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Alicia L. Simoni
Connecting After Killing: An exploration of the intersubjective space between therapist and client when combat rests between them

ABSTRACT

This qualitative study examines how the psychological dimensions of killing in combat manifest in intersubjective space between civilian therapists and service member clients. The investigation is based on interviews with 10 civilian therapists who provide psychotherapy to combat service members who have killed or think they may have killed in combat.

The reality of killing in combat renders most individuals both viscerally and existentially uncomfortable, and thus is often turned away from. Civilian psychotherapists are not immune to this. The aim of this study was to explore how therapists' subjectivities—in the form of conscious and unconscious actions, thoughts, and emotions regarding the reality of killing in combat—manifest, explicitly and implicitly, in a therapeutic dyad with combat service members.

The findings of the research reveal a range of ways in which therapists' actions and presence were different with combat service members than with other client populations, including in the form of a more powerful empathic alliance, increased self-disclosure, and greater attentiveness to power differentials and mutuality in the clinical interaction. Furthermore, analysis of some of the explicit and implicit dynamics between therapists and service members points to potentially compelling ways in which mutual influence is experienced in these dyads, particularly as it relates to intrapsychic and interpersonal experiences of alienation and denial associated with killing in combat as well as to the interplay between individual and collective responsibility for war's devastation.

CONNECTING AFTER KILLING: AN EXPLORATION OF THE INTERSUBJECTIVE SPACE BETWEEN THERAPIST AND CLIENT WHEN COMBAT RESTS BETWEEN THEM

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2013

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CHAPTER I

Introduction

Killing, to a large extent, is what war is about—and killing in combat, by its very nature, causes deep psychological wounds (Bourke, 1999; Grossman, 2008, 2009; MacNair, 2002, 2007). It fundamentally changes the way individuals experience themselves and their relationship to others; it brings about a loss of innocence and often times precipitates a deluge of guilt and shame, together with rage, sadistic pleasure, and a powerful erotic sense of intimacy; and it traps people in a moral dilemma between the job they are trained to carry out and their value system (Finley, 2011; Grossman 2008, 2009; Herman, 1997; MacNair, 2002; Shay, 1994, 2002, 2011; Tick, 2005).

The circumstances of war, particularly as it relates to killing in combat, have no counterpart in civilian life. As Tick (2005) describes, "War and its personal aftermath are, as survivors have been telling us for millennia, something different from anything we know in civilian life." The devastation, chaos, and horror that characterize combat reveal aspects of the human condition that most individuals, and much of society, would rather remain unseen. And, the reality of killing renders most individuals both viscerally and existentially uncomfortable, and thus it is often turned away from. As a result of this discomfort, civilian society perpetuates a conspiracy of silence and denial about the harsh physiological and psychological reality of combat and of killing (Bourke, 1999; Finley, 2011; Grossman, 2009; MacNair, 2002; Tick, 2005).

Civilian psychotherapists are not immune to this silence and denial. However, there is limited contemporary literature examining the unique dynamics that emerge in therapeutic work with service members who have killed or think they may have killed in combat. Literature from the Vietnam era reveals that treatment with combat veterans regularly triggered intolerable negative affects in therapists, at times going so far as to temporarily blunt their ability to listen effectively (Egendorf, 1978; Haley, 1978; Maxwell & Sturm, 1994; Lindy, 1988; Newberry, 1985; Parson, 1984). Ed Tick (1995) writes of his own experience as a civilian psychotherapist treating Vietnam veterans,

> Such therapy, requires that the therapist examine denied aspects of the self—aggression, fear, rage, revulsion, past personal experiences—and own them in a self-disclosing manner far beyond what is usually demanded by the therapeutic process. (p.2)

Despite this past evidence of powerful encounters between therapists and service members, there is a dearth of contemporary literature investigating how civilian therapists' experience killing and its aftermath.

The purpose of this study was to explore how the psychological dimensions of killing in combat manifest in intersubjective space, particularly in relational space between an individual who has experienced combat (client) and one who has not (therapist). This research utilized relational theory's understanding of mutual influence in the therapist-client dyad as a conceptual base to explore civilian therapists' subjective experience of working with individuals who have killed or think they may have killed in combat.

Given that there is limited previous research in this area, the objective of the research was to develop richer descriptions of the intersubjective dynamics in the therapist-client dyad with service members, specifically from the therapist's vantage point. This study was a qualitative study that was exploratory in nature. The researcher conducted semi-structured interviews with

10 civilian clinicians who practice individual psychotherapy with combat service members with the aim of addressing the following research questions: 1) How does a civilian therapist experience therapeutic work with a client who has killed or think they may have killed in combat? 2) What meaning does the therapist make of their subjective experience as well as of the intersubjective dynamics that arise in this work? 3) Does the therapist consciously make use of these dynamics in the treatment and if so, how?

Issues surrounding how participants conceptualize killing in combat, how they experience moments when their clients describe experiences of having killed, and what they perceive to be their influence on the therapeutic process are explored in this study. The study expanded on an emphasis in the literature on genuineness and self-disclosure with service members by exploring in greater depth therapists' decisions to disclose and what informs these decisions. Participants detailed ways in which they experience empathic attunement as well as identifying the unique dynamic issues they notice emerging in work with combat service members.

What is known about killing in combat is that it transforms individuals and restructures social relationships (Grossman, 2008, 2009; Herman, 1997; Tick, 2005). The emotional context and dynamics of the therapeutic dyad provides a meaningful window into the individual and relational changes that lay in killing's wake. It also offers service members an opportunity to process the psychological implications and repercussions of killing within a mutual encounter, and thereby shares the burden of war's devastation.

CHAPTER II

Literature Review

Since 2001, approximately 2 million American men and women have been deployed to Afghanistan and Iraq (as part of Operation Enduring Freedom [OEF]) and Operation Iraqi Freedom [OIF]) (Ruzek et al., 2011). Increasingly during this time, the significant psychological toll that war takes on deployed individuals has permeated the national consciousness, and at times been the focus of intense national interest. In addition to frequent stories in mainstream media that vividly recount the horrors of war and its psychological aftermath, there is a growing body of literature focused on identifying the mental health impacts of deployment, on understanding combat-related post-traumatic stress disorder (PTSD) as a discrete categorical disorder, and on developing models and interventions for the prevention and treatment of service members' psychological needs (Adler, Bliese, & Castro, 2011; Hoge et al., 2006; Marmar, 2009; Ramchand et al., 2010; Ruzek et al, 2011; Tanielian & Jaycox, 2008).

PTSD is the most discussed and studied mental health outcome in the context of deployment and its aftermath (Ramchand et al., 2010; Hoge et al., 2006; Marmar, 2009; Ramchand et al., 2010; Ruzek et al, 2011). Ramchand et al (2010) present a review of studies which concludes that approximately 10-15% of the military personnel who have returned from wars in Iraq and Afghanistan will experience significant post-traumatic stress symptoms. The limited research that goes beyond PTSD in examining mental health outcomes indicates that 50 percent of National Guard and reserve component soldiers, 41 percent of regular military, and 31

percent of marines will return from deployment with a diagnosable mental condition—anxiety, mild depression, transient stress reactions—that does not meet Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for either PTSD or major depression (Darwin, 2012; Ruzek et al, 2011). (See Table 1 for PTSD Diagnostic Criteria.) There are also the significant functional problems that many service members experience, including but not limited to family stress/dissolution, substance abuse, social withdrawal, job loss, homelessness, and aggression toward self and others (Vasterling et al, 2011; Tanielian & Jaycox, 2008). An observation shared by military and VA psychiatrists, and affirmed by veterans and their families is that "*all* combat veterans are affected by their experiences. The vast majority of returning veterans will not meet criteria for any DSM diagnosis yet virtually *all* will deal with significant readjustment issues" (Kudler 2007, p. 46).

Table 1

Diagnostic Criteria for Posttraumatic Stress Disorder

Criterion A: Stressor
The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror.

Criterion B: Re-experiencing
The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes,including those that occur upon awakening or when intoxicated).
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Criterion C: Avoidant/numbing
Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: Hyper-arousal
Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

Criterion E: Duration
Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criterion F: Functional significance
The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

As the extent of the psychological concerns intensifies, it has become clear that the Department of Defense and the Veterans Affairs Department do not have the capacity to meet the growing need for mental health services. As a result, civilian mental health professionals have been mobilized to assist in meeting the needs of service members and their loved ones. As Hall (2008) describes, "It is hoped that civilian counselors who understand and are interested in working with military service members and their families can begin to take up some of the slack" (p. 10). In addition to the Veterans Affairs Department hiring additional mental health professionals (many of whom are civilians), contracted services and fee-for-service arrangements are continuously expanding.

Alongside military-civilian partnerships, community-based initiatives to provide for service members' mental health needs are also growing. One powerful example of this is the *Give An Hour* initiative. Through this national network, over 6,400 licensed mental health professionals (including psychiatrists, substance abuse counselors, psychologists, pastoral counselors, social workers, marriage and family therapists, psychiatric nurses, and licensed professional counselors) voluntarily provide free mental health services to members of the military, veterans of Iraq and Afghanistan, their loved ones, and their communities. As of October 2012, *Give An Hour* providers have offered 70,000 hours of free counseling services. Likewise, *Care for the Troops* works to ensure meaningful mental health care to returning troops and their families by providing training to clinicians, congregations, and community leaders. These are just two examples of the formalized initiatives within the mental health community. There are also countless individual professionals providing mental health services to service members and their families from within community mental health agencies and private practices.

With the growth in civilian mental health services targeting service members and their loved ones there has also been an increase in resources and literature available to mental health providers addressing the unique challenges they may face in working with military populations (Hall, 2008; Ruzek et al., 2011). One of the, if not the most, common themes addressed in this literature is military cultural competency. It is widely recognized that in order to offer effective assistance, civilian mental health professionals must possess an understanding of military culture, including at the most basic level knowledge of the chains of command, acronyms and lingo, stages of deployment, as well as an appreciation of military culture's unique psychic space with its own rules, demands, and dangers (Darwin, 2012; Finley, 2011; Hall, 2008).

Regardless of what branch of military an individual serves in or if they are active duty or Reserves, everyone who is (or has been) a U.S. service member has been indoctrinated into military culture. This unique culture entails, among other features, an authoritarian structure, a rigid rank system, a deeply felt sense of mission, continuous preparedness for disaster, and a psychological world characterized by secrecy, stoicism, and denial (Hall, 2008). Whether they are deployed or not, virtually no one joins the military without anticipating they will be exposed to danger. As Hall (2008) describes, "Losses are often inevitable… The warrior must build a wall around tender emotions to be able to function in a calculated, all-about-business manner to stay alive and not jeopardize other comrades" (p. 58). Furthermore, military ideas about illness, toughness, emotional control, and self-reliance contribute to widespread stigma of mental health problems and distrust of non-military mental health providers (Finley, 2011).

The circumstances of the military, and more specifically of war, have no counterpart in civilian life. Psychotherapist Edward Tick (1995) vividly describes initiation into the military as a departure from the ordinary shared world and a descent into a world that has its own unfamiliar

rules and dimensions. He states, “The order of civilization is reversed, destruction rather than creation, death rather than life, insanity rather than sanity, are the norms” (Tick, 1995, p.3). Yet, despite this burgeoning body of knowledge targeting civilian mental health professionals', there is limited exploration into the dynamic relationship between service members and their mental health providers, particularly how civilian therapists' behavior, values, biases, preconceived notions, and personal limitations manifest in the face of the realities of war.

The Psychological Impact of War

During the past decade, as the United States has actively engaged in two wars, thousands of articles and many books have been published addressing the psychological consequences of war (Finley, 2011). A predominant focus in the literature has been on accumulating information about effective models and interventions for the prevention and treatment of service members' psychological needs, with an explicit focus on PTSD as the monolithic descriptor for combat's psychological consequences and cognitive-behavioral therapies as the answer to its suffering (Adler, Bliese, & Castro, 2011; Hoge et al., 2006; Hoge, 2010; Marmar, 2009; Ramchand et al., 2010; Ruzek et al, 2011; Tanielian & Jaycox, 2008).

Several large-scale studies concerning the experiences and mental health status of service members have been conducted assessing PTSD symptomatology before deployment, in theater, and upon return (Marmar, 2009; Ramchand et al., 2010; Ramchand et al., 2011). Collectively, these studies suggest that most service members experience some type of trauma while deployed—the most prevalent of which are traditional combat events, particularly witnessing somebody being injured or killed or seeing or handling dead bodies (Ramchand at al., 2011). The overall prevalence of PTSD among returning OEF and OIF service members is judged to be between 10% and 15% (Ruzek at al., 2011). When examining correlates of PTSD—specifically,

combat exposure, injury, branch of service, gender, race, deployment location, age and rank—combat exposure is found to predict PTSD across studies (Ramchand et al., 2010).

The literature reveals that methods for treating combat-related PTSD rely heavily on cognitive-behavioral therapies (CBT) as a first-line of treatment (Keane et al., 2011; Rothbaum et al., 2011). In 2008, the VA issued a directive for mental health services recommending that "all veterans in the VA system have access to one or both of two empirically supported, manualized CBTs that include an exposure element: CPT, or prolonged exposure (PE) therapy" (Keane et al., 2011). According to cognitive-behavioral approaches to trauma, the development of PTSD stems from extensive avoidance of trauma reminders, which is reinforced through cognitive distortions and results in a failure to adequately process the traumatic memory. Treatment, therefore, focuses on deliberately confronting trauma-related thoughts, images, and situations and clients' learning that their perceptions about themselves and the world are inaccurate. Psychodynamic therapies have struggled to compete with these models for recognition of their efficacy, although some writers argue that this is due in large part to a degree of denial about the evidence for the efficacy of psychodynamic therapy for trauma (Carr, 2011; Shedler, 2010).

How combat PTSD is conceptualized and understood varies across settings—within the military as opposed to the VA, for active-duty service members as opposed to veterans, by veterans as opposed to clinicians. Finley (2011) uses ethnographic fieldwork conducted with recent veterans, their families, and health-care providers in San Antonio, TX to examine the cultural, political, and historical influences shaping the definition of PTSD. She points out that, "PTSD—while very much a real part of the human experience, observed in one form or another across the boundaries of history and culture—is not the monolithic biomedical category it often

appears to but rather something fluid and subject to interpretation" (Finley 2011, p. 2). The manifestation of PTSD in an individual—i.e. nightmares, aggressiveness, numbness, etc.—may be seen as a natural part of the return from combat and its diagnosis may be the acknowledgment that enables a veteran to live with himself. Or, the symptoms may be seen as a sign of inadequacy and the diagnosis as worthy of shame and judgment. At a societal level, PTSD is at times associated with the past abandonment of Vietnam veterans and with the VA's failure to provide adequate care and benefits—in this light, current diagnosis of PTSD represents a long-awaited symbolic acknowledgment of veterans' service and sacrifice. Likewise, some view PTSD as a natural occurrence whose course it is possible to interrupt; a diagnosis that it is possible to gain a firm grasp of and treat. Whereas, for others, there is the question of if combat-related PTSD is over-diagnosed, inappropriately used as a blanket term to describe a wide variety of life concerns, and resultantly encourages a state of chronic suffering.

How PTSD is understood and reacted to is rooted in cultural ideas about war, trauma-related suffering and mental illness. Finley's study sheds meaningful light on the ambivalent relationship that American society has with PTSD. It is a diagnosis which to a large extent represents not only the individual aftermath of war but also the ways in which service members' suffering is (or is not) named, claimed, and made sense of. As Finley (2011) states,

> There may be a clinical definition written in the pages of the DSM-IV, but that definition becomes something far more slippery when it passes out into the world, diagnosed and lived out and claimed and apologized for and made real in the discourses and engagements of everyday life. (p.164)

On killing. It is notable that throughout the literature on the psychological implications of war, there is scant elaboration of the distinct variables that constitute combat exposure or of the potential meaning of these experiences. In discussions of the epidemiology of trauma among service members, "traditional combat events" are identified as a definitive predictor of PTSD

(Ramchand et al., 2011). These events are defined as "being injured or wounded in combat; killing, injuring, or wounding someone else; and handling or smelling dead and decomposing bodies" (Ramchand et al., 2011, p. 14). Each experience within this disparate grouping of experiences is undoubtedly stressful and potentially traumatic. However, the divergent nature of what constitutes "traditional combat events" has noteworthy significance when considered in relation to an individual's sense of self and others, as well as in regards to potential shame, doubt, guilt, and inferiority. Specifically, the act of "killing, injuring, or wounding someone else" possesses a unique capacity to assault an individual's self-image, sense of control, and sense of the world as a meaningful and comprehensible place (Carr, 2011; Grossman, 2008, 2009; Tick, 2005).

Recently a small body of literature has emerged examining “the specific nature of the act of killing: the intimacy and psychological impact of the act, the stages of the act, the social and psychological implications and repercussions of the act” (Grossman, 2009, xvi). Lt. Col. Dave Grossman has spearheaded much of the research in this area in an explicit attempt to address the cultural blind spot surrounding the psychological nature of killing in combat. He uses several quantitative studies by others as well as his own qualitative research (based on a large number of interviews with veterans) along with written accounts of wartime experiences to examine what constitutes an ability to kill, address the psychological consequences of killing, explore how proximity to death can heighten the meaningfulness of life, and illuminate the intimacy inherent in the act of killing (Grossman, 2008, 2009).

Grossman, along with others, asserts that killing, to a large extent, is what war is about—and that killing in combat, by its very nature, causes deep wounds of pain and guilt (Bourke, 1999; Grossman, 2008, 2009; MacNair, 2002, 2007). It is important to note that although killing

in war is sanctioned—and at times deemed honorable and noble—the reality is that distinguishing illegitimate murder from legitimate killing in combat is extremely complex (Grossman, 2009). Not only does the nature of modern warfare render the distinction between non-combatant and combatant blurry, but additionally, regardless of whether it is sanctioned or not, killing causes mental and spiritual harm. As Grossman (2009) describes,

> When you have killed another human being, when you have watched the mystery of life and death flicker in front of your eyes, and a living, breathing person has become a piece of meat, and you are the one the caused that, you cannot help but think 'I'm going to have to answer to my maker for what I did.' (p. 350)

The presumption is often that fear of death and injury is the primary cause of psychiatric causalities on the battlefield (Bourke, 1999; Grossman, 2009; MacNair, 2002). However, Grossman (2009) presents findings from several clinical studies that reveal that this is not an absolute given. He offers a framework for understanding combat soldiers' psychological and physiological state in which he asserts:

> Fear, combined with exhaustion, hate, horror, and the irreconcilable task of balancing these with the need to kill, eventually drives the soldier so deeply into a mire of guilt and horror that he tips over the brink into the region that we call insanity. Indeed, fear may be one of the least important of these factors. (Grossman, 2009, p. 53)

Grossman argues that more so than fear, it is balancing the obligation to kill with the resulting toll of guilt that constitutes the most significant cause of psychological distress.

Grossman's analysis of combat-related trauma is grounded in the notion that human beings possess a high resistance to killing. Even in combat—where killing is legitimized—and even under situations of self-preservation, this resistance is strong (Grossman, 2008, 2009). In fact, Grossman asserts that the history of warfare can be seen as a history of increasingly more effective mechanisms for enabling and conditioning individuals to overcome their innate resistance to killing fellow human beings. However, the psychological leverage and

manipulation required to impel individuals to kill comes at a profound cost: The potential for immense psychological distress. As Grossman (2009) describes it,

> Looking another human being in the eye, making an independent decision to kill him, and watching as he dies due to your action combine to form the single most basic, important, primal, and potentially traumatic occurrence of war. (p. 31)

Building upon Grossman's assertions, MacNair (2002, 2007) proposes the concept of "Perpetration-Induced Traumatic Stress," which she designates as a subcategory of PTSD to account for the suffering that results from perpetrating deadly acts of aggression. She draws on data from the National Vietnam Veterans Readjustment Study (NVVRS), a large stratified random sample of 1,638 combat Vietnam veterans, to conclude that PTSD symptoms show patterned differences when they result from acts of killing (MacNair, 2002). Specifically, she concludes that veterans who killed in combat exhibit more violent outburst, a high incident rate of intrusive imagery, and a greater sense of disintegration (defined as a sense of unreality, experience of depersonalization, unrealistic distortion of meanings, restlessness or agitation, hostility toward a part of the body, and panic).

Whether categorized as PTSD or not, inherent in the distress caused by killing are intense physiological and emotional responses. In an attempt to illustrate "what really happens in combat," Grossman (2008) provides frank, unwavering descriptions of the act and aftermath of killing in combat. He portrays a harsh physiological and psychological reality that often includes loss of bowel and bladder control, powerful perceptual distortions (e.g. diminished sound, tunnel vision, slow motion time, automatic pilot, dissociation), and convoluted existential dilemmas.

In response to "one of the most significant acts one human being can do to another" (Grossman, 2008, p. 167), it is not uncommon for individuals to embrace shifting, and at times

opposing, thoughts and beliefs about the event. Bourke, a historian who conducted in-depth interviews with veterans about the intimacy of killing, describes the following:

> The same combatants who admitted on one page in their diaries to feeling intense distress when killing another human being would confess, elsewhere, to feeling immensely happy while committing acts of murderous aggression. Contradictory emotions existed side by side. (Bourke, 1999, p.373)

Likewise, Grossman (2009) identifies a set of divergent emotional response stages that are frequently experienced in response to killing in combat: Exhilaration, remorse, rationalization and acceptance. The stages are considered to be generally sequential, however some individuals may skip certain stages, or pass through them so fleetingly that they do not even acknowledge their presence. Although these emotional response stages to killing in combat are not universal, they are commonplace and entail a magnitude and intensity of emotion that is undeniable (Grossman, 2009).

Chief, albeit rarely acknowledged, among the "strange elations" (Grossman, 2008) that commonly emerge during and/or after the act of killing is a powerful, often erotic, sense of intimacy. Many veterans' narratives from war include descriptions of wartime killing that sound strikingly similar to acts of intense physical, sexual intimacy. Grossman (2009) states, "Killing is a private, intimate occurrence of tremendous intensity, in which the destructive act becomes psychologically very much like the procreative act" (p. 2). In the words of one Army veteran, "I wrestled men to death in hand-to-hand combat. That experience was far more intimate and erotic than love or sex can ever be" (Tick, 2005, p. 124). Similarly, William Broyles, a former Marine and editor of *Newsweek* writes,

> Killing had a spiritual resonance and an aethestic poignancy. Slaughter was an affair of great and seductive beauty… The experience seemed to resemble spiritual enlightment or sexual eroticism: indeed, slaughter could be likened to an orgasmic, charismatic experience. (Bourke, 1999, p. 15)

Killing entails powerful physical and emotional intimacy, and for many leaves a lasting mark on how closeness is experienced.

The war stories that service members recount rarely contain their destructive acts of aggression, emergent feelings of intimacy, or the associated experiences of ambivalence (Bourke, 1999; Finley, 2011; Grossman, 2009; MacNair, 2002; Tick, 2005). Rather the intense and contradictory reality of killing in combat is often veiled by denial, or at times bravado. The internal and external incentives to mask the thorny reality of combat are powerful. Denial may serve as a much-needed defense against internal disintegration. It may also protect against perceived, and at times actual, judgment from others. Furthermore, as noted above, military culture relies upon a psychological world that is characterized by denial and stoicism.

> Even the language of men at war is full of denial of the enormity of what they have done. Most soldiers do not 'kill,' instead the enemy was knocked over, wasted, greased, taken out, and mopped up. The enemy is hosed, zapped, probed, and fired on. The enemy's humanity is denied, and he becomes a strange beast called a Kraut, Jap, Reb, Yank, dink, slant, slope, or raghead. Even the weapons of war receive benign names—Puff the Magic Dragon, Walleye, TOW, Fat Boy, and Thin Man—and the killing weapon of the individual soldier becomes a piece or a hog, and a bullet becomes a round. (Grossman 2009, p. 91).

It is not uncommon for individuals who have experienced traumatic events to resist discussing the experience, however the reluctance of those who have killed may be unique in that its antecedents lie in the psychological burden of intense, and at times well-founded, guilt and shame (Grossman, 2009; Tick, 2005).

A larger societal denial about the harsh realities of combat, including the necessary reality of killing in combat, further propels service members' reluctance to reveal the darker, more gruesome and complicated elements of their experiences (Bourke, 1999; Finley, 2011; Grossman, 2009; MacNair, 2002; Tick, 2005). MacNair (2002) purports that "Families and friends of veterans discourage them from discussing the horrors of war, especially any acts they

may have committed themselves" (p.156). Likewise, in presenting a history of killing in war, Bourke (1999) asserts that the commonly referred to process of "numbed consciousness", which is assumed to enable violent acts in warfare, may in fact apply more to civilians who dispassionately observe war and that "men who actually killed were more liable to be forced to deal with their own tortured consciences" (p.7). Civilian society, across many realms and in both explicit and implicit ways, perpetuates what amounts to a conspiracy of silence about the truth of combat (Bourke, 1999; Finley, 2011; Grossman, 2009; MacNair, 2002; Tick, 2005).

Beyond PTSD. Combat fundamentally changes the way individuals experience themselves and the world. It often times precipitates a deluge of guilt, rage, sadistic pleasure, and shame. It can be a catalyst for disconnection, and frequently traps people in a moral dilemma between the job they are trained to carry out and their value system (Finley, 2011; Grossman 2008, 2009; Herman, 1997; MacNair, 2002; Tick, 2005). Classifying and treating the psychological distress of combat as simply a discrete biomedical disorder fails to acknowledge and address the transformation of an individual's innermost self. As Tick (2005) states,

> To control the symptoms we offer medications, teach the sufferer relaxation and stress reduction techniques, lecture and couch the survivor on war neurosis and proper behavior in public, and offer rapid-eye movement and other automatic therapies… The common therapeutic model, that is, misses the point that PTSD is not a psychological but a soul disorder. (p. 103)

Among those advocating for a more nuanced framework for understanding service members' psychological distress in and after combat are psychotherapist Edward Tick (1995, 2005), psychiatrist Jonathan Shay (1994, 2002, 2011), and psychiatrist Judith Herman (1997). Both Shay (1994) and Tick (2005) emphasize identity transformation as a critical component of the psychological consequences of war. Shay (1994) characterizes the impact of combat trauma as “the undoing of character" and further underscores a holistic appreciation of the mark it leaves

on an individual. He succinctly states, "We are just one critter: brain/body, mind, social actor, and culture inhabitant at every instant. None of these has ontological priority" (Shay, 2011, p. 186). Tick (2005) defines the psychological consequences of war as "soul wounding" and "soul loss." He outlines the following characteristics as often being damaged, distorted, or at the very least transformed due to the realities of war:

> Our drive to preserve life and to persevere in our own existence; our self-awareness as autonomous and effective agents creating our destinies; our ability to think, reason, and understand; our will and motivation; our aesthetic sensibilities; our forms of intimacy, love, and sexuality; the functioning of our imaginations; and our capacity to function in society. (Tick, 2005, p. 109)

In delineating a conceptual framework for complex trauma, Herman (1997) identifies one of the primary effects of traumatic events, including that which occurs in combat, to be a shattering of the construction of self that is formed and sustained in relation to others. She draws attention to the role of shame, doubt, guilt, and inferiority, all of which are forms of disconnection and damage to the self that occur in the aftermath of traumatic events. Herman (1997) quotes combat veteran Tim O'Brien to illustrate the doubt that those who have experienced combat often have about themselves and others:

> For the common soldier… war has the feel—the spiritual texture—of a great ghostly fog, thick and permanent. There is no clarity… Right spills over into wrong. Order blends into chaos, love into hate, ugliness into beauty, law into anarchy, civility into savagery… You can't tell where you are, or why you're there, and the only certainty is overwhelming ambiguity. (p. 53)

Herman (1997) further asserts that traumatized individuals, service members among them, often feel cast out of human systems of care and protection, and that a sense of alienation pervades every relationship, from the most intimate familial bonds to the abstract affiliations of community and religion.

The fragmented and incohesive self-state that characterizes the psychological distress that lies in combat's wake is at least partly the result of empathic failure on the part of society (Bourke, 1999; Grossman, 2008, 2009; Parson, 1984). Combat—particularly killing in combat—fundamentally transforms individuals, and restructures social relationships. However, as a society "we deny our fascination with the 'dark beauty of violence' and we condemn aggression and repress it rather than look at it squarely and try to understand it" (Grossman, 2009).

Psychotherapy with Service Members

Psychotherapists are not immune to the fact that the subject of interpersonal aggression and killing renders most people uneasy, and thus is often turned away from. However, there is limited contemporary literature addressing the unique, and at times challenging, dynamics that emerge in therapeutic work with service members who have killed or think they may have killed in combat. Beyond the aforementioned literature on military cultural competency and cautionary tales of the potential for vicarious traumatization, literature addressing therapists' experience of treatment with service members has been sparse in the past decade. In light of this, it is necessary to review literature from previous war periods—namely the Vietnam era—to garner insight on the topic.

Vietnam-era psychotherapy. A shared conclusion within the literature about psychotherapy with Vietnam veterans is that the relationship between the therapist and patient is critical, and perhaps significantly more so with this population than any other population (Egendorf, 1978; Haley, 1974; Maxwell & Sturm, 1989; Lindy, 1988; Parson, 1984; Shapiro, 1984). Shapiro (1984) defines the development of the therapeutic alliance as "the relatively non-conflictual rational aspects of the relationship between therapist and patient" and he, along with others, emphasizes that it is this empathic alliance that ultimately enables the veteran to tolerate

working through traumatic material (Haley, 1974; Maxwell & Sturm,1989; Shapiro, 1984). In line with this, Haley (1974) asserts, "establishment of a therapeutic alliance for this group of patients *is* the treatment rather than the facilitator of the treatment" (p. 195). Writers on the topic suggest that, most importantly, the therapeutic alliance provides a reparative experience for the alienation and disconnection that veterans otherwise face (Egendorf, 1978; Haley, 1974; Maxwell & Sturm, 1989; Lindy, 1988; Parson, 1984; Shapiro, 1984).

An in-depth examination of the therapeutic relationship in treatment with Vietnam veterans reveals some reflection on the conscious and unconscious dynamics—commonly referred to as transference and countertransference—between service members and their therapists. In presenting a systematic examination of 37 cases of individual psychoanalytic treatment with Vietnam veterans, Lindy (1988) describes transference and countertransference phenomena in the following way:

> We monitor the emotional atmosphere in the treatment room, assessing how the patient perceives us as he repeats conflicts, deficits, and traumas from the past… Our remarks or our demeanor may trigger repressed memories of experiences with a father, a buddy in childhood, or even a platoon leader in combat; our office could remind our patient of a back porch at home or of his boot camp barracks. (p. 230)

In general, the literature from this time period reveals that transference and countertransference material is a "nearly ubiquitous phenomenon in the psychotherapy of combat veterans" (Lindy 1989, p. 412) and, although therapists may initially defend against it, the use of this material is ultimately necessary for effective treatment with veterans (Haley, 1978; Lindy, 1988; Newberry, 1985; Parson, 1986).

Therapists identify several common themes that emerge in the transferential material in treatment with Vietnam veterans. Shapiro (1984) classifies themes of distrust of authority, tendency to withdraw from close relationships, and expectation of rejection in interpersonal

situations as frequent in Vietnam veteran's transference. Likewise, in examining transference phenomena with Vietnam veterans as compared to transferences seen in "everyday psychoanalytic work," Lindy (1988) identifies the following as common with veterans: Ubiquitous danger (preoccupation with aspects of the physical space), betrayal from therapists' side (suspicion that the therapist might exploit the patient), guilt over surviving (expectation that the therapist would not understand why the patient had survived), fear of war crimes (fear that actions in combat would be judged by the therapist), anger at homecoming "comforters" (bitterness towards those who sought to explain the patient's current sufferings in way that ignored the reality of war), and intense loyalty (deep loyalty to the therapist). Additionally, Lindy (1988) delineates three over-arching types of transference with veterans: Transference to the person of the therapist, to the situation or frame of the therapy, and to the process of activity/inactivity of the therapist. He identifies both positive transferences (i.e. therapist as medic, therapist as buddy) and negative transferences (i.e. therapist as spy, therapist as interrogator) as being widespread, and useful. Parson (1986) highlights the frequent occurrence of transference towards an institution and explicitly categorizes "VAMC Transference Syndrome" (which is a veteran's transference to a VA Medical Center) and the "split transference syndrome" (which is a complex, bifurcated transference in which feelings are split between the therapist and the VAMC). In large part, the literature frames transference as being based, in combination, on previously internalized patterns of thinking, feeling, and behaving (genetic factors) and on combat world antecedents (Egendorf, 1978; Lindy, 1988, 1989; Parson, 1984, 1986).

It is important to note the acknowledgment that many writers make regarding their initial misinformed tendency to underemphasize the war-related nature of the transference dynamics

(Haley, 1974, 1978; Lindy, 1988; Newberry, 1985; Parson, 1986). In a frequently cited source on treatment implications for mental health professionals working with Vietnam veterans, Haley (1978) writes, "The denial and avoidance which have been described as characteristic of Vietnam veterans are only matched in my experience by the denial and avoidance of mental health workers" (p. 260). She describes therapists' avoidance behaviors as falling into two general categories: 1) detailed psychosocial histories and elaborate dynamic formulations with a total absence of a military history; or 2) a military history not integrated into a dynamic formulation that most typically relies solely upon a genetic reconstruction (Haley, 1978). Similarly, Lindy (1988) points out the clinical study group's defensive motives for initially ignoring transference formulations.

> Later we understood that there were two major reasons for this. First, we feared that focusing on negative transference might be overwhelming to us… Second, most of us assumed that if transference reactions did arise, they would spring from our patients' childhoods, but interventions based on that assumption left patients unconvinced and the therapy suddenly off kilter. (p. 230)

The writers who acknowledge their initial reluctance to see and appreciate the transference material in treatment tend to recognize this as part of their own countertransference (Haley, 1974, 1978; Lindy, 1988; Newberry, 1985; Parson, 1986).

Just as it is possible to identify common transference material in treatment with Vietnam veterans, it is similarly possible to delineate common countertransference themes—which Newberry (1985) defines as the "psychological responses to the patient that occur in the therapist" (p. 152). The literature reveals that treatment with combat veterans regularly triggers unbearable negative affects and countertransference resistance in therapists, at times going so far as to temporarily blunt their capacity to listen (Egendorf, 1978; Haley, 1978; Maxwell & Sturm, 1994; Lindy, 1988; Newberry, 1985; Parson, 1984). Several writers specifically address the

strong feelings, including disgust, revulsion, horror, hate, and fear that are aroused when veterans talk about their past actions in combat and discuss having to confront their own vulnerability to being murdered as well as their own murderous impulses (Egendorf, 1978; Haley, 1974, 1978; Newberry, 1985). Haley (1978) powerfully describes treatment with Vietnam veterans as being challenging and painful because of "its demands on the therapist to risk 'being there,' to share something of the overwhelming assault on the ego that the psychotic reality of combat involves" (p. 260). She further states:

> The occurrence of intense negative countertransference toward the Vietnam veteran brings the therapist face-to-face with his own murderousness and his vulnerability to being murdered... In treating Vietnam veterans the therapist must deal with his own attitudes toward vulnerability to catastrophic stress, aggression, and sanction. Mental health professionals mirror the country's ambivalence toward the Vietnam war. In order to know how many need healing, they will have to risk 'hearing' what these veterans have to tell us about themselves. (Haley, 1978, p. 267)

It is critical to note that in addition to the tendency for the therapist to be repelled by veterans' descriptions of aggression, murder, and atrocity, some writers have described feelings of "primitive admiration, awe and even envy" (Frick & Bogart, 1982, p. 438) and "lust, excitement and vicarious pleasure" (Newberry, 1985, p. 158) in the process of identifying with the aggression and sadism of veterans' descriptions of their wartime actions.

A number of writers suggest possible reasons for therapists' powerful countertransference in working with combat veterans (Egendorf, 1978; Haley, 1974, 1978; Lindy, 1988; Newberry, 1985). Haley (1978) identifies the three most important reasons for therapists' countertransference to be the following: 1) confrontation with one's own personal vulnerability to catastrophe; 2) the challenge to one's moral attitudes about aggression and killing; and 3) the fear of the intensity of the countertransference and the transference. Egendorf (1978) purports that the following undergird therapists' potentially intense reactions: seeing veterans as villains

or victims, equating war neuroses with compensation neuroses, assuming that the war is only an abstraction, and failing to comprehend the intrinsic conflict of war. Similarly, based on an awareness of his own strong countertransference feelings, fantasies, and wishes while treating Vietnam veterans, Newberry (1985) delineates five underlying sources of countertransference: general societal attitudes toward the military and military personnel, a shared view that veterans who seek psychological treatment do so primarily for compensation, specific feelings and responses regarding the Vietnam war and its participants (i.e. veterans are immoral killers, etc.), assumption that combat-related PTSD is a consequence of a characterological predisposition, and specific psychological responses of the individual therapist.

The imperative of recognizing and monitoring the intense countertransference reactions that are evoked in treatment with veterans is widely established (Egendorf, 1978; Haley, 1974, 1978, 1985; Lindy, 1988; Newberry, 1985). Egendorf (1978) elucidates that,

> Although therapists are usually well trained to recognize when feelings such as lust, jealousy and anger arise in them, they are generally less skillful at discerning and acknowledging sentiments such as hate, disgust, repugnance, condescension, and contempt. Work with veterans may very well call up such feelings, and therapists need to be prepared to see these 'negative' reactions in themselves, the better to 'deal with' them in such a way that therapeutic work can proceed. (p. 238)

Much of the literature concludes that beyond just recognizing and monitoring countertransference, therapists need to be adept at productively using their reactions in order to empathically connect with veterans and, resultantly, avoid treatment failure. Haley (1985) describes her view of the process that needs to unfold in order for therapy to progress:

> As the horror of the act emerges, the therapist is thrown back: "This cannot be! He is a monster, an animal! No human could have done that." But the treatment process requires that the therapist be able to feel, "I could well have done that." It does not have to be said, just felt; but there is a clear difference between being able or not able to feel it. And the patient can tell… one cannot understand the trauma unless one can feel what the patient felt. (p. 63)

Newberry (1985) is the most emphatic in asserting; "failure to recognize and deal effectively with these phenomena is highly contributory to, if not often directly responsible for, treatment failure" (p. 153).

A shared sentiment across much of the literature is that, in order to facilitate an empathic connection, therapists need to be more open and self-disclosing with Vietnam veterans than with almost any other group of clients (Haley, 1974, 1978; Newberry, 1985; Parson, 1986; Tick, 2005). There is an emphasis on the importance of nurturing a "real" relationship with the veteran in order to facilitate trust as well as to bring about a genuine sense of absolution. Haley (1974) asserts that it is "critical that in every sense the therapist be 'for real:' a 'real person' more so than a transference figure, and a 'real person' respectful of the veteran's strengths and concerned about but not 'put off' by their psychopathology" (p. 195). Tick (1995), writes that

> Such therapy, requires that the therapist examine denied aspects of the self—aggression, fear, rage, revulsion, past personal experiences—and own them in a self-disclosing manner far beyond what is usually demanded by the therapeutic process. (p.2)

He further emphasizes the collective responsibility for war, and asserts that a "real" therapeutic relationship serves a critical function in the transfer of responsibility for war's suffering from the individual to the group. Tick (2005) states:

> In traditional therapy, the prevalent view is that healing can best occur if the therapist remains emotionally detached from the client's life and material. In working with vets, though, the opposite is true: If the therapist maintains detachment, the story remains solely the burden of the patient. Therapy becomes effective only when the therapist can affirm that he is personally engaged with the veteran's story and accepts the need to help carry the collective responsibility. (p. 238)

It is striking to note that throughout the literature, therapists characterize their work with Vietnam veterans as some of the most intense therapeutic work that they've ever done. Newberry (1985) says of his work with Vietnam veterans, "These experiences have been the most emotionally intense of my career, and I believe that this situation occurs for many who work

these men" (p. 151). Similarly, Lindy (1988) describes individual treatment carried out by psychoanalysts with Vietnam veterans in the following way, "Often among the 37 treatments in this project, strong bonds developed between veteran and therapist. They were more durable, more intense, and more vivid than those to which we as a clinical group were accustomed" (p. 213). Writers reflecting on their work with Vietnam veterans almost universally agree to being transformed by the experience.

Present-day psychotherapy. As noted earlier, there is a dearth of contemporary material that is remotely comparable to that of the Vietnam era in examining the therapeutic relationship between service members and therapists. Recent trauma literature reveals advances in how adult-onset trauma, including combat trauma, is conceptualized, and includes an emphasis on the relational context within which the healing of basic capacities for trust, autonomy, initiative, competence, identity, and intimacy must occur (Basham, 2008; Boulanger, 2002, 2007; Carr, 2011; Herman, 1997). Furthermore, there are a number of countertransference enactments—based to a large extent on a "victim-victimizer-bystander" template—that are deemed to be "predictable" in therapeutic relationships with trauma survivors (Basham, 2008; Herman, 1997). However, aside from this, there has been little recent examination of how traumatic emotional experiences that are specific to combat play out within the interpersonal space of the therapeutic dyad.

Contemporary Relational Theory

Contemporary relational theory is uniquely positioned to provide a framework from within which to explore the complicated and unexamined intersubjective implications of combat and killing on the therapeutic relationship. At the core of relational theory is the notion that the self is intersubjective and interdependent. In this way, the therapeutic encounter is understood to

be a bipersonal and reciprocal communication process—a mutual meaning-making process—between subjective individuals, the therapist and the patient (Aron, 1996; Mitchell, 2000). Integral to the therapist's and the patient's subjectivities is the imprint of the societal context in which both are socialized members (Altman, 2010).

At the crux of relational approaches to understanding the therapeutic encounter is the influence that the patient's and therapist's subjectivity have on each other. The relational perspective attempts "to maintain a balance between internal and external relationships, real and imagined relationships, the intrapsychic and the interpersonal, the intrasubjective and the intersubjective, the individual and the social" (Aron 1996, ix). Relational theory does not position the therapist as an objective entity and the patient as the embodiment of a categorical diagnosis in need of simply behavioral change, but rather posits that it is the mutual intersubjective experiences between the therapist and the patient, both conscious and unconscious, which constitute the therapeutic encounter and ultimately inform psychological change (Aron, 1996; Hadley, 2008; Mitchell, 2000).

Within the framework of relational theory, referring to subjectivity-intersubjectivity rather than transference-countertranference has intentional implications. Subjectivity and intersubjectivity do not have pathological connotations in the way that transference and countertransference often do. Furthermore, subjectivity-intersubjectivity implies bidirectional, if not necessarily equal, influence—unlike countertransference, which minimizes the impact of the therapist's behavior on the transference and obscures the recognition that the therapist is often the initiator of the interactional sequences. As Aron (1996) elucidates,

> The relational-perspectivist approach I am advocating views the patient-analyst relationship as continually being established and re-established through ongoing mutual influence in which both patient and analyst systematically affect, and are affected by,

> each other. A communication process is established between patient and analyst in which influence flows in both directions. (p. 77)

Subjectivity-intersubjectivity capture the continuous, ongoing flow of influence (rather than implying an occasional or intermittent event).

Carr (2011) presents the only description to date of the treatment of military personnel with adult-onset trauma from an intersubjective perspective—that is, from a perspective that prioritizes the individuals' subjective experiences of the trauma and the emotional context of the therapeutic relationship. He states,

> Instead of seeing traumatic soldiers or Marines as having a dysfunctional automatic thoughts, a shattered self, or a regressed ego, I was beginning to feel that their experience of the world and themselves had been shattered. They frequently did not seem to be in the same world as the rest of us, or at least me. (Carr, 2011, p. 473)

Based on his treatment with a male soldier experiencing PTSD while deployed in Iraq, Carr makes a case for an understanding of trauma that focuses less on the event and more so on the emotional experience arising from the event and on the individual's inability to find a means to process this with others. Carr (2011) draws on the writings of Robert Stolorow (2007), Ghislaine Boulanger (2007) and other relational writers to advocate for an approach to combat-related PTSD that explicitly addresses shame and that fosters the intersubjective relationship between patient and therapist as the means to healing.

In line with relational theory, Carr understands affect to be determined between people and his intersubjective approach to combat-related PTSD is guided by this. Yet the meaning Carr makes of the therapeutic encounters falls short in taking into full account *both* the patient's and the therapist's subjective experiences. Carr (2011) writes of the therapist's experience with military personnel:

> The therapist might feel guilt and shame because of what the patient has endured while defending our country. Alternatively, the therapist might not be able to tolerate hearing

> graphic details of horrific acts the patient has done or witnessed in combat… Hearing these acts, along with the patient's frequent reaction of pleasure at the violence itself, can be difficult for many therapists to bear without withdrawing from the patient or casting a judging gaze. But those reactions are enactments of the malattunement from others that originally created the traumatized state for the patient. At those moments, the therapist needs to focus on understanding the context of the violence and the feelings of the patient from a stance of empathic instrospection. Therapists, therefore should engage in treatment themselves to help reduce the effects of vicarious traumatization and to reduce the risk of shaming a patient. (p. 482)

Despite acknowledging that difficult affective experiences may arise for the therapist, Carr gives scant attention to the potential meaning of this—instead accounting for it as the "enactments of the malattunement from others" and viewing it as a hindrance to the therapeutic work—something which should be kept in check or overcome and which should in any event be kept to a minimum.

Relational theory posits that collaboration, empathic attunement, therapeutic responsiveness, and clinician genuineness, spontaneity, realness, and self-disclosure comprise the core of the therapeutic encounter (Goldstein et al, 2009). Therapists' subjective experience represents a critical component of this encounter. It can be utilized not only to better understand the patient, but also to inform how both the patient and the therapist make sense of the intersubjective space. Therapeutic change is seen to begin “in changes in the interpersonal field between patient and therapist, as new relational patterns become interactively co-created and subsequently internalized, generating new experiences, both with others and in solitude” (Mitchell 2000, p. 70). As such, relational approaches to psychotherapy provide individuals with the opportunity to develop insight into interpersonal patterns, experience a new form of relationship, and make important changes in their interpersonal functioning. In this way, the relational home itself is the therapeutic action. And, it is impossible to adequately understand this relational home without attuning to both the patient's and the therapist's experience of it.

This study aims to fill a gap in the current literature by utilizing relational theory's understanding of the mutual influence in the therapist-patient dyad as a conceptual base to explore how the psychological dimensions of combat and killing unfold in intersubjective space between the therapist and patient. The research will expand upon current literature—and address some of its limitations—by investigating the often unexamined aspects of a civilian therapists' self as they manifest in work with individuals who have killed or witnessed killing in combat. And it will seek to understand if and how the therapist makes use of this subjective experience as well as of the intersubjective dynamics that arise between themselves and the service member.

CHAPTER III

Methodology

The intent of this qualitative study was to explore how the psychological dimensions of killing in combat unfold in intersubjective space between therapist and client. The following three research questions were explored via semi-structured interview: 1) How does a civilian therapist experience therapeutic work with a client who has killed or think they may have killed in combat? 2) What meaning does the therapist make of their subjective experience as well as of the intersubjective dynamics that arise in this work? 3) Does the therapist consciously make use of these dynamics in the treatment and if so, how? This chapter presents the methods used in this study, including study design, sample selection, data collection, and data analysis procedures.

Study Design

This study utilized a descriptive design to gain in-depth understanding of civilian therapists' subjective experiences of treatment with clients who have killed or think they may have killed in combat. As the literature review elucidates, there is limited current research in this area. As such, the study aimed to identify themes and patterns in hopes of contributing to a richer, more nuanced understanding of how the harsh realities of killing in combat manifest in intersubjective space, particularly in a space occupied by an individual who has experienced combat (client) and one who has not (therapist).

Sample

The study population consisted of 10 civilian therapists who currently provide individual psychotherapy to 1 or more clients who have killed or think they may have killed in combat.

Inclusion criteria were defined as the following: Have NOT been a member of the U.S Armed Services; currently provide psychotherapy to 1 or more combat service members; have a master's or higher-level degree in a mental health related field; read and speak English.

The sample was intended to be representative of the broad spectrum of individuals who work from a variety and/or mixture of disciplines and theoretical orientations in their treatment of combat service members. As such, recruitment was open to all individuals who met the above stated criteria for participation. The researcher endeavored to recruit a diverse sample in regards to gender, race, ethnicity, and age as well as practice settings, including a Veterans' Administration (VA) Hospital or outpatient clinics, Vet Centers, agency or community mental health centers and/or private practice. Although participants were asked to identify their professional discipline and the primary theoretical orientation from which they worked, this did not serve as exclusion criteria.

The researcher utilized non-probability convenience and snowball sampling techniques for this study. The recruitment process consisted of two sources: a) e-mail advertisement sent to researcher's existing connections with colleagues who work with service members or know individuals who work with service members and b) professional directories and online listservs targeting mental health professionals working with service members and therapists (including American Association for Psychoanalysis in Clinical Social Work (AAPCSW), International Association for Relational Psychoanalysis and Psychotherapy (IARPP), and Care for the Troops). Both the e-mail recruitment and directory/listserv recruitment (see Appendix C) consisted of a brief synopsis of the study's aim, the criteria for participation, and the nature of participation. Snowball sampling was also used, as each potential participant was asked to

forward the recruitment email and/or listserv announcement to any interested colleagues. Individuals contacted the researcher directly if they were interested in participating.

Data Collection

Procedures to protect the rights and privacy of participants were outlined in a proposal of this study and presented to the Human Subject Review Board (HSRB) at Smith College School for Social Work before data collection began. Approval of the proposal (see Appendix A) indicated that the study was in accordance with Federal Regulations for the Protection of Human Research Subjects.

Prior to participation, potential participants were given an informed consent document describing the purpose of the study and their rights as human subjects, as well as the potential risks and benefits of participation. Inclusion criteria for participation was also reiterated in the informed consent paperwork (see Appendix B).

After the researcher received signed informed consent documentation from the participant, demographic data was collected via an online questionnaire (see Appendix D). Demographic data included gender; race/ethnicity; career discipline; number of years practicing psychotherapy; theoretical orientation; primary practice setting; and approximate portion of caseload that are service members. Participants were also asked to indicate if they have a family member or significant other who has been a military service member. When participants accessed the demographic questionnaire on Survey Monkey, they were asked to indicate their name. This was done so that the researcher could track completed questionnaires and remove data if requested to do so by the participant. Identifying information was removed from completed demographic questionnaires and the data was collated for contextual information only.

The study used a flexible methods design. Qualitative narrative data was collected using open-ended interview questions. Initially, study participants had the option to be interviewed face-to-face or via Skype-to-Skype video call; those who were interviewed via Skype were required to have access to a computer equipped to communicate via Skype. Approximately one month into the recruitment process, after several potential (non-local) participants indicated that they were unfamiliar and/or uncomfortable with using Skype, it became apparent that not offering telephone interviews as an option was a barrier to data collection. At that time, the HSR application was amended to allow for telephone interviews. A total of seven study participants were interviewed via telephone, two participants were interviewed via Skype-to-Skype video call, and one participant was interviewed in-person (in the participant's private office). The interviews were all audio-recorded using a handheld digital recorder, with the consent of the participant prior to recording.

Interviews lasted approximately 60 minutes. An interview guide was used, however the researcher was flexible to content as it emerged. Initially participants were requested to have a specific client in mind and the researcher intended to ask each participant to describe a salient moment that unfolded in the therapeutic dyad with this client. However, taking into account participants' responses to this request and how the interview process unfolded, a majority of the interviews focused on more general open-ended questions pertaining to the study participant’s perception of their own thoughts, feelings, images, and sensations while working with combat service members; the meaning they made of their experiences; and if/how this moment impacted the treatment. In addition, participants were asked open-ended questions regarding if and how their work with combat service members differed from work with other clients. A full list of the interview questions and contingent follow-up questions is included in Appendix E.

Once completed, the interviews were downloaded into a free downloadable version of ExpressScribe, a dictation software that makes it possible to change the speed of playback and use keyboard controls to play and pause the recording. The researcher transcribed each interview in its entirety. The researcher was the only one to have access to the research data. To ensure confidentiality per Federal Guidelines and the mandates of the social work profession, all identifiable information from interviews was removed or/or disguised. In cases where illustrative vignettes and quoted comments are presented in the thesis write-up, they are disguised to ensure participants' confidentiality.

Signed informed consent forms have been kept separate from demographic and qualitative data. All demographic data collected is stored on SurveyMonkey.com, which is a website that is firewalled, password-protected, and encrypted. Qualitative data and digital files are stored electronically in password-protected folders on researcher's computer. All data will be kept secure for three years as required by Federal regulations. After that time, they will be destroyed or continue to be kept secured as long as needed. When no longer needed, data will be destroyed appropriately.

Data Analysis

Once interview data was transcribed, it was manually coded and analyzed using thematic data analysis. Codes were formulated through close readings of complete transcriptions of each interview. Each interview was read multiple times as codes were generated, modified, and/or discarded. Coded data was then analyzed to identify themes and patterns, consider possible similarities and differences in responses, and note material that did not fit into thematic areas. The analysis was done manually, however Word software will be used to organize and compile

the data as well as themes and patterns that emerged. Demographic date was collated for contextual information only.

CHAPTER IV

Findings

This chapter will present the findings of a qualitative analysis of interviews with ten civilian therapists who provide psychotherapy to combat service members who have killed or think they may have killed in combat. Interview questions were designed to elicit and explore therapists' subjective experience of therapeutic work with service members. Participants described how they conceptualize killing in combat, how they experience moments when their clients describe experiences of having killed, what they perceive to be their influence on the therapeutic process, how much of themselves they disclose, and what informs decisions about self-disclosure. Participants also detailed ways in which they experience empathic attunement as well as the unique issues they notice emerging in work with combat service members.

Demographic Data

This study is comprised of the responses of ten mental health professionals who at the time of the interviews, provided psychotherapy to one or more service members who have killed or think they may have killed in combat.[1] The following demographic data was collected via online questionnaire from all ten participants.

Questionnaire responses indicated that 50% of participants were female and 50% were male. All participants identified as white/Caucasian, with one participant also identifying as

[1] For the purposes of presenting data findings while maintaining confidentiality, participants are identified numerically throughout this chapter.

Native American/Alaskan Native. Of the ten participants, eight were clinical social workers and two were psychologists. Participants represented a variety of theoretical orientations, with 40% (n=4) reporting that cognitive behavioral therapy primarily informed their practice. A remaining 30% (n=3) reported integrative/eclectic therapy, 20% (n=2) reported existential/experimental therapy, and 10% (n=1) reported psychodynamic/psychoanalytic theories. The number of years participants have been in practice ranged from 2 years to 40 years. Four participants reported having been practicing psychotherapy for between 28-40 years, and the remaining 6 participants have been in practice for between 2-13 years.

Half of participants (n=5) practice primarily in private practice. Four participants practiced primarily at a VA Hospital or outpatient clinic and one respondent practiced at a Vet Center. Participants were also asked what percentage of their caseload at the time of the interviews were military service members. Four participants reported that 100% of their caseload was service members, one participant reported a caseload of 75%-100% service members, three participants reported a caseload of 25-50% service members, and two participants had a caseload of 25% or less service members. A total of three participants had a family member or significant other who has been a military service member.

Table 2

Participant Demographic Table

Category	n (%)
Gender (n = 10)	
Female	n = 5 (50%)
Male	n = 5 (50%)
Race/Ethnicity (n = 10)	
White or Caucasian	n = 10 (100%)
Native American or Alaskan Native	n = 1 (10%)
Professional Discipline (n = 10)	
Clinical Social Worker	n = 8 (80%)
Psychologist	n = 2 (20%)
# of years practicing (n = 10)	
0 – 13 years	n = 6 (60%)
14 – 27 years	n = 0
28 – 40 years	n = 4 (40%)
Theoretical Orientation (n = 10)	
Cognitive Behavioral	n = 4 (40%)
Existential/Experiential	n = 2 (20%)
Psychodynamic/Psychoanalytic	n = 1 (10%)
Integrative/Eclectic	n = 3 (30%)
Setting (n = 10)	
Private Practice	n = 5 (50%)
VA hospital or outpatient clinic	n = 4 (40%)
Vet Center	n = 1 (10%)
% of caseload are service members (n = 10)	
100%	n = 4 (40%)
75 – 100%	n = 1 (10%)
50 – 75%	n = 0
25 – 50 %	n = 3 (30%)
25% or less	n = 2 (20%)

Key Themes

Through the interview process, participants were asked a range of open-ended questions with the aim of exploring their subjective experience of working with combat service members who have killed or think they may have killed in combat. The interview questions were designed to be flexible in order to allow for a breadth and depth of information to emerge. Participant responses have been analyzed and categorized into the following themes and subthemes:

- Impact of killing in combat
  - Victim-induced versus perpetration-induced PTSD
  - Beyond PTSD
- Conceptualizing killing
  - Atrocities
- Dynamics of the treatment process
  - Disruptions
  - Therapeutic space
- Empathy
  - Therapists' use of their own feelings
  - Barriers to empathic attunement
- Clinician self-disclosure
  - Disclosure of information
  - Reciprocity and power
  - Realness

Impact of Killing in Combat

Although participants were not explicitly asked to identify or characterize the psychological impact of having killed in combat, this emerged as a theme throughout their responses. Participants unanimously reported that it was the functional implications of combat trauma—i.e., marital and parenting concerns, employment issues, and/or on-going nightmares—that brought individuals into treatment. In none of the cases was killing in combat identified as a client's primary presenting concern.

Participants were not asked specifically about clients' diagnoses, however nearly all participants utilized PTSD—its symptoms as well as its treatment—as a primary descriptor for their clients' distress. Eight participants referred to PTSD or its symptoms to describe their clients' experience, behaviors, and/or clinical presentation. One participant (P3) summarized his client's treatment by stating,

> We went around and around and around about him watching CNN and all the battles that were going on and getting on the computer and tracking down his squad and what they were doing and who was getting injured and killed and all this stuff. I told him that I understood why you'd want to do that but it just wasn't working for him because it kept triggering PTSD and the re-experiencing and the trauma and all that stuff. And he just wasn't able to heal if he kept doing that.

Another participant (P2) described her clients' distress as manifesting through characteristic re-experiencing and hyper-arousal PTSD symptoms: "They can't sleep. They're having nightmares about it. And arguments with their wives, and short with their children. So, it's still showing itself." Likewise, another participant (P4) remarked on the emergence of her client's re-experiencing PTSD symptoms,

> It took him a long time—I'm talking maybe six months—before he revealed to me that he had a terrible time driving on the freeway. Which is, as you would know, a pretty common reaction…. We talked about different symptoms… I was able to talk to him about feeling really anxious and blah, blah and kind of try to normalize that for him.

Several participants also used the language of cognitive-behavioral PTSD treatment—avoidance, stuck points, dysfunctional thought patterns, etc.—in explaining their understanding of their clients' suffering. As one participant (P1) described,

> I would see a patient doing some CPT worksheets and engaging in the treatment but their emotions not changing and the intensity of those emotions not changing. So that is when I would kind of wonder: Are these really the stuck points? Is there something else going on here? And my mind would kind of go there. Because that actually seemed to be kind of a common stuck point for the guys – was having killed someone or taken another life. So I would start wondering, you know, is that going on and they're not talking about it? Or what's the deal?

Similarly, one participant (P8) remarked on challenging her clients' problematic thought patterns by "remind[ing] them that the circumstances that it happened in are completely different than they are now…I have to try to help them reality test it." Generally, most participants described the impact of killing in cognitive and behavioral terms.

Two additional subthemes that surfaced under the theme of the impact of killing are: 1) victim-induced and perpetration-induced PTSD, and 2) characterizations of killing's impact that extend beyond PTSD.

Victim-induced versus perpetration-induced PTSD. In addressing the distress associated with their clients' experience, the majority of participants (n=8) conveyed an attitude of "trauma is trauma." That is, they did not distinguish between the suffering that resulted from perpetrating, as opposed to witnessing or being the victim of, a traumatic event. As one participant (P2) remarked, "the brain responds in a similar way whether it's being raped or in combat."

Only two participants (P5, P7) identified there being a distinction between victim-induced PTSD and perpetration-induced PTSD. One participant (P5) remarked that "It [killing] is not one of the criteria for PTSD but I think, you know, it's actually more likely that someone will

develop PTSD if they've killed someone than if not." Likewise, the other participant (P7) described noticing a difference in how PTSD manifests when it arises as a result of having perpetrated an act of violence in combat versus having witnessed or been the victim of violence. He stated,

> It's very different. There's a moral component, um, that's involved in being the actor rather than the victim. It's profoundly disturbing to know that you've killed another human being. We're not built that way.

Beyond PTSD. A total of three participants referred to deeply transformative consequences of killing in combat that went beyond its biomedical and functional implications. Two of the ten participants (P9, P10) spoke to an "unknowable" quality inherent in the trauma of having killed. One of these participants (P10) described combat trauma as "alien… in that other than soldiers who experiences this kind of trauma?… It is almost inherently unknowable. How many people are trained to kill, and then go and kill, and then go home?" The other participant (P9) referred to combat trauma survivors as "the holders of forbidden knowledge" and described their struggle in the following way,

> You are exposed to parts of being human that our whole psyche are designed to prevent us from knowing about. It's good to not know about those parts of yourself, or it's easier to not know about those parts of yourself.

One participant (P7) explicitly characterized the impact of killing in combat as a spiritual or soul wound. He stated,

> My own conceptualization of combat PTSD and specifically PTSD related to what one has done rather than what one has observed is a psychospiritual disorder. And it's not really touched by traditional PTSD treatment. The kind of treatment that is now considered evidence-based, and as you well know, is all cognitive behavioral. I think that is effective in dealing with symptoms but it doesn't get to how killing another person or harming another, let alone torturing another person, affects one's soul.

The potential meaning in how participants understood the psychological impact of killing in combat is addressed in the Discussion section.

Conceptualizing Killing

A second key theme that emerged throughout participants' responses was a conscious conceptualization of what constitutes killing in combat. All participants mentioned, in varying degrees of detail, how they made sense of the act of killing in combat and how that subsequently informed their interactions with clients.

Most participants framed killing in combat as a responsibility and an act of "survival," and they persistently characterized it in terms of "kill or be killed." The following quotes from participants (P6, P1, P10) illustrate their consistent emphasis on killing in combat as legitimate, mission-oriented, and rule-driven.

> My perspective is not that these guys have done something evil. The ones that have engaged in combat and have probably killed in combat—that's not my perception. My perception is that they truly believed in the validity of their mission and they went in and did their jobs to the best of their ability at great personal cost.
>
> As I'm sure you've learned from veterans, it's defend your buddy, defend yourself. If you defend yourself you're better able to defend yourself and then everybody goes home… They were fulfilling a mission and I think at least the guys I've talked to, on one hand tried to really think about who and what they might be shooting at and what the implications are. And it's hard to tell whose civilian and who's not. But still they were shooting back at people who shot at them. And they have some rules about that.
>
> I think a lot of that has to do with just almost that sense of choice and responsibility that is taken away from the person in the military. So, if they are given an order that's got a totally different feel than an offender who just victimizes somebody. Yeah, to me it's very different.

Participants' also emphasized the significance of the context in understanding their clients' acts of killing. The following participant (P4) framed killing as just one among many responsibilities in the midst an overwhelmingly taxing situation.

> It's not just difficult discomfort, it's hideous emotional, psychological discomfort. Whether you're talking about blast injuries or riding in a cramped vehicle with seventy pounds of gear and it's 119 degrees out. And that says nothing of what your mission is. So I'm mainly very aware that I am working with someone who has been tasked with overwhelming responsibilities. That's the way that I think about it.

Another participant (P8) remarked on her intentional efforts to keep the context of combat in mind when considering the actions of her clients,

> I have to remind myself that the state of mind people are living in on a constant basis when they are in a combat zone is a completely different way of living and sometimes that leads to making choices that wouldn't make sense in this atmosphere.

One participant (P9) offered a notably different understanding of killing in combat, which included an awareness of the potential for rage, vengeance, and pleasure in killing regardless of whether it was deemed sanctioned killing or not. This participant described understanding a firefight as "they're firing at you, you're firing at them, they're acting out their rage, you're acting out your rage. It's a sort of discharge." He expressed an awareness of the role that "impotent rage" and "sadistic pleasure" often play in the act. He also addressed the powerful erotic energy that is often experienced during and/or after the act of killing. In discussing his clients' experiences of killing he stated,

> Guys sometimes got aroused in combat. And that's like a secret they don't talk about. But I know about it so I'll ask. You know, 'Did you get a hard-on in the middle of a firefight?' And they're like, 'Yeah!'… It's thought of as shameful. You shouldn't enjoy killing. But people do. It's an intensely powerful experience.

A common subtheme that emerged within participants' conceptualizations of killing was the topic of atrocities.

Atrocities. Five participants (P1, P2, P4, P6, P8) drew a clear and deliberate distinction between legitimate killing in combat and an act of atrocity. Officially, an atrocity is defined as the killing of a noncombatant, either an erstwhile combatant who is no longer fighting or has

given up or a civilian (Grossman, 2009). However, the majority of participants who spoke of atrocities did so on the basis of the affective state and drive of the service member as opposed to the identity of who was killed. One participant (P2) explained the distinction as the difference between an individual who is swept up in an overwhelming situation versus an individual who gains pleasure from the act of killing. She stated,

> I haven't run across anyone yet that was like, 'Yay, I know those f-ers died and I loved it.' Usually it's 'Wow, in that moment everything was happening so fast that I could hear the boom of the machine gun and the bullets and the pinging all around me.' It's just more of that experience for them. I haven't run across the 'I've enjoyed killing' person yet.

Similarly, another participant (P6) highlighted the difference between an act motivated by an individual's ill intent as opposed to one guided by military mission and responsibility, and she attributed significant moral implications to the former.

> In a war situation there is no contemplation. There is no pre-meditation. It is about survival. But the pictures that we saw of this young man, what he had done to these people, it was pre-meditated. It was about power and anger and revenge and torture and humiliation. That's much more morally repugnant.

Several participants reported that had their client committed an act of atrocity, they anticipated that this would elicit a distinctly different response than the response they otherwise associated with killing in combat. Two participants (P4, P8) anticipated the difference in their reactions in the following ways,

> If he would have said, 'You know there were these women and kids standing on the sidelines and they got caught in the crossfire and boy that's too bad.' If he was real cavalier in that way I think I would have been more like "Gasp!" But he was like, 'They could have been responsible for killing any of my soldiers. I didn't know who they really were. Somebody in a dress or a veil could be a woman, but doesn't have to be.' It's not like he opened fire on anyone that wasn't a part of a plot against his convoy.

> I don't think I've come across any client where I feel that their incidences of having to kill someone were malicious. Like: Oh, I'm just going to kill this person

> for fun. That has not come up. I suppose if it was something like that that might initially set me back.

It was apparent that for the majority of participants their empathic engagement with clients was facilitated by framing killing in combat as legitimate and as guided by a particular set of rules of engagement. Several participants described their clients' experiences of killing as "making sense" to them given the context of combat. As one participant (P4) described it,

> My fellow is like 'This is not what I want to do but if I end up killing women and children who I think could be lobbying a grenade or an Iraqi or an Afghani who is dressed like a woman who is going to kill one of my soldiers I'm going after them. I don't care.' Listening to that, I have to tell you I don't care either.

The subject of how participants conceptualize of killing in combat, and the potential implications of the tendency to draw a distinction between sanctioned killing and atrocities, is explored further in the Discussion section.

Dynamics of the Treatment Process

Participants explained the interpersonal dynamics of the treatment process with combat service members in a variety of ways, particularly as it related to how they perceived of mutual influence and action in the process. This theme emerged most noticeably as it related to clients' willingness and/or reluctance to speak to and explore experiences of having killed in combat.

Half of participants (P1, P3, P5, P6, P8) focused on the client as the sole determinant of the treatment process, specifically in association with clients' reluctance to address having killed in combat. Some participants (P1, P5) framed clients' reluctance to address their experiences of killing in combat expressly as a manifestation of PTSD avoidance. As one participant (P5) stated in response to being asked how he makes sense of his clients' choice to not talk about their experiences of killing, "Avoidance of painful memories that they can't tolerate, that they don't want to deal with. That seems to be obvious." Other participants (P3, P6, P8) did not focus

exclusively on PTSD symptomatology, however their explanations of why clients were not addressing the experience of having killed in combat were distinctively located in the client's internal and/or external world—that is, it was understood as a manifestation of the client's intolerable anxiety, lack of readiness, laziness, and/or military training. The following quotes from participants (P8, P3, P6) exemplify participants' focus on the client as the sole determinant of the process.

> I'm sure often it's guilt. Not wanting to have to look at that and realize that they've taken another life and they're still living…I think part of it too is just fear of opening a Pandora's box. Some of them, I really think, are afraid that if they start allowing themselves to think about it they'll lose their minds. They'll just go completely crazy and just completely lose touch with reality and get so stuck in the emotions that they won't ever be able to get out again…Honestly, for the ones who have killed it seems like they're either very open about processing it up front or they just aren't and haven't been. It seems like they kind of come in two types.

> One thing that is frustrating for me is the entitlement of a lot of vets. It's like they want you to wave a magic wand and fix everything and they're not willing to be involved or do anything different… It's real clear that they are not doing well and it's pretty clear what they could do differently that would help a lot and they just don't do it. Whether it's substance abuse, lack of motivation, laziness, I don't know. That's my biggest frustration. The guys will come in once and then miss two or three appointments and then they'll come in once and then miss another two or three. Clearly they are just not committed to therapy.

> Honestly, having been exposed to Marines for four years I don't wonder at it [why they don't mention their experiences of having killed]. It's explicitly drilled into them so that there is almost no room for questioning the validity of the mission… I mean it's just very stark, black and white. There is no moral ambiguity trained into them.

The other half of participants (P4, P6, P7, P9, P10) identified themselves and/or the therapeutic alliance as having some degree of influence on how the treatment process unfolded, particularly in relation to clients' engagement with the experience of having killed in combat.

Several participants (n=4) spoke to their influence largely as a function of an empathic

connection and emergent trust. One participant (P4) connected the client's growing sense of trust and openness with her own receptivity. She stated,

> As time has gone on he's revealed more. He's talked more about the really tough times. He's talked more about his symptoms and how they interfere. And he's actually verbalized those things that I mentioned before about really being able to trust me. I do feel like he really trusts me… There was that session where he basically said, "I don't know who the enemy is. That woman could have been the Taliban. That kid could have been somebody that they just sent out there because that's what they do. And if I mowed them down, too bad." And I think, maybe, when I wasn't stricken to hear that I think that he felt like 'Ok, she can listen to some of this stuff.

One participant (P10) emphasized his own nonverbal communications as critical in conveying understanding and a willingness to listen.

> At times I don't know that there's anything I can say so I won't say anything. Because anything would sound rather small and probably pretty silly. And these guys have heard many small and many silly things from people like us… When it's an intense situation like that I'm less inclined to speak and more inclined to just show that "What you're saying is terrible. I realize it's terrible. It's pretty terrible for me to hear. Most importantly, it doesn't make me uncomfortable. It's an uncomfortable situation but if you can go through it, I can certainly listen to it."

This participant (P7) also cited his empathic responses as being an essential component of the therapeutic process.

> I think part of what we do in working with people with combat trauma is showing them that we can empathize with them so maybe they can begin to empathize with themselves… I will make a comment to the effect of "I know it must have been hard to share that with me and I feel honored that you would share that with me" or "That we have enough trust that you could share that with me."

One participant (P6) reported making an explicit effort to reduce the power differential and hierarchal structure between herself and her clients in an attempt to put her clients at ease and facilitate their engagement in treatment.

> Everything [in the military] is a power hierarchy and sometimes it's hard for them to understand where am I, me personally as a therapist, on the power hierarchy. I try to present this as being an equal effort and equal parts enterprise. I ask them to

> join with me and I say, "I may have questions about this or that because I don't directly know." And that sometimes will put people at ease who feel like they are basically showing up to be judged.

As well as efforts to establish trust and convey empathy, the following participant (P9) spoke to his draw to clients' intense emotionality, and the influence of this on the therapeutic process.

> I'm not scared to know about those parts of myself so that makes the work exciting and invigorating. If you're very guarded and blocked and don't want to know about those parts of yourself then the work would be torturous [for the therapist]… You'd have to do so much defending to keep it on that side of the room and not acknowledge it on this side of the room… It's like the people who at the marathon ran towards the blast. Some people turned and ran away, and crazy people like you and me run towards it. We're like: How can I help?... I'm interested to know what happened in the blast so I run towards the blast… I just ask about it the way I would ask about anything else. It's not extraordinary or different or unimaginable. Its just part of what happened.

In addition to remarking on perceptions of clients' and clinicians' influence and action in the treatment process, the following subthemes also emerged under the theme of the dynamics of the treatment process: 1) disruptions and 2) therapeutic space.

Disruptions. In some cases, participants' view of their influence in the treatment was expressed as a fear of having a potentially disruptive impact on the therapeutic process. Three participants (P1, P4, P5) described a worry that they might do or say something that would inadvertently hinder the client's process. One participant (P4) described a willful desire for her client to be able to "freely tell his story" without any implicit or explicit communication on her part to cause him to "shut down or close off because he thinks I will be harmed in some way." Likewise, a participant (P1) explained that she "didn't want to interrupt that process by moving away from it at all." One participant (P5) identified the fear of having a disruptive impact as a defining feature of his encounters with clients. He explained,

> Actually I've recently decided to stop asking that [if a client has killed in combat] because of some intense reactions I've gotten from people… In one case in particular I remember the patient getting really kind of irritated seeming. I thought he was irritated because I asked that. Because they thought I was judging them based on their answer… I came into it by saying, "Tell me about your experiences of combat in Iraq. Did you kill anybody?" And he sort of hesitated and didn't really want to answer it. And then he did answer but I could tell he was angry at me.

Therapeutic space. The way in which participants' conceived of the treatment process was also captured in how they spoke about "going there"—"there" being how many participants referred to the clients' internal world that contained their experience of having killed in combat. Participants' descriptions were indicative of differing perspectives on the process being facilitated through a therapeutic holding environment or an interactional dynamic between clinician and client.

Three participants (P1, P2, P8) described observing or "sitting with" the client as he goes "there" or vents about his experience. For example, one participant (P1) described, "I felt much more gravitation to just sit with it and let it be present in the room and let him kind of experience that it's safe to go there." These descriptions were noticeably different than that of participants (P7, P9) who portrayed a shared experience of "going there" together with their clients. As one participant (P7) described,

> I'm more likely to experience some relief or positive feelings when someone has the courage to go there and I can go there with them. And I feel very honored when somebody trusts me enough to take me there with them…You know, there is plenty of people who carry around guilt or shame from what they've done and don't feel like they can share it with anybody. So, I feel like I'm doing good work if somebody is going to take me there with them.

The interpersonal dynamics of the treatment process are explored in further detail in the Discussion section.

Empathy

Nearly all participants (n=9) identified empathy as a key component of the interactional process with their clients. One participant (P7) poignantly emphasized that, "I think there is an attunement that occurs in therapy that is particularly powerful working with combat veterans… I mean it's powerful stuff that we're dealing with here." Another participant (P10) described experiencing "general human sadness and grief along with my patient. My eyes were moist. I became teary and very profoundly empathic to what he was feeling."

When asked to identify how they experienced moments when clients discussed killing in combat, all participants conveyed experiences of emotional intensity. They described experiencing a range of emotions, including compassion, sadness, awe, anxiousness, and aggression. The variety of responses are captured in the following participants' responses:

> …a lot of sadness for him because he clearly felt incredibly guilty about it and was carrying that with him every day. And it was seriously affecting his life and his ability to function and readjust to civilian life. And, just sadness at the situation. You know, it's terrible that this kid ended up dying. But at the same time what else was he supposed to do. It might have cost him or his buddies their lives.
>
> I actually felt honored that he trusted me enough to bring in his photographs. Just to share that because that is such an intimate part and to say, you know, this was the reality of what we were doing on both sides.
>
> I felt terrible, just absolutely genuinely terrible.
>
> They'll start to share their combat experiences and the things that they were asked to do or the things that they did and it was like: Wow, they did that… they're capable.
>
> There is this piece of: "Oh my god, what you have been through. It is astonishing to me that you're standing, that you do function in this world, and basically you're a good guy." This is amazing to me.
>
> I feel aroused. I feel anxious and hyped up… I have felt that in some cases an empathic anger towards the enemy. Sometimes I've felt angry with the veteran who committed the act, especially when it's an atrocious act… And it's

> frightening. It can sometimes be exciting. And, not having served in the military myself I think that I, um, have at times taken a vicarious pleasure in hearing about the experiences of people who did fight.

More than half of participants (n=6) focused on expressions of compassion and/or sadness when discussing their empathic connection with clients. The significance of participants' tendency towards compassion and sadness, as opposed to rage or pleasure, associated with killing is explored in the Discussion section.

In light of the fact that none of the participants had personal experiences of having been in combat or of having killed another individual, several participants (n=5) identified a distinction between being capable of empathizing with and/or attuning to the client's internal experience while being unable to fully relate to his/her external experiences, in combat and otherwise. One participant (P2) described this in the following way,

> I've always said: You don't have to have cancer to know that it really sucks and it's really hard. So, you know, I acknowledge that I can't understand fully what that's like but I get that that's really hard.

Another participant (P3) described his experience of being in the "empathic mode" and attending to his client's emotional experience even when he can't necessarily relate to the details of their combat narratives:

> They're starting to talk about their battles in really gory detail and that's not anything I've really ever been exposed to. And so just getting a gestalt, I'm very empathetic, so for me developing a gestalt of what it was like for them in combat as best I could. It just was very emotional… I tuned in more to their pain or anxiety or guilt or whatever it was bringing up for them.

Likewise, one of the participants (P10) described staying attuned to his clients' here-and-now emotions as a way of connecting to their experience without having had a similar experience. He stated,

> To see him really, really choked up and very tearful was upsetting to me… The emotion, the grief, the loss, the frustration—I think that is what I was able to be

empathic with, without knowing, without having had the experience of my buddy being dead. Um, or being in a fire fight.

In cases where killing was not addressed directly by clients, participants noted that based on a client's deployment history and/or military occupational specialty (MOS), they could often surmise whether or not the client was likely to have killed in combat. As one participant (P6) stated, "Of my current active duty people or people who have recently left the military none of them have spoken about it but all have them have deployed to combat zones… Based on their MOS you can construe that [they've killed] for some of them." And, in those cases where clients were not explicitly addressing the experience of having killed in combat, several participants (P1, P5, P6) noted that they were still aware of and impacted by the unspoken experience. One participant (P1) described it as,

> If I sense there is something there and they're not talking about it that definitely makes me more anxious or more concerned about it… Anytime I get that sense that there is more going on here and they're not addressing it my PTSD radar starts going wild and just wanting to address the avoidance.

The following two subthemes also emerged in participants' reflections on empathy: 1) therapists' use of their own feelings and 2) barriers to empathic attunement.

Therapists' use of their own feelings. In addressing the empathic connection with their clients, four participants (P1, P4, P7, P9) described relying on their own feelings as a guide to understanding and attuning to their client's experience. One participant (P1) expressed this in the following way, "If I'm a civilian and I'm feeling this way I can only imagine what they're struggling with." Another participant (P7) drew a connection between his own sadness and his clients' overwhelming suffering.

> I feel tremendous empathy for the people that I work with who have been in combat… As I think about my emotions, I'm sad a lot more than I'm angry. Anybody who goes through this—knowing what I know now about PTSD and other traumatagenic disorders – what an impact it has on people's lives, on their

> ability to be intimate and to have relationships, to grow as people. It makes me very sad at times. So, that sadness is I think probably the predominant feeling I get now more than anger or more than arousal.

One participant (P4) described accessing her own subjective feelings of earnest responsibility and fierce protectiveness as a means of relating to her client's experience as a sergeant tasked with ensuring the wellbeing of his soldiers in combat:

> I probably connect better with the battle-scarred staff sergeant… I believe it is his absolutely clear, deep desire and felt responsibility that he was leading a group of soldiers and his job was to keep them alive. And that is something that just resonates with me… It is probably because there are a couple of things that I have a deep desire to do. You know, to do a good job with my patients. I don't want to at all compare it with what it must be like leading a combat troop, but I obviously want to do well with the people I see. And he, in a very real life and death situation, wants to keep his soldiers alive. And so all of our, you know, everything we talk about has kind of that as an underpinning. So, that, I think, is the reason I connect in a stronger way with him.

This same participant elaborated further on also being able to identify with her client's fear and aggression,

> If you're thinking: What does that feel like to realize your convoy was taking fire? And what is that like to start your day thinking: "I have to hope to hell that we get through."… So there's fear. But then also, me as a person who knows what I would really do, I think of myself as being aggressive. That if my life or the life of someone I love was in danger that I could do whatever I needed to do to disarm someone. And so I can feel the fear and sometimes just like "Ugh." Discomfort. And that "I'd go after them too."… You know, if I felt somebody was coming in the door after me, I don't care if they're a woman, if I have the means—and I'm not a gun person so I don't have it—but I've often felt that I could really attack back or more so…Whether I could or not I don't know but my response was, of course, I would kill somebody who I thought was going to do harm to my child.

Similarly, another participant (P9) described being familiar with his own internal experience of rage, and as a result being able to relate to his clients' comparable internal states of anger and aggression.

> It's very easy for me to identify with that state and imagine myself in that state, in that condition. And so it's not really much of a stretch for me identify with people talking about killing… I don't see a separation between me and them internally.

> We've had different external experiences but, you know, if you were to start talking about menstruation I'd be like, I don't really have a place in me to go to, I wouldn't know how to get there. But it's not that way for me when people talk about killing. I feel like I am familiar with the part of myself that was rageful. Particularly killing that was unfettered, that was just like a unit that just lost their shit and just started killing. It's just not hard for me to imagine myself.

Male therapists' and military service. Three of the five male study participants remarked on their personal experience grappling with individual and societal expectations of military service, and identified this as having a strong influence on their empathic connection with male service members.

Two male participants (P7, P9) were draft-eligible during the Vietnam War. However, they had objected to the war and to participating. Both of these participants framed their current therapeutic work with service members as fulfilling a "debt" to men who had served. One participant (P7) identified feeling "some regret and guilt for not having served in the military" and viewed this as motivating his therapeutic engagement with veterans.

> I was in college, graduate school during the Vietnam War but very early in the Vietnam War I became convinced that this was an immoral war and I would not participate in it. Um, but I've had feelings of guilt and, um, regret that I didn't have that experience of serving… So part of my motivation in working with this population has been to, um, somehow make-up for the fact that I didn't serve. So I feel, um, I feel very committed to doing my part, um, to help these veterans, who put their asses on the line instead of me.

Another participant (P9) echoed this sense of obligation. He explained that during the Vietnam period,

> Lives were organized around am I going to Vietnam or not. It was the single biggest question in every young man's life… everyone my age has lots of stuff about whether you went, you didn't go, you supported the war, you opposed the war. You couldn't get through that time without it make a big mark on you.

He identified feeling a strong sense of commitment and passion in his work with service members due to his own personal experience of not having gone to war:

> I got a conscientious objector status because I had privilege… And so if I was not white and middle class I would have gone to Vietnam and been them. So I'm very aware that this is the completion of an obligation on my part… working with veterans has to me felt very helpful. Coming full circle in the way of sort of paying off a debt… I think I have a stronger sense of commitment to the work then I would normally have. And I think they know that. And might wonder where that comes from for me… just my level of passion about them and what they've done and supporting them and normalizing their experience.

A younger male participant (P10) revealed during the interview that after over a decade of working as a civilian provider with service members he is currently awaiting a commission into the National Reserves as a psychologist for the Army. He identified his reason for entering the Reserves as an attempt to deal with,

> All the anger I have about the futility of the wars and the 4,000 soldiers. It's real anger and rage at that…. And how upset I am at the military and the government for not being prepared… so I'm a rather good example of sublimation.

Barriers to empathic attunement. Several participants' discussions of empathy entailed descriptions of actual and/or feared barriers to empathic connection with service members. These barriers have been categorized as: Getting "stuck," misogyny, and killing.

Getting "stuck". Five participants (P1, P3, P5, P7, P8) acknowledged instances in which they struggled to accept and be with their clients' affective states without wanting to change or fix them, particularly when clients remained "stuck" for an extended period of time. One participant (P3) described her experience struggling to readily empathize with a client in the following way,

> I think the best way to put it was that I felt compassion for him but not to the level that I usually do… There was probably a little bit of annoyance with the compassion for this particular patient.

Another participant (P3) spoke to finding it difficult to empathize with a client who was "just totally stuck and not able to let go of some of the memories."

> …this guy is so stuck. I've tried exposure therapy, I've tried cognitive behavioral, I've tried CBT, DBT, and it just doesn't make a dent. I'm as frustrated as he is because of his inability to move forward. And part of it is that he's an alcoholic and I think that has a lot to do with it. But regardless, he's in a lot of psychic pain. And I want to be able to help him and I haven't been able to. So yeah, it's tough.

Similarly, a participant (P8) explained feeling frustrated in the face of her clients' ongoing despair and her inability to alleviate the suffering,

> Sometimes they get very stuck in it and sort of using it to punish themselves. Like, 'I deserve to feel awful about this so I'm keep punishing myself with it.' I don't know, that's my theory anyway for some of them. Um. They can't work past it; they can't, you know, acknowledge it for what it is and allow themselves to continue living the life that they have. They just sort of get swallowed up by the misery of it. And I guess as a clinician sometimes that can be frustrating... I want you to be able to enjoy the life that you're living now. And that's just sad and frustrating when that's not happening.

Misogyny. Three female participants reported experiencing a sense of alienation and irritation in response to clients' misogynistic attitudes and/or behaviors. They each associated this misogyny with the broader military culture, which one participant (P6) described as being "very power-based and sexually charged." One participant (P2) explained that,

> There are other types of stories that they share with me about being in the military, maybe the way that they treated women or you know women's place in combat situations that I notice at times that I've been a little irked by.

Similarly, another participant (P8) described,

> If one of my Vietnam groups start talking about opinions against women in the military or, um, if a client makes some kind of comment about, you know, his wife belonging in the kitchen. If it's something that's sort of anti-feminist it tends to kind of rattle me for a second. And not even rattle me, it just, sometimes it's irritating and sometimes it's just an eye-roll kind of moment. Not that I actually roll my eyes but kind of just in my head I'm thinking: Ah, here we go again.

One participant (P6) explicitly acknowledged that "their way of speaking about women and their sort of misogyny—varying degrees of misogyny—did register in session and it did

inform my work with them." She described a specific experience of her client's gender-based antagonism,

> He talked extensively about protecting females and how that was one of the most important that he felt like he did there. He constantly had to protect the female service members from the inherent misogyny of the culture and things. And it, the atmosphere became very hostile towards me personally. I sensed a sort of hostility towards me as a woman.

This participant (P6) reported that she was conscious of the massive extent of sexual violence within the military and that this "feel[s] like an extra presence in the room to just be aware of." She identified being more attentive to the potential for erotic transference with service members, and as a result being more "stringent" about self-disclosure and rigid boundaries with her clients.

> All of my active duty folks right now are men and I am, um, in my thirties, you know, a female. And for that reason alone, because of the potential transference and countertransference I think it's important to maintain as professional, um, professional boundaries to the greatest extent possible and so, you know, I'm more mindful of that with the male military active duty folks that I see. Because I've sensed that there is more erotic transference there… With the military service people I'm just aware of it. It's out there as a potential and I'm just aware of it.

Killing. Two participants (P2, P5) expressed a subtle sense of anxiety and defensiveness associated with their clients' experiences of having killed. One participant (P2) stressed, "It's never been fear. I've never felt fear" however she went on to hesitantly describe her experience in the following way,

> You know, there is also, on some level, um, something I don't say very often, but on some level, the realization that these particular individuals are trained to kill. And, that is a different element than the general population. And I don't know if they are taking their medicine and I don't know if it's an anniversary date every time. And I don’t know a lot of these factors that could potentially maybe make them a little bit more dangerous than someone in the general population… They'll start to share their combat experiences and the things that they were asked to do or the things that they did and it was like "Wow." You know, "They did that… They're capable." Which, you know, technically, we're probably all capable if

> we're pushed far enough. But, you know, it's a special population with where they've come from.

This participant (P2) also remarked on being "really good at self care" and defined this as "Once I hear it, I document it, and then I'm done with it… I just shut it off." She went on to say,

> …it's just a story to me and I don't internalize that. I mean, that's their history and their story and I'm just there to help guide them. But, yeah, it's probably kind of creepy but you just can't take it home or you wouldn't be doing this job very long… There is kind of this disconnect when you're hearing someone's story, I think. Because, you know, I've never been in combat personally, I've never killed anyone personally. So it becomes kind of like another story.

When asked if he was aware of ways that his knowledge of his clients' experiences of having killed impacted his interaction with them, another participant (P5) stated,

> It probably does change something. But consciously I guess I'm not aware of exactly what it changes or if it changes anything. Because I still think: They're still my patient and I'm still, um, I'm still trying to take care of them. But I think maybe it does change something. If they say yes [I have killed] you're like "Woah." I don't know, that's pretty intense. It's hard to put into words exactly.

This participant also acknowledged experiencing relief when the experience of killing was not addressed,

> I don't usually think about that but I probably am relieved when people are not talking about it [having killed in combat] because, um, it's just easier to tolerate. It's an easier conversation to have… So I think in that sense there is a sense of relief perhaps when they are not talking about it. But I've never registered that before.

Each of these barriers to empathic attunement are addressed in further detail in the Discussion section.

Clinician Self-Disclosure

Therapist self-disclosure—defined as verbal or behavioral sharing of thoughts, feelings, values, life experiences, and factual information; thoughts and feelings about what is occurring in the treatment process; and countertransference reactions and contributions of the therapist-

patient interaction—was explored in considerable depth with participants. With the exception of two participants, all participants acknowledged engaging in some form and/or degree of self-disclosure with their clients. The two participants (P1, P5) who reported not consciously self-disclosing with service members accounted for this based on their treatment approach. As one participant (P1) explained, "I don't disagree with self-disclosure, I think it can be really useful. But this was on a residential PTSD unit and a lot of it was coming up within the treatment modality of CPT. So in terms of using therapist self-disclosure it didn't really fit the treatment model."

A majority of participants' (n=7) discussed self-disclosing their own thoughts and feelings about the client's material or about what was occurring in the therapeutic process. In response to being asked if she discloses her reactions to clients' experiences, one participant (P2) explained: "Sure. I'll say something like, 'Wow. That's really upsetting.' Or, 'I don't really like the way that sounded.'" Another participant (P7) stated, "I'm more self-disclosing about how I'm being effected by what they're saying and my generally positive feelings about what they've gone through or what they've experienced." A participant (P4) who asserted that she is less neutral with service members described being neutral as,

> A lack of any kind of exposure – verbally, facially, whatever – about what they are saying to you. That to me is neutral. It is a barren way of working with these people. And, I think it hinders the relationship. Maybe not with everybody. But that is why I tend to not maintain a lot of neutrality. When I talk about disclosing what I'm saying or meaning is that they might be able to look at me and understand that I think I understand what happened or where they're coming from or why they did what they did or what their reaction was. And disclosing, of course, would be saying, "It doesn't seem to me that you have much a choice but to return fire. And some of that fire may have hit people that were not necessarily a part of the hostile group. They could have collateral damage.

One participant (P3) spoke to explicitly using his own feelings and reactions as a therapeutic tool to help his clients recognize their impact on others.

> I'm pretty transparent in terms of I'd say 'Well, you know, as a none combat person, civilian, this is the way it feels or looks to me. I'm just wondering if you've experienced any of that with your family.'… So I used my own thoughts and feelings and perceptions in a therapeutic way to help them appreciate what their family and friends were maybe going through. And that really seemed to help.

In most cases, participants reported acknowledging their affective states and experiences non-verbally as well as verbally. One participant (P7) reported that he displayed his empathy towards clients in the following ways,

> I will often empathize with how difficult a job it is to be a combat soldier and how much I admire their courage or commitment to their unit or whatever it is. To verbally acknowledge it. But I suspect it probably comes out even more non-verbally than verbally… By my facial expressions, my posture. Sometimes by the tears that well up in my eyes.

Another participant (P8) described sharing her reaction to clients' emotionality with verbal acknowledgement as well as with her own emotional expression,

> If they get more emotional about it then I might stop and just acknowledge "This is really hard" and "That must be really difficult for you." I guess occasionally I may have gotten a little misty eyed. I don't know that I've ever full on balled with anyone but I mean if it really is a sad moment I definitely can connect to that with them. And pause to share that with them.

Three participants (P4, P7, P9) emphasized the significance of nonverbal cues—namely, an obvious lack of shock—in conveying acceptance and a nonjudgmental stance. One participant (P7) described displaying that "I'm not balled over by their experiences" and another (P4) stated, "I didn't react like I was stricken to hear that." One participant (P9) asserted that to convey a nonjudgmental reaction to clients' material "you don't talk about it, you just do it." He stated,

> I think that I talk about it with people in a way that it would be unusual that somebody wouldn't be willing to talk about it because I don't make it, I don't act like it's a harder thing to talk about than anything else. Because I don't think it is… It doesn't feel like a shock.

Five participants (P3, P4, P7, P8, P10) reported consciously self-disclosing more with service members than with other client populations that they work with. As one participant (P7) succinctly put it, "[with] people who are dealing with combat trauma I tend to be more self-disclosing. I think it's very hard to do work with people with combat PTSD without sharing some of yourself." And, another participant (P4) stated, "I am much less neutral with my military people." Similarly, one participant (P3) remarked on being "a little more directive or more direct with this population. It seems to work."

Two participants (P2, P6) reported that although they self-disclosed with this population they were conscious of doing so less than with other populations. Both of these participants accounted for this based on gender dynamics. As one participant (P2) explained, "I don't see these gentleman very often and the fact that they are male causes me probably to not disclose as much as I did when I was in my private practice because I saw them more often and most of them were female."

The following additional subthemes emerged under the theme of clinician self-disclosure: 1) disclosure of information, 2) reciprocity and power, and 3) realness.

Disclosure of information. When asked about self-disclosure, four participants (P3, P7, P8, P9) discussed verbally disclosing factual information and life experiences in an attempt to build rapport, to normalize experiences, and/or to encourage new ways of thinking. In an effort to convey that "I understand how you feel, it's not an odd feeling" one participant (P9) described disclosing his own experiences in the following way,

> I might say, "You know when I was the age you're talking about and I imagined myself in Vietnam it terrified me to think about me in a free fire zone, me with permission to be as violent as I wanted to be and commended for being as violent as I wanted to be. It terrified me to think about what that might look like.

Another participant (P3) explained using examples from his own life in order to create connection and to illustrate alternative thinking patterns:

> I will use a lot of examples from my life or other patients, who aren't identified of course. What other people have gone through so they [the client] can get out of that defensive prospective and not try to defend themselves and be able to see the concept better.

Civilian identity. In exploring the potential influence of clinicians' experiences and attitudes, nearly all participants (n=9) acknowledged maintaining some degree of conscious awareness of their civilian identity while working with service members. One participant (P7) described his sense of awareness in the following way,

> I am always aware that I'm a civilian and haven’t served. But I really immerse myself in military culture and military history so that I can talk the lingo. I know all the acronyms, I know most of the battles. So I can relate pretty well. But, I am always aware that even though I can relate I wasn't one of them.

Only one participant (P10) reported being at times "mistaken" for a service member. For all other participants, their civilian identity did not need to be explicitly stated in order to be known, or to potentially have an influence in the therapeutic relationship. With that said, none of the participants identified significant ways in which they perceived of their civilian status or civilian culture entering into the interaction with clients. The only way in which some participants reported experiencing it as a factor was in regards to military lingo. As a participant (P2) explained, "The military speak—I think that's probably the hardest part."

Two participants (P5, P6) described making explicit efforts to address their civilian identity with clients. The two participants that made conscious efforts to speak overtly to this aspect of their identity were individuals who otherwise reported limited self-disclosure with this population of clients. A participant (P5) who reported that otherwise "I don't think I brought myself into the room very much," stated that in regards to his identity as a civilian,

> I will disclose, "Yeah, I'm not a veteran. I've never experienced that so it must be really hard."… I think I try to be open about that. That I have a lot of respect for the shit you've been through. And I'll say it like that.

Likewise, a participant (P6) who stated that in regards to self-disclosure with service members "I will actually stop myself and that's a big deal" indicated that she felt it was important to name and speak to her civilian status early on with service members. "The fact that I have zero personal experience with the military. Yeah, that usually does come up. In fact, that's usually something that I talk to pretty quickly." This participant identified her reason for doing so in the following way, "I think that one of the things I do is that I encourage them [service members] to see themselves as being my educator in some ways…. To try to equalize the playing field in terms of power."

Opinions of war. An additional theme that emerged in regards to clinicians' experiences and attitudes was the issue of opinions on war. Four participants (P1, P6, P9, P10) made reference to their views on war entering the therapeutic dynamic in some way. Three of the four participants who addressed this theme reported conscious efforts to keep any mention of the politics of war out of their interaction with clients. One participant (P10) stated,

> We're not supposed to necessarily inject ourselves into the scenario as far as our personal beliefs about taking a life or not taking a life. And I certainly have beliefs about that. But whether I would support the war or am against the war or if it should even be called a war—I have definitive beliefs about those—but these soldiers for one reason or another found themselves in this war... These are human beings in non-human, intolerable scenarios and so whether you agree with it or not I don't see that coming into place. And it's not really my place to necessarily defend or discuss that unless that's something that they have something to say about it.

Another participant (P6) described,

> I still maintain very, very strong in my own personal perspective. But, you know, I try to deal with that appropriately in the context of the therapeutic relationship… I have had to be pretty careful in that regard. I mean, personally I was against the war in Iraq… I do have very strong personal opinions about the validity of that

> cause but, you know, these guys and girls come in and they say 'It had to have meant something or else I can't stand it.' And, that's where they are… I'm pretty comfortable with my ability to set aside my personal views about the administration that started the war for example and to just attend to individuals as individuals.

One participant (P9) offered a different perspective, asserting that to not talk about the broader politics of war "is like working with women and not talking about gender politics." He elaborated on this by stating,

> I think working with trauma survivors has to be a political process. I think you have to talk about the politics of it. Not like Democrat, liberal. But like, for example, that the last war was waged entirely by people who never served in the military. That is a political reality. People who have never been to war make different decisions about how to engage in war than people who have been to war.

Reciprocity and power. The most common explanations (n=4) for the use of self-disclosure, as well as for why self-disclosure was used more with this population than with other client populations, were that it served as a means of establishing a sense of reciprocity, decreasing distance, and reducing a power differential. Some participants (P3, P4) also indicated that they were influenced to do so by the directness and hierarchical nature of military culture while others (P7, P10) attributed their use of self-disclosure to a "gut feeling." One participant (P2) explained, "I think that if they're trying to be genuine with me I can only pay that back." Another participant (P3) described his self-disclosure as an extension of his tendency to "wear my emotions on my sleeve" and saw it as a "joining technique." He stated,

> I'm not going to go into detail but I think that makes me more human and it decreases that distance that they feel… It feels like there is a less of a barrier. They are willing to be more honest and open with me because I role model it for them.

Several participants contended that the need to reduce the power differential and foster reciprocity was particularly important, and valuable, with service members. Three participants remarked on self-disclosure in terms of "owing" it to the client or as a means of "pay back" for

the clients' attempts at genuineness. One participant (P7) asserted that he feels as though he owes it to these clients to be more self-disclosing and that through doing so he "can be more effective with them." He elaborated on this by saying,

> I think that those folks tend to be aware of a power differential with dealing with an authority figure. And, they often need to know that they're opening up that part of themselves, and that you're going to open up part of yourself… That they're taking me along with them to a place that I'll never fully understand but that they're willing to share with me. And I just feel like I owe it to them to share more of myself. I think it makes sense clinically. It certainly makes sense to me emotionally.

The subject of clinicians' sense of indebtedness in work with service members is addressed further in the Discussion section.

In addressing the increased tendency to self-disclose, several participants noted not having been consciously aware of this prior to being asked about it in the interview. One participant (P7) responded to a question about his tendency to share more of himself with service members by stating, "I had the same question in mind as I was just talking to you. And, I don't think I have an adequate answer. It just seems right."

Realness. An additional noteworthy theme that emerged in discussions of clinician self-disclosure was the perceived importance of displaying realness and genuineness with service members. Five participants (P3, P4, P5, P7, P10) noted that "being real" and "being human" was particularly important with service members. One participant (P3) characterized his realness as a way of "being congruent with the situation" and "giving them my full attention." He went on to say,

> There is this personal flavor that works for them [veterans]. And people who are impersonal in their approach, in their demeanor tend not to work well with a lot of vets… I've had numerous vets tell me "You know, you're a straight shooter, I really like that. You don't run around the bush. You just tell me the way it is and that really helps." So that's what I do to be a little more directive or more direct with this population. It seems to work.

Another participant (P4) asserted that realness was absolutely essential to effective psychotherapy with service members, and associated this with "there's a way to do things" in the military that is more direct and less "intensively related to feelings." She explained further,

> Frankly, I felt in order to be helpful to them they had to feel like they were dealing with a real person. And, I believed and I think I'm right, that had I maintained that neutral abstinence, blah, blah, blah that we at least used to be taught at Smith that they would have gone running out of my office. I believe that they need something more real.

One participant (P10) emphasized being real as "opposed to very clinical and detached" and explained,

> That isn't to say you need to break down and cry every time someone cries but if something is genuinely terrible you probably should be feeling terrible and that probably should be evident. We're not robots. We're human. Now, we need to have that clinical detachment but not to such an extent that we're actually detached.

Conclusion

These findings represent the perspectives of ten civilian therapists who work with combat service members who have killed or think they may have killed in combat. Participants' reflections on their subjective experience of this work have been categorized into the major themes of: 1) impact of killing in combat, 2) conceptualizing killing, 3) dynamics of the treatment process, 4) empathy, and 5) clinician self-disclosure. Within each of these overarching themes, a variety of subthemes have been identified and described. The following Discussion chapter will address the major themes and subthemes in greater depth, analyze relationships between the themes, and highlight the significance of unaddressed topics. The relevance of these findings in connection to previously reviewed literature will also be considered. Additionally, limitations, implications of the data for clinical social work practice, and future areas of research will be addressed.

CHAPTER V

Discussion

This study set out to explore civilian therapists' subjective experience of psychotherapy with combat service members who have killed or think they may have killed in combat. The study aimed to utilize relational theory's understanding of the mutual influence in the therapist-client dyad in order to explore how the psychological aftermath of killing in combat emerges in the therapeutic relationship, specifically from the therapist's vantage point. As discussed in the Literature Review, the act of killing possesses a unique capacity to assault an individual's self-image and sense of the world as a meaningful and comprehensible place, in addition to often leaving a lasting mark on how closeness is experienced. The Literature Review also highlighted the ways in which civilian society perpetuates a conspiracy of silence about the harsh physiological and psychological reality of combat. With these factors in mind, this study explored the explicit and implicit ways in which ten civilian therapists experienced and described interactions with individuals who killed or thought they may have killed in combat.

This chapter discusses the following: 1) examination of findings, 2) implications for practice, 3) limitations, 4) future research, and 5) conclusion.

Examination of Findings

As addressed in the previous Findings chapter, participant responses were analyzed and categorized into the following themes: 1) impact of killing in combat, 2) conceptualizing killing, 3) dynamics of the treatment process, 4) empathy, and 5) clinician self-disclosure. These themes

were subsequently examined in relation to each other as well as in connection to existing literature on the topic. A significant portion of the findings obtained from this study's ten narrative interviews are supported in the literature. In some regards, the implication of the findings was captured in what was not addressed as much as what was.

This section outlines and discusses the significance of the study's findings in the following areas: 1) psychological impact of killing, 2) reality of killing, 3) emphasis on empathy, self-disclosure, and reciprocity, and 4) empathic "failures."

The Psychological Impact of Killing

To a large extent, this study participants' reflections supported the trend in the literature to focus on the biomedical and functional implications of combat trauma (Adler, Bliese, & Castro, 2011; Hoge et al., 2006; Hoge, 2010; Marmar, 2009; Ramchand et al., 2010; Ruzek et al, 2011; Tanielian & Jaycox, 2008). Although none of the participants spoke about their clients' specific diagnosis, nearly all (n=8) mentioned PTSD in reference to their clients' experience, behaviors, and/or clinical presentation. Furthermore, most commonly, participants reported that it was marital and parenting concerns, employment issues, and/or on-going nightmares that brought individuals into treatment. The majority of participants' (n=7) responses also mirrored the bulk of mainstream literature's lack of elaboration on the specific psychological implications and repercussions of the act of killing. Similar to how divergent acts such as "being injured or wounded in combat; killing, injuring, or wounding someone else; and handling or smelling dead and decomposing bodies" are all equally defined as "traditional combat events" in the literature (Ramchand et al., 2011), the majority of study participants (n=7) conceived of combat trauma as "trauma is trauma." Only two participants distinguished between victim-induced and perpetration-induced PTSD.

For half of participants (n=5), PTSD symtomatology was the frame through which they understood and explained their clients' engagement (or lack there of) in the therapeutic process. That is, participants conceived of clients' unwillingness to directly address traumatic material strictly as a manifestation of PTSD's characteristic avoidance and psychic numbing symptoms, with no potential concurrent relational influence. Many of these participants acknowledged their own desire for clients to explicitly address traumatic material associated with killing, however they framed this desire as an objective consideration of what would lead to a reduction in his/her PTSD symptoms. This was most consistently exhibited through the use of the language and principles of cognitive-based trauma focused treatment. Participants' reflections depicted the implications of killing as a strictly intra-psychic phenomenon, which manifested through PTSD symptoms. Likewise, the therapeutic process was represented as a one-person phenomenon, focused primarily on client behaviors and attitudes. This subset of participants appeared to conceive of themselves as being present as helpers and as guides in the treatment process, all the while maintaining, either consciously or unconsciously, a safe and manageable distance from the existential discomfort of killing.

With this said, it is significant to note that three participants referred in some way to the deeply dissonant and ultimately transformative ways in which killing in combat impacts individuals' innermost sense of self. Two of these participants acknowledged an inherently unknowable quality in killing and highlighted that killing in combat obliges service members to confront parts of themselves that the human psyche is typically defended against knowing. One participant spoke to combat trauma as a psycho-spiritual "soul wounding" or "soul loss," as Edward Tick (2005), Jonathan Shay (1994, 2002, 2011) and others who advocate for a more nuanced understanding of service members' psychological distress do.

Each of these three participants mentioned during their interviews that they had personally contemplated whether or not to enter the military and resultantly engage in combat. They described, at one time, consciously grappling with, and attempting to anticipate, the psychological and philosophical implications of killing for themselves. All three participants noted a moral objection to war, and in two of these cases the participant had chosen not to serve in the military as a result of this objection. Although none of these participants explicitly drew a connection between their personal considerations and the ways in which they understood the psychological impact of killing for their clients, it seems probable that the two are linked. These participants described a powerful, experience-near engagement with killing's deeper, core meanings. Moral objections notwithstanding, these three participants appeared able to withstand a messier, rawer, and more confusing consideration of combat and its aftermath, delving beneath the symtomatology and functional implications of killing to the deeper reverberations in one's psyche and soul.

Reality of Killing

Among the key findings of this study was the relatively consistent way in which participants conceptualized of killing in combat, and the significance of this in their interactions with clients. Most participants (n=8) viewed killing in combat as a legitimate act that was part of a larger mission, directed under orders and/or motivated by survival instincts, and guided by clear rules of engagement. Only one of ten participants recognized the potential influence of rage, vengeance, pleasure, and arousal in killing. Ambiguity was also noticeably absent from most participants' conceptualizations of killing, which is potentially suggestive of their own denial of the complicated and dissonant realities—both internally and externally—of killing in combat.

In discussing how they made sense of killing in combat, several participants (n=5) drew a deliberate distinction between sanctioned killing and atrocities. Technically, an atrocity is defined as the killing of a civilian or of a combatant who is no longer fighting (Grossman, 2009; MacNair, 2002). However, the majority of participants who spoke of such incidents did so on the basis of the affect and drives of the service member, rather than on who was killed. That is, most participants associated an atrocity with pleasure, unrestrained rage, and/or malice on the part of the service member.

As both study participants and the literature acknowledge, the line between combatant and noncombatant is often unclear in combat. Lt. Col Dave Grossman (2009) and others who explore the psychological implications of killing in combat point out, "modern war, and particularly guerrilla warfare, makes such distinctions [between legitimate killing and acts of atrocity] blurry" (p. 195). As Grossman (2009) remarks, "In reality, the problem of distinguishing murder from killing in combat is extremely complex… we see killing in modern warfare, in an age of guerillas and terrorists, as increasingly moving from black and white to shades of gray" (Grossman, 2009, p. 201). In line with this literature, participants described situations in which a service member killed a civilian—either out of necessity or confusion—as understandable and justifiable. They expressed an acceptance for the need for leeway in ascertaining who the enemy was, and therefore who it may be necessary to kill.

One way of interpreting participants' distinction between legitimate killing and atrocities—particularly the focus on the affect and drives of the service member rather than on the identity of who was killed—is as an attempt to reconstitute the otherwise "blurry" line between sanctioned and unsanctioned killing. Shifting the focus away from who was killed—which as noted above often introduces extreme complexity—may have served as a means to

mitigate the difficulty in distinguishing murder from killing in combat, and thus lessened associated uneasiness on the part of both therapist and client.

The majority of participants' conceptualizations of killing failed to acknowledge the divergent emotional and psychological response states that are frequently experienced when one individual kills another—including, exhilaration (at times marked by intense, orgasmic intimacy), remorse, rationalization, and acceptance—whether the act is sanctioned or not (Bourke, 1999; Grossman, 2008, 2009; MacNair, 2002, 2007). Only one participant described clients struggling with contradictory emotions—including exhilarating aggression, emergent feelings of intense intimacy, or associated experiences of ambivalence—related to having killed in combat. It is possible that participants' focus on their clients' belief in the mission, sense of responsibility to their commanders and fellow soldiers, and lack of pleasure or personal motivation in killing served the unconscious purpose of lessoning their own visceral and existential discomfort associated with the raw and brutal intensity of one human killing another.

Participant responses also did not reflect the assertion that, although an act may be obligated under orders and be "right" under military rules of engagement, this does not preclude it from being experienced as internally conflictual. Tick (2005) explains the conflicted state that many service members experience,

> Having betrayed their ethical codes when they had to, they cannot tolerate the betrayal. They feel trapped in moral dilemmas they cannot resolve in any acceptable way, and the impasse breaks the soul. This entrapment can occur even when the actor behaves in an extremely moral and self-sacrificing way. (p. 113)

The literature reveals that often it is balancing the obligation to kill with the resulting toll of guilt—born out of the innate human resistance to killing—that constitutes the most significant psychological distress (Grossman, 2009). The majority of participants' conceptualizations of killing did not bear this in mind, and instead portrayed clients' experiences of sanctioned killing

as distressing at times but not necessarily internally conflictual. Perhaps overlooking clients' potential experiences of internal conflict permitted the therapist to also overlook his/her own unacknowledged conflict and confusion associated with the act of killing.

Four participants (n=4) adamantly reported that they have never worked with a service member who gained pleasure from killing and/or was motivated to kill by power, anger or revenge—and each of these participants anticipated experiencing discomfort and, in some cases, repudiation if they were to do so. Although participants did not identify this to be the case, it is possible that clients' lack of engagement with ambiguous and conflictual material associated with the act of killing is a manifestation of the mutual influence of the therapists' and the clients' discomfort. That is, it is likely that at times the therapist implicitly conveyed his/her uneasiness and potential repudiation, and that the service member's engagement in treatment was subsequently impacted. As Tick (2005) suggests,

> Because we as a nation are trapped in a consciousness that cannot acknowledge abject suffering, especially if we have caused or contributed to it, we do not see the reality of war. Meanwhile, survivors feel trapped in that apocalyptic reality and rarely try to explain it to people who will not understand. (p. 169)

In this way, service members' psychological distress in the aftermath of killing can be accounted for, in part, as the result of empathic failure on the part of others.

As discussed in the Literature Review section, the intense and contradictory reality of killing in combat is often veiled by denial, both on the part of individual service members and the larger society (Bourke, 1999; Finley, 2011; Grossman, 2009; MacNair, 2002; Tick, 2005). In reference to individual denial Grossman (2009) states,

> The soldier who does kill must overcome that part of him that says that he is a murderer of women and children, a foul beast who has done the unforgivable. He *must* deny the guilt within him, and he *must* assure himself that the world is not mad, that his victims are less than human, that they are evil vermin, and that what his nation and his leaders have told him to do is right… And the killer *must* violently suppress any dissonant

> thought that he has done anything wrong…. His mental health is totally invested in believing what he has done is good and right. (p. 212)

This individual denial is reinforced by a larger societal denial about the dissonant realities of combat and its aftermath, and further perpetuated by a belief that "our young men and women should be able to go to war, get the job done, and return home blameless and well" (Tick, 2005, p. 155). The ways that this study's participants conceptualized of killing in combat are indicative of a denial of the harsh, complicated realities of killing as well as of a vested belief in the service members' actions being "good and right."

Emphasis on Empathy, Self-Disclosure, and Reciprocity

Participants explained the interpersonal dynamics of the treatment process with combat service members in a variety of ways, particularly as it related to how they perceived of mutual influence and action in the process. The theme of the client's and the therapist's influence on the process most clearly emerged in participants' descriptions of clients' willingness and/or reluctance to address experiences of having killed in combat. Half of participants (n=5) identified themselves and/or the therapeutic alliance as having some degree of influence on how the treatment process unfolded. Whereas, the other half of participants (n=5) focused on the client as the sole determinant of the treatment process, particularly in circumstances in which the client was resistant to addressing the experience of having killed. In the latter cases, there was a noteworthy absence of consideration for how the therapist may have stimulated, intensified, or contributed to the client's resistance, as well as a lack of recognition for how therapeutic change may primarily be located in the relational home of the therapist-client dyad.

Participants' perspectives on "going there"—that is, to the client's internal world which contained the experience of having killed in combat—also reflected differing perspectives on how the participant viewed his/her role and influence. Some participants (n=3) focused on the

client "going there" while they, the clinician, provided a holding environment that enabled the client to feel safe and assisted them in verbalizing their feelings. Whereas, other participants (n=2) portrayed a poignant shared experience of accompanying their client to this distressing place. The descriptions appeared indicative of differing perspectives on a clinician's holding function versus an interactional process between clinician and client.

Although participants did not explicitly address the topic of therapeutic influence and action as a function of their theoretical orientation, their descriptions appeared to be reflective of this. Demographic findings indicate that 40% (n=4) of participants' practice is informed primarily by cognitive behavioral theories, which are largely focused on client behaviors and attitudes with only secondary emphasis on the therapeutic interaction. This is line with the half of participants who focused on the client as the sole determinant of the treatment process. Likewise, demographic findings reveal that 30% of participants practice from an existential/experiential or psychodynamic/psychoanalytic orientation, thus accounting for those viewpoints that place greater emphasis on mutual influence and on the interactional process between the client and clinician.

These varied perspectives on a mutual and interactional process notwithstanding, when asked to elaborate on their experiences with clients who had killed or thought they may have killed in combat, all study participants' descriptions revealed unique, and often intense, encounters with clients. Furthermore, nearly all study participants (n=9) emphasized the significance of empathy in their work with combat service members. Given that none of the participants had combat experience, many (n=5) stressed the importance of being able to empathize with clients' internal experiences of sadness, anxiety, guilt, and aggression despite being unable to fully relate to his/her external experience of combat, and particularly to having

killed in combat. Participants' descriptions depicted a sense of "associative identification" (Shechter, 1992). That is, they tended to associate from clients' experiences to their own and to draw on their own intrapsychic processes—with affect, not content, having the greatest similarity.

Several participants (n=4) noted ways in which they experienced more empathy and/or have a stronger sense of passion and commitment in therapeutic work with service members than they might typically have. This emphasis on an empathic alliance, and on the potential for a particularly strong sense of connection, is in line with literature about psychotherapy with Vietnam veterans. The literature highlights the relationship between the therapist and patient as being critical, and suggests that it may be significantly more important with this population than other populations (Egendorf, 1978; Haley, 1974; Maxwell & Sturm, 1989; Lindy, 1988; Parson, 1984; Shapiro, 1984). As discussed in the Literature Review, a systematic examination of individual psychoanalytic treatment with Vietnam veterans revealed bonds between veteran and therapist that were "more durable, more intense, and more vivid" (Lindy, 1988, p. 213) than the therapists were otherwise accustomed to.

Participants' responses also supported findings in the literature that purport that in order to facilitate an empathic connection with service members, therapists need to be more self-disclosing than they would be with most other populations of clients (Haley, 1974, 1978; Newberry, 1985; Parson, 1986; Tick, 2005). A majority of participants (n=8) acknowledged consciously using self-disclosure as a means of establishing an empathic connection with service members. Half of study participants (n=5) reported self-disclosing more with these clients than with other client populations. The self-disclosures that participants mentioned included verbal as well as behavioral disclosures of factual information (n=4), in addition to thoughts and feelings

about the client's material and what was unfolding in the treatment process (n=7). More participants acknowledged disclosing expressions of affect than factual disclosures.

Two specific topics that participants discussed in regards to self-disclosures were civilian identity and political opinions on war. Although nearly all participants (n=9) remarked that they were consciously aware of their civilian identity, only two participants reported making explicit efforts to speak overtly to this topic with their clients. The majority of the participants' descriptions indicated a preference to keep this aspect of their identity as an unspoken but known reality. None of the participants provided a particular reason for this.

Likewise, of the four participants who referenced being aware that their views on war could potentially impact the therapeutic dynamic, three reported making conscious efforts to keep any mention of the politics of war out of their interactions with clients. Each of these individuals referred to being politically opposed to the current wars. Their reflections suggested a belief that as long as explicit mention of the politics of war did not enter the interaction, the therapists' personal opinions and accountability would not influence the process. None of the participants mentioned an incident in which they perceived of their political opinions having has an impact.

Specific topics that participants preferred to not address directly notwithstanding, half of study participants (n=5) described themselves as being more "real" and "human" with service members. These participants asserted that their own genuine engagement with service members was essential to effective treatment. In most cases, participants conveyed this not necessarily as a manifestation of their theoretical orientation or practice style, but rather as an aspect of their therapeutic work that was unique to and/or accentuated with combat service members.

The reasons commonly cited in the literature for an emphasis on "realness" and self-disclosure with service members are that it conveys trustworthiness and a nonjudgmental stance, facilitates a degree of absolution for the service member, and functions to transfer responsibility for war's suffering from the individual to the collective (Haley, 1974, 1978; Lindy, 1988; Newberry, 1985; Parson, 1986; Tick, 2005). Although meaningful, these explanations fail to speak to the individual therapists' urge and desire to be more "real" and self-disclosing with this population, or to not do so as the case may be.

This study explored in greater depth therapists' subjective thoughts and feelings regarding self-disclosure and genuineness with combat service members. Participants provided various reasons for their use of self-disclosure, including as a way to build rapport, normalize experiences, and to convey acceptance and a nonjudgmental stance. Participants expressed a desire to communicate to their clients that they understood and empathized with the experience of having killed in combat despite not having had similar experiences.[2]

When asked why they disclose more with service members than with other populations, several participants (n=4) remarked on their intention to reduce the power differential and to establish a sense of reciprocity. Participants associated the need to equalize the power differential with the hierarchical nature of military culture which clients were accustomed to, and they addressed reciprocity in regards to a mutual exchange of openness. Three participants remarked on self-disclosure in terms of "owing" it to the client or as a means of "pay back" for the clients' attempts at genuineness. In each of these cases, clients' openness and willingness to share their

[2] Although many participants' highlighted not being able to fully relate to their clients' experiences in combat, none of the participants identified their identity as a civilian as influencing the therapeutic interaction.

experiences were portrayed as though it was a gift to the therapist, and the therapists' openness and genuineness was described as being offered in return.

The consideration of indebtedness is a noteworthy and distinctive quality in therapists' reflections on their work with combat service members. A total of 5 participants remarked explicitly on some aspect of their therapeutic work being the fulfillment of an obligation or debt—three participants spoke to this in relation to self-disclosure and genuineness, and two participants addressed this in regards to their personal histories as men who had actively contemplated the implications of being in combat, and potentially having to kill, during the Vietnam era. It is noted in the literature that the transfer of responsibility for war's suffering from the individual to the larger community occurs in part through psychotherapy (Tick, 2005). According to Tick (2005), therapists "need to help carry the collective responsibility" (p. 238) for war. The connections that participants drew between self-disclosure and indebtedness raise compelling questions regarding clinicians' experience—both conscious and unconscious—of bearing a degree of responsibility for war's suffering and of being indebted to their clients who have served in combat. In some regards, the clinician—as a civilian—and the client—as a service member ostensibly tasked with defending civilians' freedoms—are necessarily engaged in pre-existing relational dynamics that extend outside the therapeutic frame, and are imbued with distinct characteristics of debt and power.

Empathic "Failures"

Participant interviews included indication of overt and/or implicit barriers to empathic attunement with combat service members. In some cases, it is possible to see these "failures" as inevitable aspects of the treatment and perhaps as, in fact, representing a form of interpersonal empathy with an experience of disconnection and alienation. They are also revealing of civilian

therapists', often times unspoken and perhaps unprocessed, beliefs about combat, killing, and the psychological implications of both.

Reducing the symptoms rather than being with the pain. Half of participants (n=5) explicitly identified struggling at times to accept and be with their clients' affective states without wanting to change or fix them, particularly when clients remained "stuck" in the trauma of having killed for an extended period of time. This perspective is in line with mainstream literature's overwhelming emphasis on cognitive-based, symptom-reduction models and interventions for PTSD treatment (Adler, Bliese, & Castro, 2011; Hoge et al., 2006; Marmar, 2009; Ramchand et al., 2010; Ruzek et al, 2011; Tanielian & Jaycox, 2008). Intrinsic in this point of view, as conveyed both in participants' responses and in the literature, is an imperative for service members to expediently move past their internal dilemmas and forward with their lives. However, as Tick (2005) describes it, "We expect them to put war behind them and rejoin the ordinary flow of civilian life. But it is impossible for them to do so—and wrong of us to request it" (p. 98). Although a focus on reducing, and perhaps resolving, PTSD symptoms is important and useful, an exclusive focus on this denies the existential dilemmas inherent in many individuals' experiences of having killed. It also ignores the relational repercussions that are inherent in the trauma of killing and its aftermath (Carr, 2011; Herman, 1997; Tick, 2005). A total concentration on symptoms and on symptom-reduction disregards the possibility that clinicians' conscious and unconscious ways of being present may contribute to clients' "stuckness."

Tick (2005) compellingly describes what is rendered invisible by common interpretations of PTSD and by the belief that service members' suffering is simply a matter of dysfunctional thoughts or failed attempts at moving on,

> We deny our own complex human nature, including our capacities for greed, evil, and doing harm, clinging instead to the belief in our innocence and goodness. We deny the true destructive nature of modern warfare in order to cling to its mythic foundations. And we deny that war changes it participants forever, promoting instead the belief that PTSD can be repaired and that vets and survivors can resume an ordinary civilian identity. (p. 154)

Possible meaning in misogyny. Three of five female participants identified experiencing a common barrier to empathic connection with their male clients: Unapologetic misogyny. Each of these participants identified their clients' sexist and sexualized attitudes and, at times, hostile behaviors as being associated with the sexually charged and hierarchical nature of broader military culture. Two female participants who reported a conscious awareness of self-disclosing less with service members described doing so as a way of maintaining distance because their clients were male, with one of these participants explaining it specifically in terms of wanting to avoid potential erotic transference. This participant remarked deliberately on the prevalence of sexual violence in the military and acknowledged registering this issue as an extra presence in the room when she was working with male service members.

The misogyny, and resulting sense of alienation that participants describe feeling with male clients, can be seen as a manifestation of military culture's influence on the therapeutic alliance as well as an expression of clients' attempt to assert some power and control in the face of otherwise overwhelming feelings of powerlessness and lack of control. In addition, it is also worth considering these sexualized dynamics in light of literature that highlights the powerful, erotic sense of intimacy that emerges during and/or after the act of killing (Grossman, 2008, 2009; Tick, 2005). According to this literature, for many individuals the energies of killing and sex—a primal aggression, release, and orgasmic discharge—become difficult to separate. Tick (2005) asserts,

> Lust awakened by war for bloodletting easily transfers to sexuality back at home. In its throes, only one's partner feels debased. The survivors often do not feel shame. Rather, they feel justified or as if they are acting out of necessity. (p. 124)

Although none of the participants explicitly addressed their clients' experience of having killed in erotic or sexualized terms, it is possible that the sexualized interaction that female participants describe is, in some instances, a window into the powerfully and intimately erotic nature of killing. The sexual energy and attention that these participants describe experiencing may be expressive of the way that "the power and pleasure of explosively spewing a stream of bullets is akin to the emotions felt when explosively spewing a stream of semen" (Grossman, 2009, p. 136).

Defending against the darker side of killing. When asked to characterize the emotions they were aware of feeling in response to clients' experiences of having killed, more than half of participants (n=6) focused on expressions of compassion and/or sadness. Participants' compassion and sadness undoubtedly aligns with real and important aspects of service members' experiences of killing, yet a sole focus on these emotions potentially disavows other aspects of the experience, namely the more ambiguous and conflictual parts.

Although the literature indicates that many individuals experience a range of divergent emotions—including rage and pleasure alongside sadness and guilt—associated with the act of killing, only four participants acknowledged either their clients' or their own feelings of aggression, anger, or sadistic pleasure in relation to killing. These participants' descriptions echoed the literature on psychotherapy with Vietnam veterans that emphasizes that:

> The therapist must be able to envision the possibility that under extreme physical and psychic stress, or in an atmosphere of overt license and encouragement, he/she, too might very well murder. (Haley, 1978, p.194)

The majority of participants' tendency to overlook and/or move away from the darker, more gruesome and complicated elements of the act of killing is conceivably illustrative of Grossman's (2009) proposition that "we condemn aggression and repress it rather than look at it squarely and try to understand it" (p. xxxv).

Two participants (n=2) explicitly described defending against their clients' experiences of having killed in combat. In both of these cases, the participants' descriptions suggested a subtle sense of anxiety and defensiveness associated with the knowledge that their clients had been trained to and had the capacity to kill. One participant displayed a disconcerted sense of awe in describing her clients' killing capabilities. She also emphasized that she does not internalize her clients' experiences of having killed, rather they remain as just stories to her. The other participant acknowledged that knowing that his clients have killed changes something in his interaction with them, although he struggled to put into words precisely what he perceived this change to be. He also expressed a sense of relief when his clients were not talking about killing and described it as being easier to tolerate. Neither of these participants elaborated on if and how they made sense of these experiences of protective distance from their clients' experiences of killing. However, one way to understand these reactions is as a defense against the "dangerous aspects of our cultural psyche [that] break through and are inevitably expressed through our soldiers" (Tick, 2005, p.169). The clinicians' responses may, in fact, embody a form of empathy with the client's own experience of denial.

The literature purports that "there is within most men an intense resistance to killing their fellow man" (Grossman, 2009, p. 4) and that therapeutic work with service members can bring a therapist face-to-face not only with clients' but also their own, often well-defended,

murderousness and vulnerability to being murdered (Haley, 1978; Tick, 2005). Haley (1978) writes,

> … the therapist must confront his/her own sadistic and retaliatory feelings to an unusual degree. Psychotherapy with these men is not of use until the therapist is perceived as someone who can hear horrifying realities, and can tolerate natural feelings of revulsion, yet resist an equally natural tendency to punish. (p.191)

Therapy with service members necessitates that the therapist look at aspects of him/her self and the human condition that "we would rather leave unexamined and that the public's conscious awareness, for the most, denies" (Tick, 1995, p. 1). Participants' tendencies to subtly overlook and/or defend against the harsher and more complicated elements of their clients' experiences perhaps represents an enactment of the disconnection and alienation—from oneself and from others—that accompanies the act of killing. Participants may be defending against knowing their clients, and their own, innate potential for lethal rage and sadistic pleasure.

Implications for Practice

This study's findings indicate a range of ways in which therapeutic actions and presence are practiced differently with combat service members than with other client populations, including in the form of a more powerful empathic alliance, increased self-disclosure, and greater attentiveness to power differentials and mutuality in the clinical interaction. Furthermore, analysis of some of the explicit and implicit dynamics between therapists and service members points to potentially compelling ways in which mutual influence is experienced in these dyads, particularly as it relates to intrapsychic and interpersonal experiences of alienation and denial associated with killing in combat as well as to the interplay between individual and collective responsibility for war's devastation.

As noted in the Literature Review, it is widely acknowledged that in order to provide effective assistance to combat service members, civilian therapists must possess an

understanding of military culture. This is most often addressed as the need for knowledge of the military's chains of command, acronyms and lingo, and stages of deployment. The findings of this study however point to the significance of a more nuanced consideration of the intersection of military and civilian cultures as it unfolds in the therapeutic dyad. Killing is largely what war is about and it is what is expected of service members. Yet, there exists within most individuals, service members and civilians alike, an innate and intense resistance to killing another human being (Grossman, 2009). Furthermore, the circumstances of combat have no equivalent in civilian life. Civilian therapists must be prepared to confront the resistance to killing within themselves as much, if not more so, as within their clients and to engage with the harsh, gruesome and complicated elements of killing that the public's conscious awareness often denies.

As such, civilian therapists need to not only understand PTSD and how to reduce it's symptoms, but also to understand and appreciate the intense physiological and emotional responses that often accompany the act of killing—including exhilaration, erotic intimacy, rage, and remorse. Additionally, they need to be aware that all acts of killing, even sanctioned killing, can be gruesome, horrific, and confusing—both internally and externally. And lastly, civilian therapists must hold in mind their own relationship to and responsibility for war's suffering. It is by doing so that they can most effectively relate to and assist combat service members in meaningfully coming to terms with the distressing psychological wounds of war.

Regardless of whether the therapist is practicing cognitive-behavioral treatment, psychodynamic treatment, or utilizing an eclectic combination of approaches the findings from this study point to the influence, and value, of relational dynamics. It is apparent that an intense emotional interaction regularly unfolds between service members and therapists, and that many therapists seek to create a strong connection with service members by sharing more of

themselves than they otherwise would. Particularly given the interpersonal nature of killing—the ways in which the act of killing often shatters individuals' sense of themselves and of the world, leaving them with a pervasive sense of alienation—this powerful bond between therapist and service member can serve as an integral aspect of the therapeutic healing. And yet, on the other hand, the potential also exists for it to reinforce disconnection and isolation if the therapist does not maintain an awareness of the pull to overlook and/or defend against the harsh, ambiguous realities of killing in combat. Effective work with combat service members, therefore, calls for therapists to remain attuned to the interactional dynamics within the therapeutic dyad in order to both ensure the most meaningful therapeutic impact and to avoid further denial and alienation. Ultimately, this attunement offers service members an opportunity to process the psychological repercussions of killing within a mutual encounter, and thereby shares the burden of war's devastation.

Limitations

The limitations of this research are that the study sample was limited in size, racial diversity, and theoretical orientation. In addition, in retrospect, some of the interview questions would have benefitted from additional clarity and conciseness.

Due to a limited time frame, the researcher was only able to recruit and interview ten participants. Attempts were made to engage additional participants, however with limited success. Presumably, with additional time more focused efforts could have been made to recruit additional clinicians and more expansive findings would have been generated. Furthermore, all ten of the participants identified as white/Caucasian, with one participant also identifying as Native American/Alaskan Native. It is likely that additional perspectives and themes may have emerged had there been greater racial diversity in the study sample. In addition, the relatively

limited spectrum of theoretical orientations represented in the sample restricted the scope of insights. Particularly, given the nature of the research question, a greater number of participants who practice from either a psychoanalytic/psychodynamic or experiential/existential orientation would enhance the findings.

The research questions were designed by the researcher and in retrospect, a number of the questions would have benefitted from additional clarification, of follow-up clarifying questions, to elucidate how participants were defining or interpreting particular concepts. This would have enhanced the specificity of responses, and provided more focused and concise findings.

In addition, the nature of the overall research question required an ability and willingness to recall specific moments in the therapeutic process, as well as a considerable level of self-awareness and openness on the part of study participants. The study is necessarily limited by any constraints to these, including insufficient trust or comfort with the researcher. Also, due to the geographic location of the researcher and participants, the majority of interviews (n=9) took place via telephone or Skype. The findings are therefore restricted to what participants were capable of conveying via this mode of communication.

It is also important to note that during the time of this study the researcher was a graduate social work intern at a VA medical center practicing cognitive-behavioral trauma treatment while also receiving academic training in psychodynamically-oriented psychotherapy. Every effort was made to recognize any biases when analyzing the data and remain conscious of the possible influence of these potential biases on perceptions and observations.

Future Research

This study represents a nascent attempt at exploring how the psychological implications of killing in combat play out within the interpersonal space of the therapeutic dyad. In addition to

elucidating compelling dynamics between service members and therapists, this study's findings also highlight the need for substantially more research in this area, including a replication of this study with an increase number of diverse participants. Among the areas for further exploration, there is need for additional investigation into the specific influence of gender and racial dynamics in the therapeutic dyad between civilian therapists and service members.

This study's findings support literature that emphasizes self-disclosure and genuineness in therapeutic encounters with service members, and it also takes steps towards exploring therapists' subjective thoughts and feelings regarding the urge to do so. More in-depth inquiry is needed into the role of self-disclosure and genuineness in work with this population. What informs therapists' stance on this? How is it perceived by service members?

In addition, further analysis is needed into the potential meanings and implications of the distinct characteristics of indebtedness and erotic transference that manifest in these therapeutic dyads. Do therapists feel indebted to their clients who have served, and how does that influence experiences of power and influence in the therapeutic dyad? In what ways does the powerful erotic intimacy associated with killing destructively and/or constructively enter into the interaction between therapist and service member?

Conclusion

War, and the particularities of killing in combat, does not only affect the individuals who serve in combat—it affects everyone, including the therapists who seek to help ameliorate service members' suffering. The aim of this study was to explore how therapists' subjectivities—in the form of actions, values, biases, preconceived notions, and emotions regarding the reality of killing in combat—manifest, explicitly and implicitly, in a therapeutic dyad with clients who have killed or think they may have killed in combat.

This study is undergirded by the premise that client and clinician are two authentic human beings, and that the clinician's affects and attitudes are inevitably an integral aspect of the treatment, even if and when they are implicit and perhaps unconscious. The findings support this notion. Regardless of the therapeutic approach or technique, and whether or not it was intended or attended to, study participants detailed distinctive ways in which they, consciously and unconsciously, engaged in therapeutic work with combat service members.

In describing their therapeutic work with service members, study participants identified their understandings of the repercussions of killing, described how they conceptualize of killing in combat, and portrayed the ways in which empathy is experienced and enacted in this work. In large part, the focus of therapeutic change for many participants was on resolving impairments in clients' behaviors and attitudes associated with killing, rather than on looking squarely at and seeking to understand the dynamic implications of war and killing in combat. The majority of participants' described killing in combat as a clear, comprehensible act and staunchly asserted a belief in service members' as necessarily being "good and right." This perspective, albeit partly true and a sign of acceptance, also serves to deny the harsher, more complicated and ambiguous realities of killing.

Furthermore, although the findings revealed a marked tendency towards genuineness and self-disclosure by the clinician, many participants concurrently indicated a subtle inclination to defend against the more gruesome and discordant aspects of killing in combat. In fact, the findings reveal a potentially compensatory quality to clinicians' self-disclosure and genuineness—perhaps an attempt to "pay back" the service member for serving in combat, for having to tolerate the intolerable and unknowable.

In many ways, the findings of this study are reflective of what the literature identifies as a "conspiracy of silence" around the reality of killing. The devastation, chaos, and horror that characterize combat have little counterpart in civilian life and, furthermore, reveal aspects of the human condition that most individuals, and much of society, would rather remain out of sight. This study confirms that the distressing and dissonant reverberations of killing in combat are manifest in the therapeutic dyad between civilian therapists and service members, yet often remain in an implicit and unprocessed realm. Civilian therapists' reluctance to directly confront their own and their clients' murderous capabilities and vulnerabilities offers insight into the individual, relational, and societal transformations which lay in combat's wake, and highlights ways in which we all, consciously and unconsciously, carry the burden of war within and between us.

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APPENDIX A

HSR Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 1, 2013

Alicia Simoni

Dear Alicia,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Marsha Kline Pruett /Chair

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Vice Chair, Human Subjects Review Committee

CC: Cara Segal, Research Advisor

APPENDIX B

Informed Consent

Dear Participant,

My name is Alicia Simoni, and I am a graduate student at Smith College School for Social Work. I am conducting research for my Masters thesis, which will explore civilian therapists' experience of working with individuals who have killed or think they may have killed in combat. This study will be presented as a thesis and may be used in possible future presentations, publications or dissertations.

To participate you must currently provide psychotherapy to 1 or more combat service members, have a master's or higher-level degree in a mental health related field, and not been a member of the U.S Armed Services. Participation entails completing an 8-question demographic questionnaire (online) and participating in an approximately 60-minute interview. All interviews will be conducted either in-person in a private location (i.e. your private office), via telephone, or via a Skype-to-Skype video call. A significant portion of the interview will focus on your experience of the treatment in association with your clients' combat experience. You will be asked to focus on your own thoughts, feelings, images, and sensations; the meaning you made of this experience; if/how the moment impacted subsequent treatment. Additionally, there will be general questions addressing your experience working with combat service members and if/how it differs from work with other clients. The interview will be audio recorded and I will transcribe the interview in its entirety.

Given the personal nature of the inquiry, there is a small risk that participation in the study could cause negative emotions to arise. Possible benefits from participating in the study include having the opportunity to reflect on the dynamics and themes that emerge in treatment with combat service members. No monetary or material compensation for your participation will be provided.

All information collected as part of the study will be kept confidential. You are asked not to provide any names or identifying information about clients in your responses. Data may be viewed by my research advisor, however only after identifying information is removed. All electronic data will be stored on a computer that is password protected; it will be kept in a secure location for a period of three years, as required by Federal guidelines. If the material is needed

beyond a three year period, it will continue to be kept in a secure location and will be destroyed when it is no longer needed. When material from this study is used for future presentation and possible publication, all identifying information will be removed or carefully disguised.

Your participation in this study is voluntary. You have the right to refuse to answer any question. You may also withdraw from the study at any point up until two weeks after the interview. Upon your request, all data related to you will be destroyed.

If you have any questions or concerns about your rights or about any aspect of the study, you can contact me at asimoni@smith.edu or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Thank you for your interest in the study.

Sincerely,
Alicia Simoni

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTIPATE IN THE STUDY.

Participant's Signature: ____________________________ Date: ____________________

Researcher's Signature: ______________ Date: __________

Please print, sign, and return to researcher. Please also keep a copy for your records.

APPENDIX C

Recruitment Email

Are you a civilian therapist who currently provides psychotherapy to 1 or more clients who have killed or think they may have killed in combat? Do you have a master's or higher-level degree in a mental health related field?

If you answered yes, I am seeking your expertise.

I am a Masters degree candidate in clinical social work at Smith College School for Social Work and I am completing a graduate social work internship at the VA in Atlanta, GA. I am currently conducting research for my Masters thesis exploring civilian therapists' subjective experience of working with individuals who have killed or think they may have killed in combat.

Participation in this study entails completing an 8-question demographic questionnaire (online) and participating in a 60-minute interview (in-person, via telephone, or via Skype). If you will be participating via Skype, you will need to have Skype access.

If you meet eligibility criteria, I hope you will consider participating in this research study. If you do not meet criteria, I encourage you to please forward this email to any acquaintances or colleagues you know of who may be eligible and interested in participating.

If you are interested in participating or have any questions about the research, please reply to this email (asimoni@smith.edu).

Thank you for your time and interest in my research topic.

Sincerely,
Alicia Simoni
MSW Intern, VA Atlanta, GA
MSW Candidate, Smith College School for Social Work

APPENDIX D

Demographic Questionnaire

1. Please select the gender you most identify with:
    - Woman
    - Man
    - Transgender
    - Other (please specify): ____________________________

2. How do you identify racially/ethnically?
    - Black or African American
    - Hispanic, Latino, or Spanish origin
    - Asian
    - Middle Eastern
    - Native American or Alaskan Native
    - Pacific Islander
    - Mixed race or Biracial
    - White or Caucasian
    - Other (please specify): ___________________________

3. What is your professional discipline?
    - Clinical Social Worker
    - Psychologist
    - Licensed Professional Counselor
    - Psychiatrist
    - Marriage and Family Therapist
    - Other (please specify): ___________________________

4. How many years have you been practicing psychotherapy? (Please round to nearest year.) ___

5. What theoretical orientation primarily informs your psychotherapy practice?
    - Cognitive Behavioral Therapy
    - Existential/Experiential Therapy
    - Psychodynamic/Psychoanalytic
    - Integrative/Eclectic therapy
    - Other (please specify): ___________________________

6. In what setting do you currently primarily practice psychotherapy?
    - Veterans' Administration (VA) Hospital or outpatient clinic
    - Vet Center
    - Agency or Community Mental Health center
    - Private Practice
    - Other (please specify): ___________________________

7. Approximately what percentage of your caseload are military service members?

- 25% or less
- 25 - 50%
- 50 - 75%
- 75% - 100%
- 100%

8. Do you have a family member or significant other who has been a military service member during your lifetime?

- Yes
- No

APPENDIX E

Interview Guide

Introduction Talking Points:
- About me: I am a MSW student at the Smith College School for Social Work. I am currently completing a yearlong placement at the VA in Atlanta, GA where I am part of a PTSD program team that provides individual and group treatment to veterans.

- The purpose of this study is to explore intersubjective dynamics that arise between therapists and combat service members. More specifically, I am interested in understanding civilian therapists' personal experience of working with individuals who have killed or think they may have killed in combat.

- Do you have patients who have killed in combat?
- In general, how do you know that they have?
- Would you say it is the primary presenting concern for most of the service members you work with?
- Can you think of a patient with whom their experience of killing has been a significant factor in the therapeutic relationship?

If not,
- What do you do with the knowledge that your patient's have killed in combat?
- Although they are not talking about, do you find yourself wondering about the patient's experience of killing?
- Do you ever feel drawn to talk about it with the patients? Can you tell me more about that?
- Do you ever experience any relief that it's not being talked about? Can you tell me more about that?
- How you make sense of it not being talked about?
- Have you noticed any ways that this knowledge impacts how you are with patients?
- In the literature, some clinicians note ways in which their own feelings of aggression, fear, rage, and/or revulsion emerged during treatment with service members. Have you noticed experiencing your own feelings of aggression? Fear? Rage? Revulsion? In what ways?
    - Any other notable feelings come to mind?
- Have you worked with other populations? Are there any ways in which your work with this client – or other combat service members – differs from your work with other clients? How so?
    - Do you find that you self-disclose more? Less? Why do you think this is?

If yes, do you have a patient where killing has been significant factor,
- I'd like to ask some follow-up questions about one of those patients and the therapeutic relationship. Can you choose one of them to have in mind as I ask the following questions?
- Tell me a bit about that patient and the therapeutic relationship.

Did they talk directly about killing in combat?
Yes:

- How do you experience the moments when they are talking about killing?
- Has there been any particularly salient moments that comes to mind associated with the patient talking about having killed?
- Describe in as much detail as you can your experience of this moment?
    - What were you thinking during this moment? Feeling? Did you notice any physical sensations? Any images come to mind?
- What meaning do you make of your experience of this moment? How did you make sense of this moment?
- Are there ways this moment informed your future work with the client? If so, how?
    - Did you disclose any aspects of your experience with the client? Which aspects? Why these ones? Why not?
- In the literature, some clinicians note ways in which their own feelings of aggression, fear, rage, and/or revulsion emerged during treatment with service members. Have you noticed experiencing your own feelings of aggression? Fear? Rage? Revulsion? In what ways?
    - Any other notable feelings come to mind?
- Are there any ways in which your work with this client – or other combat service members – differs from your work with other clients? How so?
    - Do you find that you self-disclose more? Less? Why do you think this is?

No:

- Are you able to identify why it is that their having killed in combat significantly impacts your experience of the patient? How do you make sense of your experience with this client?
- Do you find yourself wondering about the patient's experience of killing?
- Do you ever feel drawn to talk about it with the patient? Can you tell me more about that?
- Do you ever experience any relief that it's not being talked about? Can you tell me more about that?
- How you make sense of it not being talked about?
- Have you noticed any ways at all in which it impacts how you are in the room with the patient?
- In the literature, some clinicians note ways in which their own feelings of aggression, fear, rage, and/or revulsion emerged during treatment with service members. Have you noticed experiencing your own feelings of aggression? Fear? Rage? Revulsion? In what ways?
    - Any other notable feelings come to mind?
- Have you worked with other populations? Are there any ways in which your work with this client – or other combat service members – differs from your work with other clients? How so?
    - Do you find that you self-disclose more? Less? Why do you think this is?