Framing and Sourcing Dynamics in Trauma Coverage: PTSD in The New York Times, 1999–2020

A thesis presented to

the faculty of

the Scripps College of Communication of Ohio University

and the Institute for Communication and Media Studies of Leipzig University

In partial fulfillment

of the requirements for the degrees

Master of Science in Journalism (Ohio University),

Master of Arts in Global Mass Communication (Leipzig University)

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August 2021

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Framing and Sourcing Dynamics in Trauma Coverage: PTSD in The New York Times, 1999–2020

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August 2021

3705409

Framing and Sourcing Dynamics in Trauma Coverage: PTSD in The New York Times, 1999–2020

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This study examined sourcing and framing in PTSD news coverage published by The *New York Times* from 1999–2020 using quantitative content analysis. Based on the findings of previous studies, it was hypothesized that the sampled coverage would overrepresent combat trauma relative to other sources of trauma, underrepresent options for treatment and recovery, privilege men and official sources over women and unofficial sources (i.e., men and official sources would speak more often than women and unofficial sources), and favor episodic/individual framing over thematic/social framing. However, these hypotheses were only partially supported.

The researcher ultimately found that, while the sampled coverage did overrepresent combat trauma and underrepresent treatment and recovery options, as well as favor men over women in sourcing, it defied expectations in other ways. Namely, it was observed that civilian/unofficial sources predominated over official sources, and that thematic/social framing predominated over episodic/individual framing.

Dedication

This thesis is dedicated to my family, for their patience and support throughout a difficult year.

.

Acknowledgments

I would like to thank Dr. Parul Jain, Dr. Victoria LaPoe, and Ms. Rosanna Planer for their guidance throughout this process, and for their service on my committee; Ms. Jessie Roark for her tireless help in the coding process; and, finally, Dr. Barbara Barnett (University of Kansas School of Journalism and Mass Communications) and Dr. Brian J. Houston (Chair in the Department of Communication at the University of Missouri) for their formative research on PTSD coverage, and aid in constructing a coding instrument for this study.

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Introduction

> We live in an era where the hard sciences are valued far and above other academic disciplines and where the humanities are frequently treated as luxury pursuits. This has resulted in a clinical culture, especially within psychiatry, that tends to treat neuroscience has the only rubric for understanding human experience . . .
> — David J. Morris, *The Evil Hours: A Biography of Post-Traumatic Stress Disorder* (2015, p. 160)

> A constructionist approach reminds us that how a problem is defined affects how (or even if) society responds to the problem, and how the experiences of individuals are influenced by the definition and response to their problem.
> — Conrad, P. & Barker, K. K., *The Social Construction of Illness: Key Insights and Policy Implications* (2010, p. S76)

Post-traumatic stress disorder (PTSD), however concrete its generative harms, was and is a product of journalistic inquiry as much as psychiatric inquiry (Scott, 1990; Lembcke, 1998; Morris, 2015). Given that PTSD—originally "Post-Vietnam syndrome"—existed as an object of media fascination well before its incorporation in the American Psychiatric Association's (APA) third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), it is only appropriate that media scholars direct their attention to the issue of its representation, especially by sources—individuals or entities quoted or paraphrased in news coverage—capable of influencing public policy and medical-scientific discourse.

The forthcoming thesis will analyze representations of PTSD in *The New York Times* using an approach informed by framing theory. *The New York Times* was selected for analysis owing to its central role in the PTSD diagnosis' early history (Scott, 1990; Lembcke, 1998; Morris, 2015), inclusion in prior studies on PTSD coverage (Houston, Spialek, & Perreault, 2016; Purtle, Lynn, & Malik, 2016; Barnett & Lee, 2019), and

popularity among news consumers; *The New York Times* was the third most-circulated daily newspaper January in 2019 (Watson, 2020). Framing theory was chosen as the dominant analytic approach because it acknowledges the selection process inherent to media representation; the act of representation (by journalists or otherwise) is necessarily incomplete, promoting some definitions, interpretations, and solutions at the exclusion of others (Entman, 1993). This thesis will build on extant framing literature, cataloging the (potential) impact of recent sociopolitical developments on the sourcing of PTSD news stories, as well as representations of the disorder's essential characteristics, relation to systemic violence, and manifestation across various identity groups in the past two decades.

PTSD news stories, as they appear in this literature, overrepresent military PTSD, underrepresent civilian PTSD, rely extensively on male and governmental sources to the exclusion of others, neglect to communicate treatment options, and portray sufferers as criminally violent (Houston, et al., 2016; Purtle, et al., 2016; Barnett & Lee, 2019). Far from an abstract consideration, these skewed representations may influence U.S. federal legislation, which also foregrounds military trauma and relegates civilian trauma and its myriad sources to the background (Purtle, 2016). As the American Psychiatric Association (APA) notes, PTSD "can occur in all people, of any ethnicity, nationality or culture," impacting 3.5% of U.S. adults annually (American Psychiatric Association, n.d.). Additionally, media effects research has "demonstrated a positive association between news coverage of violence by people with mental illnesses and stigma" (McGinty, Chosky, & Barry, 2016, p.1127). Put simply, the visions of mental illness promulgated by journalists may have a powerful influence on both broader cultural

attitudes and concrete policy outcomes. Considered as an aggregate, though, the literature on PTSD framing has solely analyzed stories published by *The New York Times* between 1950 and 2015. We might reasonably ask, how have subsequent sociopolitical developments and dialogues on PTSD shaped news coverage?

One such development would be the proliferation of mediated social movements. Empowered by the unique affordances of online communication platforms such as Twitter, these movements may choose to reject the dominant frames of systemic (and traumatic) violence, challenging traditional media agents on more equitable terrain (Burch, Frederick, & Pegoraro, 2015; Moody-Ramirez, Tait, Smith, Fears, & Randal, 2016; Molina, 2019; Moernaut, Mast, Temmerman, & Broersma, 2020). Social media platforms (including Twitter) have also been integrated into the news gathering process such that popular discourses (and popular frames) are more likely to direct and/or shape mainstream media coverage (Broersma & Graham, 2013; Moody-Ramirez, et al., 2016; Barnard, 2018; Wahl-Jorgensen, 2020). These platforms serve the needs of journalists inasmuch as they aid in rationalizing the news gathering process, but they may also empower activists by exposing journalists to "new voices, topics and publics" (Broersma & Graham, 2013, p. 448). In some cases, the members of these online publics may even attempt to influence media personnel by way of direct calls to action (Xu & Feng, 2014).

The systemic violence critiqued by contemporary movements such as Black Lives Matter and MeToo has become a topic of fervent discussion in the news media and elsewhere. Primary (Twitter, Facebook, etc.) and secondary (news publicization) representation of the MeToo movement, for instance, seems to have catalyzed a spike in treatment-seeking behavior on the part of those impacted by this violence (McCammon,

2017). Additionally, MeToo and broader public discussion of non-military trauma (Beckett, 2014; Hemmer, 2017) have the potential to encourage critical reflection among media personnel, compelling them to confront damaging trends in their field and respond accordingly. As will be discussed in the sections to follow, PTSD's trajectory from informal, to journalistic, to medical discourse began with confessional-therapeutic (as well as expressly political) "rap groups" (Scott, 1990, p.300), suggesting that social movements which encourage personal disclosures of injustice can influence subsequent media coverage. If journalism remains an earnestly inductive and/or investigative process, not overdetermined by routine and structural inertia, then one might assume an outspoken and coordinated public could reconfigure its definitions (or frames).

In observance of these dynamics, this thesis proposes a broad research question: How have contemporary socio-political developments—including popular social movements and discourses surrounding trauma—shaped news framing of PTSD? More specifically, the following hypotheses are proposed:

> *H1:* News coverage of PTSD will overrepresent military and combat experience relative to other sources of trauma and underrepresent options for treatment and recovery.
>
> *H2:* News coverage of PTSD will privilege men and official sources over women and unofficial sources (i.e., men and official sources will speak more often than women and unofficial sources).
>
> *H3:* News coverage of PTSD will favor episodic/individual framing over thematic/social framing.

Chapter 1: Literature and Research Agenda

The Social Construction of Illness and PTSD

Viewed within a constructivist framework, the formal recognition of disease by institutions vested with medical authority is distinguished from the raw experience of illness by social processes of disclosure, discussion, and debate. From this perspective, medical inquiry follows public inquiry, oftentimes led by one or another social movement:

> Social movements are central to many discovery processes. Lay discovery typically predates a social movement, though once a sufficient number of individuals recognize and act on a disease, they may form activist organizations to press their claims. . . . Social movements seek government and medical recognition of unrecognized or underrecognized diseases such as black lung, sickle-cell anemia, and post-traumatic stress disorder. (Brown, 1995, p. 44)

In other words, the classification of novel diseases does not begin with disinterested inquiry, at least not entirely. Rather, diagnoses originate with "claims-makers and interested parties who frequently have a strong evaluative agenda" (Conrad & Barker, 2010, p. S76).

In the case of PTSD, a protest movement known as Vietnam Veterans Against the War (VVAW) is typically regarded as the relevant claims-maker, though its political aims exceeded those of the psychiatrists who fought for PTSD's inclusion in the DSM-III. It was VVAW leader Jan Berry that initiated contact with the psychiatrist and anti-war public intellectual Robert J. Lifton, directing his attention to the destructive symptoms of combat-incurred trauma and requesting both therapeutic and political support (Morris, 2015, p. 141). Receptive to Berry's need for public allies, Lifton began attending VVAW "rap groups" wherein aggrieved and afflicted veterans shared their

experiences of war, engaging in a sort of informal and politically motivated psychiatry (Scott, 1990, p. 300). These meetings were also attended by the psychoanalyst Chaim Shatan, who was moved to participate after reading a 1971 exposé in The New York Times (NYT) which detailed the shooting death of Dwight Johnson, a veteran and recipient of the Congressional Medal of Honor whose traumatic wartime experiences seemed partially responsible for his eventual descent into armed robbery (Scott, 1990, p. 300). Shatan's observation of the VVAW's membership culminated in a 1971 opinion piece on the symptoms of combat-incurred trauma, which NYT published in 1972 as "The Post-Vietnam Syndrome" (Scott, 1990, p. 301).

Shatan, Lifton, and their allies in the psychiatric and veterans' advocacy communities spent much of the next decade mobilizing support for this diagnosis; marathon radio broadcasts, panel discussions, and the newly-minted Vietnam Veterans Working Group comprised a multi-pronged strategy to influence public opinion and, subsequently, medical discourse (Scott, 1990, p. 306). In 1980, the DSM-III introduced post-Vietnam syndrome, since reconfigured as post-traumatic stress disorder, into "medical psychiatric reality" (Scott, 1990, p. 294).

Lembcke (1998) adopts a critical-constructivist stance with reference to these events, portraying the diagnosis as a cynical depoliticizing framework circumscribed by "alienation" (p. 48) and "flashbacks" (p. 53–54), cinematic tropes which originated in popular and news media and were later adopted by psychiatrists—and the public at large—to medicalize (and thus defang) the radical critique of disenchanted veterans. According to Lembcke (1998), filmmakers virtually created the definition of a flashback as a trauma-induced, mental phenomenon" (p. 107). This storytelling technique would

subsequently filter into the diction of veterans and therapists (as well as the 1987 DSM-III-R) as it validated the wartime exploits of the former and the medicalizing approach of the latter: ". . . 'flashback' could be both the symptom of trauma and the evidence for the combat experience that caused the trauma: in effect a 'purple heart' that authenticates the combat experience" (Lembcke, 2013, p. 108–109).

Lembcke's (1998; 2013) skepticism towards the PTSD diagnosis arises from a long critical tradition parsing the political valence and utility of diagnoses, as well as the medicalization of trauma. Rechtman (2004) suggests that this medicalization provided the anti-war movement and midcentury feminism access to a novel "political condition;" a condition wherein activists might finally neutralize "the moral suspicion attached to the theoretical framework of traumatic neurosis" (p. 914). Likewise, Berg (2002) argues that the diagnostic character of PTSD is useful to activist feminism insofar as it recasts the symptomatology of trauma as a response to external injury and a survival mechanism(s), rather than the result of internal abnormalities These assertions are complicated, however, by the ambivalence with which these political constituencies have traditionally regarded PTSD as a diagnosis. Strands of both feminism and anti-war activism argue that medicalization decontextualizes trauma in ways harmful to political mobilization, emphasizing the purportedly dysfunctional trauma response over its social causation (Lembcke, 1998; Berg, 2002). They argue that for both the victims of traumatic experience and their witnesses by way of news media "PTSD framing asks us not to remember the war itself, but the men who fought it" (Lembcke, 1998, p. 58). Of course, a countervailing point might emphasize the simple, emotional relief and sense of solidarity a diagnosis can provide. Long before the DSM-III consecrated PTSD as "'the lingua

franca of suffering'" (Morris, 2015, p. 165), combat veterans suffered from a then-ignominious ailment known as shell shock (Scott, 1990) and untold others went without a precise language for their experiences. The PTSD diagnosis, at the crux of its utility, integrates individual needs into group need, mitigates the pain of traumatic experience, and provides a basis for political mobilization (Berg, 2002).

It should also be noted that trauma sufferers and activists are far from the only social actors with a stake in the disorder's mediation and construction. The officials and institutions responsible for representing PTSD sufferers as constituents and providing for their care are also implicated in discussion of its prevalence and epidemiology (Friedman, Resick, & Keane, 2007; Fisher, 2014). Whereas Lembcke (1998; 2013) argues for PTSD as a depoliticizing framework, others have drawn the opposite conclusion; namely, that advocates of the diagnosis used its occurrence among Vietnam veterans to critique the military as an institution and its wartime conduct (Fisher, 2014). While Lembcke (1998; 2013) and these critics agree that the PTSD diagnosis placates combat veterans "in search of *recognition of their sacrifices* by the government and general public" (Fisher, 2014, p. 4), they forward mutually exclusive appraisals of its political consequences. In the fraught history of PTSD and its various claims-makers, the scholar may locate ambiguities which support either conclusion. Friedman et al. (2007) argues that, as a consequence of the new century's ceaseless stream of mediated wars, natural disasters, and terrorist acts, PTSD debates that were formerly restricted to medical professionals found an outlet in popular print and broadcast media. In truth, though, such debates have never been restricted to the domain of scientific inquiry, and such inquiry has never been

apolitical. Moreover, media representation has never been neatly separable from these processes.

The purpose of adopting a critical-constructivist stance is not to invalidate the subjective experience of trauma, but to highlight the importance of media representation to PTSD's legitimation as a diagnosis and the political content thereof. This research will utilize framing theory to analyze (and critique) contemporary media representations of PTSD. The framing approach was selected for the purposes of this study because it provides a powerful framework by which to investigate and describe media representations of PTSD and its impact on society at large. The framing approach offers a means of systematically analyzing trends in media content (in many cases by quantitative frequency) and examining variations in this content across media and over time (Vliegenthart, 2012).

These affordances allow framing theory to capture the contested nature of meaning as enlivened through news routines and message production. In this light, claims-makers such as Shatan, Lifton, and the VVAW appear as actors in a symbolic-political struggle wherein "antagonists promote their own frames of the conflict while the news media attempt to construct a story that can be understood by their audience" (Wolfsfeld, 1997, p. 31). The particular role of the journalist in this ecosystem is such that their textual productions serve as "cultural time capsules which offer a brief glimpse of the political symbols, myths, and stories that are popular at a particular time and place," albeit ones mediated by gradients of power and influence (Wolfsfeld, 1997, p. 32).

Framing Theory

Framing is a universal activity. In Goffman's seminal Frame Analysis: An Essay on the Organization of Experience (1974), framing appears as an inadvertent function of the communication process by which, through a process of exclusion, raw experience is rendered legible and actionable. Though framing organizes experience into interpretive schema for "all social actors and individuals – consciously or not," it also provides a useful framework for studying the construction of events in the media content produced by journalists and strategic communicators (Vliegenthart, 2012, p. 937).

Professional routines guide and structure news gathering processes such that individual journalists should not be understood as possessing uninterrupted, individual agency over the frames apparent in their reporting (Tuchman, 1978). Structural determinants also influence the framing process, but do not remove its dynamism. In fact, the universal quality of framing behavior frequently manifests as a discursive conflict in which various social actors promote their distinct understanding of a given object, event, or problem (Gitlin, 1980; Wolfsfeld, 1997). Framing, as a theoretical concept, has been applied to study such diverse topics as movement dynamics (Benford & Snow, 2000), contentious social topics such as gun ownership (Haider-Markel & Joslyn, 2001; Lio, Melzer, & Reese, 2008; Steidley & Colen, 2017) or global migration (Lawlor & Tolley, 2017; Viladrich, 2019; Heidenreich, Lind, Eberl, & Boomgaarden, 2019), the effects of news frames on the cognition and behavior of message recipients (Cappella & Jamieson, 1997; Haider-Markel & Joslyn, 2001; de Vreese & Boomgaarden, 2006; Gross & Brewer, 2007), and strategic political communication (Jerit, 2008; Hänggli & Kriesi, 2010; Pluwak, 2011; Dekavalla, 2016).

This study will mobilize Entman's (1993) definition of framing as a process of selection by which an agent (a news reporter, for instance) catalogs ‘‘some aspects of perceived reality and make them more salient in a communicating text, in such a way as to promote a particular definition of a problem, causal interpretation, moral evaluation, and/or treatment recommendation for the item described’’ (p. 52). As the agent in question frames their chosen topic, it is distilled from raw information into comprehensible threats, protagonists, antagonists, and action strategies for consumption by a message recipient (Hertog & McLeod, 2001). Pursuant to this study, framing of health topics may, then, influence message recipients' perception of the threats (or symptoms) involved and appropriate strategies for preventing and/or mitigating them (Roche & Muskavitch, 2003).

Framing in Coverage of Health Topics

Frames may be general or "generic" in character—which is to say, applicable across multiple topics and contexts—or "issue-specific" and, thus, non-generalizable beyond a particular topic or context (Vliegenthart, 2012, p. 939). Iyengar's (1996) "episodic" and "thematic" frames belong to the broader category of generic frames (Vliegenthart, 2012). Houston, Spialek, & Perrault's (2016) tripartite "PTSD construct" (i.e., PTSD causes, PTSD reactions/consequences, and PTSD treatments), meanwhile, provides a relevant example of issue-specific framing (p. 241). Each of these constructions will be mobilized in this study to better understand contemporary media representations of PTSD.

Episodic frames are simple, instance-by-instance "illustrations" of a problem which eschew controversial interpretive work based upon "subject-matter expertise" and, thusly, are characteristic of coverage which is less demanding of journalists' time and mental

resources (Iyengar, 1996, p. 62). Thematic frames, by contrast, embrace the task of interpretation, situating individual instances in a broader context and exploring trends in their appearance and characteristics. For Iyengar (1996), the significance of this distinction arises from its impact on the attribution of responsibility—the "essential building block of all social knowledge" (p. 60). "Responsibility," in this context, refers to both "causal responsibility" (i.e., who or what created the problem?) and "treatment responsibility" (i.e., who or what can solve the problem?) (Iyengar, 1996, p. 60). Although the simplistic, atomized quality of episodic framing generally precludes overt attribution on the part of the journalist, it can pattern the thinking of message recipients such that they attribute causal and treatment responsibility in an individualistic manner and matters of public concern are privatized and divorced from socioeconomic or political analysis (Iyengar, 1996). Thus, the anecdotal focus of episodic framing serves to decontextualize the behavior of social actors, obfuscate the structural roots of social ills, and, perhaps most crucially, deflect accountability from institutional/governmental authority and society at large (Iyengar, 1996). The contextualizing thrust of thematic frames lends itself to the opposite effect. In health coverage, then, thematic framing nurtures a sense of collective accountability for illness and disorder, whereas episodic frames place the burden of casual and treatment responsibility on the afflicted themselves (Hawkins & Linvill, 2010). As Conrad and Barker (2010) note, the U.S. nurtures "a social predilection toward treating human problems as individual or clinical . . . rather than addressing the underlying causes for complex social problems and human suffering" (p. S75). Thus, in the U.S., episodic/individual framing has typically prevailed over thematic framing in coverage of health topics, with the result that public health

discourse—or at least the variant of it promulgated by journalists—has tended to emphasize individual-level causal factors and preventative/mitigation strategies (Sun, Krakow, John, & Liu, 2015; Kim, Tanner, Foster, & Kim, 2015). The episodic/individualizing trend in U.S. news framing has been observed in coverage of diverse health topics from obesity (Kim & Willis, 2007; Hawkins & Linvill, 2010), to postpartum disorders (Dubriwny, 2010), to avian flu (Dudo, Dahlstrom, & Brossard, 2007). U.S. news framing of mental illness has also demonstrated more episodic/individualizing tendencies than Chinese coverage of the same (Zhang & Jin, 2017), a trend which might contribute to stigmatization of these conditions (Walker & Read, 2002; Schnittker, 2008). The presence of thematic frames in health coverage encourages news consumers to consider remedies which substantially intervene "in social and environmental conditions, such as unequal distribution of economic resources, unsafe environments, or unethical business practices" (Kim, et al., 2015, p. 124). Much to the chagrin of health officials (Holton and Coleman, 2014), the routine framing behavior of journalists has, instead, likely obfuscated the origins of illness and disorder, and dampened awareness of socialized and/or policy-based approaches to remedying them (Wallack, Dorfman, Jernigan, & Themba-Nixon, 1993; Major, 2009). Where exactly do these predilections originate? One key influence on the framing of news topics is the sourcing behavior of media practitioners.

Sourcing in Coverage of Health Topics

The question of sourcing is inseparable from that of framing; news frames are shaped by the inclusion (and exclusion) of voices in news coverage and media personnel tend to assimilate the framing strategies of their sources in a (non-literal) "negotiation process"

(Vasterman & Ruigrok, 2013, p. 439). For the purposes of this study, sources are defined as actors “who provide information and context to the news narrative, offer official or unofficial opinions, and give eye-witness accounts of events” (Cross, 2010, p. 413). The habitual sourcing practices of journalists favor elite and/or official points of view due to the news media’s tendency to “index” the range of opinions evident in governing institutions—or at least those accessible to external observers in the form of public debate—as the totality of discourse (Bennett, 1990). This norm exists not so much as a facet of any consciously-held ideology, but as an organic compromise between the corporate impetus to “minimize risks” arising from undisciplined discussion, the drive for simplicity and efficiency in news production, and the desire of individual journalists to reproduce voices constitutive of their own political sympathies—at least where institutional debate allows (Bennett, 1990, p. 123). This extent of uncritical trust in the state and other loci of institutional power remains stable inasmuch as it remains “profitable for those above, and morally defensible from those below” (Bennett, 1990, p. 124).

In simpler terms, the embedded norms of news production hold that “government actions and statements are inherently newsworthy” (Brewer, Wise, & Ley, 2014, p. 26). Official and/or elite sources benefit from routinized “beat” coverage, whereas outsiders “usually have fewer opportunities to socialize reporters into their own culture” (Wolfsfeld, 1997, p. 43). Those individuals and groups who fall outside this convenient designation may insinuate themselves in coverage, but doing so often requires “civil disobedience, protests, or lawless acts that establish negative interpretative contexts for those voices” (Bennett, 1990, p. 107; Wolfsfeld, 1997). Thus, “no matter what the topic,

professional expertise is privileged over personal knowledge" and authority, governmental or otherwise, provides access to message reproduction through the press (Barnett & Lee, 2019, p. 5). In coverage of health topics, this tends to favor government officials (Pickle, Quinn, & Brown, 2002) or, in other cases, medical professionals such as researchers and physicians (Andsager & Powers, 2001). Tanner and Friedman (2011) note that governmental sources tended to predominate over those with medical expertise in online health coverage, with the caveat that physicians "were significantly more likely to be quoted in stories about chronic conditions, whereas quotes from government officials most often appeared in infectious disease stories" (p. 18).

Given the impact of sourcing upon news frames (Cross, 2010; Vasterman & Ruigrok, 2013), and journalistic preference for and deference to official and expert sources across topics of coverage (Andsager & Powers, 2001; Pickle, et al., 2002; Hermida, Lewis, & Zamith, 2014; Watts & Maddison, 2014; Brewer, et al., 2014) one would expect to observe a predominance of frames reflective of official and expert biases in PTSD coverage. One might also expect framing dynamics to reflect the overrepresentation of men in journalistic sourcing; in one study of new stories conducted by Pew Research Center, 75% of the sample included male sources, while a mere one-third included a female source (The Gender Gap, 2005).

As the following section will explore in greater detail, research on the framing of PTSD in news coverage has borne out these conclusions, exposing gaps between the epistemological reality of PTSD and its mediation by journalists. This is concerning for myriad reasons. For one, the privileging of sources with claims to governmental and medical authority can exclude the voices of those who engage with a diagnosis as

sufferers rather than specialists such as patients and their caregivers (Coleman, Thorson, & Wilkins, 2011, p. 945). Extant sourcing practices are also likely to reproduce episodic frames of PTSD which decontextualize trauma and individualize causal and treatment responsibility. As Iyengar (1996) notes, officials are "quick to claim responsibility for outcomes deemed favorable and disclaim responsibility for events or decisions with negative implications" (p. 60).

It is also concerning that men's voices would predominate in PTSD (Barnett & Lee, 2019) coverage since this disorder does not manifest uniformly across genders. Estimates suggest that the disorder is more common among women (9.7%) than men (3.6%) in the U.S. (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005, as cited in Houston, et al., 2016, p. 240; Gradus, 2014). Numerous studies conducted with reference to multiple variants of the DSM (and, thus, diagnostic criteria) have demonstrated this concretely [emphasis added]:

> Estimates of the rate of lifetime PTSD in the U.S. population have been quite consistent since the advent of DSM-III-R. The Detroit HMO study yielded a 9% prevalence (*11% women, 6% men*) of lifetime DSM-III-R PTSD (Breslau et al., 1991), the National Women's Study (N = ~4,000) yielded a 12% prevalence for lifetime DSM-III-R PTSD (Resnick et al., 1993), the NCS yielded an 8% prevalence (*10% women, 5% men*) of lifetime DSM-III-R PTSD (Kessler et al., 1995), and the revised NCS-R yielded a 7% prevalence for lifetime DSM-IV PTSD (Kessler, Berglund, Demler, Jin, & Walters, 2005). Conditional risk is the probability of having PTSD given exposure to a qualifying stressor. In the NCS, *20% of exposed women and 8% of exposed men* developed PTSD. On the basis of DSM-IV criteria, the Detroit Area Survey (Breslau et al., 1998a) found the conditional probability of lifetime PTSD to be *13% in women and 6% in men*, when estimated on the basis of a randomly selected event, *compared to 18% in women and 10% in men*, when estimated on the basis of the respondent's worst event. These results confirm suspicions that estimates of conditional risk made on the basis of "most upsetting" events are biased. (Norris & Slone, 2007, p. 87)

Additionally, women are significantly more likely than men to meet A2 (subjective experience of fear and helplessness produced by traumatic experience) criterion for PTSD and to develop chronic PTSD (Norris & Sloane, 2007). Causals factors also differ across gender, with men being more likely to report combat, witnessing an injury or death, or witnessing an accident as their most upsetting traumatic experiences and women being more likely to report rape, molestation, or physical abuse (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

Although the privileging of official voices and those of men in news coverage is deeply entrenched, it is worth considering the conditions under which these trends might be destabilized. Bennett (1990) identifies a long-lived tradition of journalistic deference to institutional power in the U.S., "a strong and enduring belief that government ought to be buffered from direct popular accountability" (p. 104). But could this deference be unsettled? It is possible that declining public confidence in traditional news reporting, or "pressures for normative change from below" could allow external voices (read: sources) to leave their mark on the reporting of PTSD (Bennett, 1990, p. 124). Framing research has traditionally foregrounded legacy media (newspapers, magazines, radio and television broadcasts, etc.), but social media platforms such as Twitter can facilitate distinct, "bottom-up" framing processes of significant importance to discourses and movement politics both on- and offline (Burch, Frederick, & Pegoraro, 2015, p. 400). Whereas conventional media framing (and, indeed, news production itself) is negotiated "backstage," networked framing on social media platforms is a public performance wherein popular/viral commentators interact with traditional media personnel and across publics (Meraz & Papacharissi, 2013, p. 159). On this fluid terrain, traditional media

agents and credentialed journalists coexist with amateur content producers who may choose to reject the framing of events advanced in mainstream news coverage (Burch, Frederick, & Pegoraro, 2015; Moody-Ramirez, Tait, Smith, Fears, & Randal, 2016; Molina, 2019; Moernaut, Mast, Temmerman, & Broersma, 2020).

Framing on Twitter is also guided by the convenient indexing function provided by hashtags (#BlackLivesMatter, #MeToo, etc.). In addition to structuring communities and topics on the platform, hashtags serve as "genre defining discourses through which action frames may be contested and negotiated" (Pond & Lewis, 2019, p. 220). Ince, Rojas, & Davis (2017) propose that the application of hashtags constitutes a form of "distributed framing" by which social movement actors may propagate their understanding of events in the absence of formal leadership (p. 1818). Hashtags compete for relevance, act as "emergent/ad hoc frames," and can even hone discussion within an "ad hoc issue public" (Meraz & Papacharissi, 2013, p. 144). This structuring influence can serve to cohere the messaging of otherwise diffuse movements, amplifying their mediated presence (Poell & Rajagopalan, 2015; Moscato, 2016; Barnard, 2018). Poell and Rajagopalan (2015) observe the benefits of social media connectivity for the decentralized Indian women's movement. In addition to nurturing relationships between activists and media personnel, and strengthening the former's media profile, Twitter allowed Indian feminists to avoid excessive reliance on the traditional media ecosystem, with its frequent cycling of news topics, and maintain their conflictual issues in the foreground of popular discourse: "The sustained interaction around this issue builds a solid foundation for activism because it endures even when there are no agitations or other intermittent forms of activism around which to coalesce" (Poell & Rajagopalan, 2015, p. 730).

Social media platforms (including Twitter) have also been integrated into the news gathering process such that popular discourses (and their attendant framing dynamics) are more likely to direct and/or shape mainstream media coverage (Broersma & Graham, 2013; Moody-Ramirez, et al., 2016; Barnard, 2018; Wahl-Jorgensen, 2020). These platforms serve the needs of journalists as they aid in rationalizing the news gathering process, and may also empower activists by exposing journalists to diverse voices and issues (Broersma & Graham, 2013). In some cases, the members of these online publics may even attempt to influence media personnel by way of direct calls to action (Xu & Feng, 2014).

These accounts of the networked framing process attest to an interlocking structure of open, rhizomatic discourses where authority is readily contested by ordinary users. These users wield the affordances of platforms like Twitter to disseminate their own interpretation of events, oftentimes challenging the frames promulgated by media elites (Meraz & Papacharissi, 2013). Minorities typically excluded from discussion of a given topic can form "counterpublics" in this online space from which they can voice their opinions by participating in an otherwise hegemonic media environment (Moernaut, et al., 2020, p. 2).

However, it is equally important to consider that social media platforms do not exist apart from the material world, nor the power relations that constitute it. Despite Twitter's facilitation of counter-framing by non-elites, legacy media personnel still tend to dominate the framing process (Siapera, Boudourides, Lenis, & Suiter, 2018; Moernaut, et al., 2020) and the "emergent eliteness" characteristic of the platform still results in the formation of an elite, however heterogenous (Meraz & Papacharissi, 2013, p. 158).

Ordinary social media users are unlikely to accrue the following enjoyed by legacy media organizations (Xu & Feng, 2014) and, while their messages are more likely than ever to be seized upon and disseminated by these larger actors, those messages may be appropriated outside of the negotiation process typical to interactions between journalists and the subjects of their coverage (Broersma & Graham, 2013). Moreover, the increased field of interaction between professional media personnel and movement activists on social media platforms cannot displace the reality that many of these personnel continue to reproduce professional norms which predate the existence of these platforms (Barnard, 2018) Finally, low-density and low-reciprocity networks may form on Twitter which are more reminiscent of traditional, broadcast media (Molina, 2019, p. 258).

Media Depictions of Mental Illness and PTSD

The mediation of mental illness has traditionally skewed towards stigmatizing depictions of violence and deviance (Sieff, 2003; Stout, Villegas, & Jennings, 2004; Corrigan, Watson, Gracia, Slopen, Rasinski, & Hall, 2005; Klin & Lemish, 2008; McGinty, Kennedy-Hendricks, Chosky, & Barry, 2016). As per McGinty et al.’s (2016) two-decade review of news coverage (1995–2014), despite the negligible interrelationship between mental illness and interpersonal violence (implicated in 4% of cases, nationally), news coverage has traditionally emphasized a connection between the two, a trend with the risk of deforming public health agendas into public safety agendas and otherwise contributing to stigmatization (p. 2). Applying the tripartite formation of causes, consequences, and individual depictions, researchers observed that over twenty years:

> . . . the most frequently mentioned topics pertained to interpersonal violence, suicide, and treatment of mental illness. Policies to improve or expand treatment were also the most frequently mentioned category of mental health policies, although such policies were mentioned in only 14 percent of stories. Criminal justice involvement was the most frequently mentioned consequence of mental illness, and when the news media portrayed a specific individual with mental illness, that individual was most frequently depicted as having committed an act of interpersonal violence. (McGinty, et al., 2016, p. 5)

Moreover, despite mental illness correlating with suicidality far more prominently than interpersonal violence, the latter was featured more often in news coverage (McGinty, Kennedy-Hendricks, Chosky, & Barry, 2016, p. 5). A mere 7% of the news stories under study depicted successful treatment of or recovery from mental illness (McGinty, Kennedy-Hendricks, Chosky, & Barry, 2016, p. 4). Several of these tendencies are also observable in news coverage of PTSD, considered as a form of mental illness.

In keeping with McGinty et al.'s (2016) findings, research on the framing dynamics of PTSD news coverage demonstrates a relative lack of emphasis on treatment options and recovery (Houston, et al., 2016; Barnett & Lee, 2019). Also in keeping with McGinty et al. (2016), interpersonal violence has been characterized as symptomatic of PTSD, particularly in cases where the disease originated with military or combat experiences: "when military service was depicted as causing PTSD, the consequence of that PTSD among soldiers and veterans was a more angry, violent, and dysfunctional disorder compared to that among civilians, who experienced more fear and sadness" (Houston, et al., 2016, p. 246). This is especially significant given that news coverage of PTSD has traditionally been dominated by stories about military and/or combat trauma (Houston, et al., 2016; Purtle, Lynn, & Malik, 2016).

Houston et al. (2016) observed that 49.14% of PTSD stories published by NYT between 1950–2012 identified military service as a source of trauma, with terrorism arriving at a distant second (14.19%) in volume of coverage (p. 244). U.S. military interventions of the period likely played a role in shaping these trends with "major social events such as wars and terrorist attacks" taking primacy over more common sources of trauma such as sexual violence (Houston, et al., 2016, p. 245). Despite this focus on national cataclysm, though, the NYT normatively portrayed PTSD as a "local experience," focusing on community experiences rather than broader, regional or national ones (Houston, et al., 2016, p. 247). Houston et al. (2016) also noted the temporal decontextualization of PTSD in NYT coverage by an overbearing focus on the present (as opposed to the past or future), a concerning trend given the potential influence of this coverage on public understanding of the disorder's causes, as well as potential treatments. Fittingly, then, nearly half of the surveyed articles failed to depict potential treatments, with military service-focused coverage being more likely to feature treatment options (Houston, et al., 2016, p. 245).

Purtle et al.'s (2016) study of NYT PTSD coverage from 1980–2015 identified similar trends, noting that 51.6% of the surveyed articles took military populations as their subject. Moreover, combat was the most frequently represented source of trauma (38%), whereas sexual assault appeared in only 8.7% of the sample (p. 634). A meager 9.6% of the sample identified potential treatment options, and this proportion decreased over the study period, as did the number of articles which identified sexual assault as a source of trauma (Purtle, et al., 2016, p. 634). The frequency with which PTSD news coverage foregrounds military and/or combat trauma is worthy of critique primarily in its

failure to capture the disorder in its full diversity. As per Kessler et al.'s (1995, as cited in Houston, et al., 2016, p. 246) study of individuals with probable PTSD, roughly a quarter of men (28%) named combat as their most upsetting traumatic experience and this proportion was lower among women. Tanielian and Jaycox (2008, as cited in Houston, et al., 2016, p. 246) estimate that a mere 13.8% of soldiers returning from deployment in Afghanistan and Iraq experience an active case of PTSD. In other words, not only is medically significant trauma far more multifocal than news coverage (Houston, et al., 2016; Purtle at al., 2016) would suggest, combat-incurred trauma may actually be a minority causal factor when PTSD is considered for its full incidence in both military and civilian populations. Interestingly, an earlier study on PTSD coverage in the national press (Pollock, Gratale, Anas, Kaithern, & Johnson, 2014) found that treatment responsibility for veterans was primarily attributed to the government. Pollock et al.'s (2014) findings are notable because research on the framing of health topics has typically observed the predominance of episodic frames, which individualize treatment responsibility (Dudo, et al., 2007; Kim & Willis, 2007; Hawkins & Linvill, 2010; Dubriwny, 2010) This would suggest that, by contrast to other health topics, military PTSD encourages thematic framing, which contextualizes problems and socializes the responsibility for the their mitigation (Iyengar, 1996).

A more recent study, by Barnett & Lee (2019), analyzed both sourcing and framing in NYT posttraumatic stress (PTS) coverage between 2003–2012, a chronology selected to encompass U.S. military interventions in Iraq and Afghanistan. Reflecting general trends in news sourcing, Barnett and Lee (2019) observed that male authority figures supplied the dominant voice in PTSD/PTS coverage:

> Given that the majority of individuals serving in the US military are men, this predominance of male sources might not be surprising. However, those male sources were typically individuals in power or individuals whose expertise comes from professional experience, rather than their first-hand knowledge of PTS. Thus, the people who tell the stories of PTS are likely to be male authority figures, not individuals who have not experienced PTS. Largely missing were the stories of women veterans at a time when women's numbers in the military were increasing. (p. 10)

Although non-governmental sources accounted for two-thirds of the sample, clearly outnumbering governmental sources, this did not represent a corresponding gain for PTSD sufferers themselves as non-governmental sourcing was dominated by researchers and other figures vested with medical authority (Barnett & Lee, 2019, p. 8). The researchers found that 30% of the sample included "comments from scientific or medical researchers," 24% included doctors as sources, 2% included nurses as sources, and 22% included "other health care workers, including therapists" as sources (Barnett & Lee, 2019, p. 8). It is possible that the privileging of medical over governmental sources in this instance is attributable to a general trend whereby governmental voices prevail in coverage of infectious disease and physicians' voices prevail in coverage of chronic illness (Tanner & Friedman, 2011). Barnett and Lee (2019) also observed that only 2% of the sample featured sexual violence as a source of trauma (p. 12) and treatment options were deemphasized as a topic of coverage relative to PTS as a persistent illness in line with previous studies (p. 11). Additionally, in keeping with the individualization of health crises in U.S. reporting, episodic framing was favored over thematic framing, a trend which "positioned PTS as a problem caused by individual dysfunction, not a problem caused by failed government policies or political bravado" (Barnett & Lee, 2019, p. 11). With Barnett and Lee (2019) as reference, then, it is arguable that Pollock et al. (2014)

identifies a framing discrepancy in PTSD coverage whereby military trauma is framed thematically and trauma as a general category framed episodically. This has dire implications, given the tendency of episodic framing to obfuscate the origins of illness and potential for its collective redress (Wallach, et al., 1993; Iyengar, 1996; Major, 2009; Holton & Coleman, 2014).

Though limited in scope (reliance on NYT coverage appears endemic to this area of study) the contemporary research on PTSD framing in U.S. print media suggests persistent overrepresentation of military/combat trauma at the expense of significantly more common traumatic experiences, underrepresentation of women and laypeople in sourcing, and a general neglect of treatment options. PTSD framing offers a dreary prognosis to news consumers, and consistently misrepresents the incidence, causation, and symptomatology of the disorder, risking a portrayal of sufferers as dysfunctional and criminal (Houston, et al., 2016; Purtle, et al., 2016). Additionally, in keeping with trends in the framing of health topics generally and mental illness specifically, coverage of PTSD has tended to be episodic and, at least in the case of former military personnel, has portrayed a correlative relationship between medically significant trauma and violent behavior. Expanding upon these studies, this thesis proposes a broad research question: How have contemporary socio-political developments—including popular social movements and discourses surrounding trauma—shaped news framing of PTSD? More specifically, the following hypotheses are proposed:

> *H1:* News coverage of PTSD will overrepresent military and combat experience relative to other sources of trauma and underrepresent options for treatment and recovery.

H2: News coverage of PTSD will privilege men and official sources over women and unofficial sources (i.e., men and official sources will speak more often than women and unofficial sources).

H3: News coverage of PTSD will favor episodic/individual framing over thematic/social framing.

Chapter 2: Methodology

Sample

This study sampled PTSD news coverage published by the NYT from 1999 (01/01/1999) to 2020 (12/31/2020). The NYT was selected as the sole news purveyor for this analysis in acknowledgement of its role in instantiating PTSD as a diagnosis (Scott, 1990; Lembcke, 1998; Morris, 2015), to establish continuity with previous research on PTSD news coverage (Houston, et al., 2016; Purtle, et al., 2016; Barnett & Lee, 2019), and owing to its popularity among news consumers; The New York Times was the third most-circulated daily newspaper in January 2019 (Watson, 2020). To collect this sample, the researcher made use of ProQuest's US Newsstream database. The Boolean operator [“post-traumatic stress” OR “posttraumatic stress” OR PTSD] was synthesized from search terms applied by Houston et al. (2016) and Barnett and Lee (2019), yielding 3,279 articles with duplicates excluded. To prepare the sample for analysis, the hyperlinks associated with each result were added to a Microsoft Excel spreadsheet. Subsequently, Excel's [=Rand()] function was used to generate 3,279 random numerals, one for each result; sorting this list in ascending order randomized the sample itself such that results were not grouped by database-assigned relevance or publication date. Working from the top of this (now random) results list, hyperlinks/articles were extracted for use in intercoder reliability testing and, subsequently, final analysis. Extracted results were marked such that they would not occur in more than one intercoder reliability test, or in the sample for final analysis after having been included in an intercoder reliability test.

Coding Scheme Development

The coding instrument for this study was adapted from Houston et al. (2016) and Barnett and Lee (2019). Codes adapted from Houston et al. (2016) included the protocol for excluding articles/units from the sample (Code 05), the framework for notating causes of PTSD (Code 06), the framework for notating symptoms of PTSD (Code 07), and the framework for notating PTSD treatments (Code 08). Codes 06–08 were maintained in close to their original form, although several categories were added by the researcher—and other, existing categories amended—in the course of testing the coding instrument where the originals were found insufficient. For instance, COVID-19 was added to Code 06 as a distinct causal category and the Code 07 category of "Suicide" was expanded to "Suicide/Self-harm." Code 05 was subject to far more extensive revisions; Houston et al.'s (2016) original protocol was expanded upon such that stories "which incidentally mention post-traumatic stress disorder, but in which PTSD is not significantly topic-linked" were also excluded with the following example offered: "a 5000-word news story about electricity bills wherein a character is described as having PTSD, but there is no further discussion of their condition." Together, these codes were designed to clear irrelevant material from the sample(s) and address the contents of H1 (e.g., overrepresentation of combat/military trauma and underrepresentation of treatment options).

Codes adapted from Barnett and Lee (2019) included those devoted to sourcing (Section 09) and framing (Section 10) in PTSD coverage and, thus, hypotheses H2 (overrepresentation of men and officials in sourcing) and H3 (predominance of episodic

framing over thematic framing) respectively. The coding instrument also explicitly mobilized Barnett and Lee's (2019) definition of a source:

> To be considered a source, an individual had to be quoted or paraphrased. We looked at direct communication – statements that were attributed and reported with use of words such as 'stated' or 'said', and indirect attribution in which words such as 'thinks', 'feels', or 'believes' were used for attribution. (p. 7)

In practice, however, many sources could not rightfully be categorized as individuals; when, for instance, an article cited a research study on PTSD this would also have been considered an "individual" source for the purposes of the research at hand. The coding instrument used here also expanded upon Barnett and Lee's (2019) original framework by introducing the directive that: "When a single source is quoted or paraphrased multiple times count each inclusion as a distinct source." This inclusion was designed to reflect the relative weighting of sources without resorting to a more unwieldy measure such as column inches. By contrast, this study's coding instrument significantly reduced Barnett and Lee's (2019) treatment of diversity within broad source categories. This instrument included no code to distinguish between veterans (retired military), NGO statements, and service workers as various types of "civilian" source, or between state prosecutors, active-duty military, and Pentagon spokespeople as various types of "government" source. This amendment was intended to streamline the coding process in acknowledgment of time constrains and the breadth of the research agenda.

This study's coding instrument also streamlined Barnett and Lee's (2019) treatment of episodic and thematic framing, reducing it to a mere five codes, each with opposed episodic (decontextualizing/individualizing) and thematic (contextualizing/socializing)

outputs. Take, for instance, Code 10C, which addressed the attribution of blame for PTSD:

10C: How do the majority of sources represented in the article (by #) attribute blame for PTS/PTSD?

1) Blame attributed to isolated, individual-level actions and events.
2) Blame attributed to societal and/or system-level forces OR mass trauma, e.g. 9/11 (also includes individual-level actions and events contextualized within system-level trends).
3) Balanced between (1)-type and (2)-type characterization.
4) No attribution of blame by any source.
5) Unclear/Unsure.

In this code, as with Codes 10A, 10B, and 10E, "1" was the episodic output and "2" the thematic output. Dominance was determined by the numerical proportion of statements in an article, with output "3" indicating a rough balance. This simple model was adopted across Section 10, with the exception of Code 10D, which addressed the representation of concrete policy and/or legal changes which might address the causes or consequences of PTSD. The final coding instrument can be found in Appendix I; therein, codes which are specifically referred to as adaptions are ones for which rough analogs existed in this study's reference codebooks (Houston, et al., 2016; Barnett & Lee, 2019). Codes lacking attribution may have been inspired by the reference codebooks but were ultimately novel with regard to their contents and language. Appendix III includes the categories most vital to this study's coding instrument, organized by section and accompanied by representative material from the final sample.

Coding Instrument Reliability

Two coders for the study met regularly and coded nearly 200 articles (including both joint coding and intercoder reliability testing) to finalize the coding instrument, a product of four cumulative iterations. Revisions were discussed by this study's two coders, who

made detailed notes while testing the coding instrument such that problematic codes could be clarified, reformed, or removed. The final coding instrument can be found in Appendix I.

Intercoder coder reliability was tested using Krippendorf's alpha (Kα) as calculated by the free online application ReCal2 (Freelon, n.d.). Krippendorff's alpha is "a reliability coefficient developed to measure the agreement among observers, coders, judges, raters, or measuring instruments drawing distinctions among typically unstructured phenomena or assign computable values to them" (Krippendorff, 2011, p. 1). The fourth and final revision of the coding instrument achieved acceptable reliability after a test of 75 articles (n116–190). Reliability coefficients ranged from Kα=.60 (%A=76) to Kα=1 (%A=100). The average reliability coefficient across all codes was Kα=.80. The full list of codes and their respective reliability coefficients can be found in Appendix II. In summary, the researcher extracted 3,279 articles based on the search terms specified above; of these, 125 articles were randomly selected to establish intercoder reliability agreement. These articles were not used in the final coding process. Once the coding instrument was amended to satisfactory reliability (Kα ≥.60), the researcher randomly selected 10% of the extracted articles (N=328) for final coding; the full list of N=328 articles is located in Appendix IV.

Analysis

Final coding was conducted using the fourth revision of the coding instrument and 10% of the extracted articles, or N=328 articles were included in the final sample IBM SPSS Statistics Version 27 was then used to analyze results by examining the frequency of occurrence for each categorical variable. As per the exclusion protocol detailed in

Code 05 of the coding instrument, n=128 of the preliminary N=328 were maintained for final analysis. This protocol excluded opinion articles or columns, reviews of media/art, articles which made only figurative/non-medical mention of trauma, and articles which incidentally mentioned trauma, but wherein trauma was not significantly topic-linked, e.g. a 5000-word news story about electricity bills wherein a source is described as having PTSD, but there is no further discussion of their condition.

For Codes 06, 07, and 08, wherein the researchers recorded features of a given article in order of appearance (e.g., causes of PTSD), cumulative or overall percentages were calculated manually. For instance, illness was the first-listed cause of trauma in 2.30% of the sample, the second-listed cause of trauma in 0.80% of the sample, and the third-listed cause of trauma in 0.80% of the sample; thus, illness was featured as a source of traumatic experience in an overall 3.90% of the sample.

Chapter 3: Results

Causes, Reactions/Consequences, and Treatments

This study's first hypothesis (H1) stated that news coverage of PTSD would overrepresent military and combat experience relative to other sources of trauma and underrepresent options for treatment and recovery. Frequency analysis of the final sample (N=328 articles; n=128 PTSD articles) supported H1. The leading cause of trauma as represented in the sample was combat and/or military experience, which appeared in 32.10% of articles. Combat/military experience was followed in frequency of appearance by violent crime and/or terrorism (15.70%) and human-precipitated accidents (7.80%). The representational frequency of other trauma sources can be observed in Table 1.

Table 1

Causes of PTSD as Represented in The New York Times, 1999–2020

Codebook ID	Cause	Frequency (%)
0	None Mentioned	25
1	Combat/Military Experience	32.10
2	War (civilian experience)	5.50
3	Natural Disaster	5.50
4	Accident (human-precipitated)	7.80
5	State Violence, Policing/Prisons, and Oppression	7
6	Violent Crime/Terrorism	15.70
7	Sexual Violence	7.10
8	Child Abuse and Domestic Violence	3.20
9	Intergenerational Trauma	1.60
10	Illness	3.90
11	Death (of another)	4
12	Economic Stress (poverty, unemployment, etc.)	0
13	Bullying and School Issues	0
14	Politics and Political Scandals (non-violent)	0
15	COVID-19	1.60
16	Pandemic (non-COVID)	0

H1 was also supported with regard to the underrepresentation of treatment options. A majority of the sample (63.30%) did not feature a treatment option. The proportion of the sample which featured at least one treatment option (36.70%) was significantly smaller the proportion which featured at least one causal factor (75%), or the proportion which included at least one symptom (53.10%). Of the articles that did feature treatment and recovery, therapy/counseling appeared most frequently (27.30%), followed by medicine/prescriptions (10.20%) and peer support (5.50%). The representational frequency of other treatments can be observed in Table 2. Regarding PTSD symptoms/reactions, sleep issues and nightmares, as well as anxiety were best represented (24.30% each), followed by flashbacks and intrusive memories (19.60%) and anger or irritability (15.10%). Notably, violent crime featured as an explicit outcome of PTSD in a minor portion of the sample (5.50%). The representational frequency of other symptoms or reactions can be observed in Table 3.

Table 2

Treatments for PTSD as Represented in The New York Times, 1999–2020

Codebook ID	Treatment	Frequency (%)
0	None Mentioned	63.30
1	Therapy/Counseling	27.30
2	Hospitalization and Residential Treatment	3.90
3	Prescription Medicine	10.20
4	Hobbies/Activities	4.60
5	Meditation/Rest	1.60
6	Peer Support	5.50
7	Pet Therapy	1.60
8	Other	1.60

Table 3

Symptoms of and Reactions to PTSD as Represented in The New York Times, 1999–2020

Codebook ID	Symptom/Reaction	Frequency (%)
0	None Mentioned	46.90
1	Anxiety	24.30
2	Numbness	7.90
3	Depression	9.50
4	Flashbacks and Intrusive Memories	19.60
5	Nightmares and Sleep Issues	24.30
6	Memory Loss	7.80
7	Guilt/Shame	4.80
8	Anger/Irritability	15.10
9	Committing Violent Crime	5.50
10	Self-harm and Suicide	3.90
11	Isolation and Avoidance	11
12	Substance Abuse and Addiction	7
13	Work/Relationship/Functioning Issues	7.90
14	Extremism	0
15	Illness and Disability	6.30
16	Empathy and Growth	0
17	Incontinence and Bedwetting	0

Table 3 continued

18	School Issues	0
19	Other	4.70

Sourcing

This study's second hypothesis (H2) stated that news coverage of PTSD would privilege men and official sources over women and unofficial sources (i.e., men and official sources would speak more often than women and unofficial sources). Frequency analysis of the final sample (N=328 articles; n=128 PTSD articles) supported H2 only in part. Men spoke most frequently in the majority of the sampled articles (67.20%), whereas women spoke most frequently in only 24.20% of the sample. However, the hypothesized privileging of official sources was not supported. While government sources (54%) and medical sources (56%) appeared at least once in the majority of the sample, they spoke most often in relatively few articles. In fact, civilian sources spoke most often in the majority of the sample (50.80%). Meanwhile, government sources spoke most often in only 17.20% and medical sources in only 25%. It is also notable that personal stories of PTSD were relatively uncommon. Sources related their own experience of PTSD in only 32% of the sample, indicating that the unexpected devaluation of professional expertise in the sampled coverage was not accompanied by a corresponding drive to represent those with firsthand knowledge of the disorder.

Framing: Episodic v. Thematic

This study's third hypothesis (H3) stated that news coverage of PTSD would favor episodic/individual framing over thematic/social framing. Frequency analysis of the final

sample (N=328 articles; n=128 PTSD articles) did not support H3. As per Iyengar (1996), episodic frames are simple, instance-by-instance "illustrations" of a problem which eschew interpretation and encourage message recipients to individualize attributions of blame and responsibility; thematic frames, by contrast, situate individual instances of a problem in a broader context and explore trends in their appearance and characteristics, assigning blame and responsibility to systems and institutions (p. 62). Working, in part, from Iyengar's (1996) definition, this coding instrument tested for episodic/thematic framing along four axes: causation of PTSD (Code-10A), scale of PTSD (Code-10B), attribution of blame for PTSD (Code-10C), and attribution of treatment responsibility for PTSD (Code-10E). For each of these codes, articles were marked as episodic-dominant when the majority of sources/statements decontextualized and individualized causation, scale, blame, or treatment responsibility. Articles were marked as thematic-dominant when the majority of sources/statements socialized or collectivized causation, scale, blame, or treatment responsibility. Thematic framing predominated over episodic framing in the sample along all four axes, as can be observed in Table 4.

Notably, for all axes but scale, even the absence of relevant (e.g., identifiable as episodic/thematic) frames/framing predominated over episodic framing. Thus, in the majority of articles (or near-majority regarding the attribution of treatment responsibility), most sources/statements portrayed PTSD as resulting from systemic and/or oppressive forces external to the behavior of individual sufferers, and as a problem of considerable scale demanding socialized redress by communities and governments. Also noteworthy: only 29.70% of the sample featured policy/legal changes that could address the causes or consequences of PTSD.

Table 4

Episodic and Thematic Framing of PTSD in The New York Times, 1999–2020

	Causation	**Scale**	**Blame**	**Treatment Responsibility**
Code	10A	10B	10C	10E
Episodic Framing	3.10%	20.30%	7.80%	4.70%
Thematic Framing	66.40%	63.30%	56.30%	44.50%
Balanced Framing	1.60%	0.80%	1.60%	0.80%
No Framing	28.90%	15.60%	33.60%	49.20%
Unclear/Unsure/Other	0%	0%	0.8%	0.8%

Chapter 4: Discussion

The NYT, as depicted in previous framing literature, has tended to overrepresent military PTSD, underrepresent civilian PTSD, rely extensively on male and governmental sources to the exclusion of others, neglect to communicate treatment options, and portray sufferers as criminally violent (Houston, Spialek, & Perreault, 2016; Purtle, Lynn, & Malik, 2016; Barnett & Lee, 2019). This project hypothesized a continuation of said trends, but this continuation was not observed in full. Although combat/military trauma's disproportionate representation relative to other sources of trauma was reproduced in this sample, as well as the traditional dominance of men's voices in sourcing, government officials played a far less dominant role in coverage than expected. Additionally, the expected dominance of episodic/individual framing over thematic/social framing was not supported.

Causes, Reactions/Consequences, and Treatments

In keeping with previous studies on news coverage of PTSD, the leading cause of trauma as represented in this sample was combat and/or military experience, which appeared in 32.10% of articles. While the proportion of the sample which featured combat/military trauma was significantly lesser than that observed in Houston et al. (2016, p. 242), wherein 49.14% of articles mentioned combat trauma, it was comparable to the 38% observed in Purtle et al. (2016, p. 635), and to the 30.90% observed in Barnett and Lee (2019, p. 9). Table 5 depicts the top five causal factors by frequency across various studies of PTSD news coverage.

Table 5

Causes of PTSD as Depicted Across Key Studies

Houston, Spialek, & Perreault (2016, p. 242)	**Purtle, Lynn, & Malik (2016, p. 635)**	**Long (2021); Thesis**
The New York Times: 1950–2012	*The New York Times*: 1980–2015	*The New York Times*: 1999–2020
I. Military Service (49.14%) II. Terrorism (14.19%) III. Rape/Sexual Assault/Sexual Harassment (8.71%) IV. Murder/Violence/ Shooting/ Robbery (7.31%) V. Genocide/ Dictatorship/Torture (7.10%)	I. Combat (38%) II. Intentional Injury (13.50%) III. Terrorism (12.1%) IV. Sexual Assault (8.70%) V. Accidental Injury (5.50%)	I. Combat/Military Experience (32.10%) II. Violent Crime/Terrorism (15.70%) III. Accident; human-precipitated (7.80%) IV. Sexual Violence (7.10%) V. State Violence, Policing/Prisons, and Oppression (7%)

As hypothesized, the sampled coverage also underrepresented treatment options for PTSD; a majority of the sample (63.30%) did not feature a single treatment option. The proportion of the sample which featured at least one treatment option (36.70%) was significantly smaller than the proportion which featured at least one causal factor (75%), or the proportion which included at least one symptom (53.10%). Additionally, the proportion of the sample which did not include a treatment option (again, 63.30%) was

significantly greater than that observed in Houston et al. (2016, p. 245), wherein 47.96% of articles did not include a treatment option, but far lesser than that observed in Purtle et al. (2016, p. 634), wherein 90.40% of articles did not include a treatment option. Barnett and Lee (2019), meanwhile, observed that 21.70% of the sample under study featured the absence of treatment explicitly, and 57.11% mentioned no treatment options at all (p. 9). That Purtle, et al. (2016) and Houston, et al. (2016) would observe such discrepant results is unusual, given the 32-year overlap in their sampling windows; ultimately, though, Houston, et al. (2016) is the only of three studies in which the majority of the sample did include a treatment option, and this majority was very slight. As to the specific treatment options represented, this study's results were markedly similar to those depicted in Houston et al. (2016, p.245), wherein the top three by frequency were therapy/counseling (34.41%), medicine (12.58%), and peer support (9.35%). In this study, the top three treatments by frequency of inclusion in coverage were also therapy/counseling (27.30%), medicine (10.20%), and peer support (5.50%).

Based on the post-hoc analysis, sleep issues and nightmares, as well as anxiety were best represented (24.30% apiece) as PTSD symptoms/reactions, followed by flashbacks and intrusive memories (19.60%) and anger or irritability (15.10%). Notably, violent crime featured as an explicit outcome of PTSD in a minor portion of the sample (5.50%). By comparison, Houston et al. (2016, p. 243) observed this feature in 15.81% of the sample. In other respects, though, the depiction of PTSD's symptomatology was consistent with that observed in Houston et al. (2016, p. 243); therein, the best-represented symptoms/reactions were anxiety (33.76%), sadness/depression (33.76%),

nightmares and sleep problems (27.53%), and memories/flashbacks (22.04%). Anger/irritability appeared in 20.21% of the sample (Houston, et al., 2016, p. 243).

Overall, it may be stated that the causes, treatments/reactions, and symptoms of PTSD observed in this study were generally consistent with those observed in previous research, especially with reference to the overrepresentation of military/combat experience relative to other sources of trauma and the underrepresentation of treatment and recovery options. This is striking for several reasons. Firstly, as per the available medical research into PTSD's incidence and origins, the proportion of U.S. citizens for whom combat experience constitutes a source of medically significant trauma is far lesser than NYT coverage would suggest (Kessler, et al., 1995; Tanielian & Jaycox, 2008). Combat-incurred trauma may actually be a minority causal factor when PTSD is considered for its full incidence in both military and civilian populations. Secondly the infrequent portrayal of treatment options for PTSD risks casting the disorder as an ailment with no possibility of redress or improvement and, thus, contributing to stigmatization. Media portrayals/frames play a key role in shaping our understanding of illness' causations, manifestations, and potentials for intervention; sometimes, they help to legitimate diagnoses before their formal, medical recognition. The NYT, as discussed, helped to popularize PTSD as a medical concept, featuring arguments for its existence before it was included in the DSM (Scott, 1990; Lembcke, 1998; Morris, 2015). News coverage may influence policymakers, too, with Purtle (2016) observing that "PTSD was constructed as a problem unique to combat exposures and military populations in the text of federal legislation between 1989 and 2009" (p. 246). Practically speaking, this would signify that media representations of PTSD can influence those who experience the

disorder, their peers and neighbors, and the lawmakers whose decisions mediate their access to official recognition and care. That the NYT continues to represent PTSD as a soldier's disorder, and expends more coverage on its symptoms than the possibility of treatment, could inadvertently result in civilians (arguably the majority of PTSD sufferers) failing to recognize or act upon their symptoms or, for that matter, encountering a lack of social and material support upon their choosing to do so.

Thankfully, this study also identifies a number of positive trends outside the strict purview of its hypotheses. A lesser proportion of the sample in this study than in previous studies featured violent crime as an outcome of PTSD and, additionally, the dominance of combat/military trauma in NYT coverage has appeared to decrease over time. This study identified combat trauma in only 32.10% of sampled coverage (1999–2020) and Barnett and Lee (2019), which surveyed coverage from 2003–2012, identified combat trauma in 30.90% of its sample. These are significantly lesser proportions than that observed in Houston et al. (2016), wherein nearly half of the sampled coverage (1950–2012) featured combat and/or military trauma. This is especially noteworthy given that the discrepancy cannot be attributed to a lack of military engagement. The sample windows applied by this study and Barnet and Lee (2019) encompass U.S. deployments in Iraq and Afghanistan, suggesting that shifts in news gathering processes, or the broader popular consciousness, are responsible for the decline in question. If we take seriously the possibility that media coverage influences the text and contents of federal legislation (Purtle, 2016), or that it "influences the health behaviors of the public by giving information that can change understanding, attitude, or help seeking intentions" (Jeong,

Kim, Oh, & Park, 2013, p. 1080), perhaps a continuation of this trend could eventually result in more robust support and recognition for non-veteran sufferers of PTSD.

Sourcing

As hypothesized, sourcing dynamics in the sampled coverage demonstrated a significant gender imbalance. Men spoke most frequently in a majority of the sampled articles (67.20%), whereas women spoke most frequently in only 24.20% of the sample. These proportions are remarkably similar to those identified in Barnett and Lee (2019, p. 8), wherein men (65%) were far more likely to be quoted or paraphrased than women (29.10%).

However, this study's findings diverged from the sourcing dynamics observed by Barnett and Lee (2019) drastically in other areas. In Barnett and Lee (2019), although non-governmental sources accounted for two-thirds of the sample, clearly outnumbering governmental sources, non-governmental sourcing was dominated by researchers and other figures vested with medical authority (p. 8). In this study, civilian (non-government, non-medical) sourcing dominated the majority of articles (50.80%). Medical sources appeared in 56.30% of the sample but were predominant in only 25%. Government sources appeared in 53.90% of the sample but were predominant in only 17.20%, making governmental sourcing the least dominant of the three recognized categories, perhaps because, as per Tanner & Friedman (2011), governmental voices tend to prevail in coverage of infectious disease and physicians' voices prevail in coverage of chronic illness It is noteworthy, however, that sources relating their own experience of PTSD appeared in only 32% of the sample. As per Coleman et al. (2011), individuals with personal experience of an illness or disease "also make credible sources that can lead

people to change their own health behaviors" (p. 945). If media personnel are committed to depicting PTSD accurately—and providing its sufferers with a voice—then it is concerning that so few articles allow those who actually experience PTSD to influence portrayals of the disorder and its consequences.

In summation, this study observed a privileging of men as sources consistent with previous research on PTSD news coverage. It did not, however, observe the expected privileging of official sources. Barnett and Lee (2019) held that "the people who tell the stories of PTS are likely to be male authority figures, not individuals who have not experienced PTS" (p. 10). As per the results of this study, the people who tell the stories of PTSD are still likely to be men, and still likely to have no personal experience of the disorder, but are not necessarily more likely to be authority figures of the conventional variety. This gender imbalance is significant, as estimates suggest that the disorder is more common among women than men in the U.S. (Kessler, et al., 2005; Gradus, 2014). It is possible that the privileging of men as sources contributes to the disproportionate representation of combat trauma in PTSD coverage, since men are more likely to report combat as their most upsetting traumatic experience than women (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Additionally, given that media portrayals of illness and those who experience it can influence message recipients' understanding and treatment-seeking behaviors (Coleman, et al., 2011; Jeong, et al., 2013), and perhaps even legislation (Purtle, 2016), it seems likely the underrepresentation of women sources in PTSD coverage would contribute to fewer women overall recognizing and seeking help for their own symptoms, and those that did being less likely to encounter official/institutional support.

It is also significant, though, that this study did not observe the privileging of official (government and medical) sources in the same manner as previous studies, especially since this trend in news gathering processes has a long history of empirical support (Andsager & Powers, 2001; Pickle, et al., 2002; Hermida, et al., 2014; Watts & Maddison, 2014; Brewer, et al., 2014). Given the influence of sourcing dynamics on framing dynamics (Cross, 2010; Vasterman and Ruigrok, 2013) and the tendency of officials "to claim responsibility for outcomes deemed favorable and disclaim responsibility for events or decisions with negative implications" (Iyengar, 1996, p. 60) it is unsurprising that research on news coverage of health topics has typically observed frames which individualized and decontextualized the disorder (e.g., episodic framing). In keeping with this relation, though, the privileging of non-official sources observed in this study corresponded with frames which portrayed PTSD at scale and in a social context (e.g., thematic framing).

Framing: Episodic v. Thematic

This study's coding instrument tested for episodic/thematic framing along four axes: causation of PTSD (Code 10A), scale (Code 10B), attribution of blame (Code 10C), and attribution of treatment responsibility (Code 10E). For each of these codes, articles wherein the majority of sources/statements individualized causation, scale, blame, or treatment responsibility were marked as episodic-dominant. Articles wherein the majority of sources/statements socialized causation, scale, blame, and treatment responsibility were marked as thematic-dominant. In an article which was episodic with reference to all four axes, then, PTSD would be portrayed as a problem experienced by a single individual (scale), as a consequence of personal attitudes/actions (causation) and isolated

or decontextualized events (blame), and as problem which that individual was responsible for addressing by way of self-action (treatment responsibility). A normative example of episodic PTSD framing might be an article on the sentencing of an individual convicted of culpable homicide and allegedly traumatized by their own actions, which does not situate this event in broader trends pertaining to the disorder (At Oscar Pistorius's Sentencing Hearing, Descriptions of a 'Broken Man,' 2014). By contrast, an article which was thematic with reference to all four axes would portray PTSD as crisis or problem shared by many individuals (scale); one caused by external forces (causation) and events constitutive of systems or trends (blame), and demanding a collective response (treatment responsibility). A normative example of thematic PTSD framing might be an article on veterans' finances (New Veterans Hit Hard by Economic Crisis, 2008) wherein the plight of wounded, including psychologically wounded, former military personnel is discussed as a systemic problem requiring mitigation by federal initiatives.

Unexpectedly, thematic framing predominated over episodic framing in the sample along all four axes, indicating that PTSD was more often depicted as resulting from systemic (and oftentimes oppressive or hostile) forces external to the behavior of individual sufferers, and as a problem of considerable scale demanding socialized redress by communities and governments. More specifically, in 66.40% of the sample a majority of sources/statements represented the causation of PTSD thematically, with similar proportions for scale (63.30%) and attribution of blame (56.30%). While only 44.50% of the sample predominately featured thematic framing of treatment responsibility, this proportion was still significantly larger than that in which treatment responsibility was

predominately framed in an episodic manner (4.70%), with the largest proportion of the sample not depicting treatment responsibility at all (49.20%).

By contrast, previous studies on news coverage of health topics have observed a predominance of episodic frames, which individualize the experience of illness, as well as the responsibility for addressing and mitigating illness (Dudo, et al., 2007; Kim & Willis, 2007; Hawkins & Linvill, 2010; Dubriwny, 2010; Sun, et al., 2015; Kim, et al., 2015). This study not only observed the opposite (the dominance of thematic framing), but a paucity of episodic frames. For all axes but scale, even the absence of relevant frames/framing predominated over episodic framing. This is heartening insofar as the coverage under study avoided the pitfalls of episodic framing, which typically serves to decontextualize the behavior of social actors, obfuscate the structural roots of social ills, and deflect accountability from institutional/governmental authority and society at large (Iyengar, 1996). In addition to dampening the possibility for effective institutional interventions into the causes and consequences of PTSD, individualizing portrayals of the disorder stand to negatively influence the self-perception of those who experience it, causing them to view their own trauma, and the events or actions which precipitated it, as isolated and abnormal. In other words, persistent episodic framing of a disorder such as PTSD could erode its status as a basis for camaraderie and political mobilization (Berg, 2002). While the results of this study did not suggest such a trend, it is worth noting that treatment responsibility was less likely to be framed thematically in the sample than other relevant axes such as scale (of the problem) and causation. This would suggest that, for media personnel anyway, it is possible to contextualize PTSD and portray its systemic roots without also portraying the necessity of system-level, collective redress.

It is possible, however, that these discrepancies are partially resulting from variations in the conceptualization of episodic framing and its mobilization in coding instruments. Barnett and Lee (2019) appear to have treated all or most coverage “linked to a specific event” as episodic owing to its “reactionary, rather than exploratory” character (p. 11). While this study adapted potions of its coding instrument from Barnett and Lee (2019), it did not treat all event-linked coverage as episodic; only that which failed to contextualize events within broader trends and trajectories. For instance, a news story about PTSD risk among witnesses of the 9/11 terror attacks (Post-9/11 Pain Found to Linger In Young Minds, 2002) would be conceptualized as thematic owing to the situatedness of induvial accounts within a broader narrative of mass trauma, and perhaps mass responsibility. The researcher feels that conceptualizing all event-linked coverage as episodic would risk over-broadening the category to include even news stories and statements which sought to provide context and social analysis to the phenomenon of traumatic illness. It is notable, though, that despite the dominance of thematic framing in the sample, few news stories (29.70%) mentioned policy or legal changes which might address the causes or consequences of PTSD. This would suggest that the thematic framing of illness in a given news story does not necessarily precipitate discussion of socialized forms of redress.

An obvious question, based on this study’s discussion of the potential for popular interventions in media framing, is the extent to which novel social movements and social media technologies may have played a role in encouraging the turn towards civilian sources and thematic framing observed in this study. The MeToo movement—devoted to exposing and critiquing sexual violence—and Black Lives Matter—devoted to exposing and critiquing police violence and systemic racism in policing—were cited elsewhere in

this study as formations which might challenge the overrepresentation of combat trauma in PTSD coverage, or even catalyze news discussion of neglected forms of systemic violence. However, as discussed, this study observed a continuation of combat/military trauma's overrepresentation among other sources of trauma. Sexual violence appeared as a source of trauma in only 7.10% of this study's sample, a proportion comparable to the representation of that same category (8.71%) in Houston et al. (2016, p. 242) and sexual assault (8.70%) in Purtle et al. (2016, p. 635). Police violence, meanwhile, was included in the broader category abbreviated as "State Violence," which was represented in only 7% of this study's sample. Houston et al. (2016) observed a comparable representation of this umbrella category at 7.10% (p. 242).

With regard to this study's sample, even removing articles which could conceivably have been sampled in prior studies (those published between 1999 and 2015) did little to shift the relevant proportions; sexual violence and state violence appear in this 2016–2020 subsample (N=100 articles; n=27 PTSD articles) at a meager 7.40% each. COVID-precipitated trauma, by comparison, was represented in the same subsample at an equivalent 7.40%, a significantly large proportion than in the overall sample (1.60%). While no definitive conclusion on this point is possible without further research, the maintenance of these proportions, at least roughly, over a cumulative sample period of 1950–2020 would suggest that contemporary social movements and their interactions with media personnel were not the impetus for the observed shift from episodic to thematic framing.

As discussed, this shift indicates that the NYT has begun to represent PTSD more productively, as a social problem demanding social redress; however, the continued

overrepresentation of combat/military trauma relative to other sources of trauma is concerning, especially since there is no necessary correlation between a trend towards thematic/social framing of PTSD and more accurate portrayals of its incidence and causation. In Pollock et al.'s (2014) study of PTSD coverage in the national press, for instance, treatment responsibility for veterans was primarily attributed to the government, an example of thematic framing. Given the predominance of episodic framing in coverage of other health topics (Dudo, et al., 2007; Kim & Willis, 2007; Hawkins & Linvill, 2010; Dubriwny, 2010; Sun, et al., 2015; Kim, et al., 2015), this would suggest that PTSD caused by military service is more likely than other disorders (and perhaps other manifestations of PTSD) to receive thematic framing in news coverage, at least with regard to treatment responsibility. Additionally, because social movement representatives and veterans alike would have been classified as "civilian" sources in this study's framework, it is possible that the observed uptick in civilian sourcing was primarily attributable to interviews with former military personnel suffering from combat-incurred PTSD. These circumstances might produce coverage which, as observed in this study, applied thematic/social framing to PTSD while continuing to misrepresent its incidence, focusing on military trauma experienced by men when, for instance, more women appear to suffer from PTSD than men (Kessler, et al., 2005; Gradus, 2014) and sexual violence and abuse are more frequent causal factors for the disorder among women than combat experience (Kessler, et al., 1995). Although military PTSD remains worthy of consideration, as well as medical and policy interventions, a journalistic practice committed to representing PTSD as it is experienced would devote a larger share of coverage to the myriad traumas experienced by civilians, including first responders,

victims of violent crime and abuse, and witnesses to disasters natural and otherwise. As new social movements arise to critique the systemic injustices and violence which pervade U.S. culture, and a global pandemic continues to inflict psychological and physical strain on both civilians and healthcare personnel, this representational task becomes more vital than ever.

Limitations

While this study sought to draw from and synthesize prior studies on the framing of PTSD, time and resource constraints were ultimately such that perfect reproduction of sample sizes and coding schemas was untenable. This study analyzed N=328 articles in the course of final analysis, of which only n=128 were ultimately determined to constitute relevant news coverage for the purposes of this study. This study's sample of n=128 was closest in size to Barnett and Lee's (2019) of n=188 articles, but, even so, a larger dataset would enhance confidence in the findings. Additionally, reliability on certain variables could have been improved even though all categories fell in satisfactory range. Perhaps replication with a larger and more diverse dataset could help to improve reliability statistics further and enhance confidence in the findings; something that future research may consider.

Finally, in the interest of synthesizing a coding instrument which addressed all hypotheses, but did not become unwieldy or infeasible for a small coding team to apply, this study removed a level of detail that was present in Barnett and Lee's (2019) analysis of sourcing. Barnett and Lee (2019) differentiated between various types of medical (researcher, doctor, nurse, etc.) and government (officials, members of the military, members of Congress, etc.) sources, as well as between various types of sources which

would be categorized as "civilian" in this study's framework (p. 8). By contrast, this study did not make such differentiations; no code existed to distinguish between veterans (retired military), NGO statements, and service workers as various types of "civilian" source, or between state prosecutors, active-duty military, and Pentagon spokespeople as various types of "government" source. This study's effort to streamline its coding instrument may be regarded as a limitation in this sense, thought it also allowed the instrument to address a broad range of concerns from various previous studies.

Directions for Future Research

The findings of this study were in line with those of previous studies on PTSD news coverage regarding representation of the disorder's causes, symptoms/reactions, and treatments (Houston, et al., 2016; Purtle, et al., 2016) and the gender of sourcing (Barnett and Lee, 2019). This study differed from previous studies, though, in its observations regarding the use of official and unofficial sources, and framing (episodic v. thematic) in PTSD news coverage. Future studies should investigate the dominance of civilian/unofficial sources observed in this study, as well as the high proportion of the sample wherein thematic framing was predominant over episodic framing. This could include reapplication and reappraisal of the coding instrument mobilized in this study, or perhaps a meta-analysis of various coding instruments and their operationalization of sourcing and framing, specifically with regard to PTSD coverage. Such research activity would help to better situate, and hopefully validate, this study's findings within their research tradition, as well as pave the way for greater internal coherency and mutual dialogue in the sub-field.

Owing to the extensive representation of the NYT in contemporary research on PTSD news coverage, it would also be productive for future studies to compare the NYT to other major national and international publications, or even to compare print with other forms of news coverage. Other topics which might benefit from closer examination would be the correlation between sourcing and framing dynamics in PTSD coverage, the correlation between representation of PTSD causes and frame dynamics, and the effect of thematic and/or episodic PTSD news coverage on news audiences. It may also be instructive to more directly address the role of news gathering processes in the sourcing/framing of PTSD coverage, as well as the role of contemporary social movements. Researchers could interview journalists who regularly cover mental illness and other health topics to observe (inductively) the impact of movements like MeToo and Black Lives Matter on journalists' conceptions of trauma and the ethics and necessary contents of PTSD coverage. A simpler approach might be amending extant coding schemas for PTSD coverage with the inclusion of codes devoted to the representation of social movements.

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Appendix I: Coding Instrument

01: Article ID

Record number assigned to article, beginning with #1

02: Coder ID

1 = Aaron Long

2 = Jessie Roark

03: Publishing Date

mm/dd/yyyy

04: Word Count

#

05: Is this a PTSD/Trauma news story? (Adapted from Houston et al., 2016)

0 = No

1 = Yes

Sports stories not actually about PTSD/Trauma (e.g., "the Knicks were shell-shocked in their loss to Boston) are not news stories. Book, movie, theatre, or art review articles are not news stories. Opinion articles or "OP-EDs" are not news stories. If an article is not a news story, code as "0", stop coding, and skip to next article.

CLARIFICATION AND ADDITIONAL CRITERION

- EXCLUDE news stories which make only figurative use of "trauma"—e.g., describing inanimate objects, organizations, or abstract entities as traumatized
- EXCLUDE news stories which do not include search term keywords—e.g., news stories which mention "trauma," but do not use the terms "PTSD," "post-traumatic stress," or "posttraumatic stress"
- EXCLUDE news stories which incidentally mention post-traumatic stress disorder, but in which PTSD is not significantly topic-linked—e.g. a 5000-word news story about electricity bills wherein a character is described as having PTSD, but there is no further discussion of their condition; a news story about a disease that *resembles* PTSD, but is not PTSD
- INCLUDE news stories about crime wherein the accused's PTSD diagnosis is used to explain their criminal behavior (e.g., by their lawyer) / EXCLUDE news stories about crime wherein the accused is described as having PTSD, but no explicit connection is drawn between their diagnosis and behavior and there is no further discussion of their condition

06: Cause (Adapted from Houston et al., 2016)

What is the cause of the PTSD/trauma in the article? Causes should be explicit (e.g., "her experience in Vietnam was traumatic" or "losing his father caused the PTSD"). Don't "read between the lines" if no cause is directly mentioned.

Record up to 3 instances of trauma cause per article. Record these in order of appearance in the article using variables 6a to 6c

CAUSE of Trauma	
0	No cause mentioned
1	Military experience or service (NOT experiencing war as civilian)
2	War (experiencing war as a civilian, NOT military service)
3	Disaster (Natural Disaster, NOT terrorism and NOT man-made accident)
4	Airplane Crash / Transportation Accident / Car Accident / Machine Accident or Malfunction / Chemical Spill / Oil Spill / Industrial Accident / Man-made Disaster or Accident
5	Genocide / Dictatorship / Government Crackdown / Imprisonment / Police Beating / Torture / Execution / Immigration and Forced Migration
6	Shooting / Murder / Mass Murder / Violent Assault / Robbery / Kidnapping / Hostage / Riot / Terrorism
7	Rape / Sexual Assault / Sexual Abuse / Sexual Harassment / Grooming
8	Child Abuse / Separation from Parents / Family Violence / Parent Beatings / Domestic Violence
9	Intergenerational Trauma (e.g. Witnessing Parent, Guardian, or Caregiver struggle with PTSD)
10	Illness / Medical Issue / Child Birth / Premature Birth / Child Medical Issue
11	Death of Someone Else (Family Member, Friend, Colleague, Neighbor, Celebrity)
12	Recession / Poverty / Unemployment / Firing / New Job / Employment Issues
13	Bullying / School Issues or Experiences
14	Non-violent Political Issue (Scandal, Impeachment, Election)
15	COVID-19/Pandemic
16	Non-COVID Pandemic and/or Infectious Disease (Zika, Ebola, Flu, etc.)

07: Symptoms/Reactions/Consequences (Adapted from Houston et al., 2016)

What symptoms are associated with the PTSD/trauma in the article?

Symptoms need to be clearly tied to the traumatic experience or PTSD.

For example, it an articles says PTSD causes nightmares or the trauma of having a parent die causes anxiety, then these are symptoms associated with the PTSD/trauma and should be coded.

Symptoms are not related to effects/consequences of PTSD. For example, if PTSD causes someone to lose their job, and they are then upset about losing their job, then "upset" is not a direct symptom of PTSD. Additionally, if PTSD causes someone to punch their boss and then they lose their job, the violence of punching the boss is a symptom of PTSD, but getting fired is not a symptom. Rather it is a consequence of the PTSD symptom. Only code for symptoms connected to the PTSD/trauma.

Record up to 7 instances of symptoms per article. Record these in order of appearance in the article using variables 7a to 7g.

Symptoms of Trauma	
0	No symptoms mentioned OR SPECIFIED
1	Fear/ Terror / Panic / Anxiety / Stress / Distress / Being "on edge" / Hypervigilant / Vigilant / Arousal / Hyperarousal / Being Cautious / Paranoia / Fear of Death
2	Numbness / Feeling Numb / Feeling Nothing / Not Feeling
3	Crying / Sad / Depression / Grief / Mood Swings / Being Emotional / Clinginess
4	Memories / Flashbacks (when awake) / Re-experiencing / Relive
5	Nightmares / Sleep Problems / Dreams
6	Forgetfulness / Memory Loss / Disoriented / Distracted / Difficulty Concentrating
7	Guilt / Shame / Self-Loathing / Humiliation / Remorse
8	Anger / Temper / Hostility / Acting Out (But not crime or violence or murder) / Misbehavior / Delinquency / Irritability / Rage / Agitation / Acting without control
9	Homicide / Mass Homicide / Urge to Kill / Getting Arrested / Committing Crime / Committing Assault / Committing Rape / Committing Sexual Assault / Domestic Violence / Revenge/ Attempt to Hurt Someone
10	Suicide / Self-harm
11	Not Socializing / Isolation / Loneliness / Avoiding Crowds / Not Trusting People / Avoidance
12	Substance Use and Abuse / Alcohol / Drugs / Addition / Smoking / Caffeine / Drugs
13	Homelessness / Unemployment / Poor Functioning / Work Problems / Work Issues / Divorce / Martial Problems / Relationship Problems / Lack of Growth (in general) / Regression (in general

14	Radicalization / Political Extremism / Brainwashed / Religious Extremism or Fundamentalism
15	Illness / Health Issues / Disability
16	Empathy / GROWTH
17	Urinating Oneself / Bed Wetting
18	School Problems / Truancy / Learning Issues or Problems
19	Other (Specify)

08: Treatment (Adapted from Houston et al., 2016)

What treatments are associated with the PTSD/trauma in the article?

Treatments are specific actions or activities that are undertaken to help the person cope with or recover from the trauma/PTSD. Going to the hospital for help, participating in therapy, or going fishing to help can be treatments.

Treatments are not consequences of things related to the PTSD/trauma. For example, if someone is arrested because they got into a fight as a result of PTSD, then "getting arrested" is not treatment.

Also, getting "studied," "assessed," or "evaluated" is not treatment unless such activities are explicitly stated to be associated with treatment. So, if veterans are in a study where they receive therapy, then that (the therapy) is treatment. If veterans are in a study where someone asks them how much PTSD they have and why, there is no treatment specified in such a situation. Also, if someone is evaluated or diagnosed as part of a criminal trial or other reasons, that alone is not treatment. Some sort of medicine, therapy, or other activity intended to help the person must be included to qualify for treatment.

Record up to 3 instances of treatment per article. Record these in order of appearance in the article using variables 8a to 8c.

Treatment for Trauma	
0	No treatments mentioned
1	Therapy / Counseling / Psychiatrist / Mental Health Professional / Mental Health Services / Eye Movement Therapy / Psychotherapy
2	Hospitalized / Residential Treatment (Has to be explicitly admitted to or be staying at hospital or treatment facility for this one…just going to hospital for treatment or services is not enough and should go in #3)
3	Medicine / Prescription / Pills / Drugs / Clinic / Hospital (not admitted or staying at hospital, but outpatient services or non-specified hospital treatment)

4	Writing / Art / Singing / Gardening / Music / Exercise / Sports / Hunting / Fishing / Hobbies / Activities
5	Deep Breathing / Meditation / Massage / Quiet / Rest
6	Support Group / Family Support or Family in General / Peer Support / Education / Training
7	Pet Therapy / Playing with Pets / Spending Time with Animals
8	Other (specify)

09: Sourcing (Adapted from Barnett & Lee, 2019)

> "To be considered a source, an individual had to be quoted or paraphrased. We looked at direct communication – statements that were attributed and reported with use of words such as 'stated' or 'said', and indirect attribution in which words such as 'thinks', 'feels', or 'believes' were used for attribution" (Barnett & Lee, 2019, p. 7).

Most codes in sections 09 and 10 are applied by counting sources. For instance, if two women and three men are represented in the sourcing of an article, the coder should choose (1) for code 09B.

ALSO: When a single source is quoted or paraphrased multiple times count each inclusion as a distinct source. This mechanic is intended to account for the relative weighting of sources without resorting to column inches as a measure, thus restricting analysis to a single variable.

09A: Dominant Gender in Sourcing (by #) (Adapted from Barnett & Lee, 2019)

1) Male.
2) Female.
3) Nonbinary gender identities.
4) No clear majority for any gender.
5) Unclear/Unsure/Other.

09B: Does the article include a source discussing their own experience of post-traumatic stress and/or post-traumatic stress disorder? (Adapted from Barnett & Lee, 2019)

1) Yes.
2) No.
3) Unclear/Unsure/Other.

09C: Does the article include a government official/employee or politician as a source?

1) Yes.
2) No.
3) Unclear/Unsure/Other.

09D: Does the article include a medical professional (physician, researcher, psychologist, psychiatrist, etc.) as a source?

1) Yes.
2) No.
3) Unclear/Unsure/Other.

09E: Dominant Source Type (by #)

1) Government official/employee and/or politician.
2) Medical professional (physician, researcher, psychologist, psychiatrist, etc.).
3) Civilian without government post, political office, or medical credentials (includes civilian advocacy groups).
4) No clear majority for any source type.
5) Unclear/Unsure/Other.

10: Episodic v. Thematic Framing (HMMM)

10A: How do the majority of sources represented in the article (by #) characterize PTS/PTSD? (Adapted from Barnett & Lee, 2019)

1) Primarily as a result of personal/individual actions or attitudes (e.g. unfounded reluctance to seek treatment, lack of mental fortitude, dangerous and/or reckless behavior, etc.).
2) Primarily as a result of external/social forces (e.g. insufficient treatment options, apathy or ineptitude of institutions, experiences of injustice/oppression/violence, etc.).
3) Balanced between (1)-type and (2)-type characterization.
4) No characterizations of either type.
5) Unclear/Unsure/Other.

10B: How do the majority of sources represented in the article (by #) discuss PTS/PTSD? (Adapted from Barnett & Lee, 2019)

1) They discuss post-traumatic stress in terms of an isolated incident or case (one event or involving one person; does not relate it to other cases).
2) They discuss post-traumatic stress in terms of a much larger issue/problem (one of many cases constituting a larger problem).
3) Balanced between (1)-type and (2)-type characterization.
4) No characterizations of either type.
5) Unclear/Unsure/Other.

10C: How do the majority of sources represented in the article (by #) attribute blame for PTS/PTSD?

6) Blame attributed to isolated, individual-level actions and events.
7) Blame attributed to societal and/or system-level forces OR mass trauma, e.g. 9/11 (also includes individual-level actions and events contextualized within system-level trends).
8) Balanced between (1)-type and (2)-type characterization.
9) No attribution of blame by any source.
10) Unclear/Unsure.

10D: Does the article (any source therein) mention/depict policy changes or legal actions that could address the causes or consequences of PTS/PTSD?

0) No.
1) Yes.

10E: How do the majority of sources represented in the article (by #) characterize the responsibility for addressing, preventing, and treating PTS/PTSD?

1) PTS/PTSD is an individual's problem to be addressed by their self-action.
2) PTS/PTSD is a public health issue (or symptom/outcome of societal injustice) to be addressed by group action.
3) Balanced between (1)-type and (2)-type characterization.
4) No discussion of responsibility.
5) Unclear/Unsure.

Appendix II: Coding Instrument Reliability

Code	Krippendorff's Alpha Coefficient
Preliminary Codes (01–05)	
01: Article ID	NA
02: Coder ID	NA
03: Publishing Date	.90
04: Word Count	1
05: Is this a PTSD/Trauma news story?	.80
Section 06: Causes (6a–6c)	
6a	.80
6b	.70
6c	.80
Section 07: Symptoms/Reactions (7a–7g)	
7a	.70
7b	.70
7c	.70
7d	.70
7e	.80
7f	.80
7g	.80
Section 08: Treatments	
8a	.80
8b	.70

8c	.80
Section 09: Sourcing	
09A: Dominant Gender in Sourcing (by #)	.70
09B: Does the article include a source discussing their own experience of post-traumatic stress and/or post-traumatic stress disorder?	.80
09C: Does the article include a government official/employee or politician as a source?	.80
09D: Does the article include a medical professional (physician, researcher, psychologist, psychiatrist, etc.) as a source?	.80
09E: Dominant Source Type (by #)	.70
Section 10: Framing	
10A: How do the majority of sources represented in the article (by #) characterize PTS/PTSD?	.70
10B: How do the majority of sources represented in the article (by #) discuss PTS/PTSD?	.60
10C: How do the majority of sources represented in the article (by #) attribute blame for PTS/PTSD?	.60
10D: Does the article (any source therein) mention/depict policy changes or legal actions that could address the causes or consequences of PTS/PTSD?	.70
10E: How do the majority of sources represented in the article (by #) characterize the responsibility for addressing, preventing, and treating PTS/PTSD?	.60
AVERAGE COEFFICIENT:	.80

Appendix III: Key Categories in Coding Instrument

Categories	Examples
Section 06: Causes (6a–6c)	
Combat/Military Experience	"Mr. Hatcher wound up hospitalized for post-traumatic stress disorder three times. 'We noticed there was a change after the first tour, but not as drastic as this time,' Mrs. Hatcher said. 'The person comes back a different person, and then you have financial issues on top of it.'" (*New Veterans Hit Hard by Economic Crisis*, 2008)
Violent Crime/Terrorism	"The study estimates that 75,000 schoolchildren in the 4th through the 12th grades, or 10.5 percent of the children in those grades, suffered post-traumatic stress disorder after Sept. 11." (*Post-9/11 Pain Found to Linger In Young Minds*, 2002)
Accident; human-precipitated	"A new study by the Mount Sinai School of Medicine suggests that the percentage of ground zero workers who suffered post-traumatic stress is roughly the same as for *airline crash recovery workers* and returning Afghanistan war veterans. [emphasis added]" (*Study Finds High Ground Zero Stress*, 2008)
Section 07: Symptoms & Reactions (7a–7g)	
Sleep Issues & Nightmares	"In 1994, for example, Veterans of Foreign Wars officials noticed a significant spike in claims of post-traumatic stress disorder -- not from soldiers returning from Operation Desert Storm or Somalia but rather from World War II veterans whose nightmares were revved by the hoopla surrounding the 50th anniversary of D-Day." (*The Permanent Scars of Iraq*, 2004)
Anxiety	"A three-week soldier 'reset' program uses cranial massage, yoga and acupuncture to alleviate the hyper-vigilance that accompanies the stress

	disorder, but the program is limited to 16 soldiers at a time." (*At Fort Hood, Reaching Out to Soldiers at Risk*, 2009)
Flashbacks & Intrusive Memories	"Doctors there said he had post-traumatic stress disorder after he described *flashbacks* and waking from nightmares in a sweat. [emphasis added]" (Robbins, 2015)
Section 08: Treatments (8a–8c)	
Therapy/Counseling	The treatment group, 88 women, participated in three sessions of imagery rehearsal therapy, while the control group, 80 women, was on a waiting list and continued with whatever treatment they had been undergoing. . . . And symptoms of post-traumatic stress decreased in 65 percent of the treatment group, while they either remained unchanged or worsened in the control group, according to the findings." (*Following a Script to Escape a Nightmare*, 2010)
Prescription Medicine	Anxiety disorders include panic disorder, which are episodes of intense fear; phobias, which are irrational fears of a place or thing; generalized anxiety disorder, which is chronic worrying; post-traumatic stress disorder, linked to a traumatic event; and obsessive-compulsive disorder, which involves repetitive behavior or disturbing thoughts. . . . Medications like selective serotonin reuptake inhibitors and older tricyclics are commonly prescribed." (*Anxiety Disorders*, 2005)
Peer Support	"Practicing self-compassion, or self-care, is meant to mitigate feelings of shame and judgment, which are often experienced by assault survivors and PTSD sufferers. . . . You may need to be with friends, nurture yourself or comfort yourself to feel safe. [emphasis added]" (Krischer, 2018)
Section 09: Sourcing	
Male Source (Code 09A)	"But the senator, Mr. Kelley recalled, 'ran into a stone wall,' as the N.R.A.

	threatened to pull its support for him if he did not drop the matter, which he eventually did.” (*Felons Finding It Easy to Regain Gun Rights*, 2011)
Female Source (Code 09A)	“‘The truth is, I'm in limbo,’ Ms. Alberto said in Spanish through a translator during a telephone interview last week from the center. ‘I don't know if I'll be released here or if they'll return me to my country, which is what I don't want.’” (Robbins, 2016)
Personal Experience of PTSD (Code 09B)	“‘It was the weirdest damned thing,’ he told me. "I didn't want to get out of bed. I didn't want to leave the house. I didn't want to do anything. I knew something was wrong, so I went up to the V.A. hospital.’ Doctors there quickly diagnosed post-traumatic stress disorder, or PTSD.” (*Bringing It All Back Home*, 2006)
Government Source (Codes 09C & 09E)	“‘This is an investigation that has only just begun,’ said Senator Patty Murray, a Washington Democrat. ‘The most important thing is that these service members and their families are provided with answers on why cost was a factor in the treatment they sought for the invisible wounds of war, and that the Army takes the right steps to fix it.’” (*‘Personality Disorder,’ a Disputed Diagnosis*, 2012)
Medical Source (Codes 09D & 09E)	“‘This study is a very good first step, and an important one, but like any first step it should lead us to ask further questions about these injuries,’ said Brian Levine, a neuropsychologist at the Rotman Research Institute and the University of Toronto, who was not involved in the study.” (*War Concussions Linked to Stress*, 2008)
Civilian Source (Codes 09E)	“The moment itself was a blur. ‘All of the sudden we were running out of there,’ said one of the four, Noah McAskill, 22. As they joined other victims, they discovered they had all been hurt. Harris Gordon was bleeding from a cut in his back; Luke Sorenson had a gash in his

	leg. Mr. McAskill had escaped with a few cuts and some hearing loss; his hearing returned, though his ears were ringing for days. But his roommate, Joshua Lee, had been hit in the face and lost his two front teeth." (Correal & Schmidt, 2016)
Section 10: Framing	
Episodic Framing of Causation (Code 10A)	"And, as throughout the trial, the latest hearings revolved around the dual persona depicted by the defense and the prosecution: on one hand, a remorseful, contrite figure traumatized by his own actions; on the other, an egotist who snuffed out an innocent life." (*At Oscar Pistorius's Sentencing Hearing, Descriptions of a 'Broken Man,'* 2014)
Thematic Framing of Causation (Code 10A)	"MGM has significant resources that could be used to pay damage awards to victims if it were to lose in court. Last year, it had almost $11 billion in revenue and $1.7 billion in operating income — including $170 million from Mandalay Bay alone. Other options for compensation may be more limited for victims, who number into the thousands, their lawyers say, including not just those with physical wounds from bullets and shrapnel, but hundreds of others suffering from post-traumatic stress disorder and other mental and emotional injuries." (Kovaleski & Oppel, 2018)
Episodic Framing of Scale (Code 10B)	"The lead defense lawyer, Barry Roux, said he would call four witnesses, beginning with Dr. Lore Hartzenberg, the athlete's personal psychologist, who said that flashback images of the shooting would always be with Mr. Pistorius. He has been found to have post-traumatic stress disorder." (*At Oscar Pistorius's Sentencing Hearing, Descriptions of a 'Broken Man,'* 2014)
Thematic Framing of Scale (Code 10B)	"'I was seeing more PTSD in my community than I saw in Iraq,' he said, referring to his yearlong tour of duty as a

	staff sergeant in 2003, during which he saw combat.” (Hoffman & Lee, 2020)
Episodic Framing/Attribution of Blame (Code 10C)	“Studies published by Dr. Shapiro and her allies were almost all positive; several reported an 80 to 100 percent cure rate in three sessions for people with post-traumatic symptoms from a single incident, like a car crash or a rape.” (Carey, 2019)
Thematic Framing/Atrribution of Blame (Code 10C)	“The documentary makes the point that the nature of the Iraq war — fuzzy front lines and guerrilla tactics — has thrust more female soldiers (who represent 14 percent of active-duty enlisted personnel) into enemy fire than ever before. And, like the men, the women sometimes find the return to civilian life difficult, suffering the symptoms of post-traumatic stress disorder and the depression and sleeplessness that come with it.” (*Battleground*, 2008)
Policy Changes or Legal Actions (10D)	“Instead of imposing outside assumptions about trauma and healing, the World Health Organization has begun recommending ‘psychosocial support’ for disaster areas. The assumption is that just as cultures have their own symptoms of trauma, they have distinct healing methods that are often tied to local rites. For every angry ghost, there is a ritual for the dead intended to lay that ghost to rest.” (*Suffering Differently*, 2007)
Episodic Framing/Attribution of Treatment Responsibility (Code 10E)	“Here’s a comforting thought in these dark days. For most of us, ‘the most common response to trauma is resilience,’ said Dr. Denise Sloan, a professor in psychiatry at Boston University and associate director of the National Center for PTSD. In fact, the overwhelming majority of people who endure a life-threatening event recover on their own and never meet criteria for PTSD.” (Taitz, 2020)
Thematic Framing/Attribution of Treatment Responsibility (Code 10E)	“Compounding the challenge, the local mental health system has suffered an

	almost total collapse, heaping onto the Police Department a great deal of the work to be done with emotionally disturbed residents. Glaudi says his unit handles 150 to 180 distress calls a month." (*New Orleans Is Awash in Mental Health Problems - Americas - International Herald Tribune*, 2006)

Appendix IV: Sample Used in Final Analysis

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