tensions in Conceptualizations of Service-Related Trauma

The previous section presented three perspectives that have figured prominently in conceptualizing psychological trauma related to military service in the Canadian context—that of military institutions, that of military members, and that of counselling psychologists. Following a closer examination of the many viewpoints within and among these three perspectives, we will turn to several points of contention that exist regarding aspects of STEs, including terminology, orientations to what constitutes trauma, and efforts to normalize traumatic suffering. Furthermore, there is an ongoing debate about whether the APA's diagnostic criteria fully capture the experiences that military members perceive to be at the root of psychological suffering within the context of an STE. The following section draws from critical, empirical, and anecdotal literature to discuss the tensions generated by these diverse experiences and viewpoints.

An *Injury* and a *Disorder*: Straddling Two Worlds or a Clash of Paradigms?

To highlight the tensions that exist regarding terminology, this section revisits the Canadian military's framework for conceptualizing psychological distress stemming from an STE. As noted previously, the Canadian military's continued and simultaneous use of the terms OSI and PTSD creates discursive tensions between the desire to align with military members' experiences and values and the need to embrace a term for medical, insurance, financial, and political purposes (Grenier, 2018; E. Jones & Wessely, 2007). This tension may send conflicting messages to veterans before and in the aftermath of an STE (R. T. Smith & Whooley, 2015). Furthermore, the tension between these terms is not easily reconciled and has spurred considerable controversy among the APA, mental health professionals, veteran advocacy groups, and the military (Ochberg, 2013; R. T. Smith & Whooley, 2015). Some veteran advocates who favour dropping the term *disorder* raise concerns about the implications of Canada's use of conflicting terminologies. Specifically, these advocates posit that transitioning to civilian life and encountering the term disorder may cause confusion and stigma among veterans who are accustomed to the injury paradigm (PBS News Hour, 2012).

There are also polarized discourses among mental health professionals about replacing the term *disorder* with *injury*. Some professionals side with Canada's template of maintaining PTSD as a disorder and as an injury, arguing that this approach addresses the stigma associated with the disorder while acknowledging the military perspective that it is an injury (PBS News Hour, 2012). Other professionals maintain the position that Canada's attempt to embrace both terms is haphazard, arguing that the APA and the military have yet to understand the implications of using the term disorder and have failed to capture the meaning, sacrifices, and inherent honour of being injured in the name of service to one's country (Ochberg, 2013; PBS News Hour, 2011; Shay, 2012). Furthermore, the

term disorder is criticized for "degrading" those who are suffering because the term implies illness and abnormality (Ochberg, 2013, p. 98). Yet, critics of this movement anticipate that using the term injury does not assist the military, professional psychologists, or military members in determining whether a reaction to a stressful event is reasonable or indicative of a more persistent and severe syndrome requiring intervention (PBS News Hour, 2011). While this debate continues in both clinical and academic arenas, some leading U.S. military psychiatrists maintain that the prominent focus on terminology diverts attention from the most important issue of all—that is, how military institutions treat military members in the aftermath of an STE (National Institute for the Clinical Application of Behavioral Medicine, n.d.). Importantly, this debate raises questions about the costs and the benefits of labelling the psychological suffering resulting from an STE and highlights the importance of considering the wider context surrounding such an experience.

Individually Located Distress and Extreme Conflict

In their analysis of various Western Armed Forces' institutional narratives about trauma, Molendijk et al. (2016) discuss the paradox in disparate conceptualizations of PTSD. Although Canada was not included in their analysis, Molendijk et al.'s critique helps to illuminate the points of contention between and within the military and military members' perspectives. According to Molendijk et al., soldiers learn in basic training that extreme stress and violence can have adverse consequences on their health and that developing symptoms consistent with PTSD later is a normal experience. Soldiers also learn in training that model soldiers should be psychologically fit to handle such stress and violence (Molendijk et al., 2016; Taber, 2009). These conflicting messages give heed to a paradox that is threefold. First, extreme violence and stress are simultaneously described as normal and abnormal (Molendijk et al., 2016). Second, PTSD is described as a normal response to abnormal stressors, even though it is labelled a disorder. Third, there exists a dominant attitude that soldiers should be psychologically fit to handle extreme conditions, even though the diagnosis of PTSD implies that one falls short of this ideal (Molendijk et al., 2016; Taber, 2009).

These conflicting messages have important implications for conceptualizing psychological distress associated with an STE. The term disorder orients the cause of suffering within the individual while overlooking cultural, political, and systemic causes of distress (Nichter, 2010). Arguably, violence and conflict are inherent to military operations, and applying a diagnostic label to common experiences within a community is not consistent with the traditional sense of a disorder (Molendijk et al., 2016; Spring, 2015). As such, the common experience of extreme violence and conflict, not to mention the effects of this in the military, is perhaps more indicative of a systemic problem (Molendijk et al., 2016). These tensions have led some researchers to argue that PTSD is not an individually

located disease process but rather a socio-cultural expression of the distress of being involved in violent and disturbing conflicts that are laden with moral dilemmas and in which ethical leadership, adequate resources, and supportive community are needed but not guaranteed (Molendijk et al., 2016; Shay, 2012).

Blurred Lines: Peacekeeping Versus Combat and the Canadian National Identity

Canada has entered an era in which its role in peacekeeping has been heavily debated. Our waning involvement in UN missions, coupled with participation in more combative missions, has led some prominent scholars to argue that Canada has departed from its traditional peacekeeping practices (Cros, 2015). Even though Canadian missions no longer adhere to the Pearsonian model, peacekeeping remains an important and esteemed element of national identity (Montgomery, 2017). Indeed, much of the civilian populace continues to perceive Canada as a peacekeeping nation in its traditional sense (Cros, 2015).

The national peacekeeping identity, and by extension the enshrinement of this identity in the civilian populace and in individual military members, creates some noteworthy tensions that may have implications for conceptualizing psychological distress associated with an STE. Critics have explored the obvious tension between our international peacekeeping reputation and evidence (e.g., operations in Somalia, Rwanda, the former Yugoslavia, and Afghanistan) that suggests that little peace occurs on these deployments (Cros, 2015). Moreover, the term peacekeeping itself represents a misnomer in that it fails to capture the moral and ethical dilemmas and extreme violence encountered during Canadian operations. At the same time, the idea that peacekeeping involves the type of stress that can lead to PTSD was initially inconceivable to the Canadian civilian populace, the mental health field, and the military institution (Montgomery, 2017). While Canada as a nation has made great strides toward altering these beliefs, anecdotal evidence suggests that the attitudes from this era prevail even within the military today (Dallaire, 2016; Grenier, 2018; Marin, 2001).

The enduring peacekeeping identity and the experiences of Canadian military members may represent another tension that contributes to the complexity of understanding psychological distress linked with STEs. On the one hand, Canadian military members may be upheld by the civilian populace as a poignant symbol of peace or as non-interventionist in nature, but on the other hand, military members may experience, witness, or perpetrate events that involve little to no peace (Montgomery, 2017). Thus, this contradiction leads to two tensions pertinent to understanding STEs. First, there exists a conflict between the national peacekeeping identity and what occurs in the context of military service (Cros, 2015). Second, there exists a conflict between military members' identity as peacekeepers and the traditional, intended role of military members and the training they undergo (Spring, 2015). The extent to which these identity

tensions influence and perhaps intensify the experience of STEs and PTSD has yet to be addressed in research studies but could offer some important context for understanding psychological distress among Canadian military members.

Discussion and Conclusion

This article examined three perspectives that have figured prominently in current debates over what constitutes psychological distress linked to STEs—military institutions, military members, and counselling psychology professionals. Hence, the discussion points that follow reiterate the tensions that emerged through the juxtaposition of several conceptualizations and their role in shaping institutional and provider responses to STEs. Moreover, these tensions are discussed in light of their potential implications for counselling and psychotherapy practice.

As pointed out earlier, disparate notions regarding terminology, orientations to what constitutes trauma, and efforts to normalize traumatic suffering between and within all three perspectives not only give way to discursive tensions in the military's framework for identifying and responding to STEs, but also, they have generated paradoxical messages surrounding what is considered an expected and understandable response to contexts in which abnormal violence and stress are relatively common. Furthermore, the lingering impact of Canada's historical peacekeeping identity contrasted with the reality of Canada's military training and missions represents yet another contextual factor to consider in conceptualizing and understanding psychological suffering associated with STEs. The extent to which these discursive tensions influence or intensify an STE for a particular client has yet to be the focus of research. Nevertheless, the counselling setting may offer an opportunity to explore military members' positions and perspectives on these themes. Such information may not only inform the selection of interventions but also foreground a client-oriented understanding of traumatic distress within the context of service. In this way, the collaborative nature of the counselling relationship—amid topics that are often addressed hierarchically—can become healing in and of itself.

With particular emphasis on the controversy regarding terminology and what constitutes trauma, it is important to reiterate that veteran advocacy groups lobbied for the effects of the Vietnam War to be medically recognized, and the PTSD diagnostic entity was, in part, a response to these forces. Thus, the PTSD model has made a significant contribution by validating previously unacknowledged STEs among military members. Yet, it seems paradoxical that the current diagnostic entity of PTSD, despite its significance in the history of veterans' grassroots advocacy groups, has diverged in some ways from the experiences of many contemporary military members. Whereas the PTSD psychiatric model emphasizes individual disorder resulting from trauma exposure, the collective literature on military members points to understandings of STEs that appear to

be heterogeneous, dynamic, and fluid. Hence, this literature prompts an alternative consideration of STEs, not as a static event but as a *process* that incorporates more insidious forms of harm that take place before, during, and after a traumatic event (Molendijk et al., 2016). The emphasis on an STE as a dynamic process rather than as a singular event has implications for the focus of counselling practice with military members. Specifically, trauma-focused interventions emphasize processing the event(s) that meets the DSM-5 definition of a traumatic experience (Steenkamp et al., 2015). While these approaches are important for addressing symptoms of traumatic distress, the counselling setting offers an opportunity to understand how pre- and post-trauma socio-political, socio-cultural, and moral contexts have contributed to military members' meanings of trauma and of its associated distress, as well as the impact of responses and actions from important actors in military members' lives in the aftermath of trauma. An exploration of these contexts may inform individualized planning and treatment delivery as well as highlight sources of distress that may remain but warrant careful attention throughout trauma-focused treatment.

Another primary rationale for this article was to generate dialogue surrounding broader, more contextualized understandings of the psychological impact of STEs through the examination of military members' viewpoints, including those that deviate from or complement PTSD or OSI models. Interestingly, an examination of military members' perspectives revealed three emergent phenomena: moral injury, loss, and betrayal. In isolation, these concepts do not capture sufficiently the range of experiences of psychological distress associated with STEs as described by military members. When taken together, however, this small body of literature has important implications for future counselling practice. As indicated previously, although loss and moral injury add important contexts to understanding STEs, the need to consider institutional factors persists. In its focus on the impact of institutional responses to traumatic experiences, IB emerges as a possible avenue for attending to the wider contexts in which trauma occurs and thus may complement and further contextualize the many understandings of such experiences that have emanated from STE research. Specifically, IB has the potential to attend to broader factors that produce the psychological distress that has mainly been framed as contained within or as resulting from the actions of the individual military member (Molendijk, 2019). Hence, the counselling setting may offer a conduit for attending to military members' experiences of IB and for considering its potential to exacerbate or interfere with the treatment of co-occurring concerns such as OSI, loss, and moral injury.

In summary, this article points to the need for counselling psychologists to consider the wider contexts surrounding STEs and their related psychological suffering among Canadian military members. Notably, an exploration and integration of military members' perceptions and experiences of STEs—including the role of military institutions in preventing, responding to, and alleviating

psychological distress caused by such experiences—may offer clinical insights that currently remain unaddressed and yet contribute to ongoing distress. Through examining these perspectives and attending to the diverse perceptions military members may hold, we as counselling psychologists may deepen and contextualize our understanding of STEs, but most importantly, we will honour the voices of those most deeply affected by these challenging experiences.

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