Battling the Stigma: Combat Veterans’ Use of Social Support in an Online PTSD Forum

Guided by the social support framework, this article identifies types of support sought and received by combat veterans with PTSD in an online forum. We conducted a thematic analysis of 466 posts by 63 military personnel and partners to identify types and frequencies of social support. Findings are partially consistent with previous investigations of support groups. The most common type of support was informational support, followed by network/community support, and idiosyncratic types of support. However, emotional support was not featured as prominently in comparison to support groups reported on in past research. In addition, our analysis identified concern for forum members and conflict/resolution as two new social support sub-categories. Selective coding revealed three broad themes of social support in the PTSD forum: stigma, group identification, and embracing conflict. We discuss implications and directions for future research using the social support framework.

Keywords: combat veterans, masculinity, PTSD, social support, stigma

Preliminary evidence suggests that psychological afflictions associated with deployment to war zones disproportionately surpass the incidence of physical injuries sustained by military forces (RAND Center for Military Health Policy Research, 2008). Post-Traumatic Stress Disorder (PTSD) is identified in the literature as one of the psychological disturbances most robustly correlated with deployment to combat zones (RAND Center for Military Health Policy Research, 2008). PTSD was defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a trauma- and stressor-related disorder resulting from exposure to a traumatic event, such as threatened death, severe injury, or sexual assault (American Psychiatric Association, 2013).

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Studies conducted after the onset of the military conflicts in Afghanistan and Iraq estimated the incidence of PTSD among military personnel at 9% before deployment and between 12 and 18 percent in the post-deployment stage (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004; Vasterling, Proctor, Amoroso, Kane, Heeren, & White, 2006). According to the Institute of Medicine (2014), approximately 8% of current and former members of the U.S. armed forces who were deployed to combat zones have a PTSD diagnosis. Despite an increased realization of the magnitude of the PTSD problem in the military, in the Department of Defense (DoD), and in the U.S. Department of Veteran Affairs (VA), the Institute of Medicine (2014) reported that only 53% of Iraq and Afghanistan veterans who were diagnosed with PTSD in 2013 received the recommended eight psychotherapy sessions within a 14-week period. The same study reported that there seemed to be little integration and national coordination of PTSD treatments available to veterans, indicating that “PTSD management in DoD appears to be local, ad hoc, incremental, and crisis-driven, with little planning devoted to the development of a long-range, population-based approach for the disorder” (p. 5).

The medical, personal, social, and economic costs of combat-related PTSD affecting military personnel and their families can be tremendous. In a review of relevant literature published by RAND Center for Military Health Policy Research in 2008, suicide, physical health and mortality, substance abuse, employment and productivity, homelessness, dissolution of marriage, parenting and child outcome, and co-morbidity with other mental disorders were identified among the most prominent issues associated with PTSD in the military. At the onset of the Operation Enduring Freedom in Afghanistan the reported suicide rate in the U.S. armed forces was 9 cases per 100,000. By 2009, the figure rose to 22 per 100,000 (Black, Gallaway, Bell, & Ritchie, 2011). Literature indicates strong association between suicide rates and PTSD. For example, Legarreta et al. (2015) found that veterans who reported suicide ideation (SI) and/or suicide attempts (SA) were more likely to meet the criteria for a PTSD diagnosis. However, the significant increase in completed suicide rate cannot be attributed solely to PTSD; major depression disorder (MDD) and traumatic brain injury (TBI) have been identified as risk factors for SI, SA, and completed suicides among military personnel (RAND, 2008). In addition, other factors such as socioeconomic status, life/identity transitions, treatment availability and seeking, trauma severity, relationship status, and co-morbidity have been found to constitute risk factors for suicide among veterans of the armed forces.

MASCULINITY AND STIGMA

A growing body of literature (e.g., Dickstein, Vogt, Handa, & Litz, 2010; Hoge et al., 2004; Kelley, Britt, Adler, & Bliese, 2014; Mittal et al., 2013; Murphy, Hunt, Luzon, & Greenberg, 2014; RAND, 2008) lends support to the hypothesis that stigma associated with seeking help for mental illness may be higher in the military compared to the general population. These studies suggest that admitting to mental illness is often interpreted as malingering and may derail one’s military career. Researchers and medical practitioners have increasingly accepted that male patients may be reluctant to actively engage in health-protective behaviors related to both physical and mental health issues (Mansfield, Addis, & Courtenay, 2005; Von Bothmer & Fridlund, 2005). One contributing factor may be masculinity, defined as display of behaviors and attitudes such as invulnerability and stoicism in an attempt to meet presumed sociocultural expectations typically associated with men (Bordo, 1999; Migliaccio, 2010; White & Johnson, 2000). Support for this hypothesis, however, is inconclusive.
For example, Mansfield et al. (2005) identified masculine gender role norms such as self-reliance, autonomy, and stoicism to strongly predict the avoidance of health-protective behaviors. Conversely, Brown and Bond (2008), in a study of Australian men found no support for masculinity norms as a relevant predictor of engagement in health-protective behaviors. We know that not all men are reluctant to seek health care (Robertson & Williams, 2009). It is possible, as previous research suggests, that gender norm construction is highly dependent on the social and cultural context, and thus is local and fluid (Addis & Cohane, 2005; Fox & Pease, 2012). Therefore, more current interpretations might deviate from the traditional conceptualization of masculinity as stoic, heroic, self-reliant, displaying limited emotional expression, and perhaps invulnerable to “unmanly” medical conditions such as mental health issues. Unsurprisingly, a substantial body of research (e.g., Fox & Pease, 2012; Hale, 2012; Higate, 2000, 2001) indicates that transnational military forces still foster traditional masculinity values. Prior research has found that those adhering to traditional masculine cultural norms are likely to seek medical treatment for substantial traumatic events such as bleeding wounds, broken limbs, or dislodged joints, because treatment for such trauma would not call into question their masculinity (Sobralske, 2006). However, traumas perceived as less masculine, among which mental health-related issues are prominently featured, are more likely to be overlooked or disguised, in an effort to conceal perceived weakness (Fletcher & St. George, 2011). It is thus possible that both men and women in the military may delay or never seek medical treatment for PTSD, because acknowledging symptoms of mental disturbance may be interpreted as weakness in a culture that strongly adheres to traditional masculine norms. In an attempt to avoid the ostracism resulting from violating such norms, it is conceivable that some combat veterans with PTSD symptoms may turn to online support groups to receive help and assistance without openly violating cultural norms prevalent in the military.

Previous studies have shown that individuals turn to online support groups to seek preliminary information about medical conditions, advice, guidance, and emotional support (Braithwaite, Waldron, & Finn, 1999; McCormack & Coulson, 2010; Winzelberg, 1997). Online forums have the benefit of being accessible 24-hours-a-day, unlike traditional services, which have limited business hours. In addition, seeking and receiving support in an online support group does not necessitate access to certain resources, such as physical access to medical facilities, insurance coverage, or money for copayments, required by most traditional medical services (Braithwaite et al., 1999).

**SOCIAL SUPPORT IN ONLINE SUPPORT FORUMS**

Social support has been defined as “verbal and nonverbal communication between recipients and providers that reduces uncertainty about the situation, the self, the other, or the relationship, and functions to enhance a perception of personal control in one’s experience” (Albrecht & Adelman, 1987, p. 19). In other words, social support can be viewed as a collection of different types of behaviors that show a person that she is valued by a group to which she belongs (Gray, 2013). Prior research (e.g., Albrecht & Goldsmith, 2003; Braithwaite et al., 1999; Eichorn, 2008; McCormack & Coulson, 2009; Peterson, 2009) has found that social support occurring in online settings often takes the form of informational, emotional, network, esteem, and other idiosyncratic types of support. Lewandowski, Rosenberg, Parks, and Siegel (2011), using a military sample, found support for the hypothesis that the amount of social support received significantly affects the outcome of a disruptive/traumatic event. Brewin, Andrews, and Valentine (2000) identified
lack of social support as a major posttraumatic predictor of the onset of PTSD. Previous research consistently suggests that social support is more likely to be sought, particularly in the anonymous environment provided by online support groups, by individuals diagnosed with medical conditions viewed as stigmatizing by societal norms. For example, Davidson, Pennebaker, and Dickerson (2000) found that individuals diagnosed with HIV were 250 times more likely than patients with a non-stigmatized condition like high blood pressure to seek membership in a support group. As noted, a growing body of evidence indicates that mental health issues may be stigmatized in the military. Therefore, there is a strong possibility that military personnel with PTSD symptoms are left with significantly limited access to traditional support, particularly at the onset of the disorder. In fact, online groups may be some of the very few venues of support that military personnel with PTSD symptoms can access at the onset of the disturbance.

Despite the growing public awareness of the magnitude of the PTSD phenomenon in the wake of the military operations in Afghanistan and Iraq, and the growing concern over cultural and systemic barriers that prevent veterans’ access to proper health care, there is a dearth of research about alternative venues of help and support for military personnel with PTSD. Following the discussion of social support in online groups and the lack of systematic inquiry of support groups for military combat veterans with PTSD, we posed two research questions to guide this investigation:

RQ1: What are the specific types of social support messages constructed by participants on an online support group for combat veterans with PTSD?

RQ2: What are the overarching themes that permeate the exchanges on the online support group for combat veterans with PTSD?

**METHODS**

**Data Collection**

In this study, we investigated the occurrence of social support in an online support group for combat veterans diagnosed with PTSD. Following guidelines established by similar inquiries, we used two criteria to select a support group: first, either the online group had to be open or, in case the group required registration, written permission to conduct research had to be obtained from the forum’s administrator(s); second, the selected group had to include a sufficient number of members who actively posted and responded to messages posted on the forum (Keski-Rahkonen & Tozzi, 2005; McCormack & Coulson, 2009). We thus selected a group created exclusively for military personnel who had been deployed to war zones and were subsequently diagnosed with PTSD. In order to preserve the anonymity of forum’s members, we provide no identification information for this online group.

In this particular online group, viewing a limited number of posts is free, un-moderated, and open to everyone. However, actively participating in the forum requires registration. In keeping with similar empirical inquiries (e.g., Keski-Rahkonen & Tozzi, 2005), written permission to collect data was obtained from the founder and administrator of the online group. The Human Rights in Research Committee (HRRC) at a Southeastern university in the United States deliberated the ethical aspects of this study and approved it with exempt status.

We collected and analyzed data until we achieved thematic saturation (Glaser & Strauss, 1967; McCormack & Coulson, 2009). Saturation was reached when coding additional data
ceased to generate new codes or subcategories but merely increased the frequency of existing subcategories. 466 posts (messages) grouped in the most popular 12 threads on the forum were selected, downloaded, and thematically analyzed. We identified the most popular threads using two criteria: 1) total number of messages posted in a thread; 2) total number of times a thread was viewed by users. For example, one thread consisted of 44 posts, but had a total of 1548 views. Participants who read the messages but make no written contributions to an online forum—lurkers—are considered a sizable and important group. The role played by lurkers in online groups has been debated, but van Uden-Kraan, Drossaert, Taal, Seydel and van der Laar (2008) have shown that participation in online support groups might be equally beneficial for active members as well as for lurkers.

Forum Members

A total of 63 group members (53 men and 11 women) posted messages in the 12 threads selected for analysis. With one exception, women who posted identified themselves as spouses or partners of male veterans with PTSD. The age and ethnicity of the group members were infrequently reported on the forum. However, the geographical location of most members was reported next to their name or pseudonym. Participants were veterans or active members of the armed forces of English-speaking countries including the United Kingdom, the United States, Canada, Australia, and South Africa.

Data Analysis

We conducted a deductive thematic analysis of the 466 posts in three stages of coding: open, axial, and selective (Glaser & Strauss, 1967; Strauss & Corbin, 1990). The first stage of thematic analysis, open coding, requires the raw data to be reduced to autonomous idea units (Strauss & Corbin, 1990). The open coding stage of the analysis yielded 2,076 idea units from the raw data in the 466 original posts.

Next, axial coding, corresponding to the integration stage of thematic analysis (Lindlof & Taylor, 2002), was performed. During this stage, the first and the second author jointly analyzed 20% of the idea units to ensure analysis consistency. The first author then analyzed the remainder of the data. Through axial coding, we grouped idea units generated during the previous coding stage in categories and subcategories based on analogous themes (Strauss & Corbin, 1990). The purpose of this stage of coding was to understand how social support occurs on the forum for combat veterans with PTSD. In addition, axial coding yielded a frequency count of social support types, in effect indicating the frequency of each type of social support occurring on the forum. Prior to performing the axial coding, we first created a coding book, using guidance provided by social support literature (Braithwaite et al., 1999; Grey, 2013; McCormack & Coulson, 2009). This research strategy had two goals: first, to reexamine existing findings regarding the occurrence of social support in online support groups; then, to discover whether any new themes or categories would be found in the analysis of the data (Smith & Krugman, 2010; Strauss & Corbin, 1994). The latter goal was particularly important because social support framework has not been previously employed to analyze PTSD support groups. Therefore, it is relevant to understand whether such forums have particular characteristics of generating and negotiating social support that perhaps are not shared by other groups.

The final stage of the coding process involved selective coding, which corresponds to the final stage of thematic analysis—the process of dimensionalization (Lindlof & Taylor,
During this stage, we extracted overarching themes from axial codes that pervaded the messages posted in the threads included in the analysis.

RESULTS

Social Support Categories

For the present study, we employed an adapted code book based on the work of Braithwaite et al. (1999). The original code book included five supercategories (information, tangible assistance, esteem support, network support, and emotional support) and multiple subcategories. For the current study, we collapsed the tangible support and information supercategories, because tangible support was not prominently featured in our data set. We added a fifth supercategory, unique support communication, informed by existing social support research (McCormick & Coulson, 2009; Peterson, 2009). Using methodological guidance from McCormack and Coulson (2009), we expanded the category of network/community support to include instances of welcoming new members and encouraging newcomers to open up to the community defined as a safe and supporting space. In keeping with Braithwaite and colleagues (1999) and McCormick and Coulson (2009), only posts aimed at creating structural connections were included in this category; messages aimed at providing emotional support were coded separately.

Many of the subcategories identified during the axial coding stage confirm and replicate previous similar research. However, two new subcategories were identified in the analysis: concern for other members as part of the emotional support supercategory; and conflict/resolution as part of the unique support communication supercategory. Table 1 provides a list of all supercategories and axial categories found in the analysis, along with counts and percentages. Similar to previous studies, we found certain subcategories to be prominently represented in the dataset, whereas others were less prevalent. As seen in Table 1, informational support was the most salient supercategory (52.7% of all idea units), followed by network/community support (19.3%), and by unique support communication (12.1%). Concomitantly, participants in the forum rarely provided or sought emotional support (11.3%) or esteem support (4.6%). In response to RQ 1, the following section discusses the supercategories of social support that were identified in the data analysis.

Informational support. The first supercategory, informational support, included idea units that created a supportive online environment in the form of (a) requesting personal disclosure; (b) providing personal disclosure; (c) requesting information; (d) providing information; (e) requesting advice; and (f) providing advice. Messages posted in this supercategory performed the broad role of reducing uncertainty and providing practical guidance, typically offered by long-term members of the forum to newcomers. The most prominent subcategories that were identified within the total number of idea units were providing personal disclosure (27.1%), providing information (17.1%), and providing advice (5.4%) (see Table 1). These subcategories occurred much more often than others such as requesting personal disclosure (1.7%), requesting information (1.3%), and the almost non-existent requesting advice (.05%). Messages in the providing personal disclosure subcategory were typically initiated by new members of the forum who would provide descriptions—varying in length—of their symptoms and how the onset of the disorder impacted their personal, social, or professional lives. The example provided below illustrates this category. In order to maintain participants’ anonymity, all usernames have been removed from the subsequent examples.
Example post:

My husband asked me to see someone about it. I tried but it didn’t work out that day. I got in my car and yelled and screamed and punched the hell out of my windshield and mirror … went home determined to get the noise levels down by hanging myself in my basement.

Messages coded in the providing information subcategory typically offered details about PTSD in terms of symptoms, definitions, effects, and struggles experienced as a consequence of living with this condition. In an example, a forum member discussed the complexities of combat-related PTSD in relation to other forms of the disorder:

Table 1
Frequencies of Social Support Supercategories and Subcategories

<table>
<thead>
<tr>
<th>Support Supercategories and Subcategories</th>
<th>Frequency</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Informational Support</strong></td>
<td>1094</td>
<td>52.7</td>
</tr>
<tr>
<td>Request personal disclosure</td>
<td>35</td>
<td>1.7</td>
</tr>
<tr>
<td>Provide personal disclosure</td>
<td>563</td>
<td>27.1</td>
</tr>
<tr>
<td>Request information</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>Provide information</td>
<td>356</td>
<td>17.1</td>
</tr>
<tr>
<td>Request advice</td>
<td>1</td>
<td>0.05</td>
</tr>
<tr>
<td>Provide advice</td>
<td>112</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Emotional Support</strong></td>
<td>234</td>
<td>11.3</td>
</tr>
<tr>
<td>Encouragement</td>
<td>71</td>
<td>3.4</td>
</tr>
<tr>
<td>Request emotional expression</td>
<td>5</td>
<td>0.2</td>
</tr>
<tr>
<td>Provide emotional expression</td>
<td>116</td>
<td>5.6</td>
</tr>
<tr>
<td>Concern</td>
<td>6</td>
<td>0.3</td>
</tr>
<tr>
<td>Empathy</td>
<td>32</td>
<td>1.5</td>
</tr>
<tr>
<td>Sympathy</td>
<td>4</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Network/Community Support</strong></td>
<td>400</td>
<td>19.3</td>
</tr>
<tr>
<td>Normative introductions/Welcomes</td>
<td>144</td>
<td>6.9</td>
</tr>
<tr>
<td>Community building</td>
<td>119</td>
<td>5.7</td>
</tr>
<tr>
<td>Forum maintenance</td>
<td>38</td>
<td>1.8</td>
</tr>
<tr>
<td>Display gratitude</td>
<td>99</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Esteem Support</strong></td>
<td>96</td>
<td>4.6</td>
</tr>
<tr>
<td>Compliments</td>
<td>36</td>
<td>1.7</td>
</tr>
<tr>
<td>Validation</td>
<td>50</td>
<td>2.4</td>
</tr>
<tr>
<td>Relief of blame</td>
<td>10</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Unique support communication</strong></td>
<td>252</td>
<td>12.1</td>
</tr>
<tr>
<td>Prayer/inspiration</td>
<td>9</td>
<td>0.4</td>
</tr>
<tr>
<td>Poetry/quotations</td>
<td>19</td>
<td>0.9</td>
</tr>
<tr>
<td>Humor</td>
<td>153</td>
<td>7.4</td>
</tr>
<tr>
<td>Conflict/resolution</td>
<td>71</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2076</td>
<td>100</td>
</tr>
</tbody>
</table>
The end result of most people’s PTSD is usually the same which equates to social dysfunction, anger, lost jobs and careers, sleepless nights, anxiety, depression, lethargy, etc. How we get there is very diverse — it’s the end result that seems quite similar.

Providing advice was shown in previous research to be one of the most prominent forms of support, especially during times of heightened uncertainty and stress (Peterson, 2009). On the PTSD forum, offering advice was one of the more salient subcategories, although not to the same extent as the previous two forms of informational support. Typically, advice took the form of providing members with practical guidance (e.g., “If you’re sort in one piece I recommend phys [sic], get a sweat on. It gets the energy out”), or prompting them to seek medical attention (e.g., “Take your DD214 and get your ass to the Vet Center today, Marine!”). Similar to prior studies, we found that requests for various types of informational support were much less frequently present on the forum (see Table 1).

**Emotional support.** Emotional support was present on the forum under investigation in the following forms: (a) encouragement; (b) requesting emotional expression; (c) providing emotional expression; (d) expressing concern; (e) expressing empathy; (f) expressing sympathy. Emotional support was much less present in this support group compared to figures reported by previous investigations. This supercategory made up approximately 11% of all messages posted on the PTSD forum. In contrast, in a similar study of a support group for men with eating disorders Flynn and Stana (2012) found that emotional support messages constituted 35% of all support messages on the forum. In an analysis of a support group primarily comprised of women with eating disorders Coulson and McCormack (2009) reported that as much as 78% of messages were coded as various types of emotional support. The most frequent subcategory of emotional support present on the PTSD forum was providing emotional expression (5.6%), illustrated by the following example: “I feel like I’m a recovered addict trying to get used to the fact that I must now live my life without ever experiencing again what I felt on drugs…. It’s so hard to come to terms with.” Encouragement (3.4%) was the second most frequently encountered category of social support, illustrated by posts such as “hang in there, it does get better!” Empathic messages (1.5%) offered support on an emotional level, stressing similarities between experiences of individuals living with PTSD, as in the following example: “Yeah those feelings are common, I guess just about all of us here can relate to them.” Interestingly, sympathy — which was relatively prominently featured in support groups investigated by other studies (e.g., Braithwaite et al., 1999) — was almost completely absent from the PTSD forum. Concern displayed for group members is a new support category that was found in the data analysis, although it was not a frequently encountered form of social support. Typically, concern occurred when a member unexpectedly ceased to participate in the forum, such as in the following example: “Does anyone think that XXXX might just be a ‘one hit wonder’? just [sic] saying a lot of energy got expended here”, to which another group member replied: “I sure hope not. Sounds like he needs both help and support.”

**Network/community support.** The network/community support supercategory comprised nearly 20% of all idea units examined and included messages aimed at creating a sense of community and expanding participants’ social support network. This supercategory included four subcategories: (a) normative introductions/welcomes; (b) community building; (c) forum maintenance; (d) displaying gratitude. The most salient subcategory
identified in the analysis was normative introductions (6.9%), typically expressed via brief messages such as “Welcome, Marine!” or “Welcome to the fold XXXX mate!” Community building was the second most prevalent category of network/community support, accounting for 5.7 percent of idea units. Messages coded as community building attempted to define the group as a tight-knit network of people with similar experiences: “…know this is a good place to find people that understand you.” We coded forum maintenance as a separate subcategory (1.8%) because some messages were meant to highlight rules having the specific goal of maintaining a functional environment in which mutual support could occur and disruptions were prevented (Flynn & Stana, 2012). Some forum maintenance messages attempted to prohibit posts that could be perceived as disturbing or “triggering” by active members or by “lurkers”. The following example illustrates such a message: “A PTSD site aint [sic] the place to come, talking about how much you liked to kill. The real deals here have seen as much if not more during their own times in battle.”

Displaying gratitude for the encouragement, support, and advice received from other members of the forum constituted approximately 5 percent of all analyzed idea units. Most gratitude messages were general and addressed to the entire forum, which justifies the inclusion of this subcategory under network/community support supercategory.

**Esteem support.** Messages coded in the esteem support supercategory sought to validate members’ self-concept, importance, and competence, and included the subcategories of (a) compliments; (b) validation; and (c) relief of blame. Compliments (1.7%) offered praise for one’s present or past accomplishments. For example, the following message mentioned a former medic in the U.S. military forces: “I have the highest regard for the Doctors and Corpsmen that I’ve met. I don’t think that there’s a tougher job than that…”. Messages that emphasized agreement or common ground and offered support on a cognitive level (and thus differed from empathic messages, which offered emotional support) were labeled validation (2.4%).

**Unique support communication.** The unique support communication category reunites idiosyncratic types of supportive communication, in the form of (a) prayer/inspiration; (b) poetry/quotations; (c) humor; and (d) conflict/resolution. Humor was the most frequently identified category (7.4%). Messages often took the form of sarcastic or self-deprecating humor, like the following example addressed to a former medic: “Love how you guys used to carry Motrin and issue it. Headache? Take two … blisters take 4 … leg fell off? Take 10 come back and see me tomorrow.” A new subcategory was generated in the analysis, labeled conflict/resolution (3.4%). The presence of this subcategory comes in contrast to previous research that found conflict to be actively avoided and/or prohibited by forum administrators, while a positive climate was persistently promoted (Peterson, 2009). Certainly, conflict itself cannot be seen as a form of support. However, virtually all conflictual situations on the PTSD forum were eventually resolved through various conflict management strategies, either directly or through other members’ mediation.

**Social Support Themes**

In response to RQ2, which inquired about the themes that permeated the exchanges on the online support group for combat veterans with PTSD, we further analyzed the data in the third stage of thematic analysis, selective coding. This stage generated three overarching themes: stigma, group identification, and embracing confrontation.
Theme 1: Stigma. Shame and guilt associated with mental illness are well documented. Recent studies (e.g., Dickstein et al., 2010; Kelley et al., 2014) suggest that institutions that adhere to traditional masculine norms like the armed forces might have even less tolerance for mental health issues than civilian institutions. Consistent with past research, we found concern for stigma of mental illness to be one of the most prevalent themes present in the PTSD support group. Participants in the forum consistently expressed regret over not seeking medical help earlier in their careers and indicated that the most salient barrier to their seeking help was the stigma of admitting to a mental illness in the military, as seen in the following example:

I went 7 years without talking about the PTSD that I have from my multiple deployments to Iraq. I just recently got professional help. I was fearful that getting help would ruin my career. Now that my career is almost over, I went to get help. I know there is not supposed to be a stigma about getting help with mental health but there absolutely is.

The struggle over the consequences of admitting to mental issues was intensified in the case of officers who hesitated to counsel or order their soldiers to seek help, knowing that such a decision would almost certainly have a detrimental impact on the soldiers’ career. The following example illustrates the preoccupation among forum members for this difficult issue:

How can I tell my Soldiers to seek help? I cannot look my Soldiers in their face and tell them it will not negatively impact their career. It will!! It stopped my career in it’s [sic] tracks…. How do I tell my Soldiers if they want to progress, they have to suck it up and live with it? Tough. Really tough.

Theme 2: Group identification. The analysis revealed the participants’ sustained efforts to construct a group identity in opposition with outside groups, particularly civilians, illustrated by this example: “The feelings of being back will eventually fade away and the horror of battle will keep going. The problem with being surrounded by selfish civilians will linger though. They are always worried about the petty stuff”. Indeed, messages in the community building subcategory demonstrates a clear sense of shared experience: “…and this site has helped many. Just having a place to go where you are accepted and where you can associate as we all have served in a war and we all have PTSD.” The strong military ethos also transcended national differences: “Young, old, American, Aussie, British, combat arms, or combat support services, it doesn’t matter, because we all have our different experiences so we can all learn from one another.” Camaraderie was emphasized on the forum’s threads using various strategies. One salient strategy revolved around the frequent deployment of informal bonding terms such as brother(s), mate, guys, or buddy. For example, the term brother or brothers occurred 22 times in our dataset, mate 83 times, and guys (used to address other forum members directly) appeared 58 times. Such relatively high frequencies suggest the importance placed by forum members on such terms used to strengthen group identification and solidarity. Previous research suggests that providing advice as opposed to receiving advice might create asymmetric power relations between peers on support groups (Morrow, 2006). Gough (2015) found that use of bonding terms, aside from their role in fostering camaraderie, serve as a device to mitigate power distance between forum participants, for example between established members of the group and newcomers.
mentioned, group members frequently expressed frustration with civilians’ inability or un- 
willingness to understand the experiences that led to the PTSD diagnosis. Consequently, 
combat veterans with PTSD may have turned to the online support group to reproduce the 
group identity of the military environment in an attempt to provide meaning and significance 
to their experiences through the exchange of support among individuals with similar back-
grounds.

**Theme 3: Embracing confrontation.** Past research (e.g., Flynn & Stana, 2012; Peterson, 
2009) consistently found that administrators and participants in online support groups sought 
to create and maintain a positive culture as a quintessential condition to provide members 
with adequate support. However, this was not the case on the PTSD forum for combat vet-
erans. As previously indicated, conflict arose fairly frequently among participants, and while 
other members would sometimes attempt to mediate conflict, the forum had no formal rules 
in place to avert aggressive communication. The use of humor in support groups is well 
documented by past research (e.g., Peterson, 2009; Seymour-Smith, 2013). Humor com-
prised a significant percentage of all posts on the PTSD forum (7.4%). In contrast to other 
groups, where humorous messages were offered in a supportive rather than conflictual or 
critical manner (Peterson, 2009), humor employed on the present forum could often be con-
frontational, sarcastic, or self-deprecating. Our findings seem to confirm previous studies 
of humor in military contexts. Although this subject received relatively little scholarly at-
tention, Ben-Ari and Sion (2005) in a study of the Israeli combat reserves found that humor 
played roles similar to the ones identified by us in the PTSD forum: entertainment and stress 
release, socialization, group cohesion, and establishment/preservation of masculinity.

**DISCUSSION**

Our analysis revealed both similarities and differences between the online group under in-
vestigation here and other online support groups. Our findings are consistent with previous 
studies (Braithwaite et al., 1999; McCormack & Coulson, 2009; Mo, Malik, & Coulson, 
2009; Peterson, 2009) and confirm that informational support, in the forms of personal dis-
closure, information exchange, and advice, is a critical form of support in online groups. 
With regard to the first theme, stigma, the high prevalence of information support in rela-
tion to other forms of support may be attributed to masculinity norms in the negotiation of 
social support within the combat veterans group. Group members were much more likely 
to offer and receive informational support than emotional support. This finding mirrors a re-
cent study (Mo et al., 2009), which found that informational support is more likely to be as-
sociated with male participants in support groups, whereas emotional support is more likely 
to be associated with women active in such forums. As mentioned, eleven participants in-
cluded in our dataset were women. However, only one identified herself as a member of the 
armed forces, whereas the other ten participated as spouses or partners of male combat vet-
erans diagnosed with PTSD. Women’s posts on the forum dealt primarily with the chal-
lenges of living with a spouse or partner diagnosed with PTSD. There were no significant 
differences between the posts of the one female veteran member of the forum and the posts 
of male participants. It is difficult to establish if these similarities are determined by our 
limited data or perhaps by the internalization of the military culture and values by virtually 
all members of military forces, regardless of gender. This aspect should be further explored 
in future research endeavors, as a growing number of nations are now allowing women to 
join their military forces in all capacities, including combat tasks.
To further highlight the influence of masculinity norms in the negotiation of support communication, we found that group members were significantly more likely to provide information than to request it. This finding is in line with previous research that emphasized that men under pressure from masculinity norms could display reluctance to seek help for certain health issues and to strive for self-reliance (Seale, Ziebland, & Charteris-Black, 2006).

In partial support of previous research, we found emotional and esteem support to be less prominently featured types of social support (11% and 4.2%, respectively). One possible explanation may again relate to the first theme, stigma. In the hyper-masculine group identity of military combat veterans, seeking or offering emotional support may be viewed as feminine. Ginossar (2008) offered a similar explanation to account for the higher degree of emotional support offered and received by women who participate in virtual support communities. However, in a study that investigated an online forum for men with eating disorders (Flynn & Stana, 2012), the authors found emotional support to be highly salient form of support. The authors proposed that, due to the stigma of men openly discussing eating disorders, forum members may have found comfort in the relatively anonymous online space of the forum to exchange emotions more freely than in face-to-face contexts. Perhaps the level of stigmatization related to discussing PTSD in the military is so high that even the in the anonymous context of the online forum masculinity norms that govern communication prevail.

Another possible explanation is that certain types of disorders might be best addressed by specific types of support (Cutrona & Russell, 1990). Developments perceived as controllable by participants in the forum may be best addressed by problem-oriented and problem-solving types of support such as informational support. As PTSD has some controllable aspects (e.g., making appointments at the nearest VA Health Center, health insurance available to current and former military personnel, wait lists, etc.), it is possible that support coming in an informational format may be perceived as more useful than emotional or esteem support by individuals with PTSD.

Somewhat ironically, the very masculinity norms that may carry stigma are also related to the creation and maintenance of a strong group identity on the forum. Thus, the second theme, group identification, is emphasized by a strong sense of network and community building through social support; one-fifth of all idea units offered network/community support. Although the high degree of network/community support seems to contradict previous findings (e.g., Braithwaite et al., 1999; Gray, 2013), it is perhaps not surprising, given that one of themes of the forum was group identification. Previous studies have found social identity theory (SIT) and self-categorization theory (SCT) to be useful in exploring the expression of group identification through qualitative thematic analyses (Giles, 2006; Jackson, 2006, Jackson & Sherriff, 2013; Morin & Flynn, 2014; Sherriff, 2007). According to SIT, group members tend to focus on similarities among the in-group and differences from the out-group (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). By doing so, group members are able to increase the perceived gap between the in-group and out-group, thereby making one’s in group membership more concrete. In a particularly relevant article, Jackson (2006) discussed the importance of masculinity as a vehicle to create similarities between group members and enhance in group identification among young adolescent boys. Others, including Seymour-Smith (2013), have also noted the importance of gendered identity cues in determining the types and frequencies of social support online.

Previous literature has also shown that members of a group will often employ polarizing language in an effort to protect the group from external criticism. Such strategies might solidify in group biases and in effect strengthen group identity in opposition with external
groups (Giles, 2006; Morin & Flynn, 2014; Sindic & Reicher, 2009). This perspective is useful to help explain frequent comments by members of the PTSD forum where they referred to and defined their community in opposition to out-group members, particularly civilians, or “civvies”, as they were often labeled on the forum, as in the following example: “PTSD is PTSD, we are all at different stages of dealing with our beasties. We have to stick together and support each other because the civvies and other sure [sic] don’t.”

Two new social support subcategories were generated during data analysis: concern for group member and conflict/resolution. Concern for a member typically occurred when a participant abruptly withdrew from the forum. In such a situation other members tried to resume communication with the missing member, either through messages posted on the forum, or via private messages. The occurrence of this type of support is likely warranted by the strong ties and the sense of community that characterized the PTSD support group. The second new category that we identified in the analysis, conflict/resolution, cannot be seen as a form of social support per se. However, as already noted, confrontation between members on the forum was frequently resolved either directly or indirectly (i.e., via mediation by other participants), and thus we coded it as a unique form of communicating support. In contrast with other online support groups, the PTSD forum had no formal set of rules established to prevent confrontation. While confrontation was not openly invited, it certainly was not formally prohibited. This finding was perhaps not surprising in the general context of the PTSD forum. As discussed, members of the forum frequently engaged in long exchanges of confrontational humor. This general context of the PTSD forum came in stark contrast with online forums analyzed by past research. While conflict in support groups has occasionally made the object of past research (e.g., Aakhus & Rumsey, 2010), such research focused on strategies used to mitigate conflict in an effort to craft supportive communication. More focused research is needed to determine whether formally creating and maintaining a conflict-free environment is indeed a necessary component in crafting support or whether conflict/resolution can constitute, at least in certain online groups, a unique form of social support.

While the benefits of online support groups have been well documented, some researchers cautioned against an unreservedly enthusiastic view of online support groups. Keski-Rahkonen and Tozzi (2005) and Tanis (2008) suggest that, at least in the case of specific disturbances like eating disorders, participation in online support groups might hinder progress and delay healing. In addition, especially on loosely moderated or self-moderated forums such as the one we investigated, the possibility exists that erroneous information or advice is being offered or sought. To ameliorate this potential issue, Veterans Affairs health facilities and private practices that treat patients with PTSD could develop more closely moderated and monitored online support groups. Thus, patients would have access to accurate information and readily available medical professional help, while maintaining anonymity and avoiding long waiting lists. This may help to circumvent the limitations of both traditional and online support while integrating their respective strengths.

One limitation of the present study is that our analysis included only one online support group. A valuable direction for future research will be to investigate similar discussion groups for different demographic categories, for example support groups for female military personnel with PTSD. Also, as suggested by previous studies, combat veterans from various eras might be affected differently by living with PTSD because of different levels of access to health care and support. The systematic investigation of PTSD in non-Western cultural context might be a fruitful venue of research. Preliminary inquiries suggest that combat-related trauma may be experienced both similarly and differently in cross-cultural
contexts (Johannessen & Holgersen, 2014). Finally, more applied communication inquiry of online support groups for veterans with PTSD is necessary in order to offer practical solutions to a growing societal concern.

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