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Lived Experience of Military Mental Health Clinicians: Provided Care to OIF and OEF Active Duty Service Members Experiencing War Stress Injury

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LIVED EXPERIENCE OF MILITARY MENTAL HEALTH CLINICIANS:
PROVIDED CARE TO OIF AND OEF ACTIVE DUTY SERVICE MEMBERS
EXPERIENCING WAR STRESS INJURY

A Dissertation

Presented to the Faculty of
Antioch University Seattle
Seattle, WA

In Partial Fulfillment
of the Requirements of the Degree
Doctor of Psychology

By

David W. Vandegrift

December 2017

LIVED EXPERIENCE OF MILITARY MENTAL HEALTH CLINICIANS:
PROVIDED CARE TO OIF AND OEF ACTIVE DUTY SERVICE MEMBERS
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DOCTOR OF PSYCHOLOGY

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December 2017

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ABSTRACT

LIVED EXPERIENCE OF MILITARY MENTAL HEALTH CLINICIANS:
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Military mental health clinicians (MMHCs) have been essential to Operations Enduring Freedom and Iraqi Freedom. They served in extreme stress conditions, including on the frontlines. As co-combatant/clinician, the MMHC bridged unique perspectives on the effects of war stress experienced by Active-Duty Service Members (ADSMs). To date, no study has focused uniquely on MMHCs narratives as they provided care from this multiple perspective.

This investigation was carried out from a phenomenological perspective. A single, open-ended question was asked of seven MMHCs about lived experiences while serving, resulting in in-depth interviews. These were textually coded. Though clinician positive and negative experiences were consistent with previous research, significant differences bear discussion.

Following data analysis, participants identified duty as the superordinate theme that led to the question, “Duty to military mission or service member?” This dilemma could not be reconciled that resulted in unrealized fulfillment of duty. MMHCs responses to unrealized duty defined an overarching polarity of Integrity—Corruption.

A hermeneutic approach was used to identify the author’s relevant understandings before, during, and after the interview process. In reconstructing and contextualizing interview material, one finding was that MMHCs were required to operate in a place of turbulence between

contradictory military and psychological traditions. Another finding concerned a growing divisive fissure between military and the public at-large, impacting reintegration efforts for those who serve. Public and governmental silence about traumas of ADSMs and MMHCs suggests a parallel, cultural dissociation occurring about war trauma. A question is posed if diagnosing trauma as pathology is a further way that external, contextual forces are consistently kept unformulated, distanced, or denied. Rather than locating the etiology and treatment entirely within the individual—resulting in blaming and isolating of those who serve—the suggestion is made for widespread discussion of socioeconomic and political factors that are behind psychological war injury. This dissertation is available in open access at AURA: Antioch University Repository and Archive, <http://aura.antioch.edu/> and OhioLink ETD Center, <https://etd.ohiolink.edu>

Keywords: military psychology, military history, deployment, phenomenology, resiliency, trauma, Adjustment Disorders, PTSD, war stress, phenomenology, evidenced based treatment, hermeneutics, unformulated experience, moral pain, dissociation, demobilization

Dedications

This dissertation is dedicated to the bravery, integrity, and commitment of the seven courageous participants of this study. In addition to your provision of the best possible care to fellow soldiers in extreme circumstances, your stories have opened my heart and my eyes to the immense struggles inherent in war and combat trauma psychotherapy. Your reflections brought me to a new understanding of places where innocence, spirit, and hope were often taken from soldiers: the killing fields of Operation Iraqi Freedom and Operation Enduring Freedom—and surprisingly to where soldiers have also been robbed of these qualities at home in America. In responding to grave needs day after day, you placed yourselves in harm's way in order to alleviate, preserve, and restore the personhoods of co-combatants. You did this even when it risked high emotional and psychological cost to yourselves.

It is my hope that both individually and in concert, your contributions will help to send a strong message to all Americans to awaken from our country-wide dissociative trance and take into account what happens to service members—and those who care for them—when we as a nation choose to send our troops into war. Such a realization can occur through a deeper, open understanding of the price that all soldiers and armed service medical teams pay in order to serve American interests. Perhaps more importantly, your unified voices helped to sound the alarm bell for America at-large to gain an understanding about the real price American society pays for its neglect, abandonment, and betrayal of those who serve.

I take from this the call that there is a pressing need for American society and the U.S. Armed Forces to re-envision ways to truly help bring home—perhaps to a new home, a changed home, yet a safe and honoring home—all who serve, have served, and will serve.

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I would like to express my deepest appreciation to each of my committee members for your continued support as I worked to complete this dissertation. I acknowledge Dr. Mark Russell, my committee chair, for setting a high bar for scholarship as I approached my research. He demanded a firm foundation for this research and set a high standard for professionalism in writing. I appreciate the commitment demonstrated by Dr. Li Ravicz and for his sharing of insights, vision, and creativity in bringing form to complex and contradictory evidence and experience that unfolded from this research.

I am grateful to Dr. Philip Cushman for the many hours he spent with me, sharing ideas and thinking critically about findings and themes. It was under his mentorship that I learned to reflect historically, politically, and morally thereby shifting into communion with the texts of this dissertation.

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Special mention also needs to be given to my family—each one scholarly in his or her own right. To Steve, my husband and our sons, Brandon and Colin, I have cherished the countless hours of dialogue, sharing of ideas, and critique. To my sisters—Elizabeth, Deborah, and my deceased sister, Catherine—You have never left my side, unflagging in your efforts to help me bring together complex, contradictory experience, even when those may have been for me disjointed or as yet, unformulated. To Mom, my dear heroine: This work is dedicated to you. You have been there with me...always. You exist as a constant in my life, now and forever.

And finally to my Dad who taught me that there is more to the story than the spoken word. Truths unfold when their silences—the unspoken and unspeakable depths of horror, shame, failure, disappointments, hope and love— are heard and lived into.

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Introduction

Our nights are broken by sounds of nearby mortars, the drone of medevac (medical evacuation) helicopters, and endless nightmares. Each new day brings us more patients who wrench our hearts. Then we get up and do it all again. We've become intimately familiar with the brutalities of war.

(Duncan et al., 2005, p. 62)

Since World War I, U.S. military mental health clinicians (MMHCs) have provided behavioral healthcare to U.S. active duty service members (ADSMs) experiencing war stress injury (Jones & Wessely, 2005; Sheppard, 2000; Wessely, 2003). In Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), MMHCs served in forward operating areas (FOA) to identify, assess, and treat combat operational stress and return them to duty (Jones, Sparacino, Wilcox, Rothberg, & Stokes, 1995; Poles & Oak, 2007).

Other researchers (Moore & Reger, 2006; Poles & Oak, 2007) noted that MMHCs embedded in FOAs contributed to the success of the U.S. military campaign by preserving manpower, mitigating the debilitating impact of psychiatric syndromes, and thereby maintained a psychologically fit fighting force. In fact, all deployed service members of all ranks worked under a degree of risk that included being exposed to enemy fire, indirect fire, improvised explosive devices (IEDs), contaminants, pollutants, and other toxic substances (Bartone, 2006). They also witnessed destruction, torture, and death. MMHCs frequently experienced unrelenting threats to their own lives. These exchanges led some to undergo acute or chronic mental health complications themselves (McDevitt-Murphy et al., 2010; Poles & Oak, 2007; Schneiderman, Braver, & Kang, 2008; Terrio et al., 2009).

While numerous investigations have been carried out on the short- and long-term effects of war stress injury on ADSMs, veterans, and their families (Hoge et al., 2004; Hoge et al., 2007;

Hoge, et al., 2008; Institute of Medicine, 2008; Kang et al., 2015; Milliken et al., 2012; Milliken, Auchterlonie, & Hoge, 2007; Seal et al., 2007), studies focusing on MMHCs themselves have yet to be conducted (Applewhite & Arincorayan, 2009; Miller & Warner, 2013; Voss Horrell, Holihan, Didion, & Vance, 2011). Accordingly, there is a dearth of professional information on the experiences of MMHCs as they cared for ADSMs experiencing war stress injury acquired during OEF and OIF.

MMHCs provide care with the knowledge that ADSMs, their families, and communities experience severe strain due to wartime deployment. Families must adjust to life without their loved ones and with the knowledge of the dangers their relatives may be facing. Family research reveals staggering rates of mental health care. According to the *Marine Corps Times* (Hefling, 2009), outpatient mental health visits to children of service members doubled from 1 million to 2 million in the five years between 2003 and 2008. In that same time period, child psychiatric hospitalizations for severe problems such as suicide attempts rose sharply (Flake, 2009). Similarly, Applewhite & Arincorayan (2009) suggested that although the psychological impact on ADSMs and their families has received ever-increasing examination since the Global War on Terrorism began in 2001, current professional literature investigating psychological impacts on deployed MMHCs has garnered little attention. As a result, MMHCs' experiences have not been well investigated. These authors argue that competing ethical and moral dilemmas and the high emotional and psychological costs present challenges that need further research. It is hoped this study will encourage discussion of this under-examined phenomenon.

Literature Review

Generally, trauma is understood to occur when a person experiences, witnesses, or is confronted with one or more traumatic events involving actual or threatened death, and intense fear, horror or helplessness (Morrison, 2006; Rothschild, 2000). This can result in disruptions in physical, psychological, and emotional functioning with profound alterations to the brain and psychobiology, as well as loss of identity and sense of self (deVries, 1996; van der Kolk et al., 1996). I focused on the general definition of trauma as it applies in the context of war. Through the literature review process, I located relevant sources particularly helpful in understanding the experiences of deployed MMHCs. These included studies conducted by Charles Figley (1995, 2002, 2006), Combat Operations Stress Control (COSC, 2010), Bartone, Adler, and Vaitkus (1998), Voss Horrell et al. (2011), and the Mental Health Assessment Team (MHAT, 2012). Findings from these sources are briefly reviewed, in turn. Interestingly, MHAT-8 (2012) was the first and only time the military included an assessment designed for the MMHCs to provide direct input about their experiences as a way to assess their psychological well-being.

Compassion Fatigue (CF)

Charles Figley is a pioneer who has worked in the field of traumatology for over 35 years. Figley developed concepts of “compassion fatigue,” “secondary trauma,” and “combat stress injury” to research on military mental health caregivers. Figley (1995) described compassion fatigue as the formal caregiver’s reduced capacity or interest in being empathic. Authors Adams, Boscarino, and Figley (2006) argue that secondary trauma experienced by MMHCs consists of “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by a person” (p. 7).

Figley (2002) concluded that providing behavioral healthcare to traumatized military personnel places clinicians at risk of developing psychological distress that can last far beyond the deployment. According to Figley, clinicians are vicariously exposed to the traumatic events of their clients. They respond empathically, and over time this can cause compassion fatigue. Specifically, when clinicians listen to stories of fear, pain, and suffering, they too are at risk of feeling similar fear, pain, and suffering. He further identified visceral expressions of compassion fatigue, including irritability, withdrawal, dissociation, and a sense of hopelessness, anger, and lowered frustration tolerance. These visceral expressions were consistent with the symptomology of PTSD (Figley, 2002; Gentry, 2006).

The risk of developing compassion fatigue was not confined to those who provided behavioral health care in wartime. Kenny and Hull (2008), in a study of the experiences of critical care nurses treating war casualties, found increased stress levels that resulted in the symptoms of compassion fatigue. The authors, themselves active-duty Army nurses, attributed workload factors, empathic responses to the suffering of young wounded service members and their families, as well as distress over the inability to alleviate pain, as the prominent factors in these responses.

Vicarious Trauma (VT)

Using constructivist self-development theory, Pearlman and Saakvitne (1995) defined vicarious trauma (VT) as the permanent “transformation in the inner experience of the therapist that comes about as a result of empathic engagement with client’s trauma material” (p. 280). The main symptoms of VT are “disturbances in the therapist’s cognitive frame of reference, identity, world view, and spirituality...affecting tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and physical presence

in the world” (Pearlman & Saakvitne, 1995, p. 280). This is to say that theoretically verbal exposure to traumatic material changes the clinician’s cognitive schemas regarding both self and others. Pearlman and Saakvitne (2005) maintained that VT resulted in therapists reporting having intrusive imagery, and painful images and emotions associated with their client’s traumatic memories. Saakvitne and Pearlman (1996) argue these effects are nontrivial and can be profound and long lasting.

Burnout

Maslach (1982) defined “burnout” as a syndrome of emotional exhaustion, depersonalization, and reduced accomplishment that can occur among individuals who do “people work.” Maslach and Leiter (1997) identified six areas within an organizational structure that led to burnout: workload, control, rewards, community, fairness, and value conflicts.

Maslach (1982) provided the most widely used construct definition, with three content domains:

- A syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment
- A response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are trouble
- A pattern of emotional overload and subsequent emotional exhaustion... (p. 3)

Combat Operations Stress Control (COSC)

COSC encompasses all policies and programs designed to prevent, identify, and treat mental injuries caused by combat or other operations (COSC, 2010). The two goals of COSC are to maintain a ready fighting force and to protect and restore the mental health of service member and their families in a manner consistent with the respect given to the physically injured. The COSC manual aided in understanding the mission of behavioral healthcare in deployment, the

challenges deployed MMHCs confront on a day-to-day basis, and the potential impact on the MMHC for untreated cumulative war stress injury.

COSC (2010) reported that recent demands faced by military and behavioral medical personnel in OIF and OEF have been dramatically different from previous wars. Organizational restructuring, heavier workloads, fewer resources, and sicker patients have intensified negative stressors for the MMHC. Complicating this situation, the MMHC rarely deployed in a cohesive unit and did not have the protective factors associated with intensive team training. Moreover, due to extended work schedules MMHCs frequently missed restorative “dwell-time” (breaks for soldiers at their domestic home bases between deployments).

Furthermore, COSC (2010) noted consequences of untreated cumulative stress in the MMHC as follows:

- Increased medical errors or near misses;
- Physical complaints, such as changes in eating habits, gastrointestinal distress, headache, fatigue, and sleep disorders;
- Change in work habits, such as tardiness/absenteeism;
- Mental and emotional difficulties, such as memory disturbances, anger, self-doubt, isolation, or impaired judgment; and
- Accidents.

COSC (2010) suggested that Navy medical personnel themselves were not meeting their own mental health needs and were neglecting to use existing mental health resources before serious consequences occurred to themselves or others. The MMHC’s code of silence, both moral and professional, their dedication to caring for injured service members, and their passions for the mission of easing suffering had added up to an increased the need for their leaders to be

vigilant in identifying early stress behaviors in the healthcare providers themselves. No MMHC is immune from these vulnerabilities.

Operational Stress

Bartone, Adler, and Vaitkus (1998) investigated key sources of stress negatively impacting the health, morale, and mental readiness of ADSMs and MMHCs. They argued that the degree of stress experienced in various psychological dimensions—specifically isolation, ambiguity, powerlessness, boredom, and danger—significantly correlated with depression, psychiatric symptoms, and low morale. Bartone (2006) further modified this model and applied it to other operations. With the exception of ambiguity, he found that these same dimensions applied to behavioral health clinicians' negative stress in OIF and OEF theaters of war. I review isolation and powerlessness dimensions in greater detail below.

Isolation. Bartone et al. (1998) highlighted a sense of “aleness” that can pervade time spent serving in a foreign land separated from loved ones. The Professional Filler System (PROFIS) system was designed to fill voids in personnel when a unit deployed on a combat or humanitarian mission. The natural feeling of being isolated was magnified for MMHCs who joined units through the PROFIS program.

Bartone (2006) argued that having a confidant has been an important source of support for the MMHC. Efforts of the MMHC to establish a relationship with a confidant, however, was made difficult by the fact that one behavioral health officer was assigned per brigade (approximately 1,500 to 4,000 service members), thus eliminating a co-professional as a logical source of peer support.

Bartone (2006) suggested behavioral health clinicians were hesitant to confide personally in others because they felt a burden of responsibility, due to being in a position in which they

were expected to be a significant source of support for others. Commanders, chaplains, battalion surgeons themselves often referred ADSMs to MMHCs for behavioral health assistance.

Divulging personal concerns or admitting to deployment-related emotional stress could damage the MMHC's professional credibility and negatively impact his or her role.

Powerlessness. Brigade behavioral health officers possessed valuable professional expertise, but their capacity for exercising direct power was limited (Bartone, Adler, & Vaitkus, 1998; Bartone, 2006). Bartone et al. reiterated a military axiom, that "MMHCs make recommendations and commanders make decisions." For example, an ADSM seeking behavioral health care for acute anxiety or a combat operational stress reaction might benefit from being placed on alternate duty that does not require him or her to go beyond the secure confines of base camp. However, behavioral healthcare recommendations that the ADSM temporarily pause from duties while receiving behavioral health support were often met with resistance up the chain of command. This practice largely arose because in recent wars units have needed all of their personnel to complete mission demands.

Bartone (2006) identified a general sense of clinician powerlessness that can grow from such psychosocial limitations. He argued that when despair was entrenched for the MMHC, it severely limited these providers' options to effect change, relieve suffering, or make positive differences in the lives of ADSMs. As the deployment grinds on and the MMHC's disappointments mount, the clinician can adopt a hardened, "don't care" attitude. Again, this is resonant with the effects of Maslach's (1982) definition of burnout. It may even be amplified in these circumstances.

Wartime Realities

Voss Horrell et al. (2011) described MMHC's experience as being either enriched or weakened through the dynamics, challenges, and realities embedded in three categories: patient factors, clinician characteristics, and organizational issues.

Patient factors. Voss Horrell et al. (2011) identified resistance to treatment, concern over damage to one's own military career, the desire to return to comrades, suicidality, a history of childhood trauma, and comorbid diagnoses as factors that negatively affected MMHCs. Erbes, Curry, and Leskela (2010) indicated that additional negative patient factors on the MMHC's experiences were age, gender, legal status prior to recruitment, previous abuse history, level and severity of war-stress traumatic injury, traumatic brain injury (TBI), level of aggressiveness and/or suicidality, session status, responsiveness to treatment, and the likelihood of deployment or redeployment of the ADSM.

Seal et al. (2010) found that MMHCs reported high levels of negative stress when treating active and reserve troops who were likely to be redeployed after treatment. Clinicians were conflicted about alleviating Post Traumatic Stress Disorder (PTSD) symptoms in soldiers only to see those soldiers sent back into battle where they were to be re-exposed to trauma and death.

Many of the OEF/OIF veterans presenting for treatment had acute onset PTSD (Andrews, Brewin, Stewart, Philpott, & Hejdenburg, 2009). PTSD was manifested in a very raw or aggressive patient presentation, resulting in additional stress for clinicians. Acute onset of PTSD among soldiers was associated with higher levels of dissociation, anger and shame, as compared with soldiers delayed onset. Other comorbid disorders commonly seen in patients with PTSD were substance abuse disorders, depression, and panic and other anxiety disorders (American

Psychiatric Association, 2000). Voss Horrell et al. (2011) concluded that each diagnosis presented a unique challenge for MMHCs, particularly given the need to determine which disorder to treat first. Clinicians felt overwhelmed with the myriad of problems that ADSMs presented, and this finding was especially true for newer MMHCs as compared to clinicians with more experience.

Clinician characteristics. In assessing resiliency and compassion fatigue among clinicians, Voss Horrell et al. (2011) examined a number of clinician factors. Theoretical orientation, training and supervision, years of experience, level of isolation, power conflicts with line commanders, and vicarious trauma already affecting the clinician were shown to be significant factors in determining clinician resiliency and, conversely, compassion fatigue.

For instance, using evidenced-based therapies demonstrated improvement in the alleviation of war stress injury (Aarons et al., 2009). Some researchers speculated that having clear treatment protocols acted to lessen MMHC ambiguity and anxiety while also decreasing emotional over-involvement and secondary trauma for MMHCs working with trauma victims (Lev-Wiesel, Goldblatt, Eisikovits, & Admi, 2009). By using various DoD/VA-approved therapies (EMDR, PE, and CPT), the MMHC gained a statistically better chance for positive experiences, compassion growth, less burnout, and lower compassion fatigue. Similarly, in a study of home-based clinicians (Aarons et al., 2009), staff retention rates were better in teams where evidence-based practices (EBPs) were implemented, suggesting a protective effect for these clinicians.

Adams and Riggs (2008) argued that newer clinicians might be more susceptible to vicarious trauma and compassion fatigue and therefore could benefit from ongoing training, education, and clear treatment protocols. This was especially true if the MMHC lacked trauma-

specific training and lacked supervision or support from other MMHCs who were themselves experienced in treating trauma. Sprang (2007) reported that specialized trauma training enhanced “compassion satisfaction” which he defined as a result of growing personally and professionally through providing care.

Organizational issues. The deleterious effects of military organizational restrictions led to compassion fatigue in the clinician, and to unrelenting, long-term damage to the MMHC (Voss Horrell et al., 2011). Restrictions included limited clinical training for behavioral healthcare officers, clinical staffing shortages, and, as mentioned, unreasonable caseloads for clinicians. Additional factors were: lack of funding, military directives limiting accurate assessment and appropriate levels of treatment, and high productivity standards that resulted in returning service members to duty. All of these undermined resilience in MMHCs. Horrell argued that insufficient attention has been given to the psychological impact these factors have on the lived-experience of MMHCs.

Mental Health Advisory Team (MHAT 8, 2012)—Background

In 2003, the Office of The Surgeon General sanctioned Mental Health Advisory Teams (MHAT) to research mental health issues of deployed active duty service members serving in Iraq (Applewhite & Arincorayan, 2009). With the support of the Office of the Surgeon General, the United States Army Medical Command, the Office of the Command Surgeon Headquarters, the U.S. Army Central Command (USCENTCOM), and the Office of the Command Surgeon U.S. Forces Afghanistan (USFOR-A), MHAT-8 teams (2012) requested behavioral healthcare (BH) clinicians to participate in these studies. (In the present study, BH is used synonymously with MMHC.) Embedded in the study design were interviews, focus groups, and a census survey. The latter, a survey of theater BH personnel, was conducted in May and June of 2012. In

total, 205 surveys were distributed to cover the approximately 175 identified providers (135 active, plus 40 who were rotating out). One hundred and seventeen surveys were returned (a 67% return rate).

The stated goal of MHAT-8 (2012) was to assess BH personnel perceptions of: standards of care; resources; combat and operational stress control concepts and skill; mental health stigma; barriers to care; and BH personnel well-being. The number of surveys collected in 2012 compromised an unprecedented 86.7% ($n=117$) of all available providers in the Afghan Theatre of Operation (ATO; total $n=135$). BH personnel focus group and interviews led to the production qualitative assessments of deployment experiences and delivery of care during MHAT-8. Twenty-one focus groups and interviews were conducted in a semi-structured format, in which open- and close-ended questions were posed. Focus groups with BH personnel were conducted across all of the Regional Commands (RC).

BH positive stress. During focus groups, BH providers reported experiences of stress in a positive light. Many respondents said that serving was the highlight of their careers. All felt privileged to support those who put themselves in harm's way. BH survey respondents felt well-prepared to complete missions and to treat patients in the deployed environment for any number of mental health conditions, including combat stress. In fact, 94% of BH survey participants felt confident in helping ADSMs adapt to the stressors of combat or deployment.

BH clinicians reported relying on each other for informal emotional support and social outlets. They engaged in social activities and professional development to keep morale high. In general, BH providers reported having the necessary resources to do their jobs and complete missions.

BH negative stress. The MHAT-8 identified a number of conditions that led to increased negative stress in the BH. I am limiting this brief review to the following topics: pre-existing mental health conditions of ADSMs, operational stress/suicide, homicidal ideation, workload disparity, and strained relationship between BH and command. For a full accounting of all stressors identified in MHAT-8 (2012), the reader can obtain an electronic copy from: armymedicine.mil/Documents/J_MHAT_8_OEF_Report.pdf

Pre-existing mental health conditions of ADSMs. A consistent issue cited by BH providers across the area of operation (AO) was concern about a significant percentage (60-70%) of new ADSMs who were inducted with non-stabilized psychiatric symptoms and pre-existing mental health conditions. BH reported feeling an enormous burden to manage psychiatric symptoms of ADSMs preparing to go into combat.

Operational stress and suicidal/homicidal ideation (SI/HI). The MHAT-8 study found that the importance of small-unit leadership was an important factor for the well-being of ADSMs. Perhaps not surprisingly, BH providers reported that the most common issue ADSMs themselves presented with was operational stress related to leadership issues. For example, this study examined a project improvement effort by reviewing 542 case files at the Bagram Combat Stress Clinic. Of those, 40% (215) revealed unit/leadership issues as the presenting problem. Comorbid symptoms associated with leadership issues included SI, HI among patients. Although SI was not uncommon, responders reported that SI was most considered “short-lived. Providers were trained to treat the suicidal patient in the field or to evacuate those who required a higher level of intervention. Providers reported that the percentage of patients with SI was similar to those seen in garrison. Eighty-seven percent (87%) of BH survey respondents felt confident in their abilities to evaluate and manage suicidal patients.

MHAT-8 (2012) identified no systemic analysis studies of HI in ADSMs. Despite previous research identifying wartime homicide and atrocities as important factors to study (Fontana and Rosenbeck, 1998), MHAT-8 offered no clear explanation as to why they removed these two components from the surveys and report. Anecdotally, BH providers explained that homicidal ideation was short-lived and was tied to ADSM's sense that supervisors did not care about them, imposed stringent command policies, treated them poorly or unfairly, and bullied them.

Authors Fontana and Rosenheck specifically included active duty homicide and atrocities in their 1998 study. They discussed psychological benefits and psychological liabilities with different types of traumatic exposure in the war zone. Benefits, particularly in the form of self-improvement, have been shown to be associated positively with most types of traumatic exposure in the war zone. The one exception to experiencing benefit among the types of traumatic exposure was when soldiers participated in atrocities. Participation in actions that are considered horrifically wrong worldwide could explain this exception (Millikan et al., 2012). It is understandable that the universal moral condemnation of such actions would make it difficult to derive psychological benefits during active duty—particularly, deriving any sense of “self-improvement” through participating in, or failing to prevent war atrocities.

Workload disparity. BH clinicians and clinics expressed concern about workload disparity. Teams talked with providers across the Regional Commands and reported that workers at some clinics and BH providers were overwhelmed by the numbers of patients seen and treated, while other clinics staff and BH providers discussed feeling “underwhelmed” and struggled to keep themselves busy in order to feel productive.

The majority of services were provided at the Combat Stress Clinics and Behavioral Health Clinics. Patient load was remarkably heavy: providers saw on average 97 patients each in the month of May 2012. BH providers indicated that the majority of ADSMs were being seen for pre-existing mental health conditions, that is, personal, or operational (non-combat) stressors. Only 41% of BH respondents felt there were sufficient BH personnel in theater to cover the mission across the area of operation (AO).

Strained relationship with line command. BH providers reported that their relationships with commanders varied across commands and clinics, ranging from mutually respectful and supportive to severely strained. BH providers also reported that command attitude towards BH varied according to the commander's relationship with the ADSM involved in the referral. For instance, if the commander had a positive attitude towards a given ADSM, that commander was most likely supportive of BH care. However, if the ADSM was not well respected by the commander, BH care was often seen as another weakness in the soldier and a way for the ADSM to shirk duty. BH providers reported that this attitude caused friction between commanders, ADSMs, and BH personnel. It is noteworthy that only 39% of BH survey respondents indicated that commanders supported BH clinicians' recommendations for medical evacuation out of theater.

The morale of BH providers varied across theaters. Participants described higher strain at clinics with higher utilization rates. Morale was reported to be generally high where there were good personal relationships between medical and line commanders and between providers and technicians. Conversely, strained relationships between command and BH created undue stress and contributed to clinician burnout and low morale. MHAT-8 (2012) reported that experienced behavioral clinicians maintained that it was incumbent upon the behavioral clinicians to learn

how to communicate with command in a role as a consultant and advocate for the command/mission, while simultaneously executing their traditional roles as patient advocates.

Summary of Background

From the early 20th Century to the present, U.S. MMHCs have attempted to treat and prevent the psychiatric consequences of war by implementing screening programs, providing early intervention strategies for acute war-related syndromes near front lines. They have also sought to mitigate symptoms of long-term psychiatric disability after deployment (Rock et al., 1995; Sheppard, 2000).

The Geneva Convention (1949) categorizes psychologists as noncombatants. However, the nature of OIF and OEF, and the guerilla tactics of insurgents, required all deployed personnel to be able to defend him or herself (Poles & Oak, 2007). In addition, most MMHCs were commissioned officers. As such, the MMHC accepted the responsibility to lead soldiers in a theater of operational combat or in the war zone and therefore would have taken an oath to be a soldier.

Clinical psychologists serving in Iraq and Afghanistan (Moore & Reger, 2006) provided behavioral health services as both clinicians and prevention specialists, in order to meet the psychological and emotional needs of service members. Their duties were to deliver preventive services, to treat active duty service members (ADSMs) experiencing war-stress injury, and to conduct fit-for-duty assessments as ways to assure a psychologically fit fighting force. This was no simple feat, given that the United States Armed Services were experiencing an acute shortage of trained MMHCs (MHAT VI, 2009).

At the time of this investigation, the wars in Iraq and Afghanistan have lasted over a decade. Hundreds of MMHCs (Linnerooth, Mrdjenovich, & Moore, 2011) have been deployed to

hostile environments, some on multiple occasions. MMHCs have regularly experienced a variety of environmental, physical, and emotional stressors while working along the frontlines of combat. As a result, MMHCs serving in the military were at high risk for anxiety, posttraumatic stress symptoms, and alcohol misuse (Gibbons et al., 2012). Despite any resiliency techniques this group may possess through training and experience (Linnerooth et al., 2011; Thompson, 2013), burnout has been recorded at high rates in the MMHC profession. In fact, Linnerooth et al. (2011) argued, “It would be unfair and perhaps hypocritical for MMHCs to encourage patients to seek mental health services when they do not do the same for themselves” (p. 91).

Taking a wider view, Bilmes and Stiglitz (2006) have argued that the MMHC experiences were negatively affected by the military’s own mental health policies. In addition, they cited the U.S. government’s “willful neglect” in providing resources to help treat returning troops afflicted with PTSD, and the military’s “criminal negligence” in denying medical evacuation for those troops suffering from severe psychological traumas.

The literature also speaks to MMHC working conditions in a setting distinctly different from the civilian psychologist. According to Linnerooth et al. (2011), Army mental-health professionals received official instructions to avoid diagnosing ADSMs with war stress injury. The *Army Field Manual* held a section 4-02.51 (FM 8-51; July, 2006) entitled “Combat and Operational Stress Control (COSC): Defer Diagnosis of Behavioral Disorders.” This document directed Army mental health workers to tilt toward a diagnosis of normal combat stress instead of an abnormal behavioral disorder when in a war zone:

During assessment, COSC personnel must always consider behavioral health (BH) disorders that resemble combat and operational stress reaction (COSR), but defer making the diagnosis. The COSC personnel favor this default position to preserve the soldier’s expectations of normalcy. This is also done to avoid stigma associated with BH disorders and to prevent the soldier identifying with a patient or sick role. Deferral is also preferred because some diagnoses require extensive history collection or documentation that is

unavailable during deployment situations. (COSC, 2006. Chapter 8, page 6, file number 8-21)

It is both inappropriate and detrimental to treat Soldiers with COSR as if they are a BDP [behavioral disordered patient]. A therapeutic relationship may promote dependency and foster the “patient” role. Likewise, medication therapy and the highly structured treatment modalities imply the “patient” role. Medication for transient symptom relief (insomnia or extreme anxiety) may not be detrimental if there is no expectation that medication will continue to be prescribed. (COSC, date pending, Chapter 4, page 60, ATP 4-02.5.)

Description of the Study

A phenomenological study was undertaken to explore the experiences of military mental health clinicians as they provided care to active-duty service members experiencing war stress injury acquired during OEF and OIF. Interpretations were made in accordance with hermeneutic approaches.

Purpose of the Study

The purpose of this study was to gain a detailed and in-depth understanding about the experiences of MMHCs as they provided care to ADSMs experiencing war stress injury.

The Research Question

“Tell me a story about a time in which you provided care to an active-duty service member experiencing war-stress injury.”

Relevance/ Implication/ Application of the Study

The relevance of this study lies in its contributions made by seven participants to understanding what it is like to provide care in wartime. The study exposed complicating and debilitating factors that hindered the participants’ own healing, wellbeing, and integrity. By gaining deeper understandings directly from the MMHCs about their experiences as they provided care, more culturally sensitive support can be offered to those who provided psychological, emotional, spiritual, and physical support to ADSMs.

Limitations of Study

This study draws from a small, non-statistically randomized sample. It was carried out over a period of six months and is non-longitudinal.

Method

Defining the Framework

Phenomenology is the philosophical study of the structures of experience and consciousness (Creswell, 2007). Creswell described the common meeting of several individuals' lived-experiences as a phenomenon. Therefore, phenomenologists focus on describing what all participants have in common as they experience a phenomenon. "The basic purpose of phenomenology is to reduce the individual experiences with a phenomenon to an universal description of the essence" (p. 76). In this study, this application of phenomenology reduced the participants' experiences of providing care to ADSMs experiencing war stress injury acquired while serving in OIF and OEF into a universal description of the essence of providing care.

By dialoguing with participants, making sense of their experiences, and interpreting the meanings with them about their world experience, I obtained in-depth first-person accounts describing the lived-experience of military mental health clinicians.

In this chapter, I will describe the role of the researcher, how data was collected, and explain data analysis procedures as ways to assure validity in this study. Interpretations are discussed through the lens of hermeneutic practice.

As mentioned, little is directly known about the human experience of providing psychological care to the war stress injured service member, and there is even less published professional research that has been derived from the actual narratives of MMHCs.

The accounts provided by seven participants generated knowledge and understanding about the rewards and risks, complexities, and dilemmas MMHCs experience in providing care in wartime. To present the nature of this approach, I will review rationale that supports its methodology.

Phenomenological studies consist of minimum structure and maximum depth of description and meaning (Creswell, 2003; Shenton, 2004). I used minimal structure through the use of open-ended research questions aimed at inviting a dialogue that is both descriptive and exploratory. I engaged in dialogue to focus on maximum depth of the participant's robust data that included in-depth personal reflections, insights, and perceptions regarding their experience.

Through the dialogic interview, Kvale (1996) believed participants could freely describe their experiencing and assign meaning that encompasses the "essence" of the human experiencing. Conducted skillfully, phenomenology provides the structure for the researcher to re-examine what is taken for granted or those experiences that are common sense (Husserl, 2001) and perhaps uncover new or forgotten meanings (Laverty, 2003).

First-person accounts provided detailed and nuanced expressions rather than attempting to support, refute, or validate a hypothesis (Denzin & Lincoln, 2000). Phenomenology does not seek to understand theoretical and philosophical generalizations, or predict outcomes through quantifiable measurements. Instead, "qualitative methods explore meanings, concepts, metaphors, symbols, and descriptions of things" (Berg & Lune, 2012, p. 3) in the service of understanding human phenomena.

This understanding is strengthened by the idea that the participant in the situation can only describe the reality of his or her own experiences and the meanings associated with them (Pollio, Henley, & Thompson, 1997). As opposed to a single participant narrative account of human experience, multiple participant narratives enhance the veracity and robust quality of the data. This was especially the case when these narratives shared commonality (Creswell, 2007) in themes, reflections, and interpretations of the human experience. When participant themes shared commonality, and when there was no evidence of substantially new data, interviews were

stopped. This is the goal of the phenomenologist, to reduce the textual (what) and structural (how) meanings of experiences to a brief description referred to as “essence” of the experience shared by all the participants (Moustakas, 1994; Polkinghorne, 1989).

Role of Researcher

The researcher conducting qualitative studies becomes responsible for assuring the integrity of the study parameters. I was able to assure integrity by maintaining the rigor and credibility of various aspects of the research. For instance, I primarily relied on eliciting participants’ experiences by asking open-ended questions, reflecting with the participant about his or her descriptions, clarifying any unclear meanings, and summarizing participant dialogues with them. This assured the discussions were participant-led.

I described the purpose of the study to each participant. After resolving any participant concerns to their satisfaction I obtained the participant’s informed consent to participate in the study (see Appendix B for Antioch University Seattle/ Participant Informed Consent). I informed each participant that all identifying information would be removed from all written records as a means to protect anonymity and assure confidentiality. I further guaranteed that the digital recording would be erased upon approval of the transcribed dialogues. Post interview, I emailed the participant information to complete basic demographic data and inquiry about their experiences (see Appendix C for Participant Informational Form).

Data Collection

Between August 2011 and March 2012, seven participant interviews were audiotaped, transcribed, and stored in compliance with Antioch University Seattle standards. The interviews were conducted in natural settings defined by the participants. Geographical distance made in-

person interviews not possible. Telephonic and Voice Over Internet Protocol (VOIP) audiotapes were used to digitally record interviews.

For any overseas interviews, I sought additional consultation from the Antioch University-Seattle technology department to secure data, anonymity, and confidentiality of the participant. I used pseudonyms to identify participants, limited access to the recordings, and password protected recordings as additional ways to safeguard participants and data.

After transcribing each digital recording within a 24–48 hour time period, I sent the completed transcription to each participant for his or her edits and approval of contents. All transcripts were returned and became the text for this study. Study results and findings were organized thematically.

My observations were documented in journal field notes that attended to participant idiosyncrasies and personal reflections. In accordance with Antioch University Seattle policies, all sources of recordings were then destroyed upon completion of approved transcripts. The transcripts remained password secured, and will remain secured for the customary timeframe of four years following successful defense of this dissertation.

Criteria for Participant Recruitment

The inclusion criteria for participant selection included being or having been a military mental health clinician. Each participant was serving as an active duty military mental health clinician or would have been recently been serving in this capacity at the time of their interview. If civilian, the participant would have had extensive involvement in treating active-duty troops experiencing war-stress injury within the military culture during OEF or OIF.

Recruitment for Participants

I used a purposeful, non-probabilistic, snowballing sampling strategy to recruit participants through professional and personal networking. To this end, I sent an email to prospective participants who had been referred for consideration. This email detailed the scope of work, intent, and purpose of this study. Potential participants included military psychiatrists, medical doctors, psychologists, social workers, and family reintegration staff members. Each person who indicated he or she wished to participate was asked to complete the Antioch University Seattle Informed Consent (see Appendix B). Once I received the signed Informed Consent documents, I initiated contact with each participant to schedule the 60–90 minute dialogical interview. Immediately following each interview, I emailed each participant the follow-up Informational Form (see Appendix C) designed to be completed after the interview.

Description of Participants

I interviewed seven military mental health clinicians, each of whom provided care to ADSMs during OIF or OEF. At the time of the interviews, three officers were still serving in current operations, one non-Department of Defense (DoD)/Veterans Administration (VA) civilian was working with both active duty service members and veterans of OIF or OEF, and three DoD psychologists were no longer in active duty status. In all, three participants used Skype and four participants used telephone to conduct interviews (see Appendix D for Description and Analysis of Participants).

Introduction to Interview

Each interview began with the following statement:

Thank you for agreeing to participate in this qualitative study. In this interview, I would like to invite you to tell me a story of when you provided care to an active-duty service member experiencing war-stress injury. My main focus is to understand your unique experience, your thoughts, feelings, and reactions as you provided your care to service

members experiencing war-stress injury acquired during OIF and OEF. I ask you to describe your experience as deeply as you wish. If I do not understand something you are discussing, I would like to ask you for clarification. Likewise, if you do not understand my responses to you, please let me know. Furthermore, you can stop this interview at any point in time and do not need to explain why. If in the process of describing and discussing this material you experience discomfort, I am available for further discussion or I can offer you a referral if requested.

Data Analysis

I cite Creswell (2007) and Colaizzi (1978) approach to phenomenology in order to provide a verifiable structure and a repeatable process in this study:

1. Organized and prepared participant data for analysis. Conducted member-checking, triangulating sources of data, and used peer auditors as a way to produce a rigorous approach to data collection, data analysis, and report writing. All seven transcripts were returned from participants that signified their edits and approval of document. These approved transcriptions became the text of this study.
2. Read through the finalized text several times. Highlighted and coded the "significant phrases" (Colaizzi, p. 332) in the text by using participants' own words.
3. Drew meaning from those phrases.
4. Coalesced the phrases into themes or subthemes.
5. Compared and contrasted these themes across the seven transcripts.
6. Differentiated and included only the common themes shared by each participant as to their lived-experience of providing care.

According to Creswell (2007), this process is consistent with the data analysis feature of phenomenology. He wrote that such analyses are:

data analysis that can follow systematic procedures that move from the narrow unit of analysis or the significant statements and onto broader units or meaning

units and onto detailed descriptions that summarize the elements of what the individuals experienced and how the individuals experienced it. (p. 79)

I digitally recorded participant interviews and then transcribed them into 190 pages of text using Dedoose Version 5.0.11. Web application for managing, analyzing, and presenting qualitative and mixed method research data (2014). Los Angeles, CA: SocioCultural Research Consultants, LLC.

Validating the Accuracy and Credibility of Findings

I emphasized the importance of validity in this phenomenological study as one means to assure integrity as outlined in Creswell (2014). He argued validity criteria differ in comparing qualitative and quantitative research. He thought, "For one, validity in quantitative research is used as a way to examine stability or consistency of responses. It is instrumental in generalizability—the external validity of applying results to new settings, people, or samples" (Creswell, 2014, p. 201). Overall, however, generalizability and reliability play a minor role in qualitative inquiry.

Validity, on the other hand, is seen as the foundation to determine if evidence is considered convincing or unconvincing rather than true or false (Ravicz, 1998). I employed the following strategies suggested by Creswell (2003, p. 196) to check the accuracy of the findings: triangulation (i.e., using different data sources of information by examining evidence from the sources); member-checking (i.e., returning text to participants for purposes of accuracy and consistency with their descriptions of experience in the dialogical interviews); and clarifying biases that I bring to this study.

Reliability and validity of findings from qualitative research depend on the quality of data management, retrieval, and interpretation or reconstruction of meaning. The robustness of data analysis is therefore an important factor in the rigor of qualitative research (Sheldon, 2004).

The following analysis of an excerpted fragment of one of the seven participants' text illustrates the phenomenological methodology employed in this study. The text is presented in the left column of Table 1 (see pp. 28–29) while the formulated meaning units derived from the text appear in its right column. In Table 2 (p. 30), the meaning units are presented in the left column and the sub themes are shown in the table's left column. Table 3 (see p. 31) presents sub themes in the left column and the development of overarching themes in the right column. Analysis of the entire interview protocols presented the same set of themes. Considered together, they provide thematic structures and are representative of the essence of what it is like to provide care during wartime. These then functioned as units as a first step towards a reconstructive understanding of the MMHC experience.

Table 1. Representative Example of Significant Statements to Formulated Meaning Units

Representative Significant Statements	Formulated Meaning Units
<p>Having been in the military, these service members are close to my heart. I have a purpose. There's nothing more meaningful that I've ever done in my life.</p>	<p>Purpose and meaning in healing co-combatants psychic pain</p>
<p>It's such and honor, such a privilege to just walk a few steps next to this person because their pain is so incredibly profound. It's just my heart; it's my calling; it's my passion; it's my entire life.</p>	<p>Profound sense of privilege and honor in alleviating psychic pain when working with ADSMs. A calling.</p>
<p>Providing care brought out an urgency that kindled in me...to act, and do something, and to make good on our job to heal these folks. That feeling of making good is a positive experience, and I think that's probably the driving force that has brought me to where I am today.</p>	<p>When providing care, an internal sense of urgency is a defining quality, and is a driving force in connecting and healing. Duty to ADSM.</p>
<p>Military clinicians are well-prepared to provide state-of-the-art assessment and treatment services war stress injury. We master these techniques. It's the old adage about success breed success.</p>	<p>Mastering EBTs as a way to keep ADSMs in field. Rapid focus. Well-prepared. Duty to mission.</p>
<p>We need to have the training necessary to square them away, though. I got plenty of supportive nods in the room, there was no commitment from the military to shift the policy to improve our training that could result in better care to our warriors. After 10 years after the war started, we have had no shift in this training policy. So even if you raise concern to Leadership, what's the point? Is anything going to change? Don't count on it.</p>	<p>Military policies hinder duty to care for the ADSM. Unsupported and disempowered via no training or ongoing training;</p>

Representative Significant Statements

Formulated Meaning Units

I want to do this work. I don't want to break rules, but I am put in a position to do so by military policies and procedures. So sometimes this work becomes a conflict internally because we are **supposed to be helping war injured people**. For me to **send them back to the front lines? I just wouldn't do that.**

Military policies creates conflict and dilemmas in care. Leads to integrity breach. Covert behaviors. Cognitive dissonance.

We are **only to diagnose and treat V-Codes** and adjustment disorders. **It's embarrassing.** They are not aligned with the real world at all. So, the real question for me is, **'How do I do the work without getting my throat slit?'** It was never about whether or not to do the work or get the treatment to the service member. **They will get care from me regardless of what I have to do...overt or covert.**

Military policies limit capacity to dx and treat

Dilemmas are created for MMHCs. Cognitive dissonance is created. Results in poor choices.

The general structure of the **military is anti-everything** that we are taught in assessment and therapy classes. Schools teach that when you conduct therapy, your therapy is to be non-judgmental; to be open, to listen... and **in the military, the first thing you're taught is to be judgmental and to order people to do things.** **You expect them to follow your orders.** Certainly, bossing around my own patient is uncomfortable. I don't like it. **I hate it. And I strongly wish that the Navy would not place me in these positions.**

Military policies leads to dual relationships, breaches in confidentiality. Powerless

But its not only the military that abandons our needs. The **civilian sector clinicians have no concept of what military clinicians are experiencing.** Things they say are stupid. They're inappropriate. These comments can be hurtful. Civilians don't understand the decisions that had to be made. They don't understand the context of deployment or the combat zone...and how the rules are different. So you add the uninformed civilian culture not knowing the military rules of engagement culture, and then you thrust the morals and ethics of a civilized society... **That's just chaotic.**

Military civilian divide

Poor awareness of cultures leads to mistrust

Military clinicians and ADSMs don't know who's the good guy and bad guy from day to day. At this point, I think that **our service members are not really treated. Clinicians and the service member are just not able to reconcile the difference between these two realities that existing these two completely different universes.**

Unrealized duty

Table 2. Representative Example of Formulated Meaning for Sub Theme Development

Meaning Units Reduction	Sub Themes
Purpose and meaning Profound sense of honor Privilege Honor A calling	<i>Subthemes</i> Honorable Vocation; Meaningful Service
Internal sense of urgency Driving force to healing Uncompromising Mastery Success Healer Commitment to healing Well-prepared	<i>Subtheme</i> Well-prepared; Mastery; Urgency to heal war stress injured;
Limited in dx and tx Unsupported and disempowered Limited supervision Line command tensions	<i>Subtheme</i> Powerlessness; loss of agency; ethical violations; Integrity breaches; Abandoned and betrayed by military Cognitive dissonance Poor choices/Integrity breach/falsifying
Civilian neglect of military culture; Mistrust and chaos due to civilian betrayed by military/civilian culture	<i>Subtheme</i> Loss of agency; isolation; alienation Betrayal by American culture Avoidance and betrayal; ever-widening gap; cynical view of U.S. civilian sector

Table 3. *Eidetic Reduction of Subthemes to Themes (Essence)*

Subthemes	Themes
Honorable Vocation; Meaningful Service Mastery; Urgency to heal	Duty
Well-prepared; Mastery; Uncompromising Urgency to heal war stress injured; Healer	Empower and control
Powerlessness; loss of agency; ethical violations; Clinician integrity breaches Abandoned and betrayed by Military structure/policies Loss of agency; isolation; alienation; betrayed by American culture	Disempower and dyscontrol

Eidetic Reduction: A Gestalt of Providing Care in Wartime

The purpose of eidetic reduction in Husserl's writings (2001) is to bracket any considerations concerning the contingent and accidental, and to concentrate on or (intuit) the essential natures or essences of the objects and acts of consciousness (p. 292). He explains that intuition of essences proceeds via “free variation in imagination” (p. 292). That is, we imagine variations on an object and ask, “What holds up amid such free variations of an original [...] as the invariant, the necessary, universal form, the essential form, without which something of that kind [...] would be altogether inconceivable?” (Husserl, 2001, pp. 292–294). This is to say that eidetic reduction is the process that shifts from fact to essence. Germane to this study, this reduction removes all contingent elements and extracts the essential elements that are invariant to participant descriptions.

Moustakas (1994) describe the process of phenomenological reduction, which includes horizontalizing, organizing invariant qualities and themes, and constructing textual description.

Moustakas defines horizontalization as the process of assigning equal value to each statement that represents a segment of meaning. The segments are clustered into themes. Segments and themes are then synthesized into a description of the texture (the what) of the phenomenon.

The textural description is examined from different perspectives (imaginative variation) and eventually arrives at a description of the structure (the how). A textual-structural description that emerges represents the meaning and essence of the experience (Moustakas, 1994). A textual-structural description was generated for each participant by repeating the above steps. The descriptions (Moustakas, 1994) were integrated into a universal description of group experience.

Applied to this study, this technique refines the essences of a complex phenomenon thereby reducing it to a coherent synthesis. In reviewing these results, data analysis and eidetic reduction led to the inclusion of positive and negative subthemes into an overarching system of duty as the superordinate theme. Duty was defined and best understood as containing subordinate themes of power and control. These polarities/contradictions were tightly woven together. For example, pieces of narrative could be interpreted as holding various themes at once; likewise, themes overlapped and complemented one another. However, parsing out the themes presented a way to interpret a potential Gestalt for MMHC experiences of providing care in these theatres of war.

While many MMHCs saw actual front-line duty, in terms of their experiences, the combat was fought along the invisible lines of an emerging polarity. Through this phenomenological examination and eidetic reduction, MMHC experiences were examined for overarching structures. These were later amenable to hermeneutic interpretation and reconstruction. That is, there is the possibility of deriving new, unforeseen meanings or questions

arising from the material, even when that content may at first seem to be contradictory, opaque, or unavailable to any kind reasonable or consensually agreed-upon interpretation.

Hermeneutic Approach to Interpretation

I used the hermeneutic approach (Gadamer, 2004) to make interpretations based on participant descriptions of their lived experiences. Hermeneutics involves the practice of reflective interpretation and understanding through historical and cultural traditions. Its purpose is not to uncover the truth of these traditions and interpretations; rather, it is to explore how these shape and determine one's way of living in the world (Stigliano, 1989). Specifically, prejudgments (an awareness of my own understandings before entering into dialogue with the material), fusion of horizons (changes of perspective or understanding that result from this engagement), and the hermeneutic circle (a way to reach new understanding of the whole through an iterative process focusing on details) influenced my interpretation formation.

Prejudgments. Gadamer (2004) claimed that methods could not be totally objective, separate from the author, nor could they be value-free. In fact, he argued what is often labeled as “bias” is actually inevitable and even necessary for our understandings. However, to obtain new understandings, the researcher must enter into dialogue with another or with a subject. Therefore, before engaging with a text,

The important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings. It is the tyranny of hidden prejudgments that makes us deaf to what speaks to us in tradition. (pp. 271–272)

To this end, I kept a journal noting my specific prejudgments and fore-meanings. In dialogues with participants and their texts, I became more aware of how my biases influenced what data I was receiving and discarding. I continually revised my fore- projections in my journal.

Fusion of horizons. For the purposes of this study, a horizon is the limit of a person's perspective in relation to the experience being investigated. This is not a real position but is rather created one's particular view of the topic of study. To expand this view, a person must change his or her position. The problem is that even if a person were able to reach maximum horizontal view, they still would be able to see only what is in their view. We both understand and are constrained by the limits of our horizon. To surpass the limits of our own perspective, others need to be involved.

By being open to the views of others, a person can get a slightly shifted perspective than she or he had before. Gadamer (2004) referred to this moment as the fusion of horizons; it is significant because it gives a person a slightly different vantage point from which to understand the world. In this way when others' understanding adds something important to the conversation, we allow ourselves to be influenced by the other and thereby gain a better understanding of what lies beyond our own horizon.

This understanding will constantly shift as each individual shares newly formed perspectives of the thing under study. Trust and relationship between the individuals allow for the larger, shared reality to exist, at least for the moment, that is, until further dialogue is needed to challenge some aspect of what has now moved into the realm of prejudice, fore-knowledge, or become part of a tradition itself.

On the other hand, a person with a rigidly circumscribed horizon, in Gadamer's thinking, does not see far enough and overvalues what is nearest at hand; to have a horizon means to be able to see beyond what is close at hand (Gadamer, 2004):

Questioning is an essential aspect of the interpretive process as it helps make new horizons and understandings possible: Understanding is always more than merely re-creating someone else's meaning. Questioning opens up possibilities of meaning, and thus what is meaningful passes into one's own thinking on the subject. To reach an

understanding in a dialogue is not merely a matter of putting oneself forward and successfully asserting one's own point of view, but being transformed into a communion in which we do not remain what we were. (p. 375)

Hermeneutic circle. Gadamer (2004) described the hermeneutic circle as a tacking between the detail and the whole unit. Kvale (1996) viewed the end of this spiraling hermeneutic circle as the point where one has reached a place of "sensible meaning, free of inner contradictions, for the moment" (p. 62).

Taylor (1976) says that:

Interpretation, in the sense relevant to hermeneutics is an attempt to make clear, to make sense of an object of study. This object must therefore be a text, or a text-analogue, which in some way is confused, incomplete, cloudy, seemingly contradictory—in one way or another, unclear. The interpretation aims to bring to light an underlying coherence or sense. (p. 153)

The hermeneutic interpretive process (Stigliano, 1989) challenges the invisible ontology in which we are embedded, our previous state of knowing. In this study, every effort was undertaken to make the invisible, visible. Through this process of questioning and examining the ordinary, identifying and redefining themes, and through the rejecting of plausible and relevant counter-interpretations, I began to rebuild an understanding. In hermeneutics, this process is referred to as "reconstruction" (see Stigliano, 1989). These reconstructions may first appear to be isolated acts or events, and it is often through the process of reconstructing understandings that seemingly isolated acts, experiences, or themes gain context and continuity. Reconstructions signify the final stages of a hermeneutic study by offering interpretations, insights and understandings.

Results

As described by participants in this study, providing clinical care as co-combatants to deployed service members and simultaneously providing for the success of the military mission as an officer seemed best characterized as a pattern that fluctuated between deeply felt positive and negative experiences. I therefore analyzed texts of narratives, labeling negative and positive experiences. I subsequently drew out material that represented consistent themes and subthemes. Using eidetic reduction (described below), I was to bring out essential and only those shared concepts expressed by all participants that appeared throughout their narratives.

An early emerging, overarching idea, and one inherent in military thinking, was the concept of duty. Further examination of themes, subthemes, and units of meaning led to an understanding of the experience of being in a fundamental polarity created by various aspects of the MMHCs' duties. From this, I was able to reconstruct the core experiences of MMHCs and to arrive at the narrative of a prototypical self experienced by the MMHC.

Questions of Duty

Because of the MMHCs' fundamental engagement is through providing duty, it was important to "drill down" to how the underlying meaning and values clustered around the concept of duty were involved with the MMHC experience. Clearly, all MMHCs felt embattled in a profound sense, beyond that of the average soldier.

The battle for the MMHC emerged as the source of a radically conflicted experience. The question came to light, "Duty to whom?" The struggles provoked by this question resulted in the actual war that can traumatize the MMHC. The below themes and subthemes concern the MMHC's experiences of duty.

When the act of fulfilling one's duty to both the military mission in general and to the service member were congruent, participants experienced professional and personal integrity. This type of experience illuminated a sense of personal power and control—the subordinate themes inextricably connected with duty. Consistent themes and subthemes concerning the concept of duty were developed from MMHC narratives.

Duty to Military Mission and ADSMs

Power and control.

Subtheme 1: Engaging in highly meaningful activity. For participants, meaningful experiences were had when they made significant contributions to the overall well-being of patients and their families. They saw the provision of care as a great responsibility, and that evoked strong feelings of devotion—"dedication," "doing God's work," and serving with "passion and privilege." Participants discussed this position as far surpassing being simply "a job." Serving as an MMHC involved a commitment to others whose lives and sacrifices transcended the norm. This in turn invoked deep feelings of honor for clinicians. They expressed a profound sense of meaningfulness, along with a poignant feelings of humility; these emotions led to growing levels of commitment despite the enormous vocational challenges involved and frequently extremely harsh working conditions:

First of all, it is a very humbling experience. I mean the bottom line is that you are sitting in the presence of war heroes. Just a sense of honor that goes with being in the process with, umm, somebody who's been willing to put his or her life on the line. I do have a strong sense of passion and duty and conviction with this work. 1

It's such an honor, such a privilege to just walk a few steps next to this person because their pain is so incredibly profound. It's just my heart; it's my calling; it's my passion; it's my entire life. 5

Having been in the military, these service members are close to my heart. As for working with our service member active-duty personnel, there's nothing more meaningful that I've ever done in my life. 7

Temporal pressures served to amplify the striving for the highest levels of excellence. Participants said they believed in, and relied upon mastering evidence based, empirical interventions as a way to address trauma in urgent, “now-or-never” scenarios. This gave an Existential quality to the meaning they derived from their work. Some participants accentuated, if unconsciously, this sense of urgency by speaking rapidly, in loud voices, or through speech dysfluencies.

Providing care brought out an urgency that kindled in me...to act, and do something, and to make good on our job to heal these folks. That feeling of making good is a positive experience, and I think that’s probably the driving force that has brought me to where I am today. 5

My God, it’s like when you think of those situations you go in and help. There’s no shortage of help that is needed. You got to find the help for these folks whatever it takes, and you must be on your game. There is no slouching back or relaxing in these situations. You must be on your game. And you encourage your fellow clinicians, and providers, and team members to take up that cause. When this happens, the feeling is overpoweringly good. 5

Additionally, feelings about giving treatment to comrades-in-arms led to a particular closeness with soldier-patients. Shared experiences of actual battles they had participated in suggested a “being-together” (and again, a profound connectedness) that subsequently improved the clinician’s perceived ability to treat soldiers. Shared meanings brought greater mutual understandings; increased mutuality was then seen as both protective and conducive to therapeutic change.

Subtheme 2: Being culturally in-line and using evidence-based care. Participants reported being supported by the military in using evidence-based therapies in order to return the ADSM to duty. Military support in turn was perceived as promoting a meaningful connection with the care provided. DoD/VA interventions were seen as offering a strong foundation from which MMHCs could apply techniques. Note, for example, the use of “we” in the following passage. This was a rare instance of a clinician seeing his own moral practices as being in line

with standard psychological practices, with military administration, and simultaneously with patients. It was also back-grounded in a contextual safety (see, for e.g., Stern, 2003):

Brevity, Immediacy, Expectancy, Proximity, Simplicity (BICEPS) is what many of us were practicing and referred to as forward psychiatry. This is an expanded form from lessons we learned from forward psychiatry in WWI. This name describes the process by which military clinicians can offer state-of-the art assessment and treatment to ADSM experiencing war stress injury. We treat injury as soon as possible...within the combat zone...so we could treat them to recovery. The controversy is...actually, the frustrating part of this whole thing is...many believe that this is not safe to do. Providing trauma-focused therapy in the site of the initial trauma...kind of like a re-trauma, site of the injury would make them freak out, and they would go and kill themselves and things like that. And this is not the case. This is very safe treatment. 7

Meaningful experience was related to the use of EBTs, forward psychiatry doctrines, and psychiatric medications. MMHCs expressed confidence in mastering these approaches, so that techniques could be deployed rapidly.

It is noteworthy that participants expressed disagreement about the best approach to use; however, the central issue was the ability to have available rapidly deployed techniques that proved to be effective and efficient in keeping the ADSM in theatre.

It's our moral and it's our ethical obligation...our moral responsibility to urgently alleviate our patients' suffering and to offer the best care possible. So, would you rather have a service member return downfield with antipsychotics and antidepressants on board, or return downfield after being successfully treated with EBTs? So when healthcare providers willingly choose not to use EBTs that are the gold standard that clearly contribute to improved functioning or reduced suffering, I...just...I...really.... It just really...bugs me. And in the military, patients, of course.... This really bugs me...*I was there with them. So, I guess it's kind of personal.* [Italics my own.] 7

The message out to service members is to be able to say, "Look, PTSD is a treatable condition. We are not back in Vietnam days anymore; we know how to treat this; we know effective treatments." We bring it to the point that we are able to deploy service members with psychotropic medications because *there is really good combat care in the field that can follow up.* [Emphasis is my own.] 5

According to MMHCs in this study, for the novice, or worse yet, for one who might not use EBTs, there remained the possibility of being completely overwhelmed when attempting to

deploy a manualized treatment to service members undergoing trauma. The threat of failure loomed large especially given the ever-present background of war.

It's very heavy material and if you don't see success with it, it can be easy to turn your internal dialogue against yourself. "I'm a failure; I'm not a good clinician; I don't belong here" or whatever it is. Practice one of the exposure therapies with some of the cases that are less complex so that you can build up some momentum and enjoy the success that you will see. It's the old adage about success breeding success. 1

The use and mastery of EBTs were linked with safety, speedy results, and increased clinician self-esteem. Reflection on these reported experiences suggests that using EBTs, and the feelings of using state-of-the-art techniques, helped to protect clinicians from some of the "fallout" reported in the preceding section. Such safety, in turn, instilled meaning into their daily activities.

Subtheme 3: Empowered through military structure. Participants described ways the military structure at least situationally reinforced feelings of omnipotence and power over the ADSM. Reflecting on military rank, clinicians discussed utilizing this structure in order to demand compliance by ADSM patients, assuring participation in both assessment and treatment. In other words, from their own perspective MMHCs were able to use military hierarchical, in order to help or protect ADSMs:

In the military setting, I have him as my captured audience. The military setting prevents for any other type of distracting deterrent, so I can feel that much more empowered. But if I was in the civilian sector, and he was contesting what I was doing, then I won't be nearly as successful. Again, in the military, it's prison life. I have a captive audience, and it lends for easier work. So grandiose as I like to make myself feel, I also am very acutely aware that I've been in a very unique environment that blends for my grandiosity of my work. Meaning, I am only as good as I am in a military setting. And I know that. 3

On occasion, paradoxical roles, being ensconced between two traditions psychology and military—were seen as being highly beneficial.

I get a caller that asks, "Is he fit for full duty?" I am like, "No. He is actually going crazy, and he is probably going to hurt himself or someone else. You should pull him off ship."

And this ADSM is saying, “No way. I want to stay on the ship.” I say, “No, you are not fit for duty.” So, when I get to determine how he operates in his work setting, that’s unique to maybe the military psychology field. No other psychologist in any other setting would have the power to dictate what their patients will do. *This is truly an oxymoronic, paradoxical decision-making process.* But I like it. It works for me. [Italics added.] 3

MMHCs revealed strategies in attempts to make peace with the tensions inherent in the dilemma between allegiances to the military mission versus standards of professional ethics.

As the psychologist in the Army, you are only doing what a psychologist does. As the psychologist in a Navy, you’re a psychologist and then you have five other jobs as well. That creates stress for sure. That is why I am Lieutenant first, not Doctor first. Like my meaning of doctor is irrelevant to the military. In fact, the military sets up the situations for me that was ethically very tricky. 4

We clinicians default to the position, “Well, if I can’t change the Navy, I can at least try and be helpful within my own sphere...within my own neck of the woods—mainly what happens in my office.” Maybe that’s the best way I can be helpful. You know, in some ways they’re right. But, there are those of us who absolutely wish that the handcuffs would come off. 1

It’s just hard because I want to do this work. I don’t want to break rules. But I am put in a position to do so by military policies and procedures. So sometimes this work becomes a conflict internally because we are supposed to be helping war injured people. For me to send them back to the front lines, I just wouldn’t do that. 2

Power may on the surface support the MMHC in realizing the goal of helping soldiers who are suffering from war stress. Economics, however, presented further limitations. One participant felt that the inability to perform appropriately as a clinician was dictated against by the lack of backing for mental health in the military establishment.

So is serving worth it? No, it’s not worth it. I want to go back to the States. But in the meantime that I am here, I am going to max it out as much as possible. No, it’s hard. It is hard. And maybe medicine and mental health can do better. And they can’t because of the lack of resources, and I get it. It’s just the nature of our work right now at this time. [Italics added.] 3

Subtheme 4: Shared connection feeling with ADSM and family. Given their powerful reactions to working with the families of ADSMs, it makes sense that MMHCs would stress relationships with service members themselves as being essential to their own experiences, both

positive and negative. Despite the pain of much of the traumatic material presented to them in session, participants felt a strong sharing, a special, deep-seated connection with service members in their treatment. Each participant discussed using mutuality (Stern, 2010) as a way to enhance recovery for the AD/SM patient. Though not labeled as such, co-creation in session was seen as allowing a spontaneity and natural unfolding in the therapeutic process. Compassion itself was joined in participant experience with interpretations of greater meaning. It was suggested that therapy at its best could involve relationship, dialogue (being “really in the moment with them”), and facilitating processing rather than intervention or problem-solving.

I feel with them when they tell their stories. In a way, a special connection, we can contain the trauma, together. Together. You know, the emotions and feelings aren't as scary as they thought. So, someone is kind of talking with you. Then giving it back to them in what they're saying or what they're feeling. It's not so scary for them. It's kind of like one of those natural process things they need to go through. 2

I go through the same emotion as them. I feel sadness for them; I feel my own frustration with the system that I see someone that needs to be seen immediately for some type of medication intervention perhaps; I get frustrated about the system that I can't get this person in immediately for a same day emergency appointment. *The most important thing that we can give them is our relationship with them.* [Emphasis mine.] 6

I was just feeling their experience with them. And I think service members pick up on that, you know, when you're really in the moment with them. There's not much you need to do when you're there...in it...with them. I think compassion gets conveyed. I think it's just a willingness to just sit there...and a willingness to feel some measure of what they're feeling...feeling regret without interrupting it, or stopping their experience, or asking a thinking question.... And without jumping in prematurely to kind of rescue that person out of that type of feeling. *So, I think providing care is mostly what you don't do.* [Emphasis added.] 2

Bifurcated Duty: The Psychological Expense to AD/SM and MMHC

Disempowered and lack of control.

Subtheme 5: Dispensability: Inadequate military support. Interestingly, participants described contradictions in how the military generally views MMHC contributions to success of the military mission as undervalued, invisible, and at the same time dispensable. Participants

experienced meaninglessness when they were denied training and supervision, when prevented from access to appropriate resources to do their work, and when performing multiple administrative jobs due to reduced staffing. Inadequate working conditions were directly linked to blocks in communication and a sense that, being ignored (see also the Alienation and isolation section below) was the precursor to endless conditions of silence and discontent, a type of doldrums created by the military's atmosphere of discipline and neglect.

We need to have the training necessary to square them away, and though I got plenty of supportive nods in the room, there was no commitment to shift the policy to improve our training that could result in better care to our warriors. And for years later, that would be 10 years after the war started, we have no shift in the training policy. So even if you do raise concern to leadership, what's the point? Is anything going to change? 1

The overall message I got was, "Be quiet." If you're allowed a voice, it doesn't matter in the end. It's going to be business as usual. But to be fair, I guess to show they're sensitive, we all met. We had a focus group. We were able to iron out some concerns...blah, blah, blah. But will it lead to effectual change? Don't count on it. 1

But the thing is, we don't have a link to higher-level headquarters to make complaints. Unless we were to go the Inspector General route, file a complaint there by Congressional leaders and that sort of thing, but there's very likely to be pushback. And whenever you embarrass someone...you will be paying a significant price. Maybe they can't find a way to fire you, but suddenly, you can have limited funding coming your way...in one way or the other. You don't get the training you need. So frankly, from start to finish, it's a crying shame. 1

The continuation of the status quo disaffected participants by eroding their perception of having their own observations heard. Therefore, a sense of meaninglessness extended into participant experiences of self-doubt, hopelessness, and being overburdened in the provision of basic care and duty.

Though interviews generally began with the MMHC expressing deeply ingrained feelings of joy, passion, and meaning, these interviews moved to expressions of impending clinical failure, in part, due to the hideousness of war and the complexity of care. MMHCs reported both vicarious trauma and a sense of losing one's own identity associated with being unable to care properly for patients.

I was like, “Wow, they’re really in a lot of distress.” These families are trying to deal with a lot of distress. Mom was just crying; Dad is deployed and just not around. Initially, that was the impact on me. It was like, “Oh, I don’t know if I can handle this. I don’t know if I am going to be able to make a difference.” So, I think it was about doubt...what I was experiencing. 2

One of the burdens I always held was when a troop member didn’t show. I begin to think, “Oh, my god. Did they self-destruct? Where is he/she?” I mean, it just always goes through your mind when you have a no-show. 5

I’m angry and frustrated. I feel like crying. I feel like lying in a bed and just crying. At times, my life is in shambles. I miss my family, my identity as a person. I don’t even know who I am anymore. 6

Subtheme 6: Helplessness to repair. When clinicians were unable to fulfill their roles, they found themselves in an ironic position of either witnessing or bringing the bad news home to children and spouses themselves. This they presented as a near-constant for the families of the psychically or physically wounded.

And, that case, umm, initially I was picking up on my own helplessness. I was like, “Oh, this case is really intense. I don’t know if I am going to be able to do anything with it. I don’t know the impact I could make.” 2

The family members experience many challenges in knowing what to do and how to reconnect with their returning loved one. *These families get hurt too.* They are anticipating excitement, “Oh wow, I can’t wait for them to get home, and everything is going to be back to normal. They can take their uniform off, and they’ll be back to the same person.” Well, it’s certainly not the case. Whatever was broken before they left for service, it’s going to be even more serious when they come home. So, a lot of the family members go through a grieving process because the person that they thought was coming home is no longer there. [Emphasis added.] 6

Subtheme 7: The hideousness of war. In cases of trauma, war was seen mostly as something that altered the character of a service member for the worse. From a psychological perspective, such changes were sometimes seen as lying beyond the powers of clinicians to address:

They are drinking all that alcohol, and they go out to party with the guys. I’m telling you, it is like, “who is this person?” “This isn’t my son; this isn’t my daughter. *I don’t know who this man is.* This isn’t my boyfriend or my girlfriend.” And other family members

are concerned, “Is this man still going to be kind to me? Is he coming home and going to hurt me?” *We need to know that providing care to the ADSM is so much more than just working with the ADSM.* [Emphasis added.] 7

I was probably seeing maybe 10 new patients, new patients per week, let alone the ones that we had started treatment with. It was quite overwhelming. Seeing these service members straight off the battlefield in rapid fashion, it was quite overwhelming. 5

MMHCs reported being enraged, overwhelmed, and traumatized by the human destruction of battle. Participants used metaphors invoking explosions, expressing feeling “blasted” and “blown away” as they witnessed—vicariously or directly—what they called the “jaw dropping” brutalities and atrocities. Explosions are seen as events that are not simply operationalized but are an assembly of forces lasting far longer in time than the actual detonation of an explosive device. The transgressions of bombs elicited strong feelings of shock, rage, numbing, and horror:

His story left my mouth dropped wide open. I provided care to a service member...another young man...an army soldier. He described being in a blast injury. I recall very vividly in seeing what he described to me. When he turned to his left, his friend was gone. But there was this gigantic mist of red, and he realized that what had happened is that his friend, basically, [he] was blown up to a point that there was actually nothing left of him but red blood. His blood scattered...everywhere. 5

I remember as he was describing himself in sort of a numb way, because this was a fellow who had severe PTSD with significant numbing. I was like...imagine for this fellow...and myself just horrified...nauseated by hearing that.... Like wow...unbelievable. I can't imagine what that might have been like. His story was so far beyond anything that I heard or experienced. I was like, “my god, these folks are exposed to so many different kinds of traumas—that they come back not psychotic is amazing to me.” 6

I remember listening to many of the warrior stories. It was like my jaw was just dropping. I can't believe the things that they did, sometimes to their fellow troops, sometimes to innocent civilians. So, a lot of these guys are experiencing rupturing from the inside. And so, initially, some of the stories were just mind-blowing. *After a while, you get used to it actually.* [Emphasis added.] 4

I don't know how gross you want to get, but I treated...you know.... Well, one of the tools of the terrorists is to be a suicide bomber. You know, strap a bomb to yourself, and you know. And so, I treated people that had human tissue inside their own tissue that was

not their own, body parts landing in ADSM's stomachs or other areas. *It's the disgusting things like that that you have to control your own anger...or else you would end up wanting to just kill every Taliban you've ever heard of.* [Italics added.] 4

Subtheme 8: Military directive: Maintain the inability to diagnose and treat. If

anything, war is about power. Contradictions emerge in military social structures when those attempting to carry out one side's power are themselves rendered powerless by that same side. Participants therefore called out inadequate policies limiting the identification and diagnosis of war stress injuries. As above, they expressed frustration at finding themselves helpless to affect policy.

Participants revealed frustration and feeling powerless to change restrictive military policies and practices that curtailed the ability to diagnose, assess, or offer treatment. They criticized inadequate policies limiting the identification and diagnosis of war stress injuries. Because of strong feelings of resentment of a frequently anonymous military power structure, along with great personal commitment to their patients, clinicians found themselves in a double bind.

Antiquated peacetime policies must be amended to meet the needs of our current clientele. For example, at the Support Center, there is an ancient policy, maybe 30 years old, that we are to only treat V codes and adjustment disorders. They are not aligned with the real world at all. It's embarrassing. Nobody can find the original policy, and our headquarters essentially just restated the policy as if it had already been in place. Headquarters reaffirmed the position that we are relegated to only diagnose and treat V codes and Adjustment Disorders. 1

So, the VA, for example, cannot determine fitness-for-duty in DoD, and DoD can't tell a Veteran what their disability level is either. So it's kind of frustrating. But for me, the real question is, "*How can I do the work without getting my throat slit?*" It was never about whether or not to do the work or get the treatment to the service member. *They will get care regardless of what I have to do...overt or covert.* [Emphasis added.] 5

Participants therefore stressed profound responsibility and strong loyalty to fellow soldiers. They described feeling trapped. This led to a sense of what I would call *being morally*

endangered by a confusing and often faceless military power structure (“...without getting my throat slit”; on the concept of “moral pain” see Marin, 1981). In order to provide the right treatment, the overarching military power structure occasionally forced clinicians to separate actual practice from ostensible activity.

Subtheme 9: Strained relationship with line command harmful to ADSM and MMHC.

Participants also felt unsupported by military higher-ups and policies when fit-for-duty assessments were overruled by superiors or the omnipresent but more amorphous “Command.”

For instance, you are the only mental health provider on the ship. So, you are God as far as mental health is concerned. Except, several people on the ship who have influence over their sailors now outrank you. So they may attempt to influence your thinking. They tell you, “No, we’re not going to do what you want. So, figure it out, and keep his ass on the ship.” 3

In this way, for MMHCs’ contracting experiences could rapidly alternate from feeling ultimately empowered or omnipotent (“like a God”) to being obliged into a state of helplessness. It should be noted that throughout all of these interviews, these feelings were consistently aligned with moral understandings about how to offer care and do what was the best in their roles as therapeutic clinicians.

The sense of helplessness was sometimes experienced as chronic. One participant felt useless and underutilized, due to organizational directives. This brought fears that hard earned psychological skills could ultimately be lost, resulting in a sense of personal displacement.

Parts for me get very frustrating. I feel like I’m not being utilized to my full potential. I feel like sometimes I feel like I’m losing skills because of not being able to use them. I feel like there are so many people out there that we could be helping, but yet, we’re not (nervous laughter). It feels like I’m in the wrong place. You know, I think that there are other jobs in the military or in the VA system that are more on the frontlines of things. Sometimes, it feels like I am in the wrong place. (nervous laughter) 2

Subtheme 10: Violating ethical codes of conduct harming to ADSM and MMH. Other restrictive military practices put the MMHC in direct contradiction to ethical codes of conduct of

the psychological profession (APA, 2003). As noted in this subtheme, participants reported feelings of frustration, powerlessness, and despair when forced to violate professional codes of conduct, including engaging in multiple relationships, breaching patient confidentiality, and denying informed consent. Caught between demands of dueling codes and antithetical values, the clinicians were forced to alternate between allegiance to military obedience or psychological trust.

The general structure of the military is anti-everything that we're taught in assessment and therapy class. Schools teach that when you conduct therapy, your therapy is to be non-judgmental; to be open; to listen. [Emphasis added.] 4

And in the military, the first thing you're taught is to be judgmental and to order people to do things. And you expect them to follow it. Just right off the bat, our role goes against to what they're taught everywhere else. 4

Well, let me tell you one thing about the Navy that nobody talks about, and I do want to bring this, a major point. This is not a story. It has to do with ethics. Maybe psychology is aware of this issue, but the rest of the population is absolutely oblivious to it. In theory the *APA Code of Conduct*, and especially the part addressing ethics. Blah, blah, blah. Fuck that shit. You have no idea. *Multiple relationships*. Your neighbor is your Corpsman, and then you have to dine with them. And then they work under you. That's a daily functioning. What a pain in the ass that is. 3

Conflicts between military practice and psychological standards appeared to be standard practice. Another participant spoke of what could be called an impossible status of subjectivity. Personal relationships for the MMHC can, at times, be untenable with a sense of professional, psychological duty:

When you have one postal office guy, and then he is your patient? Or when you have your friend's husband be your patient? And then your patient tells you about how much his wife (your best friend) is cheating. And then that relationship is terminated? How do we re-negotiate those relationships? That's a bitch. That's like, all that stuff, like, ooh, and of course everything is huge and doesn't lend itself to rational sound decision-making model. No. All shit. It's hard. 3

Being a clinician is not simple. I think some of the challenges have to do with getting the diagnosis right. On the tails of that I ask, "How do I characterize my assessment in the chart? What is the best way to give feedback to the service member, the soldier, or

airmen, or a marine? What do I say to Command?" Let's face facts, it's not like there is a lot of confidentiality with Command. Your Command owns you. 5

There is a lack of trust. Here I am a Corpsman. I work in the medical field, and people in my chain of command can read my medical records and mental health records and know my personal business. So they don't want to go down there either, but together we need to be a safe haven for those folks. 1

Multiple roles contributed to a fundamental, subjective sense of conflict:

As the psychologist in the Army, you are only doing what a psychologist does. As the psychologist in a Navy, you're a psychologist and then you have five other jobs as well. That creates stress for sure. That is why I am Lieutenant first, not Doctor first. Like my meaning of doctor is irrelevant to the military. In fact, the military sets up the situations for me that was ethically very tricky. For instance, the person who reported directly to me for an unauthorized absence, AWOL is probably the term you are familiar with, by happenstance was my own patient. I had to basically watch and be responsible for my patient in a non-therapy role. I was standing watch over my own patient I guess you could say. That is not a psychologist's responsibility. Like nothing in my Ph.D. training trained me to do that. That duty to guard a service member is completely military. That is why I am Lieutenant first, and not Doctor. Like my meaning of "doctor" is irrelevant to that. In fact, the military set up the situation for me that was ethically very tricky, because the person who reported directly to me as an unauthorized absence by happenstance was my own patient. 4

And certainly bossing around my own patient is uncomfortable. I don't like it. I hate it. And I strongly wish that the Navy would not place me in these positions. 4

Feelings of being put in unworkable conditions regarding ethical patient care resulted in expressions of anger and "hating it" (such situations). These resulted in implicit doubts about one's own self (one's personal status as a doctor or corpsman, versus, for example, being a lieutenant or a guard). Experiences here were indicative of an essential division between the openness basic to psychotherapy, and the policing activities of military life. In a field that relies on working for trust and truth, this brought consistently high levels of frustration to clinicians. It can be asked if these conflicts pose basic, ontological questions. How can proper psychotherapeutic practice be possible in a military setting?

These narratives suggested that being long-term in a space of moral ambiguity eroded clinician's own identities. Within the strict and often contradictory military hierarchy, MMHCs

at times felt they could neither furnish a sense of affective safety to their patients, nor could they find clarity about the ethical way to proceed. This in turn leached into their perceptions of safety.

Subtheme 11: Pre-existing conditions of new recruits entering deployment. In addition to attributing difficulty in treatment to various other conditions, clinicians also pointed to the pre-enlistment histories and characteristics they perceived in recruits. Treating a population already at-risk that was repeatedly exposed to and participated in the atrocities of war emerged in themes of alienation and vicarious trauma on both the clinical and patient sides. Below are examples of clinician discussions of the personal histories of recruits. Vulnerabilities were seen as generated not just in battle theatres but also in socio-economics who in America goes to war. These realities took MMHCs by surprise:

Almost every Marine that I've ever met that is enlisted, the last thing that they did before the Marines—joining Marine Corps is usually not positive. "I had to join the Marines to avoid going to jail," or "I just graduated from my school. My dad threw me out of the house so I joined the Marine Corps." "I was selling drugs. I didn't want to do that," or "I was locked up for that so I joined the Marine Corps." It's challenging to work with these service members. 5

So if that is your background, your childhood is not usually very positive either. And so it's not just Marines, it's sailors, too, that male or female, this is gender neutral, that a lot of their backgrounds suck and that really they are not good people. I would say at least among the patients that we get, physical or sexual abuse in the past, emotional abuse of some kind in the present can be so very frustrating to deal with. 1

OIF, OEF but what a surprise to me and what has not prepared me today is active duty service members talking about being child sex offenders, holy shit. Did I take a shit on that one. Not just once, two, and now three and now four times have I been exposed to that and being absolutely ill-prepared for that. I had a lot, a good handful of maybe five or six ADSM telling me they were child rapists at age 11 and 12. They molested younger children when they themselves were age 11 and 12. It's annoying, after a while it's really annoying. 3

Most people can handle it. But those that can't, come to us. Some of them just don't come to us, and they just kill themselves. [Emphasis added.] 4

I'm really not making much of a connection with these ADSM, and that's what gets me more frustrated and angry. This is a different kind of helplessness...the kind where you

just want to shake them sometimes. I have had that type of feeling before, but it's a different type of helplessness. 2

One participant was able to reflect on precisely how this permeated his own subjectivity and emerging concerns about his personal life:

So I think the bottom line for me is how does working with child rapists now that they are adults affect me when I go home to my children? I have a seven-month-old another three-year-old. And I have to keep that healthy boundary and maintain that level of innocence, and that is very challenging. Usually, I am very good about leaving things at work, but definitely, holy cow, there are flashbacks in my memory about that. 3

Another participant discussed the contagion of trauma not just for the soldier but for himself, due to the level of atrocity reported:

I was having some serious countertransference. And for me I had...to get over all the crap that was in the guy's eye. You know, I had to...I actually stared at his eye for my own exposure...just, you know, you need to get used to this. He had lost an eye. He literally gave his right eye for his country and that was an IED blast again. He had a fear of blindness that preceded his joining the Marines. Now, he is [*sic*] this one eye. So, his chances of blindness, I guess you could say, have gone up. 4

Clinicians further expressed feelings of being burdened and alienated as they provided care to a highly volatile population of ADSMs engaging in homicide, criminal misconduct, sexual assault, and suicide.

I've treated actually several females who've been raped since they've been in the service usually by other service members. I've treated actually as much PTSD for rape as I have for combat. It's one of the reasons that women join the military: "I was raped. I'm now going to join a defense organization [so] that if you try it again, I can learn to kill you." Sadly, rape happens within the service as well. There are males too that have been raped. So, you deal with that as well, so I've definitely treated that more than once, you know a few times. This is so frustrating and sad, and it takes its toll on providers. 4

The Marines, they're constantly on battle stations and ready to go to war in less than three days. And the thing is we've been at war for 10 years. So you can imagine that you are ready to be at battle stations every day for 10 years. There is not a human being that can do that. It seems to be more that the general fact that we've been at war for so long has put stress up and down every branch that it doesn't matter how many times you've been there, you're feeling stressed from the fact that other people have been there. Whether you've been there or not doesn't really matter. The possibility exists that you're probably going to go. 4

So, if you're more likely to kill yourself, because we've been at war for 10 years, you're certainly more likely to abuse your spouse, abuse your children, and engage in criminal activity. But the big thing is also just to be alienated...that feeling of being alienated. 2

Outcome for the MMHC

Fragmented—Cynical Social Hegemony—Resigned—Dissolution.

Subtheme 12: Neglect, abandon, betrayal by U.S. Military and American society.

Participants believed the military structure and American culture greatly contributed to compassion fatigue and burnout in the clinician. Despite feeling a strong commitment to the vocation, working conditions, military instructions, and relocation brought about a theme of isolation and impaired relationships for MMHCs. MMHCs both treated and reported suffering strong feelings of isolation:

One thing that concerns me within the U.S. Navy is that in a theoretical way, the Navy promotes psychology and promotes mental health. In an actual way, I think that the Navy damages both. They don't do this on purpose, but through certain actions. There are certain Navy instructions and DoD instructions that make staying in the Navy and the military as a psychologist very challenging. They make it difficult to make stay in the military as mental health clinicians. It's a sad problem considering that the military, the Navy in particular, wants to double the amount of psychologists over the next few years. They have trouble keeping the ones they have. 1

Bottom line is that we work together. We train together, exercise together, and eat together. We certainly spend tons of time with each other. So, to be uprooted and forced to another location can feel like betrayal. This Individual Augmentee Assignment (IA) [a temporary duty assignment to fill shortages of personnel that usually have a specialized skill set] can feel like, "Whoa, where is my chain of command? Who's got my back?" And that's a big question mark. Betrayed by the chain of command; feels like a "second-class citizen" at that point. And at that point the chain of command really doesn't know what to do with you. They say, "Hey, go do your job." But, we haven't been in the mix with those people. Of course, we have a unit that supports a deployment somewhere. There's a regional attachment. There's the family systems attachment back to the unit's home. But the IA is not part of any of that. So we're a foreigner in a foreign land, in a foreign unit, and so forth. 1

Results presented below involve the ways participants separated military culture from civilian culture. Participants saw military culture as being set-off from mainstream society, particularly through a different way of understanding in which language and cultural

involvement are essential to basic trust. Later narratives delineated how this separation, and a civilian denial of America's national connection to its military culture, America as a highly Military culture, has led to immense difficulties in treating soldiers with war stress injuries.

MMHCs expressed dismay at the ignorance among civilians of military culture in general. They emphasized the importance of understanding the effects of military nomenclature and other language for anyone who provides services to members of the Armed Forces. Each participant stressed the necessity to immerse oneself in military values when contemplating providing care.

I am very careful about the words I use. In my writing, I do not use the words like *victim*, *broken*, *damaged*. You will never see me say, mental illness. I don't like any of those words. The words that we use are extremely very, very important. 6

We are being tested by service members and Vets all the time. Do you think I just sit at my office all day and wait for my phone to ring? No. I get calls from other service members. I'm very involved with different groups. I've done the traveling wall...that's the traveling Vietnam Wall. I've done the Rolling Thunder [a charity active in raising awareness of the plight of POWs and those missing in action]. So I mean what I'm saying. I always say you need to immerse yourself in this military culture. 6

In a set-off culture, practicing psychology in the military required different values.

Interestingly, some of these values were seen as highly individualistic:

Our country has different values and different ideas and expectations. This includes different ways of knowing things such as a sense of identity and grasping the ideas and concepts about mental health stigma. So in the military culture the military is unique culturally within, we prize strength, elitism, superiority, resilience, and self-sufficiency, beliefs that you solve your own problem, take care of things by yourself Contrast this way of understanding with that in the civilian mental health field. It's all about emotional vulnerability, signs and symptoms, illnesses, and disorders. It's kind of a touchy-feely, kind of soft, you know, ask for help. 7

Positive aspects of being in the military were also at-risk of being overlooked in the light of high rates of soldier suicide:

There are deployments that do not have a high level of combat but have high rates of suicide. Combat in and of itself is not always detrimental. Combat for many service members can be a positive experience. And we've overlooked that. 7

Different values are also connected to unique bonds among warriors who fight together. Learn their language including honor, strength, being the best. I mean, those that do learn and use concepts within the warrior ethos language and culture... amazing. Those bonds are unlike anything you and I have ever experienced in our life. If you're not military, neither one of us will ever, in our wildest dreams, ever experience the intensity of those lives. 6

Behind some of the difference between civilian and military life is also the sense among soldiers that their direct comrades become their own families. Psychological intervention then becomes a threat to the subgroup of fellow fighters who are seen as extremely intimate and essential to one's survival:

So, let's say there is a group that is done with their tour in Iraq. And then they go to Germany to be medically evaluated and so forth. I had a Marine Warrant Officer who told me point blank, "You get to Germany. They give you the questionnaire about PTSD and everybody in the unit is marking *No, No, No, No, No.*" Remember, they have a choice. If they mark *Yes* on any of that stuff, they're going to be stuck in Germany for another two to four weeks being evaluated. So, you're either stuck there in Germany for more tests and maybe introduction to treatment of some kind, or you can go be with your family. And it's a no-brainer for them. So they don't want to be taken away from their family. They are going to hide their symptoms. They come back here and hide their symptoms. 1

More recent, and more successful interventions involved translating psychological thinking into terms that were relevant to military life and values. The importance of the clinician's role of interpreting training was also noted:

One thing I don't think gets talked about in this arena, you know, like we're [MMHCs] all trained to deal with the mental health problems. But the fact is that we don't really. We get training so confined and limited, to race, gender, sexual orientation, that we don't extrapolate or apply. Training is more of a fundamental, clinical skill set. I think having worked with the military for so long, extrapolation is a missing piece. Do you know what these newer programs are doing now, particularly like the Defender's Edge? We have an overwhelming favorable response we get from the service members. It is that "Finally, somebody's talking our language!" "They [military clinicians] understand what we're doing. We are not made to feel like we're defective." Others within our profession are so ineffective at connecting with our patients in this way especially with service members. 7

Instead of talking out clinical problems, we adapted mental health problems into operational terms. For instance, instead of talking about stress management problems, we

reframe into sleep hygiene, countermeasures, and tactical plans. We would then embed all of these psychological principles into their mission duties. They didn't even realize they were, in essence, learning mental health concepts as they were going through this programming. 7

We (MMHCs) stop saying, "Well, come over to the mental health joint, and we'll fix you to not feel depressed." What we say to them instead is "come over to figure out survival training strategies." And we embed mental health concepts with induction into training and events about survival training and all that kind of stuff. *So they didn't even know that they went through psychological help and intervention.* [Emphasis added.] 7

The Importance of the Language of Militarization

Participants maintained that it is essential for civilian therapists interested in providing care to this population that they receive culturally competent training. Using the *APA Ethical Standards* (2003), civilian clinicians will be better equipped to develop cultural competency and be better prepared to cope. Ongoing efforts must be undertaken to maintain skills. Participants saw this as historically rooted.

Civilian therapists have to be careful about how they reframe things so that civilian therapists don't think that the service members are "damaged goods," you know, like our Viet Nam folks. 6

In describing the importance of understanding the military culture, language, and the struggles ADSMs and their family's experience, one participant related a story in which the ADSM sought services from a civilian therapist who was unversed in military culture or EBTs. The patient wanted relief from rage and anger brought on when a fellow service member was killed right beside him in combat. This participant recounted her exchange with this soldier.

ADSM: Yeah, I went and saw a civilian therapist.

Participant: Really, what was that like?

ADSM: It was a nightmare.

Participant: What happened?

ADSM: Well, I went in her office, and I was telling her my story.

(As the participant related this story in our interview, she expressed how vitally important it is for ADSMs to tell their own story.)

ADSM: I was giving her some stuff. She started crying, and she ran out of the room. She left me there.

The participant discussed the ADSM's feelings of abandonment, neglect, and rejection.

The participant concluded in our interview that "You leave no man behind. That's a vow...like a cardinal vow within the military." Well, of course, that meant that she abandoned him. He got so angry and was so full of rage. This participant concluded:

So what happened? He came home to his best friend on the planet, his dog. That's right, he could talk to his dog, and he wouldn't have to explain himself. And the dog would be happy to see him. Well, that day when he returned home, he saw that his dog ate his only pack of cigarettes. And he was so enraged by the experience he had with that civilian therapist that one punch killed the dog.

Polarities I: Co-existing Oppositions in Psychological Understanding

Freud and polarities. Psychoanalysts, following Freud, believe that polarities form the very foundation of the unconscious, which is animated by opposing forces. Consider, for instance, the fundamental Freudian concept of the "splitting of the ego" (Freud, 1938). Splitting is considered a very common ego defense mechanism. It can be defined as a division or polarization of beliefs, actions, objects, or of relations or representations of other persons, into good or bad with no middle ground, through focusing selectively on their positive or negative attributes (Carsen, 1979).

Jung and polarities. Jung presented a different view on polarities that were found in his autobiographical book, *Dreams, Memories, and Reflections*. Jung and Jaffe (1962) discussed experiences with polarities, contradictions, and paradox. Jung wrote:

In any case, we stand in need of a reorientation, a *metanoia* [a struggle that leads to fundamental psychic transformation]. Touching evil brings with it the grave peril of

succumbing to it. We must, therefore, no longer succumb to anything at all, even the good. A so-called good, to which we succumb, loses its ethical character. Not that there is anything bad in it on that score, but to have succumbed to it may breed trouble. Every form of addiction is bad, no matter whether the narcotic be alcohol, morphine, or idealism. We must be aware of thinking of good and evil as absolute opposites. The criterion of ethical action can no longer consist in the simple view that good has the force of a categorical imperative, while the so-called evil can be resolutely shunned. Recognition of the reality of evil necessarily relativizes the good, and the evil likewise, converting both into halves of a paradoxical whole. (p. 329)

Contemporary psychological literature also addresses polarities and contradictions.

According to Wong (2011), meaning takes shape through the endless process of transforming apparently meaningless moments into a larger meaningful design. This process leads to personal growth that is made possible through the struggling and stretching to overcome challenges and obstacles.

Festinger and cognitive dissonance. On the other hand, behaviorists, after Festinger (1957), use the concept of “cognitive dissonance” to describe a discomfort resulting from inconsistency between conflicting pieces of knowledge. Scholars of social representation (such as Moscovici & Lage, 1976) have coined the notion of “cognitive polyphasia” to describe how different types of knowledge coexist within a single individual, and how thoughts can hold contradictory meanings (Provencher, 2011). In a different but illustrative vein, Dennett and LaScola (2010) have conducted in-depth interviews with preachers who claim that they have lost faith in God but still continue with their pastoral duties.

As above, cognitive dissonance is the psychological distress experienced by the person who simultaneously holds two or more contradictory beliefs, ideas, or values. Cognitive dissonance is a consequence of the person’s performing an action that contradicts these personally held beliefs.

In *Cognitive Dissonance*, Festinger (1962) proposed that human beings strive for internal psychological consistency. He further suggested that a person who experiences internal inconsistency is motivated to reduce the cognitive dissonance by altering parts of their thinking; justifying their stress-inducing behavior; or by adding new information to their thinking in order to alter the dissonance. Festinger reported that persons avoided situations as well as the contradictory information likely to increase the significance of their cognitive dissonance. In addition, Festinger (1962) thought that a powerful motive to maintain cognitive consistency could result to irrational and sometimes maladaptive behavior.

In fact, Festinger's (1962) statement proved to be correct in this study when participants reported misrepresenting data in patient charts with the expressed intent of providing needed care to the AD/SM, extending certain types of interventions that were sanctioned neither by military superiors nor policy, and eventually thinking and behaving in ways that eroded personal and professional integrity, honor, and the practitioner's own sense of agency. Cognitive dissonance supports the concept of simultaneously existing, contrary poles in human experience.

The Transforming Quality of Resistance

Frequently, habitual behaviors and attitudes obstruct change. During the early years of Gestalt theoretical development, Perls, Hefferline and Goodman (1994) conceived of this *resistance* as the opposition to change.

On the other hand, theorists like Roubiczek (1952) and Wheeler (1991) offered important re-conceptualizations of resistance. Instead of seeing it as avoidance of contact (as in classical Freudian thought), Wheeler looked at resistance as part of the contact process. His reframe shifted the conception of resistance from negative to positive (or neutral) and showed how these

internal defenses actually reflect a range of creative and adaptive contact styles for an individual, group, or organization.

Participants described situations in which they identified ways of dealing with trauma, conflict, and contradictions relating to providing care. These resistance strategies, even though participants did not necessarily label them as such, involved unconscious psychic process.

Contact styles that emerged in the present study included:

Introjection. Taking the “whole” experience without questioning. In this case, the participant was exhibiting being gullible or naïve:

And, that case, umm, initially I was picking up on my own helplessness. I was like, "Oh, this case is really intense. I don't know if I am going to be able to do anything with it. I don't know the impact I could make." 2

Deflection. Avoiding direct contact by breaking the mood, shifting attention or changing the subject. Examples: using a joke or sarcasm to diffuse a serious situation. One of the participants adopted a morose tone while discussing issues of battle stress on soldiers and then ended abruptly with harsh loud voice:

Most people can handle it. But those that can't, come to us. Some of them just don't come to us, and they just kill themselves. 4

Confluence. “Getting along rather than going alone.” Agreeing with others in order to avoid conflict. Difficulty differentiating self from others and still feeling valued or accepted.

Noted by a participant:

We clinicians default to the position, “Well, if I can't change the Navy, I can at least try and be helpful within my own sphere...within my own neck of the woods—mainly what happens in my office.” Maybe that's the best way I can be helpful. It's a matter of getting along [rather] than going alone. You know, in some ways they're right. But, there are those of us who absolutely wish that the handcuffs would come off. 1

Desensitization. “Numbing out.” Feeling nothing as a way to avoid dealing with difficult or painful issues. In the first example below, one participant described experiencing dissociative

episodes as a way to protect the self from further injury. Others adopted both a cynical and supercilious attitude in the face of real pain:

I'm angry and frustrated. I feel like crying. I feel like lying in a bed and just crying. At times, my life is in shambles. I miss my family, my identity as a person. I don't even know who I am anymore. 6

Again, in the military, it's prison life. I have a captive audience, and it lends for easier work. So, as grandiose as I like to make myself feel, I also am very acutely aware that I've been in a very unique environment that blends for my grandiosity of my work 3.

I remember listening to many of the warrior stories. It was like my jaw was just dropping. I can't believe the things that they did, sometimes to their fellow troops, sometimes to innocent civilians. So, a lot of these guys are experiencing rupturing from the inside. And so, initially, some of the stories were just mind-blowing. *After a while, you get used to it actually* [Emphasis added.] 4

Social desirability bias. In social science research, this bias is a type of response bias that is the tendency of survey respondents to answer questions in a manner that will be viewed more favorably by others. It usually takes the form of over-reporting positive experiences or under-reporting negative experiences. So was the case in this study. Participants verbalized moderately high rates of burnout and vicarious trauma while self-marking the opposite response in surveys dispersed after the interview (see Appendix H, Participant Online Survey).

These defenses and resistance strategies seem to oscillate between formulated and unformulated experience of the participant. This in no way suggests any pathological response to the overwhelming experiences that befall the participant.

Contact.

Again, an objective from a Gestalt perspective, of much of what is commonly taken as defense, is ultimately to connect with others or to repair or ward off perceptions of being disconnected. Participants spoke of being connected to both a system of honor (serving in the U.S. military) and with the “heroes” who ultimately produced that honor (their fellow soldiers

and/or patients). This type of connection led feelings of passion and the ability to strive beyond great hardships in order to fulfill one's vocation as a therapist:

First of all, it is a very humbling experience. I mean the bottom line is that you are sitting in the presence of war heroes. Just a sense of honor that goes with being in the process with, umm, somebody who's been willing to put his or her life on the line. I do have a strong sense of passion and duty and conviction with this work. 1

You got to find the help for these folks whatever it takes, and you must be on your game.... And you encourage your fellow clinicians, and providers, and team members to take up that cause. When this happens, the feeling is overpoweringly good. 5

Polarities II: Beyond a Positive-Negative Emotional Dichotomy

Reviewing the results of the interviews of this study, I understood participant descriptions of providing care as being alternatively positive or negative. Upon first pass, this rigid duality appeared without variance. Similarly, in MHAT-8 (2012), research data was presented as a detailed construct of positive stress or negative stress, in two mutually exclusive categories.

It was not until I examined Voss Horrell et al's 2011 study of clinician experiences in providing care to traumatized ADSMs that I saw a different application of the concept of the positive or negative polarity. These categories were not rigid dichotomies in Voss Horrell et al's work; the notion that a continuum might exist between polarities was vague in that study at best.

I came to a shift in my awareness of polarities, and I began to understand these contradictions not as disembodied extremes but rather as essential parts of the whole experience of being human. I am convinced more now than ever that polarities and contradictions constitute fundamental aspects of human life. We are all steeped in contradictory thoughts, feelings, and attitudes. Participant experience could therefore be seen as existing on a "both/and" continuum, randomly shifting positions. As a consequence of shifting from a position of rigid dualities to a position of flexible polarities, infinite possibilities of explication and interpretation could be

constructed. In a both/and conceptualization, one extreme polarity needs its opposite in order to exist.

Polarities-in-contradiction are integrated into Moustaka's (1994) universal description of the experience of representing a group as a whole—the “composite textural-structural description” (pp. 180–181). For that reason, I included only invariant or constant themes in defining the essence of how it is to provide care to OIF and OEF service members during wartime.

One result existing within these polarities for participants was a sense of a loss of power. When they hermetically fulfilled their duties to either the military mission or to the individual service member, thereby neglecting, violating, or betraying the other, participants experienced a debilitating effect on their personal and professional integrity.

Table 4.***The Polarity of Integrity and Corruption: Trauma in Servicing Two Masters*****DUTY****Primary Focus for Military Mission-----Primary Focus for Co-Combatant**

Empowered-----Disempowered

Empowered-----Disempowered

Controller-----Controlled

Controller-----Controlled

(Bi-directional/oppositional polar)

(Bi-directional/oppositional polar)

CHRONOLOGICAL TRAUMA EVENT

Meeting duty results in integrity, honorable, meaningful, purposeful service. Duty can never be realized due to impasse of serving two masters (Military Mission Success or Service Member Healing). Duty becomes incompatible with itself. MMHCs are unable to reconcile duty without causing neglect, violation, and betrayal on the other entity. Becomes bifurcated and unstable because duty cannot rest in one place. Subjected to a chronology of repeated exposure to trauma and to a seemingly endless flow of traumatized “subjects,” the sense of duty becomes dislocated. Trauma moves from being a single event with the hope of eventual remedy to something that is experienced as something both inevitable and untenable in present.

UNREALIZED DUTY

Fragmentation

Cynic/ Social Hegemony

Resignation

Dissolution

Duty was identified as the superordinate theme that best described the structure of providing care to war stress injured ADSMs and their families. Participants described it in terms of protecting America, securing safety for service members and families, healing ADSMs war stress injuries, and supporting military mission by sustaining a strong psychological fighting force.

From this vantage point, subordinate themes of power and control were described as being intrinsic. In addition, power and control were inextricably related. This is to say that power was always an exercise of control, and control was always a function of power. As such, power and control were experienced as forces that could be both productive and simultaneously constraining. Control and power not only limited what participants could do, it also opened new ways of understanding experience in relationship to others and to larger military goals.

The Fall of the Hero: Content and Form in Narrative Analysis

In analyzing and interpreting narrative research, Lieblich, Tuval-Mashiach, & Zilber (1998) suggested focusing on either content or form, as well as assessing whether the analysis is taking shape through holistic or categorical structure. They indicated that typical themes from narratives include relational aspects, belonging and separateness, closeness and remoteness, and vocation.

Categorical structure is simply thematic analysis, whereas holistic form examines the structure of stories. The holistic is a formulated approach to studying language and narrative that involves reflecting on the protagonist, or actors, events, complications, and consequences. Lieblich thought that narratives typically evolve from four major forms of Classical Greek writings and that they could be useful in explicating data.

“Romance” describes the hero, in this case the participant, and how he or she faces a series of challenges en route to his goal and eventual victory. The “Comedy” has the goal of restoring the social order and the Hero must have the requisite social skills to overcome the hazards that threaten that order. “Tragedy” can be understood as the Hero being defeated by the forces of evil and then being ostracized from society in general. A defeated soul, never obtaining benefits, and excluded from society that defines a tragic outcome. Lastly, “Satire” offers the cynical stance that provides perspective on social hegemony by setting oneself outside of society. From this position, the satirist can see the “ridiculous” nature of how people exist and the social norms they follow. It was through this process that I observed a progression of the composite narrative.

In this study, narrative began with participant accounts from a place of high respect, honor, providing meaning a source of strength and power to those in need. The protagonist-participant there is a need to provide care to a strong psychological fighting force in which social order is to be restored. Eventual victory depends on the participant’s clinical skills to overcome warfare hazards that threatened social order. The participant soon becomes aware of the overwhelming and overpowering forces that are present in unconventional guerilla warfare in which heinous tactics are barbaric and indescribably horrid. Shortly after being exposed to the dangers of war trauma, the participant/hero is injured her- or himself while providing care to those in need. Participants are confronted with a terrible conclusion: these soldiers’ conditions are beyond what any one hero can restore. With this knowledge, the collective story turns tragic and the storyline rapidly descends.

The narrative continues downward with no relief in sight; it only regresses further. There is no turning point and no advance upward to any sort of resolution. Rather, the narrative never ends, but rather appears entrenched in an unsolvable account of terror.

Though participants did not directly describe this progression, the consistent narrative thread followed this pattern, and analysis inevitably led to a story that has no reconciliation or ceasing of trauma. This for the participants was the mental health provider's own, unspoken story of terror and grief...one that was often too painful to express directly.

Different from the holistic or categorical narrative, the composite (content-focused) story turns satirical, and cynical. This suspicion, distrust, and sarcasm is noted in participants' unequivocal conviction that American society has neglected, abandoned, and betrayed those who serve and had served in OIF and OEF.

The prototypical story that emerged consisted of resentment towards a society that does not understand the military ethos, ethics, or language and remains avoidant and divided as that society's way of existing in the world. Resentment was exacerbated by a seemingly endless quality to this misunderstanding and avoidance, and the spiritual, emotional, social, and physical sufferings of the soldier patients.

As participants discussed their experiences, the chronological order of events in the narratives changed places. Experiences drastically transformed from a "heroic" view to one that meets with unprecedented trauma and tragedy.

The character and integrity of the "hero" (here, the participant) was painfully diminished by the ravages and monstrosities associated with war. Within this sharp trajectory downward into trauma the unified wholeness of MMHCs can shatter. These clinicians risked the destruction of

their integrity and their world. As a result, narratives began to unravel into blame, cynicism, resignation, and dissolution.

The trauma for the clinician exists at that point in time when he or she understands that duty has become incompatible with itself. MMHCs experience a crisis when they see that duty, vital to both military and caregiving functioning, will not be realized. There is no reconciling the rupture that occurs when the caregivers struggle with realizing duty to mission versus realizing duty to patient. Duty becomes bifurcated and unstable as it cannot rest in one place. This is to say that the value behind one duty necessitates neglecting, violating, or betraying the other. Understood morally, under such conditions a person cannot serve two masters. The below table shows effects in the MMHC experience of this fundamental conflict, moving from duty to the experience of being unable to realize one's duty.

Conflicts in moral understandings of the MMHCs own duty results in a fundamental tension between a sense of wholeness and one of being entangled in a system-situation that is not only does not make sense but that consistently produces effects that are wrong. I have referred to this polarity as Integrity—Corruption.

Figure 1 illustrates the MMHC's experience regarding Duty:

DUTY

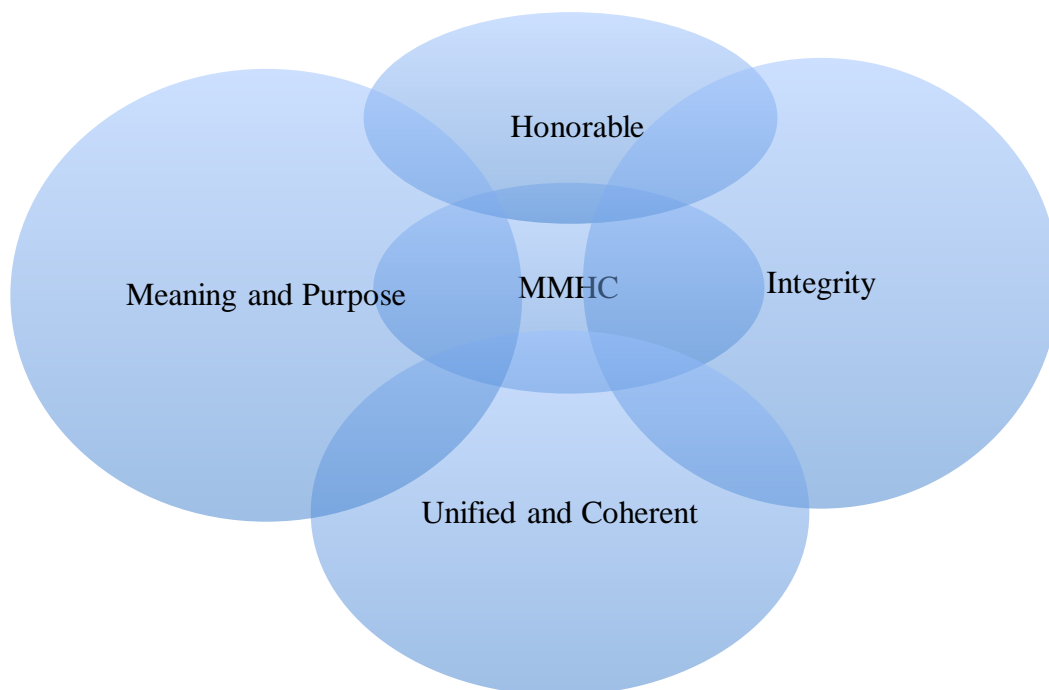


Figure 1. Duty Subordinate Theme

Participant narratives described experiencing duty as coming from power and control, a sense of wholeness, shared connection, and honorable service. Positively affecting both ADMS and meeting military mission.

This sense of control and power was greatly diminished when participants were confronted with the horrors and atrocities that accompany unconventional war. Restrictive military policies and protocols limited MMHCs' ability to identify, assess, diagnose, and treat ADMSs experiencing war stress injury that negatively affected both military mission (secondarily) and clinical care to service members (primarily). MMHCs forced to violate ethical codes of conduct primarily confidentiality, informed consent, and multiple relationships that

negatively affected ADSMs already affected by mental health stigma. Despite training, education, experience, and best efforts, this shift affects the personhood of the MMHC.

Figure 2 illustrates the MMHC's experience of bifurcated—unrealized Duty:

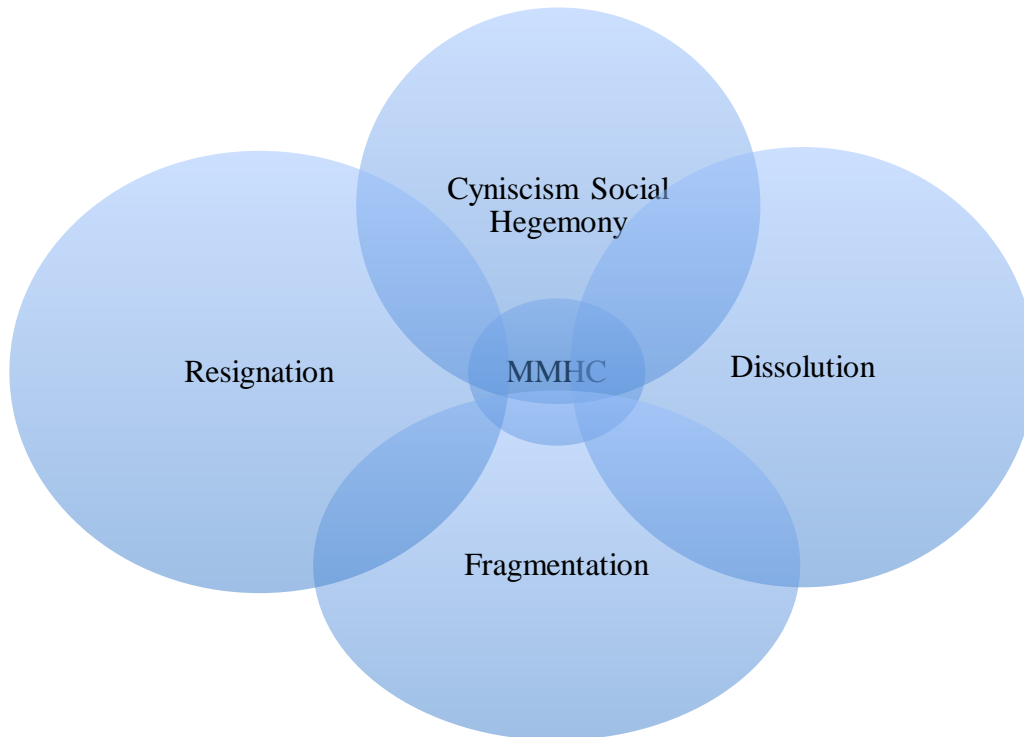


Figure 2. Bifurcated—Unrealized Duty

Political Arrangements

I now move into hermeneutic interpretation of the MMHC narrative texts and of the phenomenological understandings achieved so far. I use parts of the narratives that stand out, and bring these into the context in which these participants MMHCs are located personally, socially, and historically. From this examination, alternating between both background and highly personal descriptions, emerged a narrative of common MMHC experiences.

Reflecting on subtheme 12—the strong beliefs and feelings that participants had of the evasion of non-military U.S. society of its responsibilities towards military personnel and their families—participants were able to contextualize, focusing upon background features of their experiences. Participants described political and social structures and arrangements that intersected with the provision of care and the construction of negative experience.

Indifference was seen as leading to civilian misunderstanding of the general mission of the U.S. Military. Participants suggested hypocrisy on the civilian side, by resistance to those who are trying to protect American society.

It is my understanding that the percentage of males who joined the voluntary military during WW II was close to 35% of American males. The percentage of people, whether it is males or females, it's integrated now, is about 2% for OIF and OEF. And so whereas during the WW II, everyone had some understanding of what it was like to be in the military or to know someone in the military. Now, you could probably interview 100 people, and none of them would know anyone in the military, and would never consider joining the military. They don't even know why we have a military. They say, "We are the big superpower. Why are we bothering with this? All they do is kill Afghanis?" So, that's frustrating for me as a military psychologist, as a naval officer, that the American public does view it that way. But, once you're in the military, you recognize that it is our job to protect. And my job is to protect the people who protect America. That's what I give. 6

So it's their job (the U.S. Military) to actually protect Americans whether the Americans care or not. Essentially, as a member of the military, you sort of get used to the fact that some people will care. Some people actively prevent you from doing your job even while you are protecting them from harm. These same people may not see what you are doing as protecting them from harm. They may see it as promoting it. For instance, the polls on the war in Iraq and Afghanistan—most people would like us to get out. And they would like us to get out because they believe that we are dying for no purpose. They say, "We killed Osama Bin Laden. Why are we there? It was a waste of time. It was a waste of resources. We now have a bad economy. We need to spend this money on the things that are helpful to us and not on pointless wars that never end..." *And you won't hear that from Marines.* [Italics added.] 4

One participant suggested that this erosion of general public support for the military had brought about a change in the reason soldiers now serve. An at-large support of the U.S. was

supplanted by a conviction for one's immediate comrades-in-arms. This was seen as an intersection of psychology and military administration:

But, the military has learned to adapt to that as well. They learned that from Viet Nam that when the American public doesn't support the war, you learn to keep your people relatively pleased. And the way you do it is you send people out with their buddies...so that they're dying for their buddies and not for the United States of America. And this is a different philosophy, and it comes straight from psychology. They learned that from us. 4

Lack of faith in the American public was reflected in a strong cynicism about U.S. Government leadership. In fact, participants identified leadership to be a hindrance to the delivery of care.

We're seeing a lot of stuff being played out in Congress now. It is this time of year, especially in an election year that a lot of Congress people like to, as we say here in the Beltway say, "check off the box." Often "checking off the box" means telling VA how much we screwed up. Congress then usually touts about how much they are champions to make sure the VA complies with what Congress wants us to do. 5

Efforts to strengthen the military from within were seen as being blocked by both Congress and the Press. This caused feelings of victimization from what were ostensibly democratic social institutions.

So, we're always having to kind of bite our lip and say [to ourselves] "Okay, we just have to take it." We then thank the Congress people for being concerned for Veterans. We say to Congress, "Glad to help out. We appreciate all the funding for all that we do." But we sure do get beat up quite a bit. You'll see that a lot in the media. 5

At first it used to really, really get to me. It is like, "Gee, how can they say that about us?" And the media is just portraying us incorrectly, and [the media] really didn't get it right. Leaves me with feeling beat up, frustrated, and there isn't much that can be done about political war. 5

Misunderstanding, Betrayal, and Contempt

All participants expressed feeling betrayed by, and outrage for both U.S. military and American civilian sectors, as these larger groups abandoned moral responsibilities to the men and women who themselves provided for civilian safety and particular way of life. In his or her

own voice, each participant revealed feelings of contempt for that part of the U.S. civilian sector that ignores, neglects, or otherwise dismisses U.S. military culture.

Betrayal was also a common theme, especially when considering interactions with both the civilian at-large sector and governmental agencies. Emotions expressed went beyond mere disappointment; participants spoke of a basic cultural mix of confusion and mistrust. There was, further, a sense that ignorance of the conditions of military personnel was intentional or self-willed, the effect of a pervasive denial.

Experientially for me, what effect it had on me was like more and more, my jaw drops with war stress injuries with these ADSMs and their families. The civilian sector, they have no concept of what military clinicians are experiencing. Things they say are just stupid. They're inappropriate. These can be just as hurtful to service members as they can be to military clinicians. You know, civilians don't understand the decisions that had to be made...they don't understand the context of the combat zone...and how the rules are different. So you add the uninformed civilian culture not knowing the military rules of engagement culture, and then to have the morals and ethics of the United States—the “civilized society”—thrust in this arena, that is just chaotic. Service members and military clinicians don't know who's the good guy and who's the bad guy from day to day. The person that's working with you today will turn around and stab you in the back tomorrow. I think that now service members are not really treated. *They are not able to reconcile the differences between these two realities that exist in these two completely different universes.* [Emphasis added.] 7

Well, Yes. It's mind-blowing. It frustrates me to no end when...it's like...you know, it's like...we [society-at-large] were asking for so much for years from our military...and it's like...what did we [society] expect? Why did we think it's shocking that someone goes overseas for 12 to 15 months, experiences grief...whether it's combat or not, to come back as the same person. Why would we ever expect anyone to do that? I mean, we don't expect our kids when they go study overseas for a year of college to come back the same person. Do we? Why would we expect to send our other kids over to a combat zone for a year and expect them to be the same? 7

It's different in today's world. There are not big medals or huge ceremonies when you come back from Afghanistan...even if you come back healthy. You just go home to your families, and maybe the neighbors say, “Hey.” And maybe the neighbor ties a yellow ribbon around a tree, and maybe somebody knows that you did something. They may say, “Hey, nice job out there.” *But they're clueless. Like the American public has no real idea.* [Emphasis added.] 6

Like Viet Nam was on TV every night. And the military learned that was a bad idea, so they don't want to do that anymore. But the inadvertent consequence to that is that the

American people are clueless and actually like that. They like being clueless. They don't want to know what's going on. [Emphasis added]. 4

Society says, "It is something you did as part of your past...so why do you keep bringing it up?" Again, it's that failure to recognize there is an identity associated with being in the military and for almost every single service member who deployed, they will describe the deployment as the most life-changing event that they have ever had. Whether that is positive or negative. 7

MMHCs voiced distain for that part of the U.S. civilian sector that chooses to remain sheltered from or blind to understanding the human costs associated with sending troops into war. Violence and horror were portrayed as fundamentally separating veterans from civilian populations, due to political, legal, and moral reasons. This, they suggested, posed larger societal risks.

If it's a really bad traumatic brain—depending on where the injury is in the brain, and if you add that TBI to already existing war stress injuries, the service member is really likely to hurt somebody. The civilian world is not likely to think about that. They say, "It's just a war." Or they say, "They're dying, and I want to get out of there." Some say, "we need to win the war," while others say "I don't care about this. It's about the economy at this point." You know, like there are those sorts of political debates happening. 5

You'll hear events...horrifying events...like hearing a bomb explode and an enemy combatant just got blown up. So, here you have the guy who tried to kill you and your buddies...a suicide bomber...in which he didn't do the job right. So, he's now blown to bits. But now we [military personnel including ADSMs and MMHCs] are all alive. So we went over and, you know, we kicked his head like it was a soccer ball or we would like kick the body parts and we're laughing about it. Of course, the reason why we're laughing about it is because we survived. We were supposed to be dead but now we're overcome with exhilaration, and it's like, 'Oh, Thank God, I survived this.' And in that context, it is appropriate and makes sense to laugh. And you think that this person just tried to kill you, and then you get transferred home the next day to a society that thinks the rules are different. And so now, the warriors start ruminating about this action back in the war and they say, "I'm a monster. How can I live with such a thing that I did? It was wrong, and you know, this horrible thing that I've done, and you know, I'm this terrible disgusting person." 7

The insurgents took a child...you know the child was dead...but filled the child with explosives and used the carcass of the child to blow all the Americans who are...who were spending time with children in the street. Now strapped with explosives knowing that the Americans aren't going to shoot at the children...ah...but then they would detonate the child to hurt our service members. (*Long pause.*) Those types of

tactics emerged, you know, that would cause us to shift tactics. And so, now you would have service members being exposed to trauma when they saw a child running down the street who wasn't getting stopped. Our service members were just rolling over the child because you don't know if that child could be strapped with explosives. You start to hear from many of these guys, a lot of guys, of what we call Moral Injury. 7

The Prototypical Representation of the Caring Self

This prototypical story brings together a composite structure of participant-led theme development and textual analysis of data. A coherent story has emerged that describes the lived experience of seven MMHC defined through the lens of an integrity and corruption polarity. Overall, providing care is experienced through the superordinate theme of duty as an officer in the military and as a co-combatant clinician. They answered their "call" to provide integrated mental health care to service members experiencing war trauma. MMHCs as officers in the Armed Forces simultaneously answered their "call" to provide for the success of the military mission, in part by providing for a strong psychologically fit fighting force.

All of the examined themes above were grounded in an underlying structure for clinicians, a sense of self that was contingent on one's own ability actually to provide care to one's soldier patients and their families while also meeting the military directive for successful mission. Providing care was conducted within an environment that already produced high degrees of contradiction, conflict, and division for participants. Positive experiences of giving excellent care in frequently urgent conditions or in cases with high success were deemed highly meaningful and satisfying. This coincided with clinicians' sense of integrity and positive conceptions of themselves.

From a hermeneutic standpoint, military psychologists are located, and therefore would interpret, from two differing traditions. Institutional, historical, personal, and political and economic obstacles to the proper provision of care or performing military duties as MMHC led

to feelings ranging from consistent annoyance to utter moral despair, and even the desire to flee from one's military career. In other words, MMHCs appeared to see themselves as being identical to ADSMs both in fulfilling soldiering roles (potentially undergoing actual combat, guarding a disobedient soldier, etc.); furthermore, they experienced themselves as being subject, despite superior rank or status, to sacrifices that could be equivalent to that of their soldier patients.

MMHCs spoke in terms of explosions that entered into the consulting room. The imagined vicariousness of psychotherapy no longer held. Explosive devices were described as transcending the limits of the human body (body parts of a suicide bomber invading a soldier's stomach); a fellow fighter is suddenly converted into a "mist of blood," that is, his death becomes the atmosphere itself. Not only the soldiers but also the clinicians are described as having to "pick [themselves] off the ground" after "being blasted" by the impact of having (or hearing) these extreme experiences. Not only the patient but also the psychotherapist in this setting is "nauseated" while witnessing what happened. There is a contradictory position of concern from the clinician's perspective here, of needing to remain on the one hand sufficiently engaged to help, while also needing to maintain a safe enough distance to be of use, that is, not being numbed into a state of uncaring.

It is from this place that the MMHC was "shattered" and "blasted away" as she or he witnessed "jaw-dropping" accounts of extreme and incomprehensible traumas and atrocities that are central in OEF and OIF. At this point in the narrative, the trajectory of providing care has gone from a high position of integrity and honor into a free fall descent. Despite the occasional and brief ascent, typically brought about by the ADSM using EBTs, the story remained fixed in time. Unlike popular cinematic portrayals of war, here there was no climax to the story, except

for the level of horror that is possible with military response. Furthermore, there was no advance to return to a previous level of healthier functioning, but rather a further unraveling into morally questionable choices. It was at this point that the MMHCs shared their cynicism in light of the U.S. military and American society that neglects, abandons, and betrays service members and their families. The killing of souls and spirits is final. No one escapes this reality.

Feelings of self-sacrifice were greatest when MMHCs were unable to fulfill their missions, that is, when they were prevented from providing adequate care to ADSMs or were failing to support the military mission. Emotional survival for these MMHCs was intimately linked to vocational survival. In this sense, being a military clinician surpassed a professional position. It was rather for MMHCs an avocation, that is, a “calling” that affected their being-in-the world (“It’s my entire life”).

In the following discussion section, I use hermeneutic reflection to discuss new ideas and perspectives that emerged from these themes and the way of being demanded of the MMHC. These arise both from the foregrounding of individual experience, and in the background of providing therapeutic care in America’s longest wars to date.

Hermeneutic Discussion

Introduction

In this discussion chapter, I provide a brief summary of key findings. Participants shared their reflections on contemporary moral vision, economic structures, and the influence of power in shaping how war and its traumas are diagnosed and treated. Consequences of these political arrangements bring to light why others should care about the results of this study.

I discuss limitations of this study, concluding with suggestions for future research. I invite dialogue between the reader and this text, and to reflect historically, philosophically, morally, and politically to gain an understanding about what it is like to provide care to ADSMs experiencing war stress injury acquired in OEF and OIF.

The Context of War

Participants discussed their experiences serving with a background of the longest wars in the history of the United States. War was taken as inevitable, and the invisible wounds of war stress injury were seen as unavoidable. In relating their experiences and those described to them by service personnel, modern warfare was consistently perceived as a force that destroys physically, mentally, psychologically, and spiritually. It was taken that no military personnel are in fact immune from the fallout of war stress injury. This fallout regularly carried onto the families of soldiers such that both children and spouses, who were portrayed as suffering in parallel psychological and emotional wounds.

Moreover, like a blast syndrome from an IED, the unique vantage of military mental health clinicians gave further shape to the understanding that war trauma impacts all of members of society, on levels that range from the personal and subjective to the universal. War trauma immediately rips apart the service member or MMHC who witnesses its aftermath; it equally

crushes the corps, service family members, military, and even civilian communities. It travels across generations, cultures, and nations, and the destruction—emotional or physical—is frequently described as being beyond words.

Invisible, psychic traumas are, to those who must live with or around them, as equally real as visible, physical wounds. However, there is often a disparity between how physical and psychological war trauma are generally perceived and treated. Mental health stigma is alive and well, so that there is an insidious quality to war trauma at the psychic level.

MMHCs also emphasized that present-day American society remains unaware and unprepared to address the full array of war stress injuries of military personnel and their families. Participants described both a popular vision among civilians, and localized reactions for returning military personnel, that point to a failure by the American public to support those who serve in demobilization and reintegration efforts. This landscape of social neglect led MMHCs to portray their working conditions as a locus of betrayal that frequently led to more personal questions, despite relatively high status and position about belonging, life meaning, and hope. To some MMHCs, such betrayal and isolation was seen as forming in a direct line to the U.S. military's high rates suicide, domestic and family violence, criminal misconduct, unemployment, and homelessness.

MMHC Positive Experience

Participants' positive experiences emerged as feeling honored and sharing a deep-seated purpose and meaning in providing care to war stressed ADSMs and their families. Each participant expressed pride and accomplishment in mastering evidenced-based therapies and providing ADSMs with the best psychological services they could offer and with urgency.

MMHC Negative Experience

The participants' sense of professional integrity was severely wounded. MMHCs served both as a military officer and also a psychologist that presented moral dilemmas. Long standing damage occurred when MMHCs were forced to choose between adhering to military policy and ethical codes of conduct by profession. Underlying this were fundamental questions about what it means to care for a patient's suffering and what it means to fight a war.

Participants described a sense of powerlessness associated with changing restrictive and potentially harmful military policies aimed at limiting the clinician's ability to accurately diagnose and treat ADSM war stress injury. The MMHCs' perception of political powerlessness emerged, for example, when making (un-)fit-for-duty assessments and superiors overruled their findings. In addition, MMHCs faced ethical dilemmas when ordered by superiors to change their original recommendations, resulting in keeping the service member in theatre. In such cases, clinicians were required to author diagnoses or recommendations they believed were both erroneous and morally wrong. In effect, clinicians were required to do harm despite their best intentions.

Participants revealed struggles over being put in the position of violating ethical codes of conduct on client confidentiality, informed consent, the right to refuse, and finding themselves in multiple relationships. They felt despair and rage towards a larger military system that was regularly impervious to change and that demanded compliance to military rule at the psychological expense of all involved.

Participants used various forms of resistance, in order to deliver care that matched their patients' needs. For example, at their own peril, clinicians extended the number of sessions and provided interventions that contradicted situational or doctrinaire military mandates. Moreover,

MMHCs described forms of positive impression management, to guarantee the appearance of policy treatment compliance and thus earn positive site visit evaluations by reviewers. These resistance strategies positioned clinicians in between military and psychological ethical doctrines or moral understandings. As an overall result, the MMHCs' personal and professional integrity suffered.

Participants emphasized the stress from unmanageable caseloads. In a meta-analysis of evidence for the effectiveness of psychotherapies, Norcross (2002) found that a strong rapport was the one common factor for therapeutic change across therapeutic modalities. However, given the enormous caseloads and the quickly shifting conditions under which MMHCs often worked, as well as a natural suspiciousness among vulnerable ADSMs, establishing a strong therapeutic alliance was portrayed as a hugely problematic task. It is worth noting that one clinician used an interpersonal relational approach (one that largely rejects notions of evidence-based or manualized treatments) as the most effective way she could find to earn the trust of service members and thereby establish a strong working alliance in extremely pressured therapeutic conditions.

Unexpected Findings

Troubling revelations emerged in this study that were had little to no documentation in the psychological literature reviewed; MMHC participants expressed contempt for the way American society in general has disconnected, avoided, and neglected care to service members experiencing war stress injury. As one participant argued:

The civilian sector—they have no concept of what military clinicians are experiencing. Things they say are just stupid. They're inappropriate. These can be just as hurtful to service members as they can be to military clinicians. You know, civilians don't understand the decisions that had to be made...they don't understand the context of the combat zone...and how the rules are different. So you add the uninformed civilian culture not knowing the military rules of engagement culture and then to have the morals and

ethics of the United States—the “civilized society”—thrust in this arena that is just chaotic. 7

The conspicuous neglect of the American public, the avoidance, denial, and betrayal of the responsibility on the part of American society at-large, in caring for the men and women of the Armed Forces and their families, has resulted in what Paula Caplan has called a war-illiterate society (*When Johnny and Jane Come Marching Home*, 2011). MMHCs discussed moral struggles present in their work to provide care within a larger system that limits care, reifies outmoded stigma for mental health, and locates normal responses to abnormal conditions as pathological.

In his book, *Warrior’s Return: Restoring the Soul After War*, Edward Tick (2014) argued:

It is the utmost betrayal for any country to send its sons and daughters into slaughter for unjust reasons and afterwards abandon, neglect, and mistreat them, and then leave them in a bereft and condemned condition for the rest of their lives. (p. xiv)

While participants spoke only in passing about possibly unjust reasons behind recent U.S. military engagements abroad, they spoke at length about the subsequent abandonment of soldiers who had clearly sacrificed in the name of the nation. In their own words, participants conveyed their frustration with a nation that has failed to learn from the experiences of service members, military mental health clinicians, and veterans throughout generations of U.S. warfare. The result has been a raging cultural war just below the surface of many isolated, silenced, grieving, and dissociated service members. As a consequence, MMHCs were left to struggle with moral and ethical conflicts, and the consequences of burnout and compassion fatigue.

Interpretations

I constructed interpretations based on in-depth dialogues with seven MMHCs. Interpretation explores how the role of language, instrumentalism, and social constructs inhere in

shaping how war is constructed, sold, and reinforced. Consequences such as the true costs of war, visible and invisible, will be explored. Recommendations from these interpretations are generated in order to suggest ways in which the American public can partner with the U.S. military and fulfill its responsibility of bringing U.S. military personnel into community.

Defining Language

Language constitutes us in the world, rather than merely labeling and recording it. Meaning is expressed through language. Meaning is not already fixed as a concept. Language is random, relational, and constitutive. In other words, language is not necessarily logical, and it may not make sense upon a first reading. Language does not exist isolated from the economic, political, and cultural structures of the day. It is neither predictable nor is it inflexible.

Because this is partly an investigation into the language used by psychologists in military settings, and, as above, because language constitutes meaning in the moment it exists, it was necessary to examine some historical factors bearing on interpreting the texts generated in this study. I therefore considered several historical and political forces within the U.S. that were influential in arriving at interpretations.

Contemporary Approaches to War Stress Injury and Trauma

The current mainstream psychological view locates a diagnosis of war stress injury squarely within the self-contained individual (see, for e.g., Baumeister, 1987; Cushman, 1990; Masler, 2014; Susman, 1984). This suggests that if a person exhibited behaviors consistent with the diagnosis of PTSD, they were suffering an internal mental disorder, and then they could be treated solely by a regime of psychotherapy to help retrain brain function, and reduce symptoms with what Dr. Peter Breggin refers to as “medicating the soldier into oblivion” (Reno, 2014). Working in such a context, it makes perfect sense, therefore, to develop plans, procedures,

technical prowess to help the individual cope with his or her interior pathology thus resign him- or herself to a lifetime of readjustments to lifelong disability. Proceduralism, in this circumstance, produces warm bodies to be deployed and redeployed by normalizing the abnormal horrors of war (Cushman, 2011).

Caplan argued that grouping war stress injuries with all traumatic disorders and under a trauma label such as PTSD reveals a societal belief that the experience of war is not essentially different from, but varies only in intensity with civilian experiences. The conflation of civilian and military experience was, as seen above, vehemently refuted by participants in this study. Furthermore, Caplan suggested that applying universalist labels in a categorical fashion reduced the invisible wounds of war into a sanitized, compartmentalized code of stress and anxiety disorders, compacting moral despair into depressive disorders, and other war traumas into various dissociative disorders located within the individual (2011). It is noteworthy both in the literature reviewed and in the data of this study, social connection when denied resulted in severe problems for ADSMs and MMHCs, and social connection was related to resiliency and improved coping.

As a result of current trends in treating invisible wounds, MMHCs teach ADSMs to minimize and manage everyday stressors, and to medicate for symptom relief. The existing recipe offered to the MMCH to administer to the ADSM is to accept a chronic condition, avoid stimulating it, use corrective cognitive reprocessing, prolonged exposure, or EMDR, along with medical treatment, acquire a disability rating, and to seek appeal denials until benefits are approved.

As long as military manifestations of PTSD pertain solely to the individual patient, his or her suffering remains outside the realm of responsibility of American society. Problems stripped

of all social contexts begin to appear as nobody's business. That type of callousness was repeatedly described by the MMHCs in this study when speaking of the attitude of the American public toward war stress injuries. Isolation and alienation on all sides emerged as a consistent, over-arching theme located both within military activities and as related to the community at-large.

Reconsidering Diagnosis and Treatment

What if we were to view PTSD as a socially derived consequence of war instead of an individually derived intrapsychic mental illness? In such a case, conceptualization and treatment planning would have to be different. Could there be a way to discuss PTSD as a socially constructed entity that is intrinsic to a society that justifies, condones, and prepares often its most vulnerable citizens for war? It follows that such a social mechanism of justification and constant preparation would lead to violations in the ways we care for our service members before, during, and after service, as discussed by this study's psychologist participants. Is American society, on the other hand, reifying the very nature of traumatic war stress injury by silencing potentially meaningful conversations with members of the military community, by simply saying "thank you for your service," replacing more searching dialogue and connection with ephemeral artifacts, such as pit stop treatment plans and yellow ribbons?

Current efforts of the military and the VA are simply part of American society's wrongheaded attitudes toward and beliefs about trauma, emotions, mental health and illness, and the search for ways to help suffering people feel better. In fact, Bilmes & Stiglitz (2006) describe care to U.S. troops as criminally negligent and the military's own mental health policies as inadequate.

From World War I to the present day, MMHCs have attempted to treat the psychiatric consequences of warfare by implementing screening programs, providing early intervention strategies for acute war-related syndromes near the front lines (“forward psychiatry”), and mitigating the symptoms of long-term psychiatric disability after deployment. Principles of forward psychiatry included brevity, immediacy, centrality, expectancy, proximity, and simplicity (BICEPS) and have been a leading methodology in treating war stress injury with the goal of returning the ADSM to active service (US Department of the Army, *Combat Stress: Field Manual*, 2000).

There is significant controversy with the BICEPS principles. Proponents of the BICEPS principles argue that it leads to a reduction of long-term disability but opponents argue that combat stress reactions lead to long-term problems such as Post-Traumatic Stress Disorder.

According to Russell & Figley (2017), contemporary frontline psychiatry doctrine ensures that upwards to 95% of deployed service members diagnosed with war stress injury are prevented from leaving war zones. The only exception to this directive involved the medical evacuation of a service member experiencing gross incapacitation or one posing imminent safety risks to self or others. Russell & Figley (2017) concluded that, based on a preponderance of evidence, the military’s frontline psychiatry doctrine is substantially more likely to harm than benefit service members and their families. Moreover, they found insufficient evidence supporting military claims of individual health benefits resulting from its frontline mental health policies.

Similarly, the use of psychiatric drugs to treat survivors of war stress injury has attracted criticism, as some military psychiatrists have come to question the efficacy of such drugs on the long-term health of veterans (Reno, 2014). Likewise, MMHC participants shared their

frustration with the complex issue of medications. On one hand, a participant discussed how primary reliance on medications were helpful in maintaining combat readiness in the field:

We bring it to the point that we are able to deploy service members with psychotropic medications because there is really good combat care in the field that can follow up. 5

On the other hand, another participant referred to the dangers that come with relying on psychotropic medications in general. He strongly advocated for what he considered a safer trauma-focused care as outlined in forward psychiatry rather than reliance on medications.

We'll just medicate and help them get through it and back out there. And it just boggles my mind that others think it is safer to medicate and then want to give them a weapon, instead of using an extremely effective psychotherapy. 7

The controversy is... actually, the frustrating part of this whole thing is... many believe that this is not safe to provide trauma-focused therapy in the site of the initial trauma. It's kind of like a re-trauma site of the injury would make them freak out, and they would go and kill themselves and things like that. And this is not the case. This is very safe treatment. 7

Jamie Reno in "Medicating Our Troops into Oblivion" (2014) interviewed Peter Breggin, an American psychiatrist and contemporary critic of shock treatment and psychiatric medication. Breggin traced the intensive use of prescription medications to the influence of the pharmaceutical industry has over the military and VA. He further argued that the intense increase in pharmaceuticals cannot be accounted for by anything other than military decisions "influenced by the pharmaceutical industry, which markets from the top down, then the drugs flow to millions" (Reno, 2014, paragraph 7). Breggin further reported that troops returning from Iraq and Afghanistan with PTSD, traumatic brain injuries, and other mental health issues had been administered multiple medications by the military, "as many as 10 or even 15 drugs" (Reno, 2014, paragraph 21). He added:

The combination of increasing prescribing of such drugs during and after military service has led to violence and suicide and in many cases to chronic mental disability while being treated at the VA. This becomes a disability from which they often can't recover because of multiple psychiatric drugs. (paragraph 6)

A November 2012 report by the Government Accountability Office (GAO) further concluded that neither DOD nor VA effectively manages the medication needs of all service members during their transition from active to inactive military (Reno, 2014).

What does this suggest about the MMHCs who are in the position of enforcing a doctrine of mental health on the front line? MMHCs are not immune to the heavy burden of having to comply with, and enforce possibly well-intentioned but inadequate military rules and regulations regarding care. The MMHC is keenly aware of the power of his or her fit-for-duty assessments and interventions, and the consequence of being responsible for advocating that an ADSM be returned to duty to be further exposed to the traumas of war. For some MMHCs, the realization that they were participating in a system that could actually be harming the ADSM was too much to manage. Two participants in this study briefly discussed their plans to detach from the military at the first possible, precisely due to this state of moral quandary.

I view these plans to leave the military as resistance to a dominant, harmful, and until recently, unquestioned doctrine. In one way, these participants were achieving a greater level of compassion by separating from an entrenched system that was purported to be infallible. On one level, BICEPS, delivery of evidenced-based interventions, and huge amounts of psychiatric medications to keep ADSMs functioning served as way to keep the operating area fully staffed. To this end, these instrumental interventions work well. However, what are the short- and long-term costs to the ADSM and the MMHCs who participate in such a system? What are the consequences to the ADSMs, MMCHs, corps, family, and society? Is there not a certain hypocrisy in claiming to support mental well-being while maintaining longer-term policies that have repeatedly been labeled “damaging?”

It can be argued from a hermeneutic point-of-view that military psychologists and mental health clinicians find themselves at the confluence of two largely opposing traditions. On the one side is military rule, with an absolutism that takes total control of all aspects of the individual. On the other is Western psychological treatment, which has a long history of supporting uniqueness of subjective experience, mutual understanding, agency, and connection.

The crux of this confluence is trauma, which stultifies both relational freedom and the ability to reflect upon oneself and one's context (Stern, 2010, 2015). Military psychology includes among its targets turning a civilian population cooperative and docile; in regards to opposing forces, the goal of psychological operations has generally been to render the Other into a state of terror. Psychological treatment, contrarily, has posited a significant aim of the resolution of trauma, whether symptomatically or through a reintegration of the self and distanced or less conscious associations.

One explanation of the contradictions, frustrations, rage, and even moments of sheer helplessness experienced by the MMHCs interviewed in this study is that these clinicians are positioned at this precise point of confluence, between social forces mechanized to enact trauma at the slightest sign of rebellion or disobedience, and the place of the psychologist marshaled to fight the long- and short-term effects of traumatization. MMHCs are then in an untenable position of questioning (or at least covertly doubting, or subverting) Pentagon directives on the one hand, or denying any help to their patients towards an eventual freedom (ideally) from either being traumatized perpetrating needless violence. This social and moral turbulence occurs in a system that is, at its operational end point, essentially violent. Superficially, the military institution as described by these participants appeared to support a therapeutic goal of relief from trauma, while in fact it frequently acted to towards an objective of obliterating realistic hopes of

agency or freedom from brutality. Indeed, participants commented on the isolation they and ADSMs experienced when detached from their own groups or platoons. Participants spoke of the military in terms of an environment rife with mistrust.

Unformulated Experience, Dissociation, and Enactment

In exploring the relationship between two fundamental kinds of experience, the explicit and the unformulated, Donnel Stern (2010) argued that that which is left unformulated is too important to be erased: it is held close to consciousness. In other words, experience that is unformulated is not merely ignored. It remains unknown for a reason. It is dissociated but unconsciously available.

In trauma, experience is not easily amenable to language or formulation. The unformulated is dissociated and resists emotional or logical connection, and hence its uniqueness. “If an experience cannot belong to a category, as trauma cannot, if it must exist in isolation, as a characterization, a singularity, it must remain a thing-in-itself and cannot be cognized, known, or felt” (Stern, 2010, p. 136).

Dissociation shuts down experience, its construction, or attempts at recollection. The process of formulating the unformulated experience, on the other hand, involves a deeply felt and imagined experience, a sense of wonder, mystery, openness, and curiosity in which the client and therapist emerge greater than they were before (Stern, 2010). Formulation generally requires effort, relationship, and enough trust to maintain an active curiosity about the most difficult aspects of our lives and ourselves.

Working with unformulated experience suggests a strong alliance between patient and therapist, in which greater degrees of “relational freedom” can occur (Stern, 2015). This type of therapeutic alliance would be difficult to achieve as a course of action for the ADSM or even the

MMHC in combat deployments. The guard of what one participant described as an institutional “prison,” and one attempting to free the patient from profoundly restrictive effects of emotional wounding, the military therapist is located in an impossible position in the face of trauma.

The Politics of Diagnosis

The seven MMHC participants shared their views of diagnoses and treatment. Though participants were trained to diagnose using *Diagnostic Statistical Manual Edition 5* (DSM-5), some were not allowed to diagnose in a way they believed was clinically correct. Military policies limited them to diagnosing Adjustment Disorders in the place of the more appropriate signature war diagnoses, PTSD, Major Depressive Disorders, Anxiety Disorders, Mild Traumatic Brain Injury, and Substance Abuse.

Others were also sanctioned to diagnose these signature war diagnoses when conducting fit-for-duty evaluations and treatment purposes. However, these clinicians experienced feelings of powerlessness and frustration when evaluations were summarily dismissed and supervisors overruled their recommendations. Participants reported being ordered to change recommendations from ADSM evacuation to ADSM return to duty.

Only one participant acknowledged a wider vision of war stress injury. This participant discussed psychophysiological war stress injuries and medically unexplained symptoms as being inadequately identified, assessed, treated, and researched. He further made the point that there is a real disservice to ADSMs and the field of military trauma research by labeling the full array of war stress injury into limited signature pathological diagnoses.

Participants discussed their compliance with military diagnostic directives as a source of moral conflict. They expressed concern this practice whitewashed symptoms, reducing trauma to an uncomplicated if stressful event.

For over ten years, the military's written rationale (COSC, 2006) for restricting diagnoses has been that, by using this form of deferring, manpower is preserved through reducing the "sick-role" position that ADSMs can take on. In addition, the COSC reported that the components of forward psychiatry are designed to help reduce long-term disability such as PTSD. Not surprisingly, the military view, dating at least back to World War I, indicates that displaying psychiatric symptoms shows a weakness of character, playing the sick-role, or cowardice is still generally held (Friedman, 2004).

Interpreted in this way, diagnosis in military practice is no longer a medical evaluation *per se*; rather, diagnoses are subject to institutional and economic concerns about human resources. This is using a form of scientific falsity, even deceit: clinicians are mandated to ignore illness in order to decrease the number of soldiers who have severe and ongoing symptoms such as PTSD but who are *not* diagnosed, in order to exaggerate the number of healthy ADSMs who actually may be experiencing severe trauma in the combat zone. Aside from any social issues raised, even from an empirical, instrumentalist view, this approach is simply wrong.

Indeed, the notion of "the sick role," does not connote simply being sick. The sick role (Millon, Blaney, & Davis 1999) was an aspect of a highly disciplinary sociological theory of the U.S. of the 1950s, according to which being sick was seen as a form of social deviance, and thus a signal that the person is to be registered, monitored, and policed. The ideology here is once again intriguing: though it is couched in explanations of proper mental health diagnosis, instead this theory provides a structural approach to blaming the victim. Rather than being given an affective shelter in the midst of a psychic storm, the soldier presenting with PTSD-like symptoms is foremost to be ruled out from the class of deviance (assuming the sick role and

acting sick as a matter of free will, as opposed to being an individual who is suffering in a system that everyone agrees is broken and dangerous).

Such a psychological mandate makes PTSD first appear closer to a crime than an affliction (the same symptoms first suggest malingering, the shirking of duty). As one participant put it: “In the military, it’s prison life. I have a captured audience, and it lends for easier work.” The immediate response to the breakdown of associative control is a further denial of the individual’s agency.

Similar to the American psychiatric culture, the military psychiatric culture has a long history of addressing issues of malingerers. There is a functionality here, however, of assessment as a process not geared to providing the highest standards of treatment, but as a test of worthiness: the filtering out those who deserve treatment for a disability from the would-be frauds or deserters (see e.g., Scull, 1988). The military psychologist is to use his or her medical power as a gloss for enacting core social power. Certainly, malingering is a consideration for any medical practitioner. However, here a secret code of medico-military terminology puts the clinician in a situation where her or his role as an officer again trumps authentic consideration of the patient’s mental health. Against the duty to enforce obedience, the goal of healthcare must go underground or it inevitably falters.

A War of Alienation: Historical Causes of the Civilian/Military Divide

Leaving aside questions of accurate case formulation, I now question the wisdom of participating in a system that provides individual diagnosis for the psychological and physiological effects of war stress injury in ways that redirect pathology to individual and apolitical causation. Categorizing these invisible wounds as a psychological illness can act to cover up the effects of war. Labeling war trauma as a psychological disorder depoliticizes the

brutality of war. Even precise diagnosing decontextualizes and therefore re-packages war trauma as a series of internalized clinical diseases, placing the locus of both the disorder and the suffering uniquely “inside” the individual.

By participating in such a questionable political arrangement, MMHCs themselves are being hurt through the subversion of rhetoric away from the atrocities and perpetrations that ADSMs committed in the course of their service, and locating the relevant narrative within the psychological interior of the ADSM. From the outset, individuals characterized in this way suffer a linguistic loss of their many connections to the social world. In addition to problems in relationship, such a loss leads to problems in the way people experience their everyday lives and themselves.

As one of many consequences, the very mental health stigma that is supposedly being eradicated by military diagnostic policy is actually being reinforced by it. Labeling creates isolation, and it keeps the stigma of seeking help synonymous with weakness. Diagnosing can imply characterological shortcomings, such as overreacting, malingering, or somehow just not measuring up in contrast to those who are not diagnosed. When it must be entirely ignored, the political is repeatedly displaced into the person.

Instrumentalism

Blaine Fowers (2010) defined instrumentalism in psychology as an exclusive reliance on means–ends explanations of human behavior. He posited that instrumentalism encourages perceiving everything as a means toward one’s end, adopting an exploitive stance towards both persons and the environment. He suggested that instrumentalism effectively obscures and distorts non-instrumental activities. As a consequence, certain language comes into existence, while other non-instrumental language grows obsolete, irrelevant, and distracts attempts to seek the

truth. It is often the case the manifestations of political history on everyday life can be the first areas to disappear from sight when instrumentalism reigns supreme. As mentioned, the causes of Afghani and Iraqi military engagements entered minimally if at all in the discussions of MMHCs. Furthermore, those deciding policy were regularly referred to with a certain anonymity. MMHCs were faced conceptually with a limited equation: Repair or gives respite to our fighting service people because that is what you do, and fighting is what they do. The last “why” of it emerged in the realm of the inevitably unformulated. An orthodoxly individualistic psychology becomes ironically complicit. As one participant explained:

[T]he military has learned to adapt to that as well. They learned that from Viet Nam that when the American public doesn't support the war, you learn to keep your people relatively pleased. And the way you do it is you send people out with their buddies...so that they're dying for their buddies and not for the United States of America. And this is a different philosophy, and it comes straight from psychology. They learned that from us. 4

The (perhaps unspoken) requirement that dialogue be sequestered from questions of political and economic causation leads to an instrumental focus. Therapists are constricted to seeing and fixing symptoms and patterns of thought. We could call this a bound relationality, in which clinicians were required to focus on their patients, and their patients on their platoons. The conflicts this created for participants in this study were harshly played out in the lives everyone involved.

A similar bounding occurs in the language of military-political discourse itself. Consider the “military-industrial-government complex,” the original phrase that President Eisenhower spoke in his farewell address to the nation, broadcast on television January 17, 1961 (MIC). He warned against collaborative powers coming together in the modern world to guide us toward waging endless wars for profit.

Eisenhower was later convinced to remove “government” from his final speech. In the broadcast, he also called for “an alert and knowledgeable citizenry,” in order to keep the military-industrial complex aligned with “our peaceful methods and goals.”

Fifty-five years later, President Obama in his farewell speech to the State of the Union (2016) called for a similar process:

When we write off the whole system as inevitably corrupt, and when we sit back and blame the leaders we elect without examining our own role in electing them...it falls to each of us to be those anxious-jealous guardians of our democracy...to embrace the joyous task we've been given...to continually try to improve this great nation of ours, because for all of our outward differences, we in fact share all the same proud title...the most important office in democracy...citizen. (2016)

Now, the proliferation of MIC engagements and the militarization of the American public have morphed into what Andrew Bacevitch (2005) has called “The New American Militarism.” Currently, the United States has an unobstructed path to assert military power across the world and create regime change. The roles and strategies of the military have changed from one of Cold War defense to an aggressive colonial occupation and regime-change orientation. This aggressive path has morphed from the MIC into what Gareth Porter (2011) refers to a “Permanent War State.” In *The New American Militarism: How Americans are Seduced by War*, Bacevitch (2005) discussed the United States’ belief in, idealization of, and reliance upon the American military to solve all problems abroad. In agreement with Porter, Bacevitch traced the shift that increasingly empowered American Neocons from their basic principle, that is, from one of resistance to a vigilante notion in the face of what they regarded as evil. Bacevitch portrayed this as an aggressive crusade against notions of evil abroad, beginning with the collapse of the Soviet Union.

Hurst (2009) argued that the American invasion of Iraq in 2003 was a consequence of a closely aligned theory to both a “Permanent War State” and “The New American Militarism”

referred to as “World Systems Theory.” Hurst reported that the originator of this theory, Cumings (1990), posited various structures within which American state and its policy makers must be located. In *The Origins of the Korean War, Volume II: The Roaring of the Cataract, 1947-1950*, Cumings argued that “World Systems Theory” is characterized by a tendency toward hegemony. The lead core state is able to order the international political and economic systems according to its own preferences, thus assuring both primary benefit and the leading role. Other “periphery” nation states benefit secondarily from this arrangement.

As an example of this theory in action, the 2003 invasion of Iraq has been attributed to the prowess of a handful of individuals exploiting the events of September 11, 2001, to seize control of the American foreign policy and to implement the plan to eliminate Saddam Hussein. Hurst (2009) argued that there were arguments against this idea, the most fundamental being is that it reduces the 2003 invasion and occupation of Iraq to a singular historical trauma event: the bombing of New York’s World Trade Center buildings.

Hurst (2009) thought that transient factors are important in explaining certain historical events leading to larger actions. The invasion of Iraq may be difficult if not impossible to imagine without the events of 9/11. However, Hurst argued that the invasion of Iraq was in fact a product of a long-established American tradition or determination to maintain the position of the U.S. as the dominant power in the Gulf. Instead, a story was given to the American public that involved the production of fear associated with the horrors of weapons of mass destruction. In this case, bringing a dangerous dictator to justice meant regime change.

We see here fear and resultant traumatization—whether on the level of the culture or of the individual subject—as a means to geopolitical ends. A fearful narrative was supplied to justify America’s war with Iraq.

Analogously, could the construct of the trauma diagnosis serve at times as a practice that locates fear in the personhood of the soldier and one that thereby dissociates personal and familial sufferings from geopolitical interests that continuously wage battle for economic ends around the world?

There was an industrial quality to some participants' portrayals of their working conditions. Likewise, no MMHC interviewed discussed or implied a sense of finality to the soldiering work of the ADSMs they treated. War appeared in the background of these interviews as a given, here, too, to paraphrase Porter (2006) as a "permanent state." Victory remained a particular (as in, winning a battle) and was not posited as a foreseeable goal that would change things. "Command," one's superiors, and their policies, considering the minimal definition offered by these MMHCs, was often seen as difficult to challenge, ubiquitous, indifferent, or absent. In what was unformulated here, we can interpret that somewhere in the background there may have been an awareness that in fact a runaway MIC dictates the conditions of living and dying in the military—a hidden drive toward a world system theory in which war is part of a supposedly eternal landscape.

Marin (1981) argued that American society during in the aftermath of the Vietnam War had few useful ways to approach the expression of moral pain and guilt. Guilt remained a neurosis or a pathological symptom, something to escape rather than learn from; moral pains and its manifestations were seen as a disease rather than—as it may be for many Veterans—an appropriate if painful response to the past (p. 3). As in the present study, for Marin the American societal approach to these matters is linked directly to the experiences of service members. A simple pathologizing of the pain and shame commonly felt by frontline soldiers and clinicians

upon their return home serves to further separate them from a society that sent them (often in their youth) into battle.

Marin (1981) went further in describing what was perhaps the most painful expression of moral pain. This occurred when U.S. Veterans returning from Viet Nam realized that the American public could not, or did not want to notice the political aspects of their suffering.

As a consequence, Veterans became isolated and silenced “not only because of what they have done but because of the questions it raises for them—questions that their countrymen do not want to confront, questions for which, as a society, we have no answers” (Marin, 1981, p. 10). This betrayal left most Veterans without the moral or political language needed to make sense of their experiences. What remained was a vague, unarticulated feeling of betrayal. In response, Marin thought, the Veterans did what all of us do when confronted with an event or knowledge that is too painful to face or face alone: they dissociated from it. Participants in this study likewise presented a common theme of the destructiveness of betrayal amongst soldiers, by misunderstanding therapists and by the public at-large.

Stern (2010) and other relational psychoanalysts have written extensively about the everyday psychological process of dissociation. Stern maintained that traumatic experiences are not stored fully formed because they are not fully articulated in the first place. He argued that what is left unformulated is too important to be erased. Trauma is kept psychologically close, unformulated but somehow partially available though disguised in phenomena such as dreams, fugue states, and especially dissociative enactments.

There are times that psychotherapy contributes to silencing the ADSM and family by refusing to fully contextualize ADSM suffering. When therapists are unable or unwilling to allow the service members to talk about being the perpetrators of PTSD or to examine the

political and moral issues raised by America's now perpetual colonial wars, society is significantly limited in how it responds to the suffering that we are responsible for creating in the first place. By treating PTSD as a decontextualized, individualized, anomalous disorder that repeatedly comes about in service of a highly abstract or even covert political objective, we also depoliticize the main issue, which is the hideousness of war itself.

Participants in this study experienced a daunting task in providing care to ADSMs who were injured psychologically by war stress. Assessment and EBP treatments were used to meet mission and support the ADSM and their family heal from wartime trauma as best as can be done. Sadly, the fallout of war is beyond any one of us to truly understand. But that should not keep us from trying.

Consider the following story of Iraq War Veteran Daniel Somers who committed suicide following an arduous battle with PTSD that was caused by his role in committing "crimes against humanity," according to his suicide note. Somers was assigned to a Tactical Human-Intelligence Team (THT) in Baghdad that saw him involved in more than 400 combat missions as a machine gunner in the turret of a Humvee. He also conducted interrogations.

As reported in the Gawker online (June 22, 2013), Daniel Somers, a veteran of OIF wrote a letter to his family before taking his life. His suicide note made powerful indictment of the invasion of Iraq and the fact that it ruined the lives of both countless millions of Iraqis as well as innumerable US troops sent in to do the dirty work of the MIC. "The simple truth is this: During my first deployment, I was made to participate in things, the enormity of which is hard to describe. [These were] war crimes, crimes against humanity," (paragraph 5) wrote Somers.

Though I did not participate willingly, and made what I thought was my best effort to stop these events, there are some things that a person simply cannot come back from. I take some pride in that, actually, as to move on in life after being part of such a thing

would be the mark of a sociopath in my mind. These things go far beyond what most are even aware of. (paragraph 5)

This is what brought me to my actual final mission. Not suicide, but mercy killing,” wrote Somers, adding that for him, living “any kind of ordinary life is an insult to those who died at my hand. (paragraph 17)

The word “atrocities” itself deserves some delineation. Examples of atrocities aided directly or indirectly by US troops in Iraq have include:

- Orders to slaughter “all military age men” during some operations (Worth, 2006).
- Raping and torturing children at the infamous Abu Ghraib detention facility while they shrieked in terror. Women forced to watch, later begged to be killed (Sealey & Carter, 2004).
- Sodomizing detainees with chemical lights and broom sticks (Taguba Report, May, 2004).
- Massacring entire groups of unarmed Iraqis, including children and the elderly in Haditha (Haditha Massacre, November 19, 2005).

The cost is of this, only one of this nation’s many military interventions, is too much for MMHCs, ADSMs, the military, and the American public not to begin to talk about extremely difficult realities associated with being part of a militarized system.

Reflections on Research and Its Implications

Through examining narratives, research, and textual analysis, I began to comprehend the complexities and challenges of providing care by the context in which these MMHCs must operate. A conclusion that has been both implied and directly stated to me, is that there is nothing MMHCs can do to remove the death-dealing devastation war visits upon or demands from service members.

Nor can clinicians return soldiers to their former lives in the same condition they were in when deployed. War is “mind-blowing” and “jaw-dropping,” both figuratively and literally. It is, by its nature, a violation and a killing place of the world, the human body, the mind and the spirit. Those who survive hold the honors and the pains for a lifetime, reliving and passing on their strength and endurance—and their woundedness—in myriad untold ways. There is a tie between a destructive event and its aftermath that appears to be beyond any one person’s comprehension, a rupture in time.

The residue of participating as a combatant in war lingers long after military action is completed. War experiences and the political, economic structures that remain unexamined, unarticulated, and unformulated block any true repair. It has long been upheld that “transgenerational trauma” is carried from generation to generation (Frailberg, Adelson, & Shapiro, 1975). Unchecked, these dissociated experiences hauntingly and relentlessly resurface in various ways and throughout a lifetime. Trauma is notorious for its tenacity.

The purpose of military actions—whether they are well-guided and effective, or not—are purportedly conducted to guarantee our personal and national freedoms while assuring a dominant American political, and until recently economic position above other nations in the world. These actions not only reassure the American public of the country’s hegemony but also serve as a reminder to the rest of the world that the U.S. is what President Obama described in his last State of The Union Address as “the most powerful nation on earth. Period. Period. It’s not even close” (2016).

Obama explained, “We spend more on our military than the next eight nations combined. Our troops are the finest fighting force in the history of the world. Priority one is protecting the American people and going after terrorist networks” (2016).

President Obama may have been correct in his assessment of U.S. armed power, and the American people may gain a sense of security and national pride upon hearing such a claim. However, where is the deeper truth-telling about the human cost of being the world's hegemon? Assumedly, some of the duty here lies with our Social Scientists, whether meaningful discussions are to take place in the consulting room or the lecture hall.

Killing, bombing, handling dead bodies and body parts, continuous hypervigilance, and the many flagrantly dehumanizing activities required and endured in war remain unspoken and external to the "norm" of our civilized society. Most of us could scarcely imagine the fallout of surviving, and working in the midst of chaos of this nature. Equally unimaginable is the burden placed upon the MMHC to fix the impossibly broken. This is the unreal-reality which MMHCs provide care to ADSMs. Like those they serve, MMHCs, too, put their own lives, minds, hearts, and spirits on the line for their country, comrades, family, friends, and strangers. Their stories remain generally silent.

Even as a researcher focused on each MMHC, it has been difficult not to be drawn in and lost in the horrific details and experiences of ADSMs' stories related to me third-person. Contrarily, it has also been difficult to resist complying with the urge to stand at a distance; it has been tempting to engage in a certain separation while discussing war stress injuries for both ADSMs and MMHCs. I have confronted this by focusing on the lived experience of the MMHCs and by considering these other two aspects—the hideousness of war for our ADSMs and MMHCs, and society's detachment from it. At times, MMHCs have expressed in various ways that this dichotomy, in part, constitutes their own experience.

It is probable that there is no quick, complete, or easy way to address the stressors that produce the negative experiences of MMCHs. In fact, one of the participants expressly stated, "I

don't want to see yet another program coming out of this study to join the other 900 programs already in play." The wisdom of such a political critique is that notices the many ways psychology has developed token responses to the horrific reality of war and its always-concurrent aftermath. This clinician's response was obviously heartfelt and truthful. In enacting a split by simply delivering ever more and newer programs, psychological study recurrently colludes with the same forces that would also sanitize and divide-out the typical civilian way of being from contact with the effects U.S. military actions. In other words, newer programs, however purportedly efficient, may be experienced by the MMCH as yet another complication from an outside culture in its attempts to resolve a perpetual problem that it refuses to admit to, to confront directly, to resist, to understand, or to resolve.

Researching, interviewing, dialoguing with those directly involved, and writing about these issues is, however, a different matter. In the process of this study, I, a noncombatant myself, have discovered more detail in this rift between these two worlds. In bringing this separation to light, I hope to help society and military to find connections that may be both deeply subjective and widely political. In short, I have carried out this study also in the hopes of encouraging therapeutic and psychological approaches that are sufficiently broad-minded to have lasting effects and to fight the isolation inherent in denying the context of these problems.

"History allows us to think, even after atrocities," wrote Guadillière & Davoine (2004, p. 26). In the process of this investigation, I have grown closer to those caught within the currents of a highly misunderstood military, and I have felt growing urgency to advocate for, and in so far as possible, with them. Through confrontation with that which we avoid, and by mapping these areas of uncertainty, there is also hope for change. I would like to suggest that it is important to reexamine these conflicts and struggles that harm and debilitate not just ADSMs, but also the

MMHC's wellbeing. By focusing on these individuals, we also must focus on their families and their communities. If there is to be any potential for uncovering and exposing these issues for further examination, and if we can bring about a re-envisioning of ways to think about war, mitigate harm, and promote healing with those who mitigate harm and promote healing in others, it is our responsibility to do so.

We live in a technologically oriented society in which we are urged to treat every feeling besides happiness as mental illness, so that there can be a putative quick fix for most of the population with medication and some form of evidenced-based treatment. Americans—including therapists—long to believe the myth that clinicians, armed with manualized treatment procedures, can heal the emotional and spiritual carnage wrought by war, and all will be well, returning our service members as good as they were before. But all will not be well unless psychotherapists acknowledge the limits of our ability to heal and alleviate suffering and pain, regardless of technique or the latest use of manualized tools. Again, my hope is that in recognizing such limits we can find ways to see beyond them. This will require some new ways of thinking, not just another batch of newly-minted, highly scientized programs.

Caplan (2011) has suggested that therapists need to acknowledge their limitations. She argues that all ordinary citizens can do as much, if not more than therapists, to bring our military men, women, and their children out of harm's way, and to help them return home. Caplan recommended meetings between civilians and active or retired military in which the service member can share more about his or her story. As noted from an MMHC participant in this investigation, the process can be challenging. People who become therapists often do so because they want to help. Nonetheless, the mission of helping to alleviate human suffering can be daunting. Given the context of war, helping to alleviate pain and suffering from the accelerated,

accumulative, and the relentless exposure to devastating levels of trauma can leave those who attempt to help heartbroken, stymied, unnerved, and as exposed to war stress injuries as are those they treat.

On one hand, it is perhaps understandable that many therapists therefore adhere to the safety and the structure that is created with performing techniques or manualized therapies they learned in their training. Structure and method attenuate clinician anxiety and psychic unrest; the appeal to an authority that is present or absent helps everyone avoid interpersonal conflict.

Could the push for such an empirically dictated approach to psychotherapy, however, be a product of the wish to ignore the effects of so many social contradictions in which we are all implicated? As soon as we, as therapists, rely on someone else's words, we silence the dialogue; we replicate the kinds of social powers that bring about endless cases of PTSD and then require the subjects of these, the people behind the acronyms, to remain silent about it.

When MMHCs are required to diagnose and treat ADSMs as passive and injured victims, or to discourage ADSMs from talking about what may be their least accessible experiences and opinions, the social human costs of the quest for an insurmountable American hegemonic state goes up. Social censure in its most subtle or overt forms robs ADSMs and MMHCs of the chance to articulate their extreme pain and instead forces them to remain silent and complicit with instrumentalist procedures far and near. As a public, we turn our collective backs on those who are commanded to serve in colonial occupations of distant countries. As one participant indicated, many join up at a young age because they already find themselves insufferably isolated and marginalized.

As the gap between civilian and military life grows apart, society achieves an "invisible" goal of remaining conveniently numb, dissociated, and avoidant of responsibility while

maintaining an insincere, neglectful, and unformulated concern for the sacrifices of MMHCs, ADSMs, and their families. On the other hand, allowing for a larger frame of reference—one that includes political, economic, and moral understandings—into discussions on both sides of the civilian-military divide, can diminish suffering, by confronting the sense of isolation, stigma, and helplessness, of ADSMs and the valiant clinicians who treat them daily.

References

- Aarons, G. A., Sommerfield, D. H., Hecht, D. B., Silvosky, J. F., & Chaffin, M. J. (2009). The impact of evidence-based practice implementation and fidelity monitoring on staff turnover: Evidence for a protective effect. *Journal Consulting Clinical Psychology, 77*, 270–280.
- Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry, 76*, 103–108.
- Adams, A. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology, 2*, 26–34.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (DSM IV-TR). Arlington, VA: American Psychiatric Publishing.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (Fifth ed.). Arlington, VA: American Psychiatric Publishing.
- American Psychological Association. (2010). *Ethical principles of psychologists and codes of conduct*. Washington DC: American Psychological Association.
- Andrews, B., Brewin, C. R., Stewart, L., Philpott, R., & Hejdenberg, J. (2009). Comparison of immediate-onset and delayed-onset posttraumatic disorder in military veterans. *Journal of Abnormal Psychology, 118*, 767–777.
- Applewhite, L., & Arincorayan, D. (2009). Provider resilience: The challenge for behavioral health providers assigned to brigade combat teams. *U.S. Army Medical Department Journal, 24*, 24–30.
- Bacevitch, A., (2005) *The new American militarism: How Americans are seduced by war*. New York, NY: Oxford University Press.
- Bartone, P. T. (2006). Resilience under military operational stress: Can leaders influence hardiness? *Military Psychology, 18*, 131–148.
- Bartone, P. T., Adler, A. B., & Vaitkus, M. A. (1998). Dimensions of psychological stress in peace keeping operations. *Military Medicine, 163*, 587–593.
- Baumeister, R. F. (1987). How the self became a problem. *Journal of Personality and Social Psychology, 52*, 163–176.
- Berg, B. L., & Lune, H. (2012). *Qualitative research methods for the social sciences* (8th ed.). New York, NY: Pearson.

- Bilmes, L., & Stiglitz, J. (2006). The economic cost of Iraq war. *Milken Institute Journal of Economics, 4th Quarter*.
- Caplan, P. J. (2011). *When Johnny and Jane come marching home: How all of us can help veterans*. Cambridge, Mass: MIT Press.
- Carsen, D. (1979). The defense mechanism of splitting: Developmental origins, effects on staff, recommendations for nursing care. *Journal of Psychiatric Nursing and Mental Health Service, 17*, 21–28.
- Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), *Existential phenomenological alternatives in psychology* (pp. 47–71). New York: Oxford University Press.
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, mixed methods approaches. 2nd Edition*. Thousand Oaks: Sage Publications.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches. 2nd Edition*. Thousand Oaks: Sage Publications.
- Creswell, J.W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches. 4th Edition*. Thousand Oaks: Sage Publications.
- Cumings, B. (1990). *The origins of the Korean War: Volume II: The roaring of the cataract, 1947–1950*. Princeton NJ: Princeton University Press.
- Cushman, P. (1990). Why the self is empty: Toward a historically situated psychology. *American Psychologist, 45*, 599–611.
- Cushman, P. (1995). *Constructing the self, constructing America: A cultural history of psychotherapy*. Boston, MA: De Capo Press.
- Cushman, P. (2011). *Multiple Selves, Virtual Worlds, and the Procedural Empire: Relational Psychoanalysis as Political Resistance*. Paper presented at The American Association for Psychoanalysis in Clinical Social Work Convention, Los Angeles, CA.
- Dedoose Version 5.0.11. Web application for managing, analyzing, and presenting qualitative and mixed method research data (2014). Los Angeles, CA: SocioCultural Research Consultants, LLC.
- Dennett, D. C., & LaScola, L. (2010). Preachers who are not believers. *Evolutionary Psychology, 8*, 122–150.
- Denzin, N. K., & Lincoln, Y. S. (2000). The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1–36). Thousand Oaks: Sage Publications.

- deVries, M. W. (1996). Trauma in cultural perspective. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 398–413). New York: Guilford Press.
- Duncan, R., Pansoy, C., Towe, L., Nosalik, B., Sundam, B., & Snyder. (2005). Grace under fire. *Nursing, 35*, 62–64.
- Eisenhower, D. D. (1961). State of the Union Final Farewell Speech to the Nation. Originally televised January 17, 1961.
- Erbes, C. R., Curry, K. T., & Leskela, J. (2010). Treatment presentation and adherence of Iraq/Afghanistan era veterans in outpatient care for posttraumatic stress disorder. *Psychological Services, 6*, 175–183.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Evanston, IL: Row, Peterson.
- Figley, C. R. (1995). *Compassion fatigue*. New York: Brunner-Mazel.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Psychotherapy Practitioner, 58*, 1433–1441.
- Flake, E. M. (2009). The psychosocial effects of deployment on military children. *Journal of Behavioral Pediatrics, 30*, 271–278.
- Fontana, A., & Rosenheck, R. (1998). Psychological benefits and liabilities of traumatic exposure in the war zone. *Journal of Traumatic Stress, 11*, 485–503.
- Fowers, B. (2010). Instrumentalism and psychology: Beyond using and being used. *Theory and Psychology, 20*, 102–124.
- Frailberg, S., Adelson, E., & Shapiro, S. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry, 14*, 387–421.
- Freud, S. (1938). *The basic writings of Sigmund Freud*. New York, NY: Modern Library.
- Friedman, M. J. (2004). Acknowledging the psychiatric cost of war. *New England Journal of Medicine, 351*, 75–77.
- Gadamer, H. G. (2004). *Truth and method*. Second Revised Edition. (J. Weinsheimer & D. G. Marshall, trans.) New York, NY: Continuum.
- Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. 21 April–12 August 1949*. Geneva, Switzerland: Geneva Convention; 1949: D–1.

- Gentry, J. E. (2006). *Compassion fatigue: Prevention and resiliency*. Eau Claire, WI: PESI Health Care, LLC.
- Gibbons, S. W., Shafer, M., Aramanda, L., Hickling, E. J., & Benedek, D. M. (2014). Combat health care providers and resiliency: Adaptive coping mechanisms during and after deployment. *Psychological Services, 11*, 192–199.
- Guadilliere, J. M., & Davoine, F. (2004). History beyond trauma, (S. Farifield, trans.). In K. Donegan (Ed.), *Seasons of misery. Catastrophe and colonial settlement in early America*. New York: Other Press.
- Hefling, K. (2009). More military children seeking mental care. *Marine Corps Times*. Springfield VA: Army Times Publishing Company.
- Heidegger, M. (1962). *Being and time*. New York, NY: Harper and Row.
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cutting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine 351*, 13–19.
- Hoge, C. W., Terhakopian, A., Castro, C. A., Messer, S. C., & Engel, C. C. (2007). Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq war veterans. *The American Journal of Psychiatry 164*, 140–153.
- Hoge, C. W., McGurk, D., Thomas, J. L., Cox, A. L., Engel, C. C., & Castro, C. A. (2008). Mild traumatic brain injury in U.S. soldiers returning from Iraq. *New England Journal of Medicine, 358*, 453–463.
- Hurst, S. (2009). *The United States and Iraq since 1979: Hegemony, oil, and war*. Edinburgh: Edinburgh University Press.
- Husserl, E. (2001) [1900/1901]. *Logical investigations*, 2nd ed. D. Moran. (Ed.). 2 volumes. London: Routledge.
- Institute of Medicine. (2008). *Gulf War and health: Physiologic, psychological and psychosocial effects of deployment-related stress* (Vol. 6). Washington, DC: The National Academies Press.
- Joint Mental Health Advisory Team-8 (2013). Operation Enduring Freedom 2013 Afghanistan. Office of the Surgeon General United States Army Medical Command and Office of the Command Surgeon HQ, USCENTCOM and Office of the Command Surgeon U.S. Forces Afghanistan (USFOR-A).

- Jones, F. D., Sparacino, L. R., Wilcox, V. L., Rothberg, J. M., & Stokes, J. W. (1995). *War psychiatry*. Published by the Office of The Surgeon General at TMM Publications, Borden Institute. Walter Reed Army Medical Center Washington, DC: Office of the Surgeon General.
- Jones, E., & Wessely, S. (2005). *Shell shock to PTSD: Military psychiatry from 1900 to the Gulf War*. London: Psychology Press.
- Jung, C. G., & Jaffe A. (1962). *Memories, dreams, reflections*. London: Collins.
- Kang, H. K., Bullman, T. A., Smolenski, D. J., Skopp, N. A., Gahm, G. A., & Reger, M. A. (2015). Suicide risk among 1.3 million veterans who were on active duty during the Iraqi and Afghanistan wars. *Annals of Epidemiology*, 25, 96–100.
- Kenny, D. J., & Hull, M. S. (2008). Critical care nurses' experiences caring for the casualties of war evacuated from the front line: Lessons learned and needs identified. *Critical Care Nursing Clinics North America*, 20, 41–49.
- Kvale, S. (2006) Dominance through interviews and dialogues. *Qualitative Inquiry*, 12, 480–500.
- Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: a comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3). Article 3. Retrieved on July 2012 from http://www.ualberta.ca/~iiqm/backissues/2_3final/html/laverty.html
- Lev-Wiesel R., Goldblatt H., Eisikovits Z., & Admi, H. (2009). Growth in the shadow of war: The case of social workers and nurses working in a shared war reality. *British Journal of Social Work*, 39, 1154–1174.
- Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis and interpretation*. Thousand Oaks, CA: Sage Publications.
- Linnerooth, P. J., Mrdjenovich, A. J., & Moore, B. A. (2011). Professional burnout in clinical military psychologists: Recommendations before, during, and after deployment. *Professional Psychology Research and Practice*, 42, 87–93.
- Marin, P. (1981). Living in moral pain. *Psychology Today*, November, 1981.
- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, NJ: Prentice Hall.
- Maslach, C. & Leiter M. P. (1997). *The truth about burnout: How organizations cause personal stress and what to do about it*. San Francisco: Jossey-Bass.
- Masler, D. (2014). *The self of the field and the work of Donnel Stern*. Retrieved from: Dissertations and Theses. <http://aura.antioch.edu/etds/178>.

- McDevitt-Murphy, M. E., Williams, J. L., Bracken, K. L., Fields, J. A., Monahan, C. J., & Murphy, J. G. (2010). PTSD symptoms, hazardous drinking, and health functioning among U.S. OEF and OIF veterans presenting to primary care. *Journal of Traumatic Stress, 23*, 108–111.
- Mental Health Advisory Team-VIII (2012). Mental Health Advisory Team (MHAT-8). Operation Enduring Freedom 2012 Afghanistan. Office of the Surgeon General United States Army Medical Command; Office of the Command Surgeon Headquarters, U.S. Army Central Command (USCENTCOM); and Office of the Surgeon General U.S. Forces Afghanistan (USFOR-A).
- Mental Health Advisory Team-VI (2009). Mental Health Advisory Team (MHAT-6). Operation Enduring Freedom 2009 Afghanistan. Office of the Command Surgeon US Forces Afghanistan (USFOR-A) and Office of the Surgeon General, United States Army Medical Command.
- Miller, P. E., & Warner, B. (2013). Post deployment experiences of military mental health providers. *Military Medicine, 178*, 1316–1321.
- Millikan, A. M., Bell, M. R., Galloway, M. S., Lagana, M. T., Cox, A. L., & Sweda M. G. (2012). An epidemiologic investigation of homicides at Fort Carson, Colorado: summary of findings. *Military Medicine, 177*, 404–411.
- Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *Journal of the American Medical Association, 298*, 2141–2148.
- Millon, T., Blaney, P. H., & Davis, R. D. (1999). *Oxford textbook of psychopathology*. New York, NY: Oxford University Press.
- Moore, B. A., & Reger, G. M. (2006). Clinician to frontline soldier: A look at the roles and challenges of Army clinical psychologists in Iraq. *Journal of Clinical Psychology, 62*, 395–403.
- Moore, B., & Reger, R. (2007). Historical and contemporary perspectives of combat stress and the Army combat stress control team; In C. Figley & W. Nash (Eds.), *Combat stress injury: Theory, research, and management* (pp. 161–182). New York: Taylor & Francis Group.
- Morrison, K. (2006). *Marx, Durkheim, Weber: Formulation of modern social thought. 2nd Edition*. London, Thousand Oaks, New Delhi: Sage Publications.
- Moscovici, S., & Lage, E. (1976). Studies in social influence III: Majority versus minority influence in a group. *European Journal of Social Psychology, 6*, 149–174.

- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks: Sage Publication.
- National Public Radio, Inc. Retrieved November, 2005. Investigating the Haditha Killings. <https://www.npr.org/series/5439816/investigating-the-haditha-killings>
- Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs*. New York, NY: Oxford University Press.
- Obama, B. H. (2016). State of the Union Address. Capital Building, Washington DC.
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton.
- Perls, F.S., Hefferline, R., & Goodman, P. (1994). *Gestalt Therapy, Excitement and Growth in the Human Personality*. Gouldsboro, ME: Gestalt Journal Press, Inc.
- Phillips, D. L., & Clancy, K. J. (1972). Some effects of social desirability in survey studies. *American Journal of Sociology* 77, 921–940.
- Poles, H., & Oak, S. (2007). Public health then and now. *American Journal of Public Health*, 97, 2132–2142.
- Polkinghorne, D. E. (1989). Phenomenological research methods. In R. S. Valle & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology: Exploring the breadth of human experiences* (pp. 41–60). New York, N.Y.: Plenum Press.
- Pollio, H. R., Henley, T., & Thompson, C. B. (1997). *The phenomenology of everyday life*. New York, NY: Cambridge University Press.
- Porter, G. (2006). *Perils of dominance: Imbalance of power and the road to war in Vietnam*. Berkeley, CA: University of California Press.
- Provencher, C. (2011). Towards a better understanding of cognitive polyphasia. *Journal for the Theory of Social Behavior* 41, 377–95.
- Ravicz, L. (1998). *The experience of longing (desire, yearning)*. Doctoral Dissertation. University of Tennessee, Knoxville.
- Red Cross. (1949). *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*. Geneva, Switzerland: Geneva Convention.
- Reno, J. (2014, April, 14). *Medicating our troops into oblivion: Prescription drugs said to be endangering U.S. soldiers*. International Business Times.

- Rock, N. L., Stokes, J. W., Koshes, R. J., Fagan, J., Cline, W. R., & Jones, F. D. (1995). U.S. Army combat psychiatry. In *War psychiatry* (pp. 149–175). Washington, DC: Office of the Surgeon General, Borden Institute.
- Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, N.Y.: W.W. Norton & Company, Inc.
- Roubiczek, P. (1952). *Thinking in opposites, an investigation of the nature of man as revealed by the nature of thinking*. London: Routledge and Kegan Paul.
- Russell, M. C., & Figley, C. R. (2017). Is the military's century-old frontline psychiatry policy harmful to veterans and their families? Part three of a systematic review. *Psychological Injury and Law, 10*, 72–95.
- Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain*. New York: W.W. Norton & Company, Inc.
- Schneiderman, A. I., Braver, E. R., & Kang, H. K. (2008). Understanding sequelae of injury mechanisms and mild traumatic brain injury incurred during the conflicts in Iraq and Afghanistan: Persistent postconcussive symptoms and posttraumatic stress disorder. *American Journal of Epidemiology, 167*, 1446–1452.
- Scull, A. (1988). Insanity in the 18th and 19th centuries. *Journal of the Royal Society of Medicine, 81*, 67–70.
- Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S., & Marmar, C. (2007). Bringing the war back home: Mental health disorders among 103,788 U.S. veterans returning from Iraq and Afghanistan seen at Department of Veterans Affairs facilities. *Archives of Internal Medicine, 167*, 476–482.
- Seal, K. H., Maguen, S., Cohen, B., Gina, K. S., Metzler, T. J., Ren, L., & Marmar, C.R. (2010). VA mental health services utilization in Iraq and Afghanistan veterans in the first year of receiving new mental health diagnoses. *Journal of Traumatic Stress, 23*, 5–16.
- Sealey, A., & Carter, B. (2004). *Applied linguistics as social science*. London: Continuum.
- Sheldon, K. M. (2004). The independent effects of goal contents and motives on well-being: It's both what you pursue and why you pursue it. *Personality and Social Psychology Bulletin, 30*, 475–486.
- Shenton, A. K. (2004). The analysis of qualitative data in LIS research projects: A possible approach. *Educational Information 22*, 143–162.
- Sheppard, B. (2000). *A war of nerves: Soldiers and psychiatrists, 1914–1994*. London: Jonathan Cape.

- Simon, W. (2005). Risk, psychiatry, and the military. *British Journal of Psychiatry*, 186, 459–466.
- Somers, D. (2013, June 22). *I am sorry that it has come to this: A soldier's last words*. Gawker Media. [True Stories]. Retrieved from gawker.com/i-am-sorry-that-it-has-come-to-this-a-soldiers-last-534538357.
- Sprang, G. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma*, 12, 259–280.
- Stern, D. B. (2003). The fusion of horizons. *Psychoanalytic Dialogues*, 13, 843–873.
- Stern, D. B. (2010). *Partners in thought: Working with unformulated experience, dissociation, and enactment*. London: Routledge.
- Stern, D. B. (2015). *Relational freedom: Emergent properties of the interpersonal field*. London: Routledge.
- Stigliano, A. (1989). Hermenetical practice. *Saybrook Review*, 7, 47–69.
- Susman, W. (1984). *Culture as history: the transformation of American society in the twentieth century (Vol. 1)*. New York: Pantheon Books.
- Taguba Report (May, 2004). *Article 15-6 Investigation of the 800th military police brigade on treatment of Abu Ghraib prisoners in Iraq*. Retrieved from news.findlaw.com
- Thompson, M. (2013, January 11). Dr. Peter J.N. Linnerooth 1970-2013: How an Army psychologist, who won a Bronze Star in Iraq for keeping troops from killing themselves, couldn't save his own life. *Time Magazine*. Retrieved from <http://nation.time.com/2013/01/11/dr-peter-j-n-linnerooth-1970-2013>.
- Tick, E. (2014). *Warrior's return: Restoring the soul after war*. Boulder, CO: Sounds True.
- U.S. Department of the Army. (1994). *Combat Stress Control Panel, Medical Re-engineering Initiative*. AMEDD Center and School. Fort Sam Houston, Texas.
- U.S. Department of the Army, *Combat Stress: Field Manual (2000)*. Combat and Operational Stress Control FM 6–22 Washington, DC.: Department of Defense.
- U.S. Department of the Army, *Combat Stress: Field Manual (2006)*. Combat and Operational Stress Control FM 8–51 Washington, DC.: Department of Defense.
- U.S. Government Accountability Office. (2012). DOD and VA healthcare: Medication needs during transitions may not be managed for all service members. GAO 13–26.

- van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, F. S., McFarlane, A., & Herman, J. L. (1996). Dissociation, affect regulation, & somatization: The complex nature of adaptation to trauma. *The American Journal of Psychiatry*, *153*, 83–93.
- Voss Horrell, S. C., Holihan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized OEF/OIF veterans: How does trauma treatment affect the clinician? *Professional Psychology Research and Practice*, *42*, 79–86.
- Wessely, S. (2003). Forward psychiatry in the military: Its origins and effectiveness. *Journal of Traumatic Stress* *16*, 411–419.
- Wheeler, G. (1991). *Gestalt reconsidered: A new approach to contact and resistance*. New York: Gardner.
- Wong, P. T. P. (2011). Positive psychology: Toward a balanced interactive model of a good life. *Canadian Psychology*, *52*, 69–81.
- Worth, H. (2006). Unconditional hospitality: HIV, ethics, and the refugee problem. *Bioethics*, *20*, 223–232.

Appendix A

Description and Biographies of Participants

Appendix A

Description and Biographies of Participants

MMHC John (1)

Age: 42

Race: Caucasian

Gender: Male

Degree: Psy.D.

Service Branch: United States Naval (USN) officer stationed overseas.

Provider Status: Department of Defense/Civilian

Professional Experience: Licensed family and marriage therapist (LFMT) for 15 years.

Military Experience: 9 years with the USN

Primary Therapeutic Modality: Eye Movement Desensitization Reprocessing (EMDR).

John (1) At the time interviews were conducted, John was a 42-year-old Caucasian United States Naval (USN) officer stationed overseas. His provider status was documented as a Department of Defense/Civilian, and he had been a licensed family and marriage therapist for 15 years. During John's 9-year history within the USN, he identified that his primary theoretical orientation belonged to the theory behind and application of Eye Movement Desensitization Reprocessing (EMDR).

John had gained a high level of confidence in his ability to deliver EMDR in a productive manner that returned very favorable results in helping warriors get through their immediate and extreme suffering and pain associated with war stress injury and return to duty. Along with a high level of satisfaction with EMDR as his primary treatment modality, and as a skilled advocate for warrior healing, John reported a high level of job satisfaction, high personal morale, and low compassion fatigue.

John described his overriding personal motivation as being able to serve as a strong and effective advocate with and for warriors. His advocacy was expressed in terms of his work being "an honor – being in the presence of heroes," as creating a sense of "humbleness," in him and a sense of "purpose and passion to guide them through 'the fog of war.'"

John discussed ways in which the military culture created well-meaning directives to military mental health providers addressing how to provide diagnoses and resulting psychological care for war stress injured warriors; however, these directives actually resulted in limiting psychological care to war stress injured warriors. For example, John discussed how, by directive, he and his peers are instructed to diagnose V-codes and Adjustment Disorders—regardless of actual diagnosis. He explained that a diagnosis of a V-code or Adjustment Disorder does not require or allow for the more in-depth, longer-term interventions and therapies, not even the use of DoD/VA approved evidenced-based therapies like EMDR, Prolonged Exposure, or Cognitive-Reprocessing. He explained that most of the warriors that he sees have a true diagnosis of PTSD, Major Depression, or Anxiety that would indicate longer-term intervention and treatment using such therapies as EMDR, Cognitive-Reprocessing, or Prolonged-Exposure. Because of military directives, John is only sanctioned to diagnose V-Codes or Adjustment disorders requiring only limited intervention.

John discussed ways in which he successfully resisted these "antiquated military directives" that had the effect of limiting psychological care to warriors experiencing war stress

injury. While obeying the letter of the directive and limiting his diagnosis to V-codes or Adjustment Disorders, John used the longer-term therapy, EMDR, with patients who needed it and continued to provide treatment to his patients until he felt they were able to return to active service.

When responding to criticism from superiors, John was able to continue this meaningful resistance by sharing his belief that financial exposure was a leading force for the directives that limited treatment. He voiced that opinion to his superiors, if only in an implied way, with his impassioned plea to them, “We are at war, and nothing these soldiers need should be denied to them.” In this way he was able to provide rapid and comprehensive assessment and treatment of war stress injuries to his comrades who sacrificed so much, regardless of directives that sought to limit financial loss.

John was clear that prospective therapists who would want to provide psychological care to this clinical population, would be well-advised to take on one of the evidenced-based DoD/VA approved therapies, or else these therapists “will have a relatively short shelf-life” in their efforts to successfully provide care. Finally, he concluded by making an emphatic exclamation, “Systemic issues should never get in the way of providing care...Never.”

MMHC Mary (2)

Age: 32

Race: Asian

Gender: Female

Degree: Psy.D.

Service Branch: USN

Provider Status: DoD/Civilian overseas

Years of Professional Experience: 7 years

Years of Military Experience: 2 years (officer/psychologist USN)

Primary Therapeutic Modality: None specified/within psychodynamic theories

Mary (2) was a 32-year-old Asian female contracted with DoD/Civilian overseas. She had provided seven years of mental health care as a Psy.D with two of those years serving in the capacity of an officer/psychologist in the United States Navy. During Mary's branch service, she identified her theoretical orientation from within the psychodynamic theories, but did not specify any particular method from those theories. Mary indicated that the overall impact of providing psychodynamic methods of therapy to this clinical population is somewhat effective. She described experiencing a general sense of uneasiness or discontent with her own confidence in delivering therapeutic interventions to the war stressed injured warrior, and she was equally disquieted about her overall satisfaction with clinical outcomes and resolutions to the psychological traumas brought about by war stress injury.

Mary discussed her personal and professional interest in working with family members of active-duty service members experiencing war-stress injury. She identified insufficient clinical training for military mental health care providers, staffing shortages, high caseload demands and pressure to diagnose in a certain way as factors that limited her effectiveness. Despite these military institutional barriers, Mary reported that she was generally satisfied with her job duties in the military, and that she maintained adequate personal morale, while experiencing some minimal compassion fatigue.

MMHC Susan (3)

Age: 37

Race: Caucasian

Gender: Female

Degree: Psy.D.

Service Branch: USN

Provider Status: Active Duty

Years of Professional Experience: 4 years

Years of Military Experience: 3 years

Primary Therapeutic Modality: Prolonged exposure/interpersonal relational theory

Susan (3) was a 37 year-old female active duty psychologist (Ph.D.) for 4 years, 3 of those years in the United States Navy. Her primary theoretical orientation was based in prolonged exposure, though she described developing her own method by integrating interpersonal relational theory into prolonged exposure therapy. In responding to the Participant Information Form, Susan classified her ability to deliver intervention as very high. She also indicated that her level of satisfaction with treatment design as very high. Interestingly, she noted only average results with regard to treatment effectiveness, highlighting that the low level of patients' readiness and commitment were barriers and challenges that impeded higher rates of treatment effectiveness. Susan marked her level of job satisfaction and personal morale as high. She did not mark any significantly negative or positive experiences that led to any concerns about her level of compassion fatigue.

Susan reported experiencing passion in providing care to the service members in an environment that she described as hostile and unforgiving at times. She took particular pride in her ability to quickly establish a rapport and connection with warriors experiencing war stress injury. She expressed feeling an internal pressure to relieve the severe pain and suffering these warriors were experiencing. Susan discussed her excitement and feeling of importance in connecting with service members by using a "no bullshit" approach as she conducted fit for duty evaluations and established treatment plans. For those service members who resisted or were not willing to engage in her evaluation or treatment plans, she unabashedly discussed how she used her rank to force service members into compliance or face reprimand. Susan described using interpersonal relational therapy as a way to earn the trust of her clients, and she described earning the trust of her clients as her main objective in conducting this therapy.

Susan discussed how commanders would only challenge her clinical judgment when she recommended separation or medical evacuation from the front lines for her clients. When commanders ordered her to change her recommendations and retain the service member, Susan would decline and remind command about her responsibility and accountability to ADSMs. She would then say, "If you go against my evaluation and recommendations for separation, his suicide is on your head, not mine." She reported that commanders would back down.

MMHP Pete (4)

Age: 35
Race: Caucasian
Gender: Male
Degree: Psy.D.
Service Branch: USN
Provider Status: Active Duty
Years of Professional Experience: 10 years
Years of Military Experience: unspecified
Primary Therapeutic Modality: Cognitive-reprocessing

Pete (4) was a 35 year-old Caucasian male serving as an officer and psychologist (Ph.D.) in the United States Navy. Though he did not identify his length of service in the military, Pete had been a mental health clinician for over 10 years. He subscribed to the cognitive-reprocessing theoretical orientation.

Pete did not provide written information on his Participant Information Form regarding his level of treatment satisfaction, effectiveness, and confidence, nor his level of job satisfaction, personal morale, and level of compassion fatigue versus compassion growth. When describing his internal experience of being a provider, Pete frequently expressed his frustrations in his job satisfaction. He described how the military operation set up situations in which he experienced increased anxiety, hopelessness, and marginalization, specifically when dealing with professional ethics issues such as client abandonment, dual relationships, and confidentiality breaches. He holds the military structure responsible for his internal experience of powerlessness and limitation.

Pete held onto evidenced-based DoD/VA approved empirical strategies as a way to ground his work as well as himself, and to give himself a way to attenuate his own anxiety and depression in experiencing so much unrelenting horror of war.

In a straightforward manner, Pete described one of his coping strategies was to know his own limits: first as an officer, and then as a psychologist. Pete felt that many ambiguous moral dilemmas could be overcome in short order by being aware of where one's primary allegiance rested. Pete verbalized barriers that negatively impacted his experience as a military mental health clinician. As with John and Mary, Pete also felt limited in his ability to make an honest and full diagnosis of what he saw in soldiers under his care, because of directives issued by the military leadership regarding what kinds of diagnosis were to be made.

MMHP Mark (5)

Age: 54

Race: Asian

Gender: Male

Degree: Psy.D

Service Branch: none

Provider Status: DOD/VA Civilian psychologist

Years of Professional Experience: unspecified

Years of Military Experience: unspecified

Primary Therapeutic Modality: Cognitive behavioral

Mark (5) was a 54 year old Asian male identified as a DOD/Civilian psychologist (Ph.D.) whose primary theoretical orientation was cognitive behavioral. He came from a strong background in providing neurocognitive rehabilitation as well as supervising clinical psychologists at a large metropolitan Veterans' Administration hospital. Mark was sought out by DOD/VA to lead the development and coordination of policy and standards throughout the military. He took his position directives very seriously, and described his initial goal as introductory in nature, "Hello, DoD. This is VA and VA, this is DoD." He described many current differences between DoD and VA obligations and standards in terms of mental health.

When completing his Participant Information Form, Mark did not identify his levels of treatment satisfaction, confidence, and effectiveness. He did not indicate his levels of job satisfaction, personal morale, and compassion fatigue or compassion growth. He was able to discuss that evidenced-based treatment was effective in alleviating PTSD symptoms and that treatment for PTSD had greatly improved from the Vietnam Era.

Furthermore, Mark described and discussed his experiences relating to providing care to war-stress injured service members. He was profoundly impacted by hearing traumatic and repeated traumatic stories. He also was profoundly impacted by the level of neuropsychological functioning impairment of those with PTSD. He described his initial reactions as being "blown-away" and his "mouth dropping to the floor." He expressed a general sense of not being prepared for what he saw. Mark noted that only a few signature war injuries are being identified, tracked, treated, and researched, leaving a large number of warriors untreated or undertreated.

MMHP Rachel (6)

Age: 59

Race: Caucasian

Gender: Female

Degree: Ph.D.

Service Branch: none

Provider Status: non DoD/VA civilian contracted by military

Years of Professional Experience: not specified

Years of Military Experience: 21 years

Primary Therapeutic Modality: not specified

Rachel (6) was a 59-year-old Caucasian female Ph.D. who was the only Non DoD/VA civilian participant included in this study. By way of being contracted by the military, she has over 21 years of experience in providing psychological care to U.S. military active duty and veteran populations experiencing war-stress injury. In addition to providing direct care, her most recent contracted work also involves educating and training military and civilian clinicians working with this population. She is an avid proponent of using language consistent with the warrior ethos of pride, honor, duty, bravery and strength. In order for civilian clinicians to begin to understand the military culture, its values, use its language and learn to be strong advocates at every turn, Rachel requires the civilian clinicians she trains to become immersed in military culture. She requires them to accompany clients to medical and psychological evaluations, to participate with them in military-based activities such as motorcycling, playing softball and going to special family events. She also encourages civilian clinicians to express their advocacy for government support services by writing letters to senators, representatives in congress and other governmental offices that could be supplying services to support military personnel and their families.

Rachel identified very high levels of treatment confidence and satisfaction but only marginal treatment effectiveness, noting staffing shortages and lack of funding as negatively impacting overall treatment effectiveness. She listed her level of job satisfaction and personal morale as high with low levels of compassion fatigue.

MMHP Tim (7)

Age: 32

Race: Caucasian

Gender: Male

Degree: Psy.D.

Service Branch: USAF

Provider Status: Active Duty

Years of Professional Experience: 6 years

Years of Military Experience: 4 years

Primary Therapeutic Modality: Cognitive-Processing/Prolonged Exposure

Tim (7) was a 32-year-old Caucasian Psy.D. in the United States Air Force. He had provided psychological services for over 6 years, 4 of which had been as an officer within the USAF. Tim had served six-months in Iraq, and through that experience had become an outspoken advocate for providing evidenced-based care to warriors experiencing war-stress injury. He strongly endorsed using Cognitive-Processing and Prolonged Exposure therapies. As was the case with John, Tim also stated that he would mandate required education and training in one of the major DoD/VA approved theoretical orientations for civilian therapists who wanted to work with war-stress injured warriors.

Tim provided insight and nuance into understanding the difference between PTSD and Moral Injury within the context of being a military combatant during OEF and OIF. Tim described how PTSD had to do with a soldier surviving a traumatic battlefield event, whereas Moral Injury had to do with causing and/or failing to prevent atrocities that transgressed beyond the boundary of what would be considered morally and ethically acceptable.

Tim was relentless in his advocacy for prompt, rapid, and comprehensive intervention for these warriors whom he saw as being in excruciating pain, experiencing PTSD, and intractable from the unrelenting guilt, shame, and judgment associated with moral injury.

Appendix B

Participant Informed Consent Form

Appendix B

Participant Informed Consent Form

Antioch University Seattle Informed Consent Form

Antioch University Seattle supports the practice of protection for human participants in research and related activities. The following information is provided to you so that you can decide whether you wish to participate in this study. Even if you agree to participate, you are free to withdraw at any time. If you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach by this institution.

(Tentative) Title of Research: Gaining Understanding about the Complexities of Treating Combat-Stress Injury: Active Duty and Department of Defense (DoD)-Civilian Mental Health Clinicians' Views

Investigator: David Vandegrift, Psy.D. Student

Faculty Advisor/Dissertation Chair: Mark Russell, Ph.D.

Study Topic

This phenomenological-interpretive study is designed to obtain a richly detailed and in-depth description of a participant's personal/professional experience(s). Specific to this dissertation, I will be inquiring into your personal/professional experiences as you provide care to soldiers suffering from combat stress injury. The overarching dissertation research question: "What is the experience of active military and DoD-civilian mental health care providers as they provide services to soldiers suffering from war- stress injury?"

What to Expect

I will be conducting a confidential interview with you at a time and place of your choosing. This could be in person, Skype, or other means as directed by you. You will be asked to respond to the following research interview question: "Can you talk about some times when you provided care to an active military soldier experiencing war-stress injury?" After completion of this 45 to 90 minute interview, I would like to ask you to complete a brief survey that will take about 5 minutes. You can request an additional follow up session if you would like. I want to be accurate with our interview data. I will transcribe our word-by-word interview and return this text to you for your clarification and/or additional comments. This final written document constitutes the text to be studied.

Current Risk

There are no risks or discomforts that are anticipated from your participation in the study. However, your participation in this study may run the risk of exposing you to personal traumatic memories. As a result, you could experience personal emotional pain.

Future Risk

There are no future risks or discomforts that are anticipated from your participation. All effort will be utilized to protect your identity. Data, text, and records will remain in a double locked

safe with two protected combination codes. Digital and audio/visual equipment will be erased and destroyed the day after verification of accuracy of transcriptions. Only my dissertation chair will have access to these codes in case of some unforeseen circumstance affecting this researcher. All text data must be maintained in a secured situation for at least one year after analysis and longer if the report is publicized.

Provisions for any possible emergency that might arise as a result of participation in this study:

You can have access to 24-hour emergency support to help deal with any negative consequence of participation in this study. Access to this support can be facilitated in consultation with you. You would have access to debriefing sessions with this researcher to assist with managing any negative consequence of participation. Referrals to community professionals would also be available if requested.

Benefits

Your participation in this study can contribute new knowledge to the field of combat-stress injury and war trauma. As experts in this field, you have the chance to offer your experiences and knowledge to your colleagues and potentially to others invested in providing care to military warriors. Your participation in this study can contribute to the welfare of the very men and women of the military who answer their call to duty. Moreover, this study is designed to give voice and recognition to active duty and Department of Defense mental health clinicians who have answered their call to duty. (MD's, Psychiatrists, Psychologists, Nurse Practitioners, Social Workers, and Family Reconciliation Workers.)

Incentives

There are no added incentives for participation in this study. Participation is voluntary. No financial or other form of incentive is used.

I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved. I understand the potential risks involved, and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach. I may also ask for a summary of the results of this study. If I have questions, I may contact the investigator, David Vandegrift, at dvandegrift@antioch.edu or Faculty Research Advisor and dissertation chair, Mark Russell, at mrussell@antioch.edu.

In lieu of my signature, I indicate my choice to participate with an "X".

Signature (if you wish) _____

In lieu of signature, you may simply mark one of the following informed consent designations:

_____ I do offer my informed consent _____ I do not offer my informed consent.

Date _____ Code Identifier: ANSE-XXXX

Appendix C

Informational Form: Participant Demographics Questionnaire

Appendix C

Informational Form: Participant Demographics Questionnaire Adapted from Mark Russell, Ph.D.

Date: _____

Gender (circle one): Male Female

Age _____

Provider Type (circle one): Active-duty DoD-civilian DVA Non-DoD/VA-civilian

Credential (circle one): MD Ph.D./PsyD MSW/LCSW MFC/LMC Other: _____

Branch (circle one): USA USAF USN USMC VA Non-DoD/VA How many years? _____

Total number years as practicing MH clinician? _____ **Deployed to:** OIF OEF **Total Months:** _____

Race (select one or more): American Indian or Alaska Native ___ Asian ___ Black or African American ___

Native Hawaiian or Other Pacific Islander ___ White ___ Other ___

Ethnicity (circle one): Hispanic or Latino ___ Not Hispanic or Latino ___

Theoretical Orientation or Preference to Clinical Care: Psychoanalytic ___ EMDR ___ Psychodynamic ___

Cognitive-Behavioral ___ Rational Emotive Therapy ___ Exposure Therapy ___ Family Systems ___

Alternative Therapies _____ **Other:** _____

A. Practitioner Level of Confidence, Effectiveness, Satisfaction in Clinical Outcomes of War-Stress Injury

1. Please rate your overall level of confidence to successfully treat war-stress injury: (circle one)

(1) Very Low (2) Low (3) Neutral (4) High (5) Very High

2. Please estimate your overall level of effectiveness in providing symptom improvement in war-stress injury treatment cases?

(1) Not effective/marginally effective (2) Somewhat effective (3) Very effective (4) Very effective
(0 – 25% improvement) (25 – 50% improvement) (51 - 75% improvement) (76 - 100% improvement)

3. How would you rate your overall level of satisfaction with clinical outcomes in treating war-stress injury?

(1) Very Dissatisfied (2) Dissatisfied (3) Neutral (4) Satisfied (5) Very Satisfied

B. Which of the following barriers impact your ability to provide the highest quality of care? (check or circle all that apply):

None staffing shortages insufficient clinical training competing collateral/administrative duties

attrition high caseload demands provider compassion fatigue/burnout

pressure to diagnose or treat in particular way Other:

_____.

C. Clinician Morale and Job Satisfaction

1. Over the past year, how would you describe your overall level of job satisfaction as a provider working in military healthcare?

(1) very dissatisfied (2) dissatisfied (3) neutral (4) satisfied (5) very satisfied

2. Over the past year, how would you describe your overall level of morale as a provider working in military healthcare?

(1) very low (2) low (3) no change (4) high (5) very high

3. Over the past six months, my level of 'compassion fatigue' and/or 'burnout' would best be described as:

(1) none (2) very low level (3) low level (4) no change in level (5) high level (6) severely impaired function

D. Please provide additional comment(s) about any of your experiences while providing care to those suffering from war-stress injury:

Thank you for taking the time to complete this information form.

Please return this informational form and the informed consent in the self-addressed stamped envelope or email these completed forms to dvandegrift@antioch.edu

Appendix D

**Antioch University Seattle
Institutional Review Board to use Human Participants**

Appendix D

Antioch University Seattle Institutional Review Board to use Human Participants

This application should be submitted electronically to the IRB Chairperson, at IRB_AUS@antioch.edu after pre-scientific review and approval by student Faculty Research Advisors or Dissertation Chair. Please include the Informed Consent Document and a copy of any fliers, questionnaires, or assessment instruments you plan to use. When the application is approved you will be requested to provide a hard copy with all the signatures to the Academic Dean's office.

Name of Researcher: David Vandegrift

Phone Number: (xxx) xxx.xxxx.

Email Address: dvandegrift@antioch.edu

Department: Antioch University Seattle Psychology Department

Research Advisor or Chair of the Dissertation Committee: Mark Russell, Ph.D.

Date Proposal Submitted: 03. 01. 2011.

Title of Research Project: Understanding the Complexities of Treating War-Stress Injury: Active Duty and Department of Defense-Civilian Mental Health Clinicians' Views

Funding Agency: NA

Project Purpose(s):

Using a phenomenological hermeneutic framework, I will inquire into the experiences of active duty and Department of Defense civilian mental health clinicians who provide care to military personnel experiencing war-stress injury. By using research questions designed to uncover the meanings of the clinicians' experiences while providing care to active military service members, I will attempt to create a dialogic atmosphere in which the clinician can describe some of their understandings of and perspectives about providing care. Descriptive data will be collected, analyzed, and coded for thematic content. This data will then be the text from which interpretations and increased understandings may take place. Data will then be analyzed and interpreted to increase understanding of what it is like to provide care to active military personnel in current day operations.

Describe the Proposed Participants:

Active duty and Department of Defense civilian mental health clinicians who provide care to the warrior population experiencing war-stress injury will be identified and approached to participate in this study. Variables collected in this project will include age,

gender, ethnicity, theoretical orientation/preference, number of years providing care, training and education in the area of war-stress injury and trauma.

Describe the Participant Selection Process:

Military mental health clinicians (active and civilian) from within the field of psychology, psychiatry, and social work will be recruited in order to be interviewed about their clinical work while providing clinical care to warriors experiencing war-stress injury. These participants will be purposely, rather than randomly, selected to insure that those interviewed will have direct experience working with soldiers suffering from war-stress injury. Participants will be recruited through personal networking. Moreover, these participants may be selected from a variety of active military bases located in forward deployed locations. I will contact prospective participants by a secured and confidential letter or email containing a brief statement about the intent and significance of the study. Interested parties will be sent Antioch Informed Consent Form with the researcher's request to read, ask questions, and sign that document if a participant has interest in participation. Upon receiving these forms, I will contact the potential participant by their preferred method contact to answer any questions and schedule interview availability.

The Proposed Procedures in the Project:

Participation in the study involves a dialogic interview process. After completion of the interview process, the participant will be requested to complete a short demographic survey form estimated to take about 5 minutes to complete. Interviews are to be conducted in an agreed upon process that includes ways to protect confidentiality, anonymity, scheduling, methods of recording and data collection, and location of interviews. Insuring privacy is of the utmost concern and responsibility of the interviewer. By assuring confidentiality, the interviewer can help create an open atmosphere in which dialogue with active duty and Department of Defense civilian mental health clinicians' attitudes, feelings, expectations, reactions, and associations connected with providing clinical care to active warriors suffering war-stress injury. Each interview will be allotted 1-1.5 hours long. An additional follow up session may be requested as a means to assure authenticity to the respond to the participant's interview process. Each participant will complete a coded and secured Information Form and the Informed Consent to Research Statement. Time will be allotted to answer any questions regarding research transactions to foster an atmosphere of trust and openness in which dialogical expression is encouraged.

Research questions were designed to elicit both direct and indirect experiences and feeling of active and civilian military mental health clinicians while providing care to war-stress injured soldiers. Verbatim transcriptions will be completed for each interview. These transcriptions constitute the text to be studied and interpreted. All interviews, texts, and records will be kept confidential. Each interview will be recorded and kept on a separate audiotape until such a time that the verbatim transcript has been approved by participants. All texts and interviewer notes will be stored in individualized and separate envelopes identifiable only by corresponding code number of interviewee. Each packet will contain information form, consent for research, participant's code number, sex, ethnicity, theoretical orientation. All envelopes are to be kept in a locked file cabinet. The identifying codes are to be kept as a reference on the researcher's computer backed up on encrypted files and protected by a two level password system that is inaccessible to anyone except the researcher. Furthermore, if any of the interviewees have additional requirements for

anonymity, confidentiality, or other unforeseen issue, this researcher will make any and all effort to meet any additional requirements for participation in this study.

Observations may be detailed in hand-written notes that makes comment on the setting, the interview process, behaviors and activities of participants at the research sites, personal reflections regarding the actual process prior to, during, or post interviews. These observation notes will be catalogued by time and date and will be securely filed in locked file cabinet.

Interviews and any follow up interview process will be conducted in a face-to-face scenario. If in-person face-to-face interviews are not possible, interviews will be conducted by secured audiovisual equipment through Skype or as directed by Antioch University Seattle.

The main phenomenological research inquiry for this study has to do with understanding the experiences of military mental health clinicians while providing clinical care to active military soldiers suffering war-stress injury. The research question may be best understood by the following overarching inquiry: “What is the experience of military practitioners while providing clinical care to active military service members suffering from or impacted by war-stress injury?”

To elicit personal experiences in providing clinical care, the main interview question has been constructed in an open-ended inquiry: “Can you talk about some times when you provided care to an active military soldier experiencing war-stress injury?”

If further inquiry is needed to draw out the experiences of the practitioners, the following questions may be used for this purpose. They read as follows:

“What tensions, competing interests, or dilemmas did/do you experience in your clinical care examples?”

“What have been your personal successes or struggles in treating war-stress injured soldiers and their families?”

“What is not being talked about that needs to be talked about in the field of war-stress injury?”

“Why might that be?”

Public documents, private documents, and professional peer-reviewed documents may be collected and incorporated into this qualitative inquiry into the experiences of practitioners. These may include newspaper articles, minutes of meetings, official reports, personal journals, letters, and e-mails. All identifying information regarding the originating or receiving parties will be vetted in which privacy, anonymity, and confidentiality is assured.

Audio-visual digital recorder will be used to obtain data. Digital recording will be destroyed once data has been transcribed verbatim and verified for authenticity and correctness. Transcriptions will become the text to be interpreted. These transcriptions will remain in the software application until the completion of this study and for the customary timeframe of four years following successful defense of this dissertation. Any and all records will be stored in a secured filing cabinet accessible only to the researcher. The Dissertation Chair will have an emergency key for the locked filing cabinet for the purpose of obtaining and destroying any and all research materials in this locked filing cabinet in the event of unforeseen circumstances preventing the researcher from completing this study. The Dissertation Chair will destroy all materials as per Antioch University Seattle protocol.

Data Organization for Analysis:

The following order of organization is a purposefully obtained way in which data could be handled.

1. Organize and prepare the data for analysis. This includes all observations, interviews, follow-up interviews, all documents, and all transcriptions.
2. Read through all the data. Obtain a general sense of the information and reflect on the overall meaning. What general ideas are participants saying? What is the tone of the ideas? What may be the impression (s) of overall depth, credibility, and use of information? Start writing notes in margins.
3. Code all information into “themes.” These themes will be interpreted, meanings obtained, and new unfolding of knowledge and understanding will be facilitated. A systematic purposeful process of analyzing textual materials would include the following general ideas.
 - Get a sense of the “whole” and the “parts” of this phenomenon from the understanding of the participants.
 - Choose one text and carefully read for its underlying meaning. (Do not think about the substance of what specifically was said.)
 - Complete this process for several participants’ texts. Begin list of all topics that emerge at this time. Cluster similar topics into major topics, unique topics, and leftover topics.
 - Take list back to data and begin the process of coding.
 - Find the most descriptive words for topics and turn them into categories. Look for ways to reduce total list of categories.
 - Alphabetize these codes and categories.
 - Assemble the data material belonging to each category in one place and perform a preliminary analysis.
 - Re-interpret existing data.
4. Use this coding process to generate a description of the setting, participants, and the studied phenomenon. Use this process for creating themes for analysis and to inter-relate themes to enrich higher level of interpretation and abstraction.
5. Use a narrative passage to convey the findings of the analysis. Possibly use graphs, tables, figures or other visuals to enhance these descriptive qualities of war-stress injury.
6. Interpretative Analysis Process. Leonard (1994) outlined three steps for the interpretive analysis that will be utilized in this study:
 - 6.1. Thematic Analysis, where each case is read several times in order to arrive at a global analysis. Lines of inquiry are then identified from the theoretical background that grounds the study and from the themes consistently emerging in the data. An interpretive plan emerges and then each interview I re-read from the perspective of this plan. After this re-reading general categories will be identified and these categories form the basis of the study’s findings.
 - 6.2. Analysis of specific episodes or incidents: all aspects of a particular situation and the participant’s responses to it are analyzed together. The individual’s situation—his or her concerns, actions, and practices—is analyzed, not his or her opinions, analyses, or ideology. From this analysis come ‘exemplars’: stories or vignettes that capture the meaning in a situation in such a way that meaning can be recognized in another situation that might have very different objective circumstances.

- 6.3. Identification of paradigm cases, that is, strong instances of particular patterns of meaning. Paradigm cases embody the rich descriptive information necessary for understanding how an individual's actions and understandings emerge from his or her situational context, concerns, practices, and background meanings (Leonard, 1994, p.59).

PILOT STUDY: A pilot study will be utilized as a pre-test or trial-run in which processes of this full-scale qualitative inquiry will be conducted, reviewed, and evaluated (Polit, Beck, & Hungler, 2001). However, a pilot study can also be the pre-testing or 'trying out' of a particular research instrument (Baker 1994). One of the advantages of conducting a pilot study is that it might give advance warning about where the main research project could fail, where research protocols may not be followed, or whether proposed methods or instruments are inappropriate or too complicated (DeVuas, 1993).

This pilot study will be written up as part of the methods section of this dissertation; however, the findings therein will not be included in the actual texts elicited, coded, and interpreted from military practitioners dealing with war-stress injuries of war veterans. Rather, this pilot is constructed to offer a detailed report as to design, findings, leaning from, and necessary changes that may be necessitated for the full-scale inquiry. Information, both successful and less than successful, in this pilot study might be very useful to others embarking on projects using similar methods and instruments. This is particularly important because pilot studies can be "time-consuming, frustrating, and fraught with unanticipated problems, but it is better to deal with them before investing a great deal of time, money, and effort in the full study" (Mason and Zuercher, 1995).

The term "pilot study" refers to mini versions of a full-scale study (feasibility study), as well as the specific pre-testing of a particular research instrument. In this case, the research instrument is a series of possible questions and specific processes meant to elicit a discussion or dialogue with military practitioners who provide services to the warrior population of OIF and OEF suffering from war-stress injury. As will be reflected in the actual qualitative inquiry, this pilot will include the collecting, coding, and theme analysis of the interview text. Upon completion of this document, I will review this with the pilot interviewee for his/her comment on its content and any needed corrections. Once this second meeting is completed, I will use hermeneutic philosophy to interpret the findings of this pilot. Reasons for conducting pilot studies include:

- Assessing the feasibility of a (full-scale) study/survey;
- Designing a research protocol;
- Assessing whether the research protocol is realistic and workable;
- Establishing whether the sampling frame and technique are effective;
- Identifying logistical problems which might occur using proposed methods;
- Collecting preliminary data;
- Assessing the proposed data analysis techniques to uncover potential problems;
- Develop or Re-develop a research question and research plan;
- Uncover local and national politics, cultural tensions, biases and prejudices that are important in any research process (Peat, Mellis, Williams, & Xuan, 2002).

There are many benefits associated with conducting a pilot study. On the other hand, pilot studies may have limitations. For one, there is a possibility of making inaccurate predictions, assumptions, or interpretations on the basis of pilot data. For another, problems could arise from contamination. These problems of contamination could arise in at least two ways. Data from the pilot study could be and are frequently included in the main results. Secondly, contamination may result where pilot participants are included in the main study, but new data are collected from these people. These pilot participants theoretically have already been exposed to an inquiry, and therefore, may respond differently from those who have not previously experienced the research inquiry.

Given that this research is qualitative and interpretive, limitations such as contamination is less of a concern. In fact, frequently pilot data is included with the primary study. Qualitative data collection and analysis is often progressive, in that a second or subsequent interview in a series may be 'better' than the previous one as the interviewer may have gained insights from previous interviews which are used to improve interview schedules and specific questions. Some have therefore argued that in qualitative approaches separate pilot studies are not necessary (Holloway 1997). Frankland and Bloor (1999) argue that piloting provides the qualitative researcher with a "clear definition of the focus of the study" which in turn helps the researcher to concentrate data collection on a narrow spectrum of projected analytical topics. Piloting of qualitative approaches can also be carried out if "the researcher lacks confidence or is a novice, particularly when using the interview technique" (Holloway, 1997).

Will questionnaires, tests, or related research instruments not explained above be used?

Yes No

Will electrical or mechanical devices (biofeedback, electroencephalogram, etc.) be used?

Yes No

Will audio-visual devices be used?

Yes No

I will be using an Antioch digital recorder for voice recording the individual sessions. Next, I will transcribe recorded data verbatim on a secured computer. Once transcriptions are completed, verified, and re-verified for accuracy and comprehensiveness, the digital recording device will be erased in full. If the participant wants to be present at the time of the erasing of the recording, I will facilitate this meeting time.

Current Risk:

There are no risks or discomforts that are anticipated from your participation in the study. Participation in this study potentially runs the risk of having exposure or re-exposure to personal experiences that could result in emotional and psychological harm through the process of interviews. This process could result in personal re-exposure to past or current traumatic experiences or increasing the possibility of contributing to professional burnout or compassion fatigue. If this is the case, there could be harm done not only to the individual

research participant, but potentially compromising the quality of care and therapy to active military patients and their families.

Future Risk:

Exposure risk of the participant to colleagues, supervisors, or higher levels of command will be minimal given that participation will be anonymous and confidential. All effort will be utilized by this researcher to protect participant identity by not collecting any identifiable information. Moreover, all digital and audio/visual equipment will be erased and destroyed the day after transcription completion and verification that text reflects verbatim content of recordings. I will notify the participant as directed by them as to how they want to be notified i.e. email, in person, phone call, etc. This will be one measure to protect participant anonymity and confidentiality. No other person, other than my dissertation chair, will have access to any content or text as all data will be kept in locked combination safe with a protected combination code. Only my dissertation chair will have access to this code in case of some unforeseen issue like death or impairment of this researcher. All text data must be maintained in a secured situation for at least one year after analysis and longer if the report is publicized.

How do the benefits of the research outweigh the risks to human participants? The field of psychology needs to constantly assess current practice, participate in the contribution of new knowledge and understanding of complex human conditions. By seeking to understand the experiences of the study participants, it is hoped that new knowledge will be gained through the very mental health clinicians who are providing clinical care to warriors exposed to war-stress injury. Specific to this research, issues of identification, assessment, diagnosis, treatment, and evaluation of trauma in general and war-stress injury in particular can be brought to light by military psychologists heavily involved in these endeavors. By utilizing the phenomenological-interpretive design, it is the hope of this research that data gathered, analyzed, and interpreted can contribute to the welfare of military service members and their families by seeking greater understanding from the military mental health clinicians who offer their professional lives to the men and women who answer their call to duty.

Are there any possible emergencies that might arise in utilization of human participants in this project?

Yes No

As mentioned before, research inquiry into the personal and professional impact of providing care to active military service members could create a situation in which distressing thoughts, feelings, and or actions could emerge in the participant. Provisions for dealing with emotional and or psychological distress would include access to 24 hour emergency psychological support, access to debriefing sessions with this researcher in which to increase the alleviation of traumatic memories that could have come about by participating in this study. In addition, a participant could reach this researcher via contact information listed in this document for the purpose referrals to community professionals if requested. Moreover, this researcher will include in this document any additional requirement that a participant may have as a condition of their participation.

Any additional requests and or requirements will be addressed in consultation with this researcher's faculty advisor/dissertation chair.

What provisions will you take for keeping research data private?

Exposure risk of the participant to colleagues, supervisors, or higher levels of command will be minimal given that participation will be anonymous and confidential. All effort will be utilized by this researcher to protect participant identity by not collecting any identifiable information. Moreover, all digital and audio/visual equipment will be erased and destroyed the day after transcription completion and verification that text reflects verbatim content of recordings. I will notify the participant as directed by them as to how they want to be notified i.e. email, in person, phone call, etc. This will be one measure to protect participant anonymity and confidentiality. No other person, other than my dissertation chair, will have access to any content or text as all data will be kept in locked combination safe with a protected combination code. Only my dissertation chair will have access to this code in case of some unforeseen issue like death or impairment of this researcher. All text data must be maintained in a secured situation for at least one year after analysis and longer if the report is publicized.

Are there any incentives for participation?

There are no incentives for participation in this study. Participation is voluntary no financial or other form of incentives are used in any way, shape, or form.

Attach a copy of the informed consent document as it will be used.

STATEMENT OF AGREEMENT: I have acquainted myself with the policies and procedures regarding the use of human participants in research and related activities and will conduct this project in accordance with those requirements. Any changes in procedures will be cleared through the IRB.

Signature of Principal Investigator(s) _____ Date _____

For Research Conducted by Students: This research involving human participants, if approved, will be under my supervision. I have reviewed and approved this proposal.

Responsible Faculty or Dissertation Chair: Mark Russell, Ph.D.

Faculty Signature _____ Date: _____

PLEASE SUBMIT AN ELECTRONIC COPY OF THIS INFORMATION TO:

IRB_AUS@antioch.edu. Please also submit one hard copy to the Academic Dean's office after the project has been approved. Approval must be reviewed on a yearly basis. Any change or amendments require IRB approval

By completing and submitting this form I certify that:

- The information provided in this application form is correct.
- I will notify my Advisor/Committee Chairperson and the Chairperson of the Review Committee in the event of any substantive modification in the proposal, including, but not limited to changes in cooperating investigators and agencies, as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study will be promptly reported.
- Any significant new findings which develop during the course of this study which may affect the risks and benefits to participation will be reported in writing to my Faculty Advisor/Committee Chairperson, the IRB Chairperson, and to the participants.
- The research may not and will not be initiated until final written approval is granted.
- This research, once approved, is subject to continuing review and approval by the Faculty Advisor/Committee Chair and IRB Chairperson. The Principal Investigator will maintain complete and accurate records of this research.

If these conditions are not met, approval of this research could be suspended.

David Vandegrift	XXXXXX
Name of Principal Investigator:	Student ID #

dvandegrift@antioch.edu	Tuesday, March 1, 2011
Email Address	Date

As Faculty Advisor/Dissertation Chair, I assume responsibility for ensuring that the student complies with University and federal regulations regarding the use of human participants in research. I acknowledge that this research is in keeping with the standards set by the University and assure that the Principal Investigator has met all the requirements for review and approval of this research.

Mark Russell, Ph.D.	Tuesday, March 1, 2011
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Appendix E

Description and Analysis of Participants

Appendix E

Description and Analysis of Participants

Gender: Three female
Four male

Race: One Korean
Two Asian
Four Caucasian

Age: Mean age 44
Range 32 to 59

Branch: United States Navy: 4 participants
United States Air Force: 1 participant
Unspecified: 2 participants

Licensure: Seven Psy.D or Ph.Ds.

Years in Branch: Range in years in Branch 0-9

Years of Service as Clinician: Range is years from 4 to 25

ID	Gender	Age	Branch	Provider Status	Clinical Discipline	Years in Branch	Years as MH Clinician
1	Male	42	USN	Active-Duty	Psy.D.	9	15
2	Female	32	USN	Active-Duty	Psy.D	2	7
3	Female	37	USN	Active-Duty	Ph.D.	3	4
4	Male	35	USN	Active-Duty	Ph.D.	unspecified	10
5	Male	54	unspecified	Active-Duty	Ph.D	unspecified	25
6	Female	59	unspecified	Non DoD/VA Civilian	Ph.D	unspecified	21
7	Male	32	USAF	Active-duty	Ph.D.	4	6

Appendix F
Participant Online Survey Results

Appendix F

Participant Online Survey Results

Five of seven post-interview surveys were returned after the completed interview. Likert-like scales were used to record participants' experiences in two general areas: Treatment and Clinician Well-Being. Specifically, the treatment section assessed the clinician's belief in treatment effectiveness, clinician confidence in ability to deliver treatment, and the clinician's satisfaction with treatment outcome.

Clinician's well-being was assessed through self-rating of clinician job satisfaction, clinician's morale, and clinician's compassion fatigue. The following composite scores were reached by averaging the five participants' scores located within Treatment and Clinician Well-Being inquiry.

Supplemental Participant Writing

Post-interview, John was the only of the seven participants who filled in "additional comments.

As I noted in the interview—it's humbling. To think that I am in the presence of heroes who are coming to me for help is very humbling, an honor, and a sacred trust. It is a true gift to see them blossom and flourish before my eyes (and most importantly in their eyes and the eyes of their families whose own sacrifices often go unheralded), and I can't thank EMDR pioneers and trainers *Name Vetted*, Ph.D., *Name Vetted*, Ph.D., *Name Vetted*, Psy.D., and *Name Vetted*, Psy.D enough for their ongoing generosity of spirit and unparalleled standard of professional excellent in meeting the needs of those who met ours—our men and women in uniform. I'm also very grateful for local and regional *vetted* leadership for having my back. May God bless all of them and all who endeavor to pursue this great work!

Susan used the “other” category on two occasions. First, she identified her primary therapeutic orientation as Prolonged Exposure, and then “interpersonal relational theory.”

Level of Treatment Effectiveness, Confidence, and Satisfaction in providing clinical care to active-duty service members experiencing war-stress injury

1. Please estimate your *overall level of effectiveness* in providing clinical care to warriors experiencing war-stress injury. (Mean 3.2)

1	2	3	4
not effective (0-25%)	somewhat (26 – 50%)	effective (51 - 75%)	very effective (76 - 100%)

2. Please rate your *overall level of confidence* in your ability to deliver clinical care to successfully treat war-stress injury. (Mean 4.6)

1	2	3	4	5
very low (0-25%)	neutral (26-50%)	neutral (51-59%)	high (60-75%)	very high (76-100%)

3. How would you rate your *overall level of satisfaction* with clinical outcomes in treating war-stress injury? (Mean 4.6)

1	2	3	4	5
very dissatisfied (0-25%)	neutral (26%-50%)	satisfied (51%-59%)	very satisfied (60%-75%)	very satisfied (76%-100%)

Treatment Composites

Level of Treatment Effectiveness: Mean of 3.2

Based on the Likert (1) to (4) with (1) “non-effective,” (2) “somewhat effective,” (3) “effective,” and (4) “very effective”

Level of Clinician Confidence in Treatment Delivery: Mean of 4.6

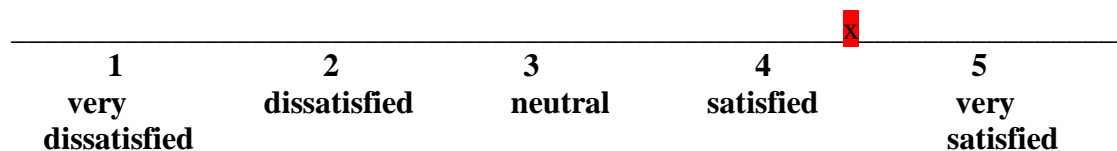
Based on the Likert (1) to (5) with (1) “very low,” (2) “low,” (3) “neutral/not sure,” (4) “high,” and (5) “very high”

Level of Clinician Satisfaction with Treatment Outcome: Mean of 4.6

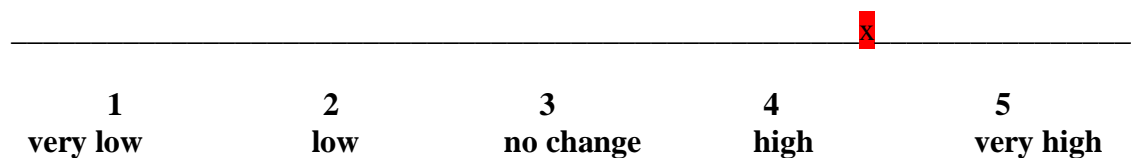
Based on the Likert (1) to (5) with (1) “very dissatisfied,” (2) “satisfied,” (3) “neutral/not sure,” (4) “high,” and (5) “very high”

Level of Clinician Morale, Job Satisfaction, Compassion Fatigue

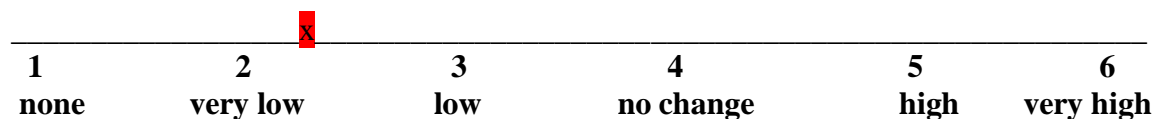
- A. Over the past year, how would you describe your overall level of job satisfaction as a provider working in military healthcare? (Mean 4.4)



- B. Over the past year, how would you describe your overall level of morale as a provider working in military healthcare? (Mean 4.4)



- C. Over the past six months, my overall level of compassion fatigue and/or burnout would best be described as: (Mean 2.2)



Clinician Well-Being Composites

Level of Job Satisfaction: Mean of 4.4

Utilizing Likert (1) to (5), (1) “very dissatisfied,” (2) “dissatisfied,” (3) “neutral/not sure,” (4) “satisfied,” and (5) “very satisfied”

Level of Clinician Morale: Mean of 4.4

Using Likert (1) to (5), (1) “very low,” (2) “low,” (3) “neutral/not sure,” (4) “high,” and (5) “very high”

Level of Clinician Compassion Fatigue: Mean of 2.2

Likert (1) to (6), (1) “none,” (2) “very low,” (3) “low,” (4) “no change,” (5) “high,” and (6) “very high”

Barriers

Participant information forms included a question designed to examine obstacles MMHCs might experience as they provide care to ADSMs experiencing war stress injury: “Which of the following barriers impact your ability to provide the highest quality of care?” Each barrier was identified with a corresponding number that identified the number of participants who recorded an affirmative answer:

- no barrier impacted care 0
- staffing shortages 3
- insufficient clinical training 3
- competing administrative duties 4
- patient attrition 2
- high caseload demands 4
- provider compassion fatigue 2
- pressure to diagnose in predetermined manner 4
- lack of funding 2
- treat in mandated manner 4
- other: patient readiness and commitment 1

Appendix G

Participant-led (12) Subthemes

Appendix G

Participant-led (12) Subthemes

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