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The impact of therapy : a qualitative analysis of clinicians working with combat veterans diagnosed with post-traumatic stress disorder

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THE IMPACT OF THERAPY: A QUALITATIVE ANALYSIS OF CLINICIANS WORKING WITH COMBAT VETERANS DIAGNOSED WITH POST-TRAUMATIC STRESS DISORDER

by

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CERTIFICATE OF APPROVAL

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PH.D. THESIS

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ABSTRACT

For some people, exposure to trauma results in the development of psychological maladjustment in the form of posttraumatic stress disorder. Veterans returning from combat zones tend to meet criteria for PTSD at rates significantly higher than what is observed in the general population. Mental health professionals, particularly those working with U.S. Department of Veterans Affairs, play an important role in the recovery of these Veterans. Research suggests that facilitating trauma therapy and/or being exposed second-hand to traumatic material can have negative consequences for the therapist. The current study focuses on the impact of trauma therapy on therapists who work with combat veterans through the VA. The study includes seven psychologists in the state of Iowa employed by VA. Findings support previous research by highlighting the impact therapy has on the clinician providing it. The impact of facilitating trauma therapy or working with traumatized populations is not wholly positive or negative, but often both. The current study suggests that what clinicians do in response to hearing trauma narratives that is of key importance.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

The U.S. military is increasingly recognizing the multitude of psychological consequences of serving in the military. However, the combat veterans are not the only ones impacted by military combat. Families, friends, and healthcare workers are also affected. Significant amounts of money are being poured into mental healthcare within the United States Department of Veterans Affairs (VA) system, but little is known about how the effects of treating survivors of trauma impacts the healthcare providers who deal with these types of clients on a daily basis. To effectively provide the best health care for the men and women returning from combat, it is necessary for the military, along with members of the field of mental health, to investigate the indirect but significant impact of combat on the men and women attempting to care for these veterans. Specifically, more information, understanding, and action are needed to fully appreciate and address the experiences of the psychologists who work with clients affected by combat trauma.

Increased understanding of the experience and effects of being a psychologist working with combat veterans who regularly share narratives of trauma can help improve services for the combat veterans and promote the well-being of psychologists. The current study investigates the experiences of civilian psychologists working within the VA and their experiences with veterans who have been in combat and are seeking mental health services to address the effects of it. More specifically, the aim of the current study is to understand how VA psychologists cope with repeated exposure to trauma narratives from their combat veteran clients.

The Beginning of Services Specifically for Veterans

The VA was initially developed to "consolidate and coordinate Government activities affecting war veterans," (U.S. Department of Veterans Affairs, 2010, page 1). Within the VA there are divisions that are devoted specifically to health and benefits. The Veterans Health Administration (VHA) is devoted specifically to meeting the health needs of veterans by implementing the best, integrated health care possible (U.S. Department of Veterans Affairs, 2011a). The Veterans Benefits Administration (VBA) is also a division under the VA. The VBA is focused on assisting veterans with such things as insurance, disability or service connection for physical and mental health concern, GI Bill, etc (U.S. Department of Veterans Affairs, 2011b). The Department of Defense (DoD) is a separate entity from the VA. The DoD, which is in charge of the U.S. military, strives to provide the necessary services to maximize national security (Department of Defense, 2012).

The Development of Psychological Services in the VA

Early after the establishment of mental health services in the VA, it was noted in an annual report that more than half (58%) of the patients seeking services at the VA were being treated for psychiatric disorders (U.S. Department of Veterans Affairs, 1947). After this report was released, the Servicemen's Readjustment Act was passed (American Psychological Association, 2003). This act allowed for specific services related to work, education, and health to be provided to veterans and would begin decades-long efforts for psychological support for military veterans. PTSD has been a primary focus for research according to a literature review published by Demers (2011).

Under the direction of President Hoover, the Veterans Administration (VA) was established in 1930 (American Psychological Association, 2003). Roughly ten years after the creation of the VA, administrators began to realize the need for mental health services for veterans (American Psychological Association, 2003). Immediately after World War II, millions of veterans required health care services (Baker & Pickren, 2006). Health care providers were in high demand because there were such high numbers of combat veterans returning from combat.

Following the realization of the mental health needs of veterans, psychologists began to take on an ever-growing role at the VA (American Psychological Association, 2003). Psychologists within the VA helped create and improve services for veterans (Baker & Pickren, 2006). They created specialized programs for mental health services that not only improved the care offered to veterans, but also reduced the cost of treatment incurred by the VA.

The Role of Psychologists in Current Conflicts

The VA has played a significant role in the field of psychology, just as psychologists have played a significant role in the VA healthcare system. In its more than 60 years of existence, the VA has played an active role in the development of mental health services for veterans that have gone beyond the VA and into the public sector. (Rodolfa, Kraft, & Reilley, 1988). J.G. Miller, the first chief psychologist of the VA clinical psychology program, had a broad vision for the future of psychological services at the VA (Baker & Pickren, 2006). His plan was to have psychologists fill a wide variety of positions in order to best serve the needs of veterans. Miller envisioned creating departments such as, “mental hygiene clinics, regional offices, neuropsychiatric hospitals,

neuropsychiatric convalescent centers, and paraplegia and aphasia centers (Baker & Pickren, 2007, page 22). This would open up a wide variety of positions to be filled by psychologists.

According to Demers (2011), "war is widely acknowledged as a public health issue, and there is a growing body of literature documenting the negative health effects of war on combat veterans who have served in either the Iraq or Afghanistan wars," (page 1). The current conflicts in Iraq and Afghanistan have produced great need for VA psychologists (Danish & Antonides, 2009). The demand for services has overwhelmed the available resources; the number of VA psychologists has not been sufficient to meet the needs of the combat veterans returning from overseas (Danish & Antonides, 2009). Efforts to recruit mental health clinicians have since increased, as the VA tries to meet the needs of those veterans.

An estimated 1.64 million people have served in one or both of the conflicts in Iraq and Afghanistan since 2001 (Brenner, Vanderploeg, & Terrio, 2009). To help address and meet the needs of men and women returning from combat, the DoD and the VA have begun screening for both physical and mental health concerns among veterans (Brenner et al., 2009). The Army has responded to the needs of those involved in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) with improved screening and improved mental health services provided to combat veterans (Cornum, Matthews, & Seligman, 2011). If mental health service providers are able to improve PTSD symptoms even slightly, the impact on the VA health care system would be reduced considerably (Cornum, Matthews, & Seligman, 2011).

Mental Health Needs of Combat Veterans

As mentioned above, roughly 1.64 million troops had been deployed to Iraq and Afghanistan as of 2008 (Danish & Antonides, 2009). At any given time during the conflicts in Iraq and Afghanistan, an estimated quarter of a million combat veterans (active duty and reserve) are either preparing to deploy or are already deployed (APA Task Force on Military Deployment Services for Youth, Families, & Service Members, 2007). Of the 1.64 million deployed men and women, approximately 620,000 experienced some need for mental health services (i.e. experienced conditions such as PTSD, traumatic brain injury, or depression). To meet the health care needs of veterans, the VHA employs more than 53,000 independent, licensed health care practitioners (U.S. Department of Veterans Affairs, 2014).

Occupational Stress for Psychologists in the VA System

Psychologists and other mental health professionals have been quite effective in reducing the symptoms of PTSD and helping military veterans with PTSD and other disorders improve their well-being (Tuerk et al., 2010). However, this work is not without its difficulties, including what can be significant occupational stress. Occupational stress is often unavoidable for the working population. There are many published studies that have looked at the impact of occupational stress and effective ways to deal with its consequences.

Stress has three components: the environmental stimulus, the response to the environment, and the interaction between the two (Beehr & Franz, 1987). Occupational stress is defined as the interaction of job-related factors and an individual. This interaction affects the person's psychological or physiological functioning in a way such

that alteration of typical or normal functioning is necessary (Newman & Beehr, 1979). Acute stress negatively affects combat veterans in terms of psychological and physical health (Day & Livingstone, 2001). The experience of acute work-related stressors is related to an increase in the number of negative complaints reported by combat veterans. The number of acute stressors experienced could increase during times of conflict, thereby increasing the number of negative psychological complaints as well (Day & Livingstone, 2001).

Combat veterans have a unique work environment. The types of stress they may encounter on the job are also unique, shared by relatively few individuals in other occupations. Stress encountered during combat is often severe and life threatening. According to the U.S. Surgeon General's Mental Health Advisory Team, 83% of combat veterans who were deployed for at least six months reported being in situations in which they could be seriously harmed or killed or knowing someone who was injured or killed (Mental Health Advisory Team VI, 2009). Many combat veterans report having been attacked or ambushed at some point during their deployment (Milliken, Auchterlonie, & Hoge, 2007). Roughly one-third reported seeing ill or injured women and children they were unable to provide assistance to; this was a highly distressful situation for most of the combat veterans. These stressors are unique to combat, likely resulting in unique needs of combat veterans returning from deployment.

Factors Contributing to Mental Health Needs of Combat Veterans

Deployment length and level of experience affect well-being for combat veterans (Adler, Huffman, Blises, & Castro, 2005). Longer periods of deployment correlated with an increase in depression and posttraumatic stress scores. This finding, however, was

only observed for male combat veterans. In terms of previous deployment experience, Adler et al. (2005) found that more experience served as a buffer against depression and posttraumatic stress scores. Further, Durai et al. (2011) observed that veterans who endorsed PTSD symptoms from one or each of the symptom clusters (as delineated in the DSM-IV-TR) were more likely than their counterparts to report a number of negative mental or interpersonal issues after deployment. For example, veterans who report PTSD symptoms are more likely to smoke, be divorced, have little to no social support, more likely to report mental health distress and poor general health (Durai et al., 2011).

Combat veterans who develop PTSD may experience a variety of negative consequences as a result of the disorder. For example, PTSD has been linked to difficulties with relationships, communication, intimacy, sexual function, and relationship instability (Monson, Taft, & Fredman, 2009). Gottman and Levenson (1986) demonstrated the impact of PTSD symptoms, specifically dysphoria symptoms, on emotional well-being. Combat veterans who experience PTSD symptoms such as dysphoria often have difficulty with emotional engagement and, as a result, withdraw from their partners. Durai et al. (2011) found that combat veterans returning from Iraq and Afghanistan who report PTSD symptoms often experience difficulties with relationship adjustment compared to their counterparts who do not report experiencing PTSD symptoms.

Combat veterans returning from deployment encounter a number of readjustment issues. Their families also face readjustment issues (U.S. Department of Veterans Affairs, 2010). Even though all returning combat veterans face readjustment issues, the VA reports that only half those eligible for services through the VA have accessed them. Of a

sample of female veterans, 19% reported not having their health care needs met (Washington, Bean-Mayberry, Riopelle, & Yano, 2011). These women identified lack of or inadequate insurance, lack of knowledge of available services, perceptions of sexist attitudes of VA providers, and histories of military sexual trauma, as some of the common barriers preventing them from getting the care they need.

Research indicates that there are an overwhelming number of combat veterans who are not getting the services they need (Milliken et al., 2007). For example, of a sample of 88,235 combat veterans returning from Iraq, about one-fifth of active duty combat veterans and about two-fifths of reserve combat veterans were identified through post-deployment health assessements as being in need of mental health services (Milliken et al., 2007). Therefore, it is important that service providers routinely check for the impact of PTSD (Erbes, Meis, Polusny, & Compton, 2011). Some of the negative consequences of combat, such as the impact it has on interpersonal relationships, impede combat veterans and their families from successfully readjusting into their lives in the U.S. Upon return to the U.S., many veterans experience difficulty with relationships. In fact, the divorce rate nearly doubled in the early part of the century for U.S. Army personnel. For officers, the divorce rate nearly tripled (Danish & Antonides, 2009). Because social factors are positively related to reductions in PTSD symptoms, it is important that services are readily available to veterans (Erbes et al., 2011).

The Impact of Trauma on VA Psychologists

Given that an estimated 1.64 million troops have served in Iraq, Afghanistan, or both (Brenner et al., 2009), and the related trauma often experienced as a result of being deployed, VA clinicians encounter clients who are working through the effects of combat

trauma. Sometimes, psychologists who work with trauma populations experience negative consequences as a result of their work. This appears to hold true for any type of trauma the client presents with. The current study, however, will focus primarily on combat trauma. Negative effects for these psychologists include burnout, vicarious trauma, and secondary traumatic stress or compassion fatigue.

Burnout, Vicarious Trauma, and Secondary Traumatic Stress

Briefly described, burnout is job stress that results in emotional exhaustion (Maslach, 1982). Vicarious trauma is a "transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material," (Pearlman & Saakvitne, 1995, page 31). This suggests that the therapist's worldview changes over time in response to the trauma narratives they hear. Secondary traumatic stress is a third possible outcome from working with clients who have trauma histories. Secondary traumatic stress refers to the development of PTSD-like symptoms and cognitive changes in response to exposure to distressing material presented by trauma clients; the symptoms of secondary traumatic stress mirror closely those of post-traumatic stress disorder as defined by the DSM-V (Figley, 1999).

Operationalization of Terms

For the purposes of the current study, vicarious trauma will be understood as the cumulative effects that psychologists experience in response to repeated work with trauma clients. Vicarious trauma can be observed through shifts in worldviews and changes in cognitive schemas about the world and the people who inhabit it. Secondary traumatic stress, also called compassion fatigue, can be observed through the development or mirroring of traditional PTSD symptoms. For the sake of depth, the

current study will focus solely on vicarious trauma and secondary traumatic stress, leaving the concept of burnout to be included in future studies. The purpose of the current study is to understand how VA psychologists are affected by, and cope with, repeated exposure to trauma narratives from their combat veteran clients who have been diagnosed with post-traumatic stress disorder.

CHAPTER 2

LITERATURE REVIEW

This chapter is used to present literature that pertains to the impact of facilitating trauma therapy. Currently, the literature is inconsistent, and at times, more confusing than clarifying. The literature also lacks breadth of focus in terms of the types of trauma investigated. As a result, continued research in this area is needed to provide clinicians and other researchers with conceptual clarity; raise awareness of the issue and its potential impact on therapists and their clients; and to expand on the populations investigated.

Presented first is a conceptualization of trauma reactions and research behind it. Then literature that pertains specifically to combat trauma and the effects of repeated exposure to such trauma is outlined. The next section presents information on the impact that trauma work, in particular combat trauma, can have on the therapists who interact with combat veterans. This chapter then concludes by considering literature on secondary traumatic stress and vicarious trauma, as these are potential results of trauma work that may have a negative impact on the therapist. The negative impact that clinical work can potentially have on therapists could affect their ability to provide the best care possible for their clients.

Stress and (Combat) Trauma

This section discusses stress and trauma, focusing on the nature of combat stress and its impact on combat veterans in particular. Because stress has the potential to damage both mind and body, it may also affect the therapeutic process and the therapist, along with the client. Repeated exposure to trauma has the potential for additional

serious, negative consequences for both the client and the therapist. As such, repeated exposure to trauma will also be addressed in this section.

In general, researchers conceptualize stress a stimulus (e.g. a change in the environment) that provokes both a psychological and physiological response (Selye, 1973). Stress demands are unique and often specific to situation and environment, but responses may be similar across situations. For example, heat is a physiological stressor, and perspiration is a physiological response to that stressor (Seyle, 1973). Public speaking is a psychological stressor that may also provoke a physiological response such as perspiration. Stressors can range from acute to chronic (McEwen, 2009).

According to Anshel (2000), the experience of extreme or unusual stimuli, if perceived as threatening, often results in the experience of acute stress. Acute stress affects physiological, psychological, and behavioral responses. Acute stress is relatively brief in nature, with a clear and specific onset (Barling, 1990 as cited in Day & Livingstone, 2001). This type of stress is often singular in that it is not likely to reoccur. Acute stress promotes adaptation and survival through activation of several systems in the body (e.g. autonomic, immune, metabolic; McEwen, 2005).

Day and Livingstone (2001) investigated the effects of acute stress among combat veterans. They found that the experience of acute work-related stressors was related to an increase in the number of negative psychological, behavior, and physiological complaints (e.g., being jumpy, easily startled, increased smoking, headaches, etc.) reported by combat veterans. The number of acute stressors experienced may increase during times of conflict, thereby increasing the number of negative psychological complaints as well.

Chronic stress is experienced when a person is faced with repeated or ongoing exposure to acute stressors (Smyth, Zawadski, & Gerin, 2013). When a series of acute stressors is experienced the stress response is prolonged and often leads to both psychological and physiological difficulties. Deployments to combat zones, especially in the recent conflicts in Iraq and Afghanistan, increase the likelihood of exposure to both chronic and acute stressors.

Combat, as defined by the Oxford English Dictionary, refers to a fight between two armed people (Oxford University Press, 2012). This is a primary task faced by military when deployed to war zones. Combat is a situation that, "creates a high-risk, high-stress situation for military service members, with survival as the primary goal," (pg. 349, Gaylord, 2006). Combat environments include serious threats to life, violence, physical and psychological demands of the body and mind (Reeves, Parker, & Konkle-Parker, 2005).

The wars in Iraq and Afghanistan are the first conflicts involving the United States forces where military personnel are subject to (re)deployments to combat zones that can last as long as eighteen months (Tyson, 2007). Some veterans received redeployment orders even before they made it home from their current deployment (Jordan, 2010). Repeated deployments to these countries are not the only influence on the mental health and well-being of combat veterans. These conflicts also include repeated exposure to the devastation sustained in each country as a result of the wars (Litz, 2006). Those who have served in these conflicts report higher rates of combat exposure than veterans from previous conflicts (Renshaw, Rodrigues, & Jones, 2009).

The specific dangers presented to veterans in OIF/OEF may contribute to the stress reactions observed in these veterans. They are repeatedly exposed to unidentifiable enemies, difficult terrain, equipment deficiencies, etc. These factors, Litz (2006) argues, exacerbate adverse reactions to combat. Some of the traumatic experiences encountered during combat include taking the life of another person; injuring others; being exposed to corpses, accidents, and atrocities; making difficult moral decisions; and feeling responsibility for one's peers (Beals et al., 2002). These experiences are associated with higher rates of persistent mental health difficulties and lower rates of remission (Brinker, Westermeyer, Thuras, & Canive, 2007). Some researchers have found that the act of killing another person may be a causal factor in terms of combat-related posttraumatic stress disorder (PTSD; Maguen, Metzler, Litz, Seal, Knight, & Marmar, 2005). According to O'Donnell, Begg, Lipson, and Elvander (2011), one of the most important factors contributing to the onset of mental health difficulties for combat veterans is combat exposure rather than deployment itself.

The impact of combat on the veterans who are deployed to combat zones is far reaching. Combat trauma is unique and complex, making work with combat veterans also unique and complex. The trauma encountered during combat " involves a unique brand of horror that involves exposure to terrifying violent events along with a mixture of fear, anxiety, and despair, as well as pride, excitement, loyalty, and patriotism" (Basham, 2008, page 87). Combat trauma is unlike other traumas such as motor vehicle accidents and natural disasters (Terr, 2010). Combat trauma and other traumas, such as persistent childhood abuse, are characterized by ongoing life-threatening events that evoke feelings of powerlessness.

Reactions to Trauma

For some people, exposure to trauma results in the development of psychological maladjustment in the form of posttraumatic stress disorder (PTSD; U.S. Department of Veterans Affairs, 2007). PTSD was first introduced as a formal diagnosis in 1980 with the release of the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III; American Psychological Association, 1980). It was initially thought that people developed only passing responses to trauma. This idea was challenged by some and resulted in the development and inclusion of PTSD into the DSM. PTSD was intended to address the enduring pathology exhibited by some individuals after exposure to trauma (Brewin, Lanius, Novac, Schnyder, & Galea, 2009).

After its introduction as a diagnosis in the DSM-III, PTSD underwent various changes (American Psychological Association, 1980; 1987). In particular, Criterion A was elaborated. The DSM-III-R included examples and descriptors of Criterion A stressors that were absent in the previous edition. Criterion A consists of two parts (DSM-IV-TR; American Psychological Association, 2000). Criterion A1 says that to receive this diagnosis a person must experience, witness, or be confronted by an event that involves threat of death or serious injury to that person or to others. Criterion A2 says that the person must respond with intense fear, helplessness, or horror (DSM-IV-TR; American Psychological Association, 2000).

The DSM-IV-TR divides the diagnosis of PTSD into three symptom clusters (DSM-IV-TR; American Psychological Association, 2000). The first cluster consists of symptoms related to re-experiencing the trauma; this is Criterion B. For example, one might experience intrusive memories, nightmares, flashbacks, or reactivity when

encountering specific cues related to his/her trauma. The second cluster, related to avoidance symptoms and numbing, includes behaviors of avoidance of things that serve as reminders of the trauma, loss of memory or emotion related to the trauma, and decreased interest in previously enjoyed activities; this is Criterion C. The third cluster of symptoms consists of hyperarousal symptoms. Hyperarousal symptoms are characteristic of anxiety, such as difficulty sleeping and/or concentrating, hypervigilance, irritability, and an exaggerated startle response; this is Criterion D (DSM-IV-TR; American Psychological Association, 2000). Criterion E stipulates that the duration of symptoms be longer than one month. Criterion F stipulates that the symptoms be severe enough to cause distress or impairment.

Prior to the release of the DSM-V, some researchers and clinicians challenged Criterion A for PTSD. Authors such as O'Donnell, Creamer, McFarlane, Silove, and Bryant (2010) argue that, Criterion A2 specifically, needs to be addressed. Studies have shown that the experience of fear, helplessness, or horror is not always necessary for the development of PTSD. For example, O'Donnell, Creamer, McFarlane, Silove, and Bryant (2010) found that nearly one quarter of their participants who developed PTSD according to criteria B-F did not experience symptoms of Criterion A2. These researchers argued that the experiences necessary for the development of PTSD are much broader than currently stated under Criterion A2, pointing to evidence that other feelings, such as worry about others, also lead to the development of the disorder. Also, the intensity as previously outlined was not always necessary for PTSD to develop. In fact, some participants developed PTSD without emotional memory of the experience (O'Donnell, Creamer, McFarlane, Silove, & Bryant, 2010).

In their review of the DSM-IV-TR diagnosis of PTSD, Brewin, Lanius, Novac, Schnyder, and Galea (2009) considered the popular criticisms offered by psychologists. Some researchers propose that Criterion A be eliminated from the diagnosis entirely (Brewin, Lanius, Novac, Schnyder, & Galea, 2009). Other authors argue for restricting Criterion A1 and eliminating Criterion A2, returning to a classification that requires direct experience of trauma to receive the diagnosis (McNally, 2009).

The most recent version of the DSM includes an updated version of the diagnosis. The DSM-V includes, "experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related)" under Criterion A (retrieved from http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf, September 4, 2013). The updated diagnostic criteria are important, especially in consideration of the experience and response of the therapist. In the future, secondary trauma may no longer be differentiated from PTSD.

The diagnosis of PTSD and undergone several changes since its first inception in the DSM-III. Changes are made in accordance with clinical research in an attempt to yield accurate and useful diagnostic criteria. Although the changes are meant to facilitate the mental health field and veterans (and other trauma survivors) in optimizing functioning and well-being, changes are not without debatable consequences.

Combat Veterans with PTSD

Veterans returning from combat zones tend to meet criteria for PTSD at rates significantly higher than what is observed in the general population (Brinker et al., 2007; Hoge et al., 2004). Hoge et al. (2004) investigated PTSD prevalence rates among four

groups of U.S. Military personnel deployed to Iraq and Afghanistan. Three to four months after returning from combat, as many as 11-20% of U.S. Army and Marine Corps personnel met criteria for PTSD. Seal et al. (2009) investigated rates of PTSD among Iraq and Afghanistan veterans receiving services at the VA from 2002 to 2008. These researchers found that 22% of those veterans met criteria for PTSD. Schlenger et al., (1992) reviewed data from the National Vietnam Veterans Readjustment Study. They found rates of PTSD among male Vietnam theater veterans to be around 15%. Rates of PTSD among adults in the general public are estimated to be eight percent (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012).

PTSD can occur immediately after (immediate-onset) exposure to trauma or after some time (delayed-onset; Andrews, Brewin, Stewart, Philpott, & Hejdenberg, 2009). For delayed-onset PTSD, criteria were usually met between two and three years after the traumatic event, with the most common onset being just after discharge. Some combat veterans may experience temporary increases in affect post-deployment (Sundin, Fear, Iversen, Rona, & Wessely, 2010). The positive experience of returning home may overshadow the negative effects of the deployment experience. People who meet criteria for delayed-onset PTSD tend to accumulate stress over the course of time. For combat veterans, this may mean that physical responses to stress do not return to baseline, but rather continue to accumulate as more and more stressful encounters occur (Andrews et al., 2009). For clinicians, this means that their clients may take several months, years, or in some cases decades before they seek treatment. Veterans may not recognize or acknowledge their symptoms.

Veterans from previous eras (conflicts prior to OIF/OEF/OND) experienced difficulties with relationships that were attributed to PTSD (Monson, Taft, & Fredman, 2009). More specifically, among previous generations of combat veterans, PTSD was associated with more relationship distress generally. PTSD was also linked to difficulties in communication with partners, which also affected intimacy. PTSD negatively influenced sexual functioning and contributed to greater relationship instability (Monson et al., 2009). When compared to combat veterans who do not screen positive for PTSD, OIF/OEF/OND combat veterans commonly report greater difficulty with relationship adjustment (Erbes et al., 2011). Symptoms such as dysphoria, which is characterized by internalization and emotional distress, often exacerbate relationship difficulties by increasing emotional withdrawal on the part of the veteran (Gottman & Levenson, 1986). Such symptoms (dysphoria) also limit or diminish the capacity of combat veterans to experience positive engagement; it also limits their ability for emotion experiencing (Gottman & Levenson, 1986). Other symptoms, such as emotional numbing, also interfere with relationship adjustment for combat veterans (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Monson et al., 2009).

Combat veterans who develop delayed-onset PTSD often begin experiencing symptoms early in their careers and continue to develop symptoms, positioning them to be significantly more symptomatic at the time of trauma than comparison groups. In one study, combat veterans who exhibited delayed-onset of PTSD reported more combat events and more war trauma than comparisons. However, when the number of deployments was taken into account, the differences previously observed in terms of combat events and trauma were no longer there (Andrews et al., 2009). Whether

immediate- or delayed-onset, those in the study who at some point met the criteria for PTSD did not differ in terms of the amount of time between first enlisting and experiencing their first trauma. No differences were reported in terms of the type of the main trauma experienced (Andrews et al., 2009).

Some researchers suggest that warfare encourages the use of denial and numbing as coping strategies (Horowitz & Solomon, 1975). Combat veterans often report experiencing increases in feelings of shame after discharge (Andrews et al., 2009). Andrews et al. (2009) suggest that while active, combat veterans are better able to contain and deal with intense emotions related to trauma, but once out of that heightened environment, upon retirement or discharge for example, combat veterans are without the support (environmental factors) needed to continue containing those emotions. When in dangerous situations, intense emotional reactions can create additional danger; in those situations, combat veterans must keep strong emotional reactions in check. Once out of those situations, it is no longer necessary to keep intense emotional reactions in check. At that point, these combat veterans may become overwhelmed by the rush of emotions that previously they may not have been aware were there. When combat veterans are deployed multiple times, they often report experiencing more difficulty with readjustment (Mental Health Advisory Team VI, 2009). After multiple (three or four) deployments, combat veterans report increased difficulty with mental health, acute stress, and marital problems than they reported after their first or second deployment. After their third or fourth deployment, compared to the first or second, combat veterans also report experiencing lower morale in general (Mental Health Advisory Team VI, 2009). Therefore, it is extremely important that clinicians properly assess for PTSD and be alert

to the potential negative consequences it tends to have on interpersonal relationships and social interactions (Erbes et al., 2011).

According to some research, exposure to trauma prior to combat increased susceptibility and likelihood of the development of a mental illness, often PTSD, after exposure to combat-related trauma (Ford, 1999). Childhood trauma, especially if repeated and/or followed by combat trauma, positions combat veterans to be more susceptible to developing PTSD (Dorahy et al., 2009). Survivors of repeated or prolonged trauma exhibit symptoms that are much more complex and diffuse than those exhibited by survivors of other types of trauma (Herman, 1992). For example, changes in personality are often observed where survivors develop "deformations of relatedness and identity" (Herman, 1992, page 379). Physiological symptoms tend to be worse among survivors of repeated trauma compared to single trauma survivors (Herman, 1992). Symptoms such as hypervigilance, anxiety, and agitation tend to be greater for people who are repeatedly exposed to trauma (Hilberman, 1980). As a result of prolonged physiological arousal, other significant physical issues may also arise. The physical symptoms experienced not only include insomnia, exaggerated startle responses, and agitation, but also include headaches, body aches, nausea, and even tremors (Herman, 1992).

To cope with the intense experience of repeated exposure to trauma, sometimes survivors will develop sophisticated dissociative coping skills (Herman, 1992). For example, prisoners will engage in practices of thought suppression or minimization to overcome aversive states of pain, hunger, and cold (Partnoy, 1986 as cited in Herman, 1992). For veterans in combat situations, dissociative coping strategies may be lifesaving. However, those (dissociative) coping strategies may also create more adversity than they

help overcome once the soldier is out of the threatening situation. Survivors of prolonged exposure to trauma are often more vulnerable to repeated trauma, sometimes inflicted by their own hands (Herman, 1992). Regardless of whether or not they are repeatedly exposed to trauma, there are observable consequences for the combat veterans, friends, families, and health care providers who work with them.

In summary, research suggests that combat veterans tend to exhibit higher rates of PTSD than the general public. Symptoms of PTSD may occur immediately upon returning from deployment or may not appear for some time after returning home. Regardless of when symptoms appear, they tend to cause difficulties for veterans and their social support systems in most areas of functioning. Characteristics of the recent conflicts in Iraq and Afghanistan create rich opportunities for combat veterans to be negatively affected by their work and leave them more vulnerable to PTSD. Clinicians in the VA system are especially likely to encounter these veterans in their work and are faced with the challenge of helping these individuals reclaim their lives.

Reactions to Working with Someone Who Experienced Trauma

According to Tucker, Sinclair, and Thomas (2005), stressful experiences have an effect at the group level and at the individual level. Stress felt by any one member of an intact group is also thought to be felt in some way by the group as a whole. The group dynamic within the military often results in shared experiences of stress (Tucker, Sinclair, & Thomas, 2005). The experience of stress at the individual level can leave group members more susceptible to the effects of stress at the group level. Given the strong group nature of the military, attention should be given to the additional effects group membership may have on individual combat veterans in terms of stress and strain. Many

veterans have spouses and families they return to after combat. Because the family unit is a system, the person diagnosed with PTSD is not the only person affected by it. The family unit develops collective coping strategies, or in some cases, the family unit dissolves.

This section outlines potential relationships between trauma therapy and clinician well-being. Jordan (2010) speaks to the need for research that specifically investigates how reactions or consequences of therapy such as vicarious trauma have on therapists who work with combat veterans. The conflicts in Iraq and Afghanistan present combat veterans and those involved in their lives with issues such as repeated, long-term (re)deployment that combat veterans from previous eras were not faced with (Jordan, 2010). Some researchers in the area of secondary trauma affirm, "the desire to identify and respond to occupational hazards, such as secondary trauma, is a laudable one (Elwood et al., 2011, page 35).

Treatments commonly used for PTSD, such as Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE), require that therapists listen to graphic accounts of combat trauma (Foa, Hembree, & Rothbaum, 2007; Resick, Monson, & Chard, 2007). This is because these types of interventions serve to disrupt and prevent avoidance tendencies that are a significant part of PTSD (Foa, Rothbaum, & Murdock, 1991; Resick & Schnicke, 1992). As such, clinicians who work with combat veterans in addressing their PTSD are regularly listening to explicit details of traumatic events as they provide services.

Burnout

Burnout is similar to secondary traumatic stress in that both involve emotional drain that sometimes comes as a result of one's professional work (Adams, Boscarino, & Figley, 2006). More specifically, burnout is, "a psychological syndrome in response to chronic interpersonal stressors on the job," (Maslach, 2001). It centers on feelings of emotional exhaustion, cynicism, detachment, and inefficacy in relation to the job (Maslach, Schaufeli, & Leiter, 2001).

Researchers consider emotional exhaustion to be the central or key component of job burnout (Maslach et al., 2001). The development of emotional exhaustion often leads to some of the other dimensions of burnout, such as cynicism and lower self-efficacy (Maslach, 2001). As a result of experiencing exhaustion, therapists begin to take action to protect themselves by creating distance between themselves and their clients (Maslach et al., 2001). Impersonal views of clients are developed, and therapists begin to interact with their clients with indifference and cynicism.

Feelings of inefficacy sometimes develop from prolonged exposure to exhaustion and depersonalization. In a literature review of research on burnout, Maslach (2001) noted the difficulty involved with being effective when regularly experiencing exhaustion and working with people towards whom you have feelings of indifference. Using semi-structured interviews with a variety of psychotherapists (psychiatrists, psychologists, and social workers), Farber and Heifetz (1982) were able to assess therapeutic factors that contribute to burnout. They found that burnout often results from a lack of reciprocation felt by therapists from their clients (Farber & Heifetz, 1982). Therapists felt especially prone to burnout when stressors at home impaired their ability to cope with the impact of

their clinical work. When burdened with symptoms of burnout, therapists noted their ability to effectively attend to the needs of their patients was impaired. To continue to engage with clients and behave empathically, therapists need to feel as though their efforts are accomplishing something. Without this, therapists may feel ineffective in their work and, as a result, experience burnout.

From information gathered in a literature review, Maslach, Schaufeli, and Leiter (2001) concluded that therapists who are early in their career tend to be more at risk for experiencing job burnout. Also noted as correlates of job burnout are: younger age, insufficient training in trauma work, homogenous caseloads (in terms of diagnoses), and working with in-patient client populations (Craig & Sprang, 2009). Craig and Sprang (2009) found that the use of evidence-based practices to buffer against the development of burnout. Therapists suffering from burnout are more likely to miss work, consider job changes or transitions, and are more likely to leave their positions. Measurement of job burnout shows that scores tend to be consistent over time, indicating that burnout is, "a prolonged response to chronic job stressors," (Maslach et al., 2001).

Emotional exhaustion, cynicism, and decreased self-efficacy appear to be the hallmark symptoms of burnout. As time goes on and these symptoms increase in severity, empathic engagement becomes increasingly difficult. Early career psychologists appear to be particularly at risk for burnout, as they tend to have the fewer protective characteristics and behaviors in place than do more experienced clinicians.

Vicarious Trauma (VT)

Psychologists who work specifically with clients on their traumatic experiences will be exposed to the trauma narratives of their clients. Regular and consistent exposure

to stories of traumatic experiences creates specific needs for psychologists. Failure to properly address these needs may have deleterious effects on clinicians. Psychologists who work primarily with trauma populations are at risk in terms of developing or experiencing negative changes in response to their clinical work (Elwood et al., 2011). Vicarious traumatization (VT) is a term used to describe one of the possible negative outcomes of ongoing clinical work with trauma survivors (McCann & Pearlman, 1990).

After investigating the effects of repeated exposure to trauma histories, researchers concluded that for some, there are consequences that result in profound changes in the psychologist (McCann & Pearlman, 1990; Saaktvine & Pearlman, 1990). VT is a "transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material," (Pearlman & Saakvitne, 1995, page 31). It is a change that occurs in reaction to ongoing empathic engagement with trauma clients. It also refers to the cumulative effects that occur over the course of time, as clinicians are repeatedly exposed to stories of their clients' trauma experiences.

Vicarious trauma may last for months or years after a clinician is exposed to trauma narratives of their clients (McCann & Pearlman, 1990). The therapist's cognitive schemas are altered, which can have a negative impact on the therapist's life, professional and personal. McCann and Pearlman (1990) propose that therapists experience disruptions in their cognitive schemas; these disruptions alter how the therapist views himself/herself and the world.

There are several schema domains that may be affected by working with trauma survivors. These areas include schemas related to trust, safety, power, control, independence, esteem, intimacy, and frame of reference (McCann & Pearlman, 1990;

Pearlman & Saakvitne, 1995). Incidentally, several of these areas are directly addressed in Cognitive Processing Therapy (CPT), one of the empirically supported, trauma-focused therapies often used for the treatment of PTSD (Resick, Monson, & Chard, 2007). Any one of these schemas may be impacted as a result of vicarious trauma. For example, a psychologist might begin to see the world as an unsafe place. They may become distrustful and suspicious of others. Psychologists experiencing vicarious trauma may come to feel powerless or lose their sense of self-efficacy as a result of hearing their clients' trauma narratives (McCann & Pearlman, 1990).

The memory system may also be altered in the process of working with trauma clients (McCann & Pearlman, 1990). As psychologists listen to stories of trauma, some begin to internalize their clients' memories associated with the trauma experience(s). As clients recount their experiences, some therapists will create visual images of their clients' trauma. Should a therapist develop vicarious trauma, he or she, after mentally creating images of their clients' traumatic experiences, could experience something likened to flashbacks, dreams that include the created imagery, and/or intrusive thoughts about his or her clients' experiences (McCann & Pearlman, 1990).

In a meta-synthesis of 20 research studies on vicarious trauma, Cohen and Collens (2013) concluded there is evidence to support the existence of vicarious trauma. The cognitive changes, both positive and negative, were observed in therapists who were exposed to client trauma through their clinical work; authors identified empathy as a key component for these cognitive changes. These researchers concluded that, "it was quite clear that the experiences of working with trauma had triggered a cognitive activity that resulted in changes to internal schemas," (page 6).

Secondary Traumatic Stress (STS) and Compassion Fatigue (CF)

Although PTSD was described previously, because of its significant overlap with secondary traumatic stress, the progression and characteristics of the diagnosis will be revisited in this section. The parallels between the two responses to trauma make them appear almost identical. By presenting again the diagnosis of PTSD, the "diagnosis" of STSD readers will be able to clearly understand the overlap and difference between the experience of the client and the experience of the therapist.

PTSD was first introduced as a formal diagnosis in 1980 with the release of the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III; American Psychological Association, 1980). The current version of the DSM divides the diagnosis of PTSD into three symptom clusters (DSM-IV-TR; American Psychological Association, 2000). Those symptom clusters are further discussed here.

The first cluster consists of symptoms related to re-experiencing the trauma; this is Criterion B. For example, one might experience intrusive memories, nightmares, flashbacks, or reactivity when encountering specific cues related to his/her trauma. The second cluster, related to avoidance symptoms and numbing, includes behaviors of avoidance of things that serve as reminders of the trauma, loss of memory or emotion related to the trauma, and decreased interest in previously enjoyed activities; this is Criterion C. The third cluster of symptoms consists of hyperarousal symptoms. Hyperarousal symptoms are characteristic of anxiety, such as difficulty sleeping and/or concentrating, hypervigilance, irritability, and an exaggerated startle response; this is Criterion D (DSM-IV-TR; American Psychological Association, 2000). Criterion E

stipulates that the duration of symptoms be longer than one month. Criterion F stipulates that the symptoms be severe enough to cause distress or impairment.

Secondary traumatic stress (STS) refers to the development of PTSD-like symptoms and cognitive changes in response to exposure to distressing material presented by trauma clients; the symptoms of secondary traumatic stress mirror closely those of post-traumatic stress disorder as defined by the DSM-IV-TR. Figley (1999) defines secondary traumatic stress as, "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping to wanting to help a traumatized or suffering person." STS was the original term given this phenomenon. In later conceptualizations, researchers use the term compassion fatigue (CF; Figley 1995).

STS/CF is not confined to clinicians who work with trauma clients (Figley, 1995). It can be experienced by anyone with an intimate relationship with a trauma survivor. Empathic engagement with clients is an important ingredient for the development of compassion fatigue. Empathic engagement becomes increasingly difficult to maintain when a therapist develops compassion fatigue (Adams, Boscarino, & Figley, 2006). As part of their work with trauma clients, therapists vicariously share their clients' traumatic experiences as their clients recount, often in detail, their trauma histories (Bride & Figley, 2009). Through graphic verbal descriptions of traumatic experiences, therapists are provided with images of the trauma and with knowledge of the human cruelty that exists in the world.

Bride and Figley (2009) developed a conceptual model of the factors that contribute to the development of STS/CF. First, caregivers are exposed to a traumatic

event, and through the course of therapy, begins to engage empathically with their clients (or significant other). Certain factors serve to further the development of secondary traumatic stress; identified factors include compassion satisfaction, support mechanisms, and other risk factors such as level of experience (Bride & Figley, 2009). It is important to note that, in addition to these factors, perceived systemic failures that impede client care are also associated with compassion fatigue (Killian, 2008). Even though these concepts have been differentiated in the literature, secondary traumatic stress and vicarious trauma have been used interchangeably, which contributes to the lack of clarity in the research to date (Jenkins & Baird, 2002; Najjar, Davis, Beck-Coon, & Doebbeling, 2009).

Recent research suggests there is a relationship between facilitating trauma therapy and/or being exposed second-hand to traumatic material and the development of secondary trauma symptoms (Bonach & Heckert, 2012). Trauma workers of various disciplines have been investigated and found to exhibit symptoms of STS/CF. For instance, approximately one-third of social workers surveyed by Choi (2011) reported moderate to severe trauma symptoms. Nearly two-thirds of respondents to the Oklahoma City trauma exhibited symptoms of PTSD (Wee & Myers, 2002). Fifteen percent of social workers (who treated trauma) surveyed by Bride (2007) met criteria for PTSD and 70% experienced at least one symptom of STS. Research by Bride, Jones, and MacMaster (2007) showed PTSD rates as high as 34% among child protective services workers. Respondents to Hurricanes Katrina and Rita showed signs of CF and VT at rates double that of comparison groups who were not involved in the disasters (Lambert & Lawson, 2012).

Symptoms of CF, STS, VT, and burnout are exhibited in studies from other countries as well as the United States. A study of Israeli childcare workers indicated that 25-31% of participants exhibited symptoms of secondary trauma and burnout above the 75th percentile (Zerach, 2013). Thirty-five perent of physicians and ten percent of nurses working in Lebanon and Israel exhibited high levels of PTSD (Ben-Ezra, Palgi, & Essar, 2007). In Australia, more than one-fourth of community mental health case managers working with trauma survivors exhibited "extreme stress" as a result of their clinical work (Meldrum, King, & Spooner, 2002).

Overall, research suggests the existence of at least some components of these concepts, however, the literature remains unclear to date, particularly because of the heterogeneity in the operationalization of these concepts. Many studies do not do an adequate job of differentiating the terms and concepts, thereby clouding the results (Craig & Sprang, 2009). A mixed-method study done by Ortlepp and Friedman (2002) illustrates such confusion. Analyses indicated that nonprofessional trauma counselors exhibited STS symptoms (e.g. helplessness, increased emotional arousal, dreaming of the incident, hypervigilence, etc.) initially following a trauma counseling incident, but these counselors did not show any of these symptoms six weeks later. Researchers go on to report that lay counselors endorsed changes to their worldviews (e.g. increased sensitivity to the suffering of others, increased awareness of vulnerability in self and others, increased need to appreciate life, etc.) well after they provided services to trauma survivors. To measure STS in this study, researchers used the Compassion Satisfaction/Fatigue test, which was developed to measure CF, not STS, thereby further confusing the concepts and the literature. In another example, Brady, Guy, Poelstra, and

Brokaw (1999) conclude from their study of 1,000 female psychotherapists who provided therapy for sexual abuse survivors, that no significant changes in cognitive schemas resulted from exposure to trauma narratives. However, these researchers later indicate that VT was observed among clinicians working with sexually abused populations. The confusion again lies with the operationalization of the term VT. Brady, Guy, Poelstra, and Brokaw (1999) use the term VT seemingly interchangeably with STS/CF.

In a study done in 2002 by Jenkins and Baird using a population of trauma counselors (sexual assault and domestic violence), results indicated that STS and VT were indeed two different constructs. While acknowledging some overlap in symptom manifestation, these researchers concluded that STS and VT differ in that one focuses more on emotional symptoms and the other focuses more on cognitive symptoms. They conclude that, "there is adequate evidence that neither of these measures [Compassion Fatigue Self-Test for Psychotherapists and Traumatic Stress Institute Belief Scale Symptom] is reducible to the other, and that their associations are not merely shared response bias," (page 431). Devilly, Wright, and Varker (2009) concluded that, contrary to the conclusions made by Figley and other researchers of vicarious trauma and secondary traumatic stress/compassion fatigue, these concepts do not display construct validity. These researchers argue that VT/STS/CF appear to overlap enough to consider them the same construct rather than stand-alone concepts.

Trauma Services at the Department of Veterans Affairs

The VA is comprised of two separate but collaborative entities, the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA). The VHA is devoted specifically to meeting the health needs of veterans while the VBA is

focused on assisting veterans with such things as insurance, disability or service connection for physical and mental health concern, GI Bill, etc. (U.S. Department of Veterans Affairs, 2011). In 1984, the Chief Medical Director's Special Committee on PTSD advised the VA on treatment facilities for mental health (Karlin, Ruzek, Chard, Eftekhari, Monson, Hembree, Resick, & Foa, 2010). Specifically, the committee recommended that each of the VA's hospitals at that time be funded for treatment efforts for PTSD. Under the direction of the Comprehensive VHA Mental Health Strategic Plan, the VA began work on its mental health care system (Edwards, 2008). The VA has worked to expand its workforce by more than 6,000 staff members. The VA currently has more than 20,000 staff members who are part of the mental health workforce (Karlin et al., 2010). Currently, the VHA has more than 230 specialized programs dedicated to PTSD. These programs include PTSD specialists and clinical teams, specialized outpatient services, dual diagnosis services to provide assistance for PTSD and co-occurring substance abuse difficulties (Karlin et al., 2010).

Veterans serving in Iraq and Afghanistan face challenges previously unseen by members of the U.S. military (Jordan, 2010). As of 2009, roughly one-fourth of those veterans who served in Iraq or Afghanistan who have received services through the VA have been diagnosed with PTSD (U.S. Department of Veterans Affairs, 2010). As PTSD is increasingly becoming part of the normal lexicon, awareness of and actions to address PTSD have also increased. Greater awareness of the issues faced by those involved in the conflicts in Iraq and Afghanistan can only benefit those who deal directly with the effects combat can have on veterans, which will then help meet the needs of combat veterans themselves.

A growing number of OIF/OEF/OND veterans are suffering traumatic brain injuries, amputations, etc. As a result of these conditions of service for many combat veterans, new and previously unseen psychological consequences are prevalent. Suicide rates have trended down over recent years (Kemp & Bossarte, 2012). However, the number of completed suicides among services members has increased. According to the DoD, 301 service members completed suicide in 2011 (Luxton et al., 2011). An estimated 134 of those suicides were completed by military personnel deployed to Iraq and/or Afghanistan (46.69%). Direct combat experience was noted in an additional 158 suicide attempts (Luxton et al., 2011). Therapists providing services for these veterans therefore also face dealing with the same issues through their clinical work (Jordan, 2010).

The growing and ever-changing needs of veterans returning from combat directly impact the needs of the clinicians who provide them services. The sheer number of veterans returning from combat is enough to overwhelm the mental health field, at least within the VA system. The impact clinical work with combat veterans has on therapists is important to study because it can directly impact the quality of care provided, the well-being of the client, and the well-being of the therapist. And, as recent research suggests, those working heavily and closely with OIF/OEF/OND veterans are at risk for developing adverse reactions to trauma work (Beder, Postiglione, & Strolin-Goltzman, 2012). To further this line of research, the current study will expand upon the literature by focusing on the impact of trauma therapy on therapists who work with combat veterans through the VA.

As a result of the growing number of combat veterans in need of mental health treatment, the number of therapists and mental health workers within the VA system is also growing (Chamberin, 2008). Over the course of the past decade, the number of psychologists working in the VA has more than doubled. The VA has allotted more than $5.3 million in efforts to recruit and employ quality psychologists to meet the growing needs of returning combat veterans (Chamberin, 2008).

Significant efforts are being made to provide appropriate and effective services for veterans returning from Iraq and Afghanistan. The impact of the discrepancy between the need for services and the availability of service providers has been great and has resulted in efforts to address the discrepancy. The potential consequences of clinical work with OIF/OEF/OND veterans is important to understand because they can result in impairment on the part of the therapist, which may compromise services. Therapists ought to be well-supported and mentally and emotionally able to provide high-quality treatment to veterans. Jordan (2010) encourages civilian therapists to familiarize themselves with military culture (e.g. language, rank, traumatic brain injury risks and symptoms, etc.) and to the best of their abilities, seek to understand the unique nature of combat.

The Impact of Providing Trauma Services on the Clinician

According to Elwood, Mott, Lohr, and Galovski (2011), the construct of trauma is one that has been difficult to conceptualize and measure. If the theories of secondary traumatic stress and vicarious trauma hold true, the degree of exposure to trauma narratives of clients should be positively correlated with the development of secondary trauma symptoms (Elwood et al., 2011; Figley, 1995; Pearlman & Saakvitne, 1995). To

measure the impact of trauma work on the therapist, researchers have often used the percentage of trauma clients on the therapist's caseload (Elwood et al., 2011). Another variable often used to measure the impact of trauma work on the therapist is the number of hours spent each week working with trauma clients.

Researchers such as Deighton, Gurris, and Traue (2007) report that it is not so much the exposure to their clients' experiences of trauma that affect the therapist. Rather, it is what the therapist does in response to hearing such narratives that affects the therapist in terms of the development of what they term work-related symptoms. More specifically, it is what therapists do to cope with their reactions to trauma narratives that determines how they will be affected. It is important that therapists know what effects their work potentially has on their well-being and mental health. Lack of awareness of risks such as secondary traumatic stress can result in the therapist withdrawing from his or her clients and avoiding empathic engagement (Figley 1978; 2002).

The dynamic nature of the therapy process means that trauma therapy, whether positively or negatively, affects both the therapist and the client. The experiences of combat veterans during deployment make them vulnerable and susceptible to traumatic encounters. Upon return, these men and women require and deserve the best services available. To provide such services, therapists and other mental health care providers must be aware of issues such as VT and STS, as they may compromise the quality of services provided. "Given the increased risk of negative mental health outcomes beyond the first year following homecoming, returning soldiers and their families need reliable community support and immediate and short-term interventions to normalize acute stress responses" (Basham, 2008, page 91).

Risk Factors for Service Providers

Empathic engagement, although most often thought of as a valuable component of therapy, can be the mechanism by which a therapist becomes vulnerable to, and/or develops VT (Jordan, 2010). By imagining oneself in the position of the veteran, the therapist is able to empathize with the client. But by mentally creating such a scenario, the therapist is also likely to experience the emotions of the veteran. Trauma therapy with combat veterans often involves repeatedly hearing details of the trauma. As a result, the therapist is repeatedly left vulnerable to the negative consequences of empathic engagement (Jordan, 2010). Over enough time, the therapist may develop VT.

Empathic engagement is not the only risk factor to be aware of in trauma therapy. Personal and organizational factors may also negatively contribute to the mental health of the trauma therapist. From existing literature, Jordan (2010) detailed several factors that impact the symptom severity of VT. Jordan (2010) identified eight factors that contribute to VT, some of the factors were investigated among clinicians working with combat veterans. Those factors include: the number of combat veterans and the severity of symptoms on the therapist's caseload, personal history of trauma, professional trauma, perceived adequacy of training, consultation, social support, self-care, and resiliency. However, some of the proposed factors were not well represented by supporting literature. For example, professional trauma was discussed in terms of military psychologists' own combat experiences potentially interfering with their ability to provide quality treatment, however, no empirical evidence was cited.

Therapist's personal trauma histories are important when they are not properly addressed. It is during clinical work with trauma survivors that strong, potentially

confusing emotions could be brought up. The therapist could misattribute feelings about his or her own trauma to feelings evoked solely by the content of the therapy session, countertransference, the therapeutic process, etc. (Jordan, 2010). For therapists who work with combat veterans, it is important to be aware of their own inner experiences in response to their work, as well as the unique experiences of their clients (Tyson, 2007). According to Tyson (2007) "it is vital for clinicians to be aware of how the global shattering of their clients' lives will inevitably alter their own professional and personal experience" (page 187). Having that awareness will benefit both the therapist and the client(s). Interest in and awareness of one's own experiences in reference to trauma work is important. Therapists working with trauma clients need to be aware of the impact their clients' experience can have on them.

Therapists must be aware of their own personal trauma histories, means of coping, organizational issues that have an impact on clinical work, and the social context within which the therapy process takes place, as these factors contribute to the well-being of both the client and the therapist (Saakvitne & Pearlman, 1996). Responders to a plane crash (e.g. volunteer health care workers, EMTs, radiologists, dental students, firefighters, maintenance workers, flight attendants, and administrative personnel) who reported prior experiences of trauma exhibited more intrusion symptoms in the year following the crash (Dougall, Herberman, Delahanty, Inslicht, & Baum, 2000). Researchers concluded that respondents who accumulate traumatic experiences become more sensitized to new stressors. If the therapist has not adequately addressed personal experiences of trauma, working with traumatized clients can evoke negative emotions. Jordan (2010) recommends that therapists who have personal trauma histories seek out

their own therapy experiences to address their feelings so they may be able to provide assistance to trauma-affected combat veterans.

Therapists who are doing trauma work with combat veterans from the recent conflicts may find themselves working long hours and being immersed in their clinical work. As a result, these therapists run the risk of isolating themselves socially and therefore lacking the social support they often need (Jordan, 2010). In a recent study of social workers within the VA, those working with OIF/OEF/OND veterans at least 50% of the time showed the highest levels of compassion fatigue, which were slightly above the cut point level (Beder, Postiglione, & Strolin-Goltzman (2012).

Literature on the impact of clinical work with combat veterans in the VA system is available, but minimal. The current study intended to explore the experiences of therapists who facilitate trauma therapy with combat veterans within the VHA. Through improved understanding of the experiences of these clinicians, advancements can be made within the VA system in terms of caring for Veterans who serve in the United States military and the mental health service providers who treat them.

CHAPTER 3

METHODOLOGY

The purpose of the current study was to understand how VA psychologists are affected by, and cope with, repeated exposure to trauma narratives from their combat veteran clients who have been diagnosed with post-traumatic stress disorder. To address this question, this study employed Consensual Qualitative Research (CQR). Qualitative research methods allow for the exploration of events as they occur (Hill et al., 2005; Hill, 2012). Because the research question sought to describe experiences rather than explain why they occur, CQR was chosen to collect and analyze the data. Included in this chapter is an explanation of this particular methodology, as well as why it was chosen and how it was used in this study. This chapter concludes with an explanation of the analysis procedure.

Consensual Qualitative Research (CQR)

One notable advantage of qualitative research methodology is that is allows the researchers to remain open throughout the data collection process, which allows them to follow the data as they are collected rather than being constrained to the measures and methods established at the beginning of the research process (Hill et al., 2005). Many psychological phenomena are considered complex, and traditional research methods are seen as inadequate means to fully capture these complex phenomena (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005). Traditional quantitative methods do not allow for the rich, interactive characteristics of the therapy process, for example, to come through in the data the way some qualitative methods do. The inductive approach to research that characterizes CQR allows researchers to develop an understanding of

personal experiences. Comparatively, deductive approaches begin with a hypothesis on which the subsequent research is based.

CQR was chosen over other methods of qualitative analysis for its key components that promote rigor and trustworthiness of data. CQR not only incorporates multiple perspectives through the research team and auditor, but emphasizes constant adherence to the data. Compared to grounded theory, for example, CQR uses set interview questions with a predetermined number of participants, which insures that every participant is asked the same questions (Hill, 2012). The structure of CQR allows for consistent processes between researchers, which allows for replication and verification of findings.

CQR was introduced in response to perceived inadequacies of the available research methods (Hill, Thompson, & Williams, 1997). CQR incorporates procedures that comply with the expected rigor of traditional research methodology with the flexibility and fluid approach offered by qualitative research (Hill et al., 2005). Researchers developed CQR in an attempt to integrate the desired characteristics of qualitative research designs with the desired characteristics of rigor, replication, and scientific integrity.

The CQR method involves nine components and three general steps (Hill, 2012). This study followed the procedure delineated by the developers of CQR. The key components of CQR center on consensus, the use of words and language, and stress the importance of awareness (self, other, context, culture, etc). The current study incorporated those components and follows the general steps, and adheres to a constructivist, inductive approach to data collection and analysis.

In conducting CQR, researchers identify the topic to be investigated and begin with a review of the literature (Hill, 2012). The primary research team and an auditor are identified. The primary research team develops and then pilot tests the interview protocol based on the literature review. Once the interview protocol has been developed, the research team identifies the population to be investigated, then recruits and interviews participants (Hill, 2012). Once interviews have been completed, they are transcribed and sent to the participants for review.

Once the primary research team has completed data collection, they begin the within-case analysis (Hill, 2012). Domains are developed from individual cases. The domains are labeled based on content and/or topic of the included data. After the team has developed the domains, they work to construct core ideas, or summaries of the domains, for each case. The analyzed data (domains and core ideas) are then sent to the auditor for review. The primary research team then revises domains and core ideas based on feedback from the auditor (Hill, 2012).

After the within-case analyses have been completed, the team works on the cross-analysis (Hill, 2012). Now looking across all cases in the study, the research team develops categories within domains. The auditor then reviews the cross-analysis and provides feedback, which is again incorporated by the primary research team (Hill, 2012).

Participants

The population of the current study were therapists treating combat veterans who have been diagnosed with post-traumatic stress disorder within the VA system; all participants were employed in the state of Iowa. In keeping with the spirit of CQR, the

population chosen is familiar with concepts under investigation. This is an important characteristic of the participants because of the small number of participants (Hill et al., 2005). CQR does not require a specific number of participants. However, eight to fifteen participants is the recommended range. A sample size of eight to fifteen is large enough to determine if the results are applicable to several people or to just a few people. Larger sample sizes are often difficult to accommodate with the CQR process and often yield diminishing returns (Hill et al., 2005).

Participants were recruited in consultation with VAs. With the guidance and direction of the staff at the VA, appropriate advertising materials were developed and disseminated. To be included in the study, participants must have been full-time employees at the VA, engaging in therapy with at least one combat veteran with a PTSD diagnosis, and holding any level of degree in a helping services field (e.g. MSW, PhD, etc.) at least one year post licensure or certification.

This study used semi-structured interviews with open-ended questions, conducted either in person or via telephone. The interviews were expected to last between one and two hours. Prior to beginning the interview, informed consent was obtained. Participants were given the option of completing the interview during normal business hours or after normal business hours (pending approval from the clinical director at each site). Although the developers of CQR suggest using two interviews per participant, this study limited the interviews to one per participant (Burkard, Knox, & Hill, 2012). The time commitment requested from participants for a single interview was estimated to be one hour. It was thought that the additional time required to complete a follow-up interview would be excessively burdensome for the participants and limit participants' ability to be

included in the study.

Research Team

Interviewer

A white, female graduate student pursuing a doctoral degree in counseling psychology conducted the interviews. The interviewer, also the primary investigator, was both personally and professionally involved with military personnel. She was raised in a military household (her father served in the United States Navy for 20 years) and completed two years of clinical training with the Iowa City VA before completing internship at a VA in northeast Tennessee. Lifelong involvement with the military shaped the interviewer's views on military personnel and influenced her expectations and biases as they relate to the research process. Expectations and biases are presented and discussed in future sections.

The developers of CQR outline desirable characteristics of the interviewer. According to Hill, Thompson, and Williams (1997), it is preferable to have an interviewer who has adequate training and well-developed interview skills. The interviewer had roughly 500 hours of direct client contact (including intake interview experience) at the time of the interviews and was under the supervision of an experienced, licensed psychologist throughout the entire process. Interviewers often use the same skills collecting data as are used when conducting therapy with clients (Burkard et al., 2012).

This study used one interviewer to help ensure consistency. Restricting the number of interviewers introduces limitations; it was important to be aware of factors such as bias that could influence the outcome of the study. The introduction and influence

of bias was monitored throughout the research process; it was an ongoing endeavor. In preparation for the interview process, the interviewer followed the suggestions of Burkard, Knox, and Hill (2012). More specifically, the interviewer listened to interviews on National Public Radio to get a feel for the general flow and process of interviews. The pilot testing served as additional training in the interview process. During the interview, detailed notes were taken and kept with the transcribed interviews.

Analysis Team

The analysis team was responsible for the data interpretation process. The team was responsible for developing domains, core ideas, and conducting the cross analysis. The use of a set team allows for each member to be immersed in the entire data set. However, by using a set analysis team, the risk for repetition in the development of domains was present.

The team consisted of two graduate students in a counseling psychology program: the primary investigator and a White, male, nontraditional student in his forties enrolled in the Counseling Psychology Doctoral Program at the University of Iowa. The analysis team developed domains and core ideas, and conducted the cross analysis (Hill et al., 2005).

Auditor

The auditor was a White female graduate student in her mid-twenties. She served as a check for the analysis team and reviewed the data and the analysis after the analysis team finished preliminary work (Hill et al., 2005). The auditor's perspective provided another view of the data and was intended to keep the analysis team "on track." Hill et al. (2005) updated the expected role of the auditor and differentiated between internal and

external auditors. This study used an external auditor, one who was not a member of the primary research team and who was not involved in the data collection or initial analysis procedures. The auditor was provided with the interview transcripts and the consensus version of the domains and cross analysis documents. The auditor reviewed the data as sorted by the analysis team. She double-checked the placement of the raw material within domains, ensuring that all relevant material has been abstracted and that the language used by the analysis team was consistent with the language used by the participants (Hill et al., 2005). She reviewed the core ideas for each case as well. Core ideas were reviewed for redundancy and appropriateness for the domain. The auditor ensures the core ideas are clear and concise and reflect accurately the words of the participants (Hill, 2012). After the auditor completed these tasks, she provided feedback to the analysis team. Feedback was provided in written form.

Transcriptionist

The transcriptionist was unaffiliated with the current research project, but was trained in the transcription process. She is a White, nursing student in her late-twenties. The transcriptionist worked in a quiet, secure location (Hill, Thompson, & Williams, 1997). Each interview was typed verbatim and checked for accuracy by the interviewer. Once accuracy was assessed, all identifying information was removed from the files and replaced with code numbers. Each interview transcript was then sent to the participant for review and final approval. The interview transcripts were kept in a secure location.

Expectations and Bias

Expectations and bias were recorded before the data collection began, as suggested in the literature (Sim, Huang, & Hill, 2012). These expectations and biases are

presented to allow the reader to gauge their influence on the study. Expectations are "beliefs that researchers have formed based on reading the literature and thinking about and developing the questions" (Hill et al., 1997, page 538). Biases are "personal issues that make it difficult for researchers to respond objectively to the data" (Hill, Thompson, & Williams, 1997, page 539).

Members of the research team recorded their own expectations and biases prior to beginning data collection. This was intended to bring awareness of these factors to each member so that each member was able to make an effort to minimize the influence of expectations and bias on the data analysis. The rationale behind this step is that it helps ensure that the interpretation stays true to the data and minimizes the impact of the individual team members' views and experiences (Sim et al., 2012). It is also thought that the recording of expectations and biases can help enrich the research process, at the very least by enhancing self-awareness and self-knowledge of the team members.

The primary research team identified three expectations and three biases. The three expectations included: therapy with trauma survivors affects the clinician, self-care is important, and the boundaries between therapist's personal and professional lives are clear. Through both personal and professional experiences and training, both members of the primary research team had learned that traumatic experiences often have an impact on the people close to the survivor. Such experiences led to the expectation that clinicians would also be affected by working with trauma survivors. The primary research team members are both counseling psychology students in a program that actively models and promotes the value of self-care. Expectations of valuing self-care were formed in response to the cultural norms and practices of the primary research team's training

program. Perhaps as a result of limited professional experience, the primary research anticipated clear boundaries between participants' work and personal lives. Training often emphasizes clear boundaries with clients. As such, the primary research team members expected that established professionals would have developed clear boundaries between their personal and professional lives.

The primary research team identified three biases at the outset of the research process. Those biases included: providers in the VA share an outlook of respect for Veterans, Veterans make significant personal sacrifices for the general public, and most providers do not have insight into how their personal lives affect their therapy. Particularly in the case of the primary investigator, military service is a respected community of men and women. Growing up in a military household, the primary investigator was raised in a culture that emphasized respect and appreciation for the dedication, commitment, and sacrifices made by Veterans and their families. After working clinically with Veterans for several years, both members of the primary research team developed an appreciation for Veterans and their service. Given the first two identified biases, the primary team members viewed others who appear to have established careers with Veteran populations would share such biases towards Veterans. Because the focus remains primarily on the Veteran or client during therapy and the identified expectation of clear boundaries between personal and professional lives, the primary team doubted the presence of insight regarding the affect one's personal life has on the therapy he or she provides to Veterans.

Interview

The data collection protocol included two main sections and pre-scripted probes

to be used as needed. The first section included questions and prompts to capture demographic information, including data about caseload, training, experience, etc., as those variables pertain to the participants' clinical work. This section of the interview was deliberately less emotionally charged than the second section in an attempt to develop rapport with the participants before delving into the (potentially) more difficult questions and content area (Burkard et al., 2012).

The second section included the research questions, which included several focused questions related to the research question and that were intended to prompt participants to reflect on the broader issues related to the topic. These questions were open-ended and aimed at soliciting information about the constructs being investigated in this study. The interview questions were developed based on the literature. See Appendix.

Procedures

Recruitment

The study was first reviewed and approved by IRB. Upon receipt of approval from IRB, the primary investigator began the recruitment process. A recruitment email was sent to potential participants. This email contained inclusion/exclusion criteria and directions for acceptance/interest in participating in the study. Participants were asked to respond directly to the primary investigator via email indicating their decision on participation in the study; a hard copy flyer was placed in the mailboxes of the potential participants. The recruitment email and the flyer were identical and included directions for declining further contact from the research team.

After the initial email was sent out to invite participation, the principal

investigator followed up with a second email to confirm participation. For those clinicians who indicated an interest in participation, an email was sent that included the Consent Letter as an attachment. An "ignored" email was also followed-up with a second email. Potential participants were considered uninterested or unavailable for participation if no response was received after the second email.

If interest in participation was indicated, a letter of information was sent to the individual as an email attachment and an interview was scheduled. The interviews took place in person unless circumstances did not allow for in-person interviews. In such cases, telephone interviews were conducted. Subjects verbally gave their consent at the outset of the interview. The participants were given a printed copy of the Consent Letter/Information Sheet at the time of the interview, unless the interview is done by phone, in which case it was confirmed that the participant received a copy of the Letter of Information via email.

Data Collection

As stated previously, semi-structured interviews comprised of open-ended questions were used in the data collection process. This type of interview is suggested for CQR because it not only lends itself to rapport building with the participants, but it also allows the researcher(s) to have flexibility and a means for soliciting clarity and depth in participant responses (Hill et al., 1997). Interviews were recorded and labeled with individual participant codes. The recorded interviews were kept in a locked storage container. Prior to collecting data, approval to record was obtained through the privacy officer of each VA facility where data is collected.

Analysis of Data

After the interviews and transcription processes were completed, the research team analyzed the data according to the procedures outlined by Hill (Ed.; 2012). As an overview, the first step involved developing domains, which were used to cluster the data into similar topic areas. The second step, once the domains were developed and coded, is to construct core ideas, which are summaries of the core domains (Thompson, Vivino, & Hill, 2012). The next step is to audit the domain and core ideas. The final step is cross-analysis of the data, a process to identify common themes across cases. How each of these steps was carried out in the current study is described in detail below.

Domain coding. Domains were used to group and organize the data into meaningful and distinct categories (Thompson et al., 2012). Each member of the analysis team reviewed the transcribed interviews and independently looked for themes. Once each team member had identified an initial set of domains, they met to discuss the list of domains and supporting excerpts from the transcripts. The primary team then revised the list of domains and derived a consensus list. Three interview transcripts were then independently reviewed and the data was sorted according to the list of consensus domains. After the first three transcripts were reviewed and the data from each sorted, the team met, presented their analyses, and revised the list of domains accordingly.

After consensus was reached on the first three interviews, the remainder of the interviews were reviewed and analyzed. Blocks of data were assigned to a domain as appropriate. A block of data is anything from a simple phrase to several sentences related to the same topic (Hill et al., 1997). Domain names were written next to blocks of data. Some blocks of data were assigned to multiple domains. “Double coded” blocks of data

were reviewed and domains were refined as necessary. In some cases domains were combined, while other domains were split into multiple domains.

After each team member had independently reviewed and coded each of the seven transcripts, the team met to reach consensus for all of the analyzed data. Once the team had reached consensus regarding the domain coding of each transcript, a final version of the transcripts was produced. The final version of each transcript was presented with all data categorized by domain. Data considered irrelevant to the study (e.g. greetings, debriefings, etc.) were removed from the transcripts. Original transcripts were retained for auditing purposes.

Abstracting core ideas within domains. Once the data were sorted, the domains were summarized into core ideas. The intention was to create clear, concise representations of the "essence of what the interviewee has said about the domain…" (Hill et al., 1997, p. 546). Core ideas are summaries of the data, presented in clear and concise prose. The developers of CQR caution researchers against losing tracking of context throughout this process; context serves an important informative purpose in regards to decisions made about each domain. As such, the core ideas were developed based on transcript evidence and with consideration of the context of the given domain.

After each member of the analysis team had constructed core ideas for the first three interviews, the team convened to reach a consensus (Thompson et al., 2012). The primary team members recategorized core ideas to different domains when determined necessary. After the team had developed a common understanding of the core ideas construction process, the remainder of the transcripts was reviewed. The team then discussed the results and discrepancies were resolved. Documents containing each of the

interview transcripts, domain coding, and core ideas were sent to the auditor for review. The auditor provided written feedback on the development of the domains, including the placement of data within each domain. The auditor also provided feedback on the core ideas. Feedback from the auditor was reviewed by the primary research team and incorporated into the analysis.

Cross-analysis. After incorporating feedback from the auditor, the primary research team began the cross-analysis process in which they reviewed domains and core ideas across cases. Cross analysis involved examining the data for patterns and themes across participants (Ladany, Thompson, & Hill, 2012). The team reviewed and discussed the core ideas across domains and began analyzing how they fit together, seeking to identify and capture the essence of the phenomena while adhering to the data. During this process it was important to be sure that the categories were developed to fit the data. The categories were continuously refined as the analysis team became increasingly familiar with the data. Once consensus had been reached and the cross-analysis was complete, the documents were sent to the auditor for review. Feedback was provided in written form and incorporated into the results as appropriate. All feedback from the auditor was included in the final analysis of the data.

External audit of domains, core ideas, and cross analysis. The study used an external auditor, one who was not a member of the primary research team. The auditor's role was to ensure the quality of the analysis produced by the primary team. The auditor reviewed the work of the analysis team, including the transcripts of each interview, and provided input on the creation of domains, the appropriate placement of the core ideas and specified categories (Schlosser, Dewey, & Hill, 2012). The auditor carefully

reviewed the cross analysis and provided feedback to the analysis team. The auditor's feedback was presented to the primary team. The analysis team reviewed the auditor's comments and incorporated them appropriately. All recommendations made by the auditor were incorporated.

Frequency. The analysis team examined the data and evaluated the representativeness of the sample (Ladany et al., 2012). The developers of CQR propose categories to describe representativeness; the categories are *general*, *typical*, and *variant*. These categories indicate to the reader that the category applies to all (general), at least half (typical), or fewer than half the cases (variant; Ladany et al., 2012). Narrative frequency labels are favored over numerical frequency labels in CQR because they are thought to provide more meaningful information that is consistent with the overall philosophical approach to qualitative research (Ladany et al., 2012).

Trustworthiness of data. A stability check is a process whereby two cases are withheld from the cross-analysis process in order to determine whether all the data in those two cases fit appropriately into the defined categories (Hill et al., 1997). This process is also intended to verify the frequency categories developed from the remaining transcripts. Hill et al. (2005) suggests the stability check is no longer necessary. Based on the updated recommendations of Hill et al. (2005), a stability check was not used in this study.

Charting results. Charts were used to diagram the relationships between specific categories among the domains (Hill et al., 1997). Only those connections between general and typical categories were charted. As a result, the charts will represent only those cases that apply to at least half the participants in the study.

CHAPTER 4

RESULTS

Seven domains emerged from the data. The domains include: *Social Support, Treatment, Impact on Therapist, Self-Care*, *Empathy, Challenges,* and *Knowledge.* The domains will be discussed in greater depth below, along with any categories that emerged within each domain. Categories within each domain were identified and labeled based on the number of responses assigned to them. Categories with seven responses received a label of "general." Categories with four to six responses were given the label of "typical." Finally, categories with three or fewer responses were given the label of "variant." A summary of all results, along with demographic information, can be found in Tables A1 and A2.

Demographic Information of Participants

The study included seven psychologists employed by the VA in the state of Iowa. There were four women and three men, all of whom identified as White or Caucasian. The seven psychologists held doctoral degrees in psychology (counseling, clinical, and marriage/family). Only one participant served in the military; no combat experience.

Social Support

The interview protocol asked participants to identify their current social support systems. Seven of seven participants identified some form of social support, leading to the development of the category, *All participants have an identifiable social support system.* Most commonly identified forms of social support were friends, family, and coworkers. For example, Ruth listed the following as components of her social support system:

> "That would be my husband, and I have two sons, we have two sons in their twenties and thirties, a good friend that's a psychologist, and colleagues here, good friends here, and a sister."

Alice shared the following comment about her social support:

> "I have wonderful, collegial support here. Many, many other providers that I trust and could go to with any of my own personal struggles with a client. In my personal system, my husband...and three sisters that I'm very close to."

The other six responses were very similar in identifying friends, family, and coworkers. In no case did a participant fail to identify a social support system. Brian describes how his wife is effective as a source of social support:

> "To have colleagues to talk to when you need to...to have a life other than therapy. I'm very grateful to my wife that she never asks me how the day went other than, "Well how was your day?" and I give her the standard, "It was fine." And then we start to go out, we pluck around in the garden, and we watch Family Guy, and we have a chance to get away from it and laugh and do some other things."

Each of the seven clinicians interviewed identified some form of social support, often including a spouse or significant other and colleagues. Although each person identified social support, the clinicians indicating reliance on social support to varying degrees. Those participants who described their social support systems indicated appreciation and value the support they receive.

Treatment

Client factors influence therapist's approach to treatment. Participants were asked to describe their approaches to trauma therapy. Six of the seven respondents identified client factors as a consideration in the treatment approach chosen and implemented when working with trauma. Ruth responded by saying:

> "Well, I'm certified in both prolonged exposure and cognitive processing therapy, so if [clients] can come weekly for ten to twelve weeks that would be definitely my approach. I would use those evidence-based therapies, if that's what you

> mean. If they can't do that, then it'd be more cognitive behavioral therapy, and just as soon as I can get them in, which can vary between five weeks and two to three months depending on schedule."

Brian's approach focuses creating a safe environment in which he empowers his clients:

> "Basically the way that I look at therapy is [clients] get a chance to put out their experiences, be able to step back in a safe environment and begin to look at not just the experience, but the effect that the experience has had on their life. Hopefully be able to not just process what happened to them, but feel a little bit more empowered to make some different choices if they don't like the direction their PTSD has taken their life, their family's lives, and those around them."

Some clinicians track the progress of their clients and continue to reassess their treatment approaches and modify as necessary. Paul's response is an illustration of this:

> "I'm trained in Prolonged Exposure, the manualized Prolonged Exposure therapy and I do like that. I used that; I have a PE caseload. But, PE isn't for everybody…periodically when I'm doing PE with someone I sometimes wonder, you know, is this going in the direction it should? Because I've had some people who respond just the way I'd want them to respond to PE, meaning that it's very, very tough for them, that they seem to be getting it, going in the right direction. For other people either that I've worked with directly or for interns I've supervised, it seems like "This is rough and not going in the direction I want it to go." So trauma, particularly doing PE, is this basically the person kind of going through a bit of hell, but I can sort of get the sense that it's temporary and they seem like they're moving in the right direction, versus does this person seem to be going through a hell and I'm not 100% sure or not confident that they seem to be going in the right direction. I guess, is it long-term productive or long-term destructive pain?"

Therapists develop a theoretical approach to facilitating therapy. For many of the clinicians interviewed, a primary approach to therapy was identified. Each of the seven clinicians interviewed identified a favored approach to working with trauma survivors. The identified approaches to therapy varied, and included cognitive behavioral, marital and family, family systems, mindfulness, etc. Bonnie incorporates family systems with her cognitive-behavioral approach:

> "Well, I'm trained in prolonged exposure and cognitive processing therapy. I like PE a lot better than CPT. I do a lot of the internal family systems work too, the

> IFS stuff that Dick Schwartz's work...been training in that the last few years and find it really useful."

Brian describes how he approaches trauma therapy from a narrative perspective, focusing on the importance of collaboration and transparency:

> "In my narrative orientation, I say, "I'm hoping we can all team up to try to fight this PTSD and get it out of your life. It served a purpose at one time, served a great purpose at one time in your life. But now not so much. It's just causing a lot of heartache and a lot of trouble. I think we're gonna have much better outcomes if we can all get on the same page, but that means we're gonna have to be real open and honest with each other. So, if at any point in time you feel like I'm not understanding or I'm missing it or I am not being as respectful as I need to be, I may not even be aware of it and I'll be very appreciative if you tell me." I try to set a tone that we're in this together and that we all have different areas of expertise. Nobody's expertise is any more or less important than the other person's, but if we work together we're going to get the best possible outcome."

Some therapists' understanding of, and approach to, trauma therapy have shifted over time. For example, George gave the following response:

> "I no longer think of therapy as something that happens up here (points to head) in your head. People really come to us for help with something down here (points to abdomen) that they interpret as disturbing to them, and if you fail to deal with that sensation in their lives, give them a way to work with it, you fail that individual that's come to you for help."

Responses indicate that each of the clinicians interviewed practice psychology from a favored approach or theoretical orientation. Although each participant identified a guiding orientation for their work with trauma, no single approach was identified by everyone. Approaches to facilitating trauma therapy are considered in conjunction with the needs of the Veterans being served.

Impact on Therapist

Participants were asked for their impressions of how their work has affected them, both personally and professionally. These questions yielded four categories, which are

each listed below. Overall, responses indicated that clinicians are in fact affected by their work, however, the perceived effects are varied and result in a range of coping strategies motivated to address those effects.

Therapists are affected by their trauma work; the perceived effects of trauma work on therapists are mixed. Interestingly, the perceived effects of facilitating trauma therapy do not appear to be universal nor consistently detrimental or negative. In fact, some respondents identified positive effects that resulted from their clinical work with trauma survivors. For example, Ruth has noticed an increased or exaggerated startle response as a result of her clinical work with traumatized populations. She notes an increased awareness of danger in the world, which sometimes leaves her feeling anxious, especially when she is alone; she thinks that therapists who work with sexual assault victims would be more concerned with the well-being of young family members:

> "I've noticed that I have more of a startle response than I did before. I never had that my whole life until recently. I have a little bit more of an exaggerated startle. That was a surprise. I'm certainly more aware of danger, and more alert to things I didn't think about before; I do now. I work with sexual assault as well as combat veterans and other kinds of accidents and injuries. I think I'm just more aware of danger, and, you know, things like that… I think I feel a little more anxiety when I'm places alone. Again I think about that more when I'm in an elevator alone…I think more about assault. I think while driving…I've worked with accidents, those who survived accidents or come upon an accident scene. So I think it's made me…I'm a careful driver; I always wear my seatbelt, but I think it's made me more aware that sometimes you have no control. People run red lights. I'm more alert to that."

Brian has also noticed negative effects of his trauma work:

> "It is stressful, I'll admit that. My wife has noticed that there are times when my sleep is not real good. She said a few times I've woken up in bed reaching out choking somebody that wasn't there. But mostly, you feel just a profound sense of sadness when you work with these folks. At least I do. Because when you imagine them at 18, 19 years old going through what they had to go through and then

> battling it ever since. And so, there's just a sense of sadness at a loss of part of who they are or who they could have been had they not been traumatized and having to learn to live with and deal with PTSD."

Lisa noticed that, in spite of some of the negative feelings she experiences as a result of facilitating trauma therapy, that her clinical work brings about feelings of competence and hope:

> "Sometimes I'm sad, and horrified at some of the things our veterans have been through or experienced. Or I'm angry that they have had certain experiences. But I also feel competent that I can help them in some way, that I personally or our system can. So there's a hopeful aspect as well."

Although she has noticed some negative impact from her trauma work, Ruth also acknowledged that her work is rewarding and she has enjoyed specializing in her clinical work.

> "I've enjoyed specializing, 'cause I was in private practice before this, in a small town, and it's kinda nice to specialize in trauma, especially combat trauma, but I do other kinds of trauma; that's been kind of a fun thing."

Bonnie also enjoys the specialization in trauma:

> "It's become my niche, what I love doing, what's focused me as a therapist. I did a few things before that early in my career...gerontology and addictions, and I just find this makes more sense to me as a focus for what I do. So it's focused...psychologists can do so many things...and then PTSD becomes more of an interest focus that I like… I've been here for so long, that I think it's helped me feel more efficacious than just being a generic kind of therapist...to have something I can do that I'm good at."

Many of the respondents indicated positive effects of their trauma work. Paul and Brian both noticed that their work with trauma has helped them feel more appreciative of the positive experiences they have had. Brian feels motivated not only to be appreciative of what he has in his own life, but of the services and sacrifices that Veterans make:

> "I'm more kind of appreciative of the people in my life. It makes me much more thankful that my kids...because my kids are at the ages of these younger guys...that they didn't have to go through what a lot of these guys and gals have

> gone through and I am grateful for that. I'm much more focused in on making sure veterans feel honored. Me, personally, that was never a big deal to me. I was much more of an in-the-background type of person, that's what I always preferred. I'm much more cognizant to express appreciation to people who have been in the military whether they've been in combat or not...make sure that they understand that there are people that really do appreciate the sacrifices that were made, whether they shot their rifle or not. But how they were willing to alter the course of their life for a number of years for folks that may or may not ever express any appreciation. I'm much more quick to do that with veterans now."

Paul also notes appreciation that results from his trauma work:

> "Trying to be more mindful, appreciating what I have. That is probably the main thing that pops to mind, is trying to be more appreciative of what I have."

The perceived impact on the therapist sometimes changes over time. For example, Paul has noticed he is less reactive to the content of trauma narratives now than compared to early in his career—he is less sensitive or reactive to the brutality of life. Paul draws a distinction between being desensitized to unavoidable aspects of his job and being desensitized as a person—drawing a parallel between a surgeon seeing blood for the first time while performing surgery:

> "I guess I am probably less easily shocked by things, I suppose. What used to sort of get an emotional reaction out of me when I first started probably doesn't get that much of an emotional reaction out of me now, because now I'm well-versed in man's inhumanity to man. It probably doesn't faze me as much."

Therapist factors influence their trauma work. Nearly all clinicians interviewed identified personal factors, such as their own experiences of trauma (or lack thereof), that influence their approaches to trauma work (six of seven), which resulted in a general category. Ruth believes her own traumatic experiences have helped her understand different kinds of trauma and through those experiences she has realized that people can survive and cope in spite of traumatic experiences. George has experienced trauma in his personal life, which he believes informs his clinical work by increasing his compassion

and understanding of trauma, as well as forcing him to make peace with his own traumatic experiences.

> "I'm more compassionate because I understand the "thing" and the impairments, how it can constrict your life if you don't work with it…I think it always did help my clinical work, it was just making peace with my personal life, doing the work."

Lisa believes that the absence of personal trauma has left her with resilience due to not having had to deal with the impact of trauma.

> "I've had a charmed life. I've had normative stressors like a parent dying...it's not a lot of fun. Or health injuries with spouse...not a lot of fun. I've had no traumatic exposures, I don't have PTSD. I've not been in combat or been assaulted, so no, I have had a charmed life by comparison…I have lots of resilience because of not having had repeated health impact or repeated trauma impact."

Therapists have ethical responsibilities to their clients when facilitating trauma therapy. Six of the seven clinicians indicated a belief that therapists have an ethical responsibility to their clients when facilitating trauma therapy. For example, Lisa believes that clinicians who have experienced personal traumas run the risk of confusing their own needs with the needs of their clients in terms of trauma recovery.

> "One of the problems of people who have experienced the diagnosis or even that our patients have, is that they confuse their own way to recovery with what their patients should do."

This sentiment was echoed by the majority of respondents. Paul offered the following:

> *"*…everybody's gone through some crap, but I tend to be big on the idea of being very mindful, being very cognizant as much as you can be, so that you're making sure as much as you can that your crap isn't rubbing off on them. Try to be mindful of anything that might be a countertransference issue when you're working with people. I know that I've worked with people, where my vibe…and not closely, but I think people I just met, like at workshops and stuff, where quite honestly, my vibe is I wouldn't hire them because it seems like they've got a lot of unacknowledged personal issues that they're not dealing with; that they're instead throwing themselves at the trauma work."

George believes it is important to acknowledge feelings experienced in reaction to facilitating trauma therapy. In particular, he found being aware of feelings that may have stemmed from his own traumatic experience to be important.

> "It awakened my own latent traumas when I started here. All the worse because I didn't know what it was that was coming up on me. I think I did good clinical work the whole time too. But I think that my personal life...for a long time I only lived with alarm; I just felt alarmed all the time. I'm Irish. I just assumed you're supposed to feel that way all the time. That goes with being Irish, I think...you don't think you have a right to feel any other way. You ought to feel guilty. But it's taken a lot of time to work with that. And, we have a lot of responsibility to work with that too. We should be at least....much further down the line in the process than the people we try to help…I think you have to keep your own house in order if you're going to do it. You have a big responsibility, you know."

Some responses indicated concern for other therapists and alluded to the importance of self-awareness and honesty when working with trauma. Brian shared such a sentiment:

> "But I do think that some other people, that their profession is their total identity, I think that can be a pit of quicksand for them...where they just can't get away from it. It's the topic of conversation, it's the topic of thought, it can be a topic of research, it can just be a consuming thing for them. I know for me, that wouldn't be a good thing for my personality. Other people, it might be good for them. I just know for me, I can't allow myself to live in PTSD World, 24/7."

When therapists recognize they are being affected negatively by their work with trauma, some decide to make a change in their careers by limiting the time they spend facilitating therapy. Lisa recognized the need to make such a change, and shifted her focus from primarily clinical work to a more research-oriented focus:

> "It has led to me pursuing a research career that, after my post-doc, I had chosen to do all clinical work. After doing the clinical work and being frustrated that there wasn't enough evidence to help prevent trauma in military or treat trauma in military, it sent me back to doing research; motivated me to doing research."

Therapists develop strategies to stay/remain effective. Four of seven participants identified practices and/or behaviors they engage in to address their reactions to facilitating trauma therapy, resulting in a general category. The identified strategies were

used to address potentially negative reactions to facilitating therapy. Some therapists use meditation and seek their own personal therapy. Other therapists practice mindfulness to address negative reactions to facilitating trauma therapy. For example, Bonnie monitors her physical self through her clinical work, which helps her stay relaxed, calm, and connected in session. She notes the interconnectedness of physical and emotional selves and the importance of mindfulness as a therapist; monitoring these helps her remain at a more centered place to cope with therapy.

> "I notice part of me becoming say, kind of ready...well, I kind of notice what that's about and relax and get back in that more centered state. I don't usually get scared of patients, but if I did, I'd just sort of notice that. Or I'd notice that I'm starting to argue or something and I notice that...you just become aware of those ebbs and flows of being caught up in something and learn to get more to that more centered place of coping in self in therapy."

Overall, responses indicate that clinicians working within the VA recognize that facilitating trauma therapy for Veterans does affect them. This seems to be true regardless of any personal experience of trauma on the part of the clinician; both clinicians who have and who have not experienced trauma in their personal lives commented on the impact those experiences (or lack thereof) have had on their clinical work. Therapist responses indicate and advocate for an awareness of the impact one's personal experiences can have on one's professional functioning, as several therapists commented on the importance of being aware of the effects of one's own experiences as well as the effects of facilitating trauma therapy.

Self-Care

Participants were asked several questions aimed at understanding their practices and views of self-care. Each therapist was asked how they personally cope with the impact (if any) of their professional work. They were also asked for advice they might

have for other therapists who facilitate trauma therapy. Responses yielded two categories, which are discussed below.

Trauma therapists encourage the use of self-care. Six therapists directly mentioned the importance of self-care for clinicians who engage in or facilitate trauma therapy, resulting in a general category. However, as indicated in the second category, *Self-care is individualized*, each of the seven respondents identified some form of self-care they personally engage in. When asked if she had any advice for other therapists, Ruth offered the following:

> "Have good self-care. Know how to comfort yourself in healthy ways without abusing substances, whether that's food or alcohol or drugs or something like that. Balance the hard work with fun; doing things where you're doing fun things. I sometimes feel like I, like on a Friday night going out to eat, having someone care for me and I sit and rest. I don't want to stand in line to get food, I want to sit and have someone nurture me. I'd say be aware of when you need to rest and be taken care of. Don't push yourself to always give, give, give, give. Make sure you take care of you in a healthy way."

Lisa also cautioned against the negative impact of facilitating trauma therapy and noted the importance of good self-care:

> "I think it has the ability to invigorate people and to make them feel proud of the invaluable work they do. But I also think it can be very wearing and negatively impact people. I was fortunate to find a pathway that allowed me to continue to do work and to continue to do something that I hope is beneficial in terms of addressing traumas or preventing traumas, but I think that for people who work clinically five days a week, or even less than that, they really need to find ways to take care of themselves, because otherwise it can weigh on them and they can get secondary traumatization because they're exposed to so many traumas and the wear and tear."

Like most of the responses, Paul's response indicated that he prefers to use consultation, staffing, and supervision to process his work. He has found it beneficial to acknowledge his feelings and allow himself the opportunity to experience them. Additionally, Brian

commented on the importance of agency-level protection in addition to the individual, therapist-level care.

> "…it's important for clinicians to take care of themselves, but also for agencies to be aware of clinicians being overly consumed and figure out something to do to help clinicians decompress a little bit."

Self-care is individualized. All participants identified some form of self-care. They were each asked to think about difficult cases and to then discuss how they dealt with those cases on a personal level. Therapists were asked specifically about difficult cases under the assumption that self-care is required more often for negative versus positive experiences. Most responses identified one or more members of their primary support system as a key element of their self-care habits. Ruth shared the following about her self-care behaviors:

> "I may talk with a colleague, and say 'I need to tell you something this person described.' Just to not carry that burden by yourself. Other times I may just walk around the building, get some fresh air, clear my head. Try not to eat if it's not time to eat. I try to avoid that. I may just take a break; I won't just sit down and write out the note right away. I may go get the mail, go to the restroom, clear my head a little bit, or go pick up something downstairs from the file room that I need to get…just to move, get out of the office a little bit, shake it off a little bit.

George often uses meditation for self-care, but will occasionally seek out support from other people:

> "Meditation is my most common way. I think you have to take it head on. If you try not to think about it, it will haunt you. If you're upset you have to rest for a while feeling upset. Maybe do some long breathing to increase your vessels' capacity to handle it. Occasionally I can talk to somebody, but it's rare."

Responses indicate that each of the clinicians interviewed engage in some form of self-care. However, no one type of self-care was singularly identified, indicating the importance of finding something that works for the individual. Recognizing the

importance of self-care for themselves, the therapists interviewed stress the importance of good self-care for anyone facilitating trauma therapy.

Empathy

Empathy is essential for trauma work. Six of the seven clinicians interviewed expressed the belief that empathy is an essential component of treatment, resulting in a typical category. Three illustrative comments are listed below:

> Ruth: "I think it's very important to be able to understand or be able to put yourself in their shoes and have some sense of what it was like. I think it's important. Part of establishing rapport and trust in people."
>
> Lisa: "It's huge, it's 100%. You have to be empathic to people, to care, or you shouldn't be doing clinical work."
>
> Alice: "It's absolutely essential. It's a necessary but inadequate element of therapy, but it's the first, perhaps the most important element, because this wonderful human being is opening up herself or himself in your room, in your office. So, I can say, I can't emphasize enough how important it is; it's huge. And frankly, it's hard not to empathize with some of the anger, and fear. It's all so logical once you start learning their experiences through their eyes."

Empathy flows authentically from the therapist. Two of the seven participants discussed drawing upon their own experiences as a source of empathy, yielding a variant category. These two clinicians specifically discussed personal experiences and/or issues that they actively and intentionally recall when working with trauma survivors. For example, Paul uses the example of a physical condition such as blindness to draw parallels to his veterans' traumatic experiences, particularly to address acceptance and commitment to change.

> "…generally I'll say, well blindness and PTSD aren't the same thing…but I will say to the guys in group settings, "Is it fair to say that whether it's blindness or PTSD, that life deals you some poopy…I use another term…but sometimes life deals you some poopy cards and all you can do is do your best and try to play your hand the best you can. Generally that gets universal agreement. So I guess that although I'm mindful of not playing that card too much, about the parallel

> between the blindness and PTSD, but every now and then I'll play that…basically the idea that, you know, this sucks. You shouldn't have had to deal with it. It's not fair, but lucky you, it's there anyway. Wishing it will go away just isn't that effective."

When working with combat veterans, Brian often draws upon his childhood experiences:

> "Because on the surface, as you know, when people are starting with PTSD they're doing all they can to live a life that's as normal as can be with tremendous struggle, and they don't always necessarily make choices in their lives that a lot of people would see as positive. So the potential to be real judgmental is there. I think that's where growing up in a family where dad had PTSD...seeing him and knowing deep down that's not the way he really wants or wanted to be growing up, that he was doing the best he could with what he had to deal with...that really continues to play a big part in how I look at these folks."

Empathy is necessary but not sufficient. Although the majority of the clinicians emphasized the importance of empathy in therapy, two of the seven explicitly commented on the insufficient nature of empathy. Lisa believes empathy is a requirement for trauma work. She equates empathy with compassion, respect, and remorse for client experiences. Some therapists caution that empathy is necessary but not sufficient for clinical work. Lisa and Alice note that:

> "Empathy shouldn't be your total therapy model."

> "It's a necessary but inadequate element of therapy…"

Empathy was recognized as an essential component of therapy. Some therapists cautioned, however, that empathy is simply not enough. To generate empathy, many of the clinicians draw on their unique experiences and sources of information.

Challenges

Trauma therapists experience a variety of challenges in their clinical work. Clinicians were asked about challenging cases and each was able to provide a response describing therapy-related challenges. They were asked about difficulties faced in

facilitating trauma therapy. Responses yielded a single, general category. Clinicians perceive challenges broadly and not exclusively to the content of trauma therapy. For example, Ruth finds it challenging when veterans may be seeking treatment for secondary gain, such as disability or service connection. She also finds it challenging to hear narratives that include seemingly random details, such as when a veteran describes finding a lipstick in the debris after an explosion.

> "…there are sometimes small details, like in an explosion or something, and finding personal belongings that seem out of place. Again, I would want to avoid reporting any personal details…I'm thinking of one case where there was a woman soldier killed and the other person was describing finding pink lip gloss or something that seems so out of place in a vehicle that was blown to bits. It makes it more difficult. I'm trying to think of how to say this because if this is published he would recognize himself…but, you know, when someone has a child, so that would probably be more difficult to help the person deal with."

Other clinicians also commented on the specific trauma narratives of therapy sessions with regard to challenging clients. When asked about challenging clients and therapy sessions, Alice and Paul said the following:

> "Absolutely...it's those who have seen the abuse of children, because I see my children in those scenarios. So that's the stuff of nightmares for me and for them."

> "In terms of the trauma narrative? One or two isn't jumping out at me. Certainly there's plenty that have just, you know, you hear about pretty awful stuff…about a guy throwing a grenade into a bunker and it turns out a woman and her baby were in the bunker, although he didn't know they were in the bunker. All he knew was that someone was shooting at him from that bunker. Things along those lines. I'm thinking of a guy…his trauma narrative was going through a marketplace in Bagdad, I believe it was. Or another major Iraqi city. And essentially having to go through it and assess it and explain…he was a medic and was trying to explain to privates and other foot soldiers… 'What's that? Oh that's a piece of brain from a skull.'"

Some clinicians talked about challenges that were not related specifically to the content of the session or the veteran's trauma narrative. For example, George finds it challenging

to work with veterans who question his competence as a therapist and resist trusting in the therapeutic process:

> "Well usually if they have, if something bothers them enough that the therapeutic relationship itself troubles them...it's very rare to get one like that, because they're usually used to cooperating from the military, but I've occasionally gotten someone who derided the experience of therapy, made fun of what you were doing. Sometimes they were so traumatized…the person I'm thinking of was so traumatized, that he told me himself that he could just barely sit still. 'I might look normal on the outside,' he says, 'but I'm just going crazy on the outside.' So that would be an example of a tough one, because he was questioning me quite a few steps of the way, you know, in the therapy."

Ruth, in addition to noting content-specific challenges, shared that she finds secondary gain to be challenging:

> "I find the ones most difficult are those who are applying for disability at the same time."

Bonnie identified challenges related to psychosis:

> "I think the hardest ones for me are not the goriest, worst, awful. They're the ones that doesn't make much sense and I'm starting to question, " Are they putting this on? Are they semi-psychotic?" Probably not even some malingering, but...I've encountered a few that I was pretty sure that was...but the ones that I think they believe it, but they could not have been the only one of 200 to survive and then they were the last one out of the country and then they were the only one at the White House the day Reagan was shot...you know those kinds of things. Then I get kind of confused as to what is their reality, what am I dealing with...So it's not the horror of the trauma so much as it starts not making sense and I don't know what to do. Things dealing with psychotic disorders of some kind. I have lots of stories and things they've told me that I remember, but those don't affect me in the same way as the weird stuff does."

Trauma therapy can be challenging for a variety of reasons. Clinicians identified a variety of challenges they encounter through their work facilitating trauma therapy. Some clinicians commented on specific details of trauma narratives and identified those things as the most challenging aspects of therapy. Sometimes these details were identified as challenging because the therapist is able to relate to them or identify with them. Other

clinicians identified client behaviors and diagnoses as more challenging aspects of facilitating trauma therapy.

Knowledge

Vicarious trauma is not universally understood. Each clinician was asked about his or her familiarity with the concepts of vicarious trauma and/or secondary traumatic stress, and each participant expressed familiarity with the terms, yielding a general category. Some clinicians had more formal exposure to the concepts through research and/or training. Lisa, having had more formal exposure to the concepts, shared the following:

> "I know it's an important concept. I don't know the proportions with which different types of medical and mental health clinicians are exposed and then subsequently have it. But I do know it contributes to burnout, physical health, emotional health, and negative health habits like substance abuse or trying to increase vicarious excitement or hyperarousal because of the types of experiences that people have in therapy sessions or in health settings."

Participants were also asked about their knowledge and/or understanding of how something such as vicarious trauma may develop. Responses often indicated an appreciation for the perhaps global impact of trauma that can go beyond the individual who directly experiences some form of trauma. For example, George believes that PTSD affects the family as well as the veteran and vicarious trauma occurs for those in the support system of the traumatized individual. One clinician noted:

> "I don't see that it's possible for that not to happen, it's just to what degree it happens. Because of the way that I look at PTSD, it doesn't affect just the person who's been identified, but anyone who's part of that person's life is probably going to make contact with PTSD through that individual's PTSD, or change up the way that their lives go. So, not necessarily the classical symptoms of PTSD, but absolutely being affected by PTSD."

Other therapists also commented on the pervasive impact of trauma, noting that family systems are often affected in addition to the Veteran. Alice noted that,

> "It's a very important phenomenon with partners of, and family members of people diagnosed with PTSD because of the hyperarousal and the hyperagitation that comes with PTSD shapes the entire family to be searching the social environment for potential dangers...emotional dangers, social dangers, physical dangers...everybody in the system becomes hypervigilant."

Respondents who commented on the development of vicarious trauma and secondary traumatic stress pointed to empathy and the ability to imagine oneself in another person's situation that make a person vulnerable to secondary trauma. For example, Alice went on to say:

> "I think VT or secondary trauma always manifests when we're emotionally connected, when we're close to another human being and spend a good deal of time with them."

The therapists interviewed varied in terms of the amount of formal exposure they have had to the concepts of vicarious trauma and secondary traumatic stress. Each of the clinicians was able to talk about the potentially negative impact trauma therapy can have on people close to the person who directly experienced a traumatic event. Some therapists believe it is inevitable that close others, the therapist included, are affected by trauma. Other therapists are more reserved in how they conceptualize trauma and its sequelae.

Overall, the data gathered from the participants yielded seven domains, each with one or more categories. As detailed above, the domains include: *Social Support, Treatment, Impact on Therapist, Self-Care*, *Empathy, Challenges,* and *Knowledge*. Findings support the idea that facilitating trauma therapy with combat Veterans diagnosed with PTSD does affect the clinician. Further, the data indicate significant importance of self-care and self-awareness, as well as intentionality in one's work with trauma survivors. Findings also indicate that by facilitating trauma therapy with combat

Veterans, clinicians working in the VA encounter a bi-directional impact on their personal and professional functioning. Personal characteristics intersect with professional characteristics, which mutually influence the practitioner's ability to sustain successful careers in the VA. These findings will be discussed further in chapter 5.

CHAPTER 5

DISCUSSION

The purpose of this study was to understand how VA psychologists are affected by, and cope with, repeated exposure to trauma narratives from their combat veteran clients who have been diagnosed with post-traumatic stress disorder (PTSD). Psychologists working with the Veteran's Administration in the state of Iowa were asked a series of questions relating to their experiences working with combat veterans who have experienced trauma. Increased understanding of the experience and effects of being a psychologist working with combat veterans who regularly share narratives of trauma can help improve services for the combat veterans and promote the well-being of psychologists.

As mentioned in previous chapters, roughly 1.64 million troops have served in Iraq, Afghanistan, or both (Brenner et al., 2009). Due to the related trauma that may be experienced as a result of deployment to combat zones, VA clinicians regularly encounter clients who are working through the effects of combat trauma. As a result of such frequent contact, psychologists who work with trauma populations are vulnerable to the experience of negative consequences as a result of their clinical work.

This chapter will discuss the results of the study and related findings in the literature. The general themes will each be discussed in turn. Recommendations for practice will then be presented, followed by directions for future research. The chapter will conclude with implications of the findings on future research and practice.

The Bi-Directional Impact of Trauma Therapy

The main finding of the current study indicates that trauma therapy with combat Veterans blurs the boundaries between the therapists' personal and professional lives, with a bi-directional impact requiring constant monitoring, self-awareness, and self-reflection. Therapists who work with combat Veterans diagnosed with PTSD face several challenges, but perhaps the most important challenge is that they must constantly respond to struggles between personal and professional needs. Results indicate that the clinicians interviewed for this study actively address the following issues: reward v. cost, competency v. impairment, aspirations v. fit, and empathy v. desensitization. Addressing these issues appears to be an ongoing process for this population.

Therapists in this population weigh the rewards obtained from helping Veterans against the personal cost of regular, repeated exposure to trauma narratives. These clinicians consider their ability to provide quality services for Veterans through their clinical training and skills, especially if there is any personal history of trauma. The therapists reflected on their professional aspirations in relation to how well they fit in the role of a psychologist who works with combat Veterans diagnosed with PTSD. This population is also aware of the balance between empathy and desensitization. They noted that clinicians could become desensitized to specific details of trauma narratives without losing their ability to engage empathically with the Veteran sharing the narrative.

Understanding the experiences of these VA psychologists is important. From such information, future and current VA psychologists can navigate successful careers with combat Veterans diagnosed with PTSD. Prior to beginning a career at the VA or with combat Veterans diagnosed with PTSD, psychologists may consider the findings of this

study to determine if a similar career would be appropriate for them. Findings indicate what questions are important to consider, what personal and professional characteristics implicate a successful match between therapist and population served, and what actions may be taken to improve personal and professional functioning for psychologists who may already be working in the VA system and/or with combat Veterans diagnosed with PTSD.

Trauma Therapy Affects All Involved

One general theme that came from the results is that facilitating trauma therapy affects the clinician. Facilitating trauma therapy for these clinicians has not resulted in wholly positive or negative outcomes. These therapists' experiences have included both positive *and* negative outcomes.

Negative Consequences of Clinical Work with Combat Veterans

Some of the therapists in the current study reported signs and symptoms of the negative impact of their clinical work that are in keeping with typical signs and symptoms of vicarious trauma and secondary traumatic stress. However, they have been relatively unburdened by the negative consequences of facilitating trauma therapy. The few clinicians who reported feeling negatively affected by their work were female clinicians.

Previous literature on risk factors for developing conditions such as vicarious trauma provides some understanding on the absence of significant negative consequences observed in the present sample. For example, many of the participants indicated they do not work exclusively with combat veterans who experienced trauma. Balanced caseloads appear to have successfully protected these clinicians from VT and STS. Participants are

well-established in their careers with the VA and combat veterans. The accumulation of experience also provides a buffer for these clinicians. As these clinicians gained experience they also improved and refined their coping strategies, which promotes continued professional functioning. A circular pattern appears to have developed whereby more experience led to better coping, which allowed for the acquisition of more experience. The participants comprise a group of psychologists who are well-established in their careers, which indicates successful navigation of the potential pitfalls of the profession. The majority of the participants in this study work with heterogeneous caseloads and out-patient populations. These characteristics likely contributed to the longevity of careers observed as well as the apparent job satisfaction.

Positive Consequences of Clinical Work with Combat Veterans

Therapists in the current study noted often an appreciation for the opportunity to specialize in their clinical work, which may contribute to increased feelings of efficacy. Some of the therapists noted feelings of appreciation of their own life circumstances in light of the traumatic experiences shared by their clients. Clinicians in this study respect and appreciate the service and sacrifices made by their clients, which also promotes an overall feeling of appreciation of the individual clinician's life experiences.

The feelings of respect and appreciation for the work of their clients have facilitated a buffer for clinicians in this study. Through their positive feelings for their clients, these therapists have been able to withstand and endure the potentially negative impact of their clinical work. Some of the respondents indicated a general and genuine liking for their veteran clients. This view of their clients likely enables these therapists to focus on the end goal of their work and maintain the motivation and energy needed to

continue to provide quality services. A positive regard for the population may also allow these clinicians to make meaning of the impact their work has on them; something that for some may be necessary when faced with difficult trauma narratives or traumatic experiences.

The positive experiences that have resulted from their clinical work may also explain why these therapists are not endorsing signs and symptoms of VT/STS. Several protective factors were outlined by Harrison and Westwood (2009). Participants in the current study identify and embody many of those factors, including but not limited to: self-awareness, countering isolation, holistic self-care, and professional satisfaction.

The typical caseload composition of the participants is not homogeneous in terms of diagnosis and conflict in which the Veterans served. Beder, Postiglione, & Strolin-Goltzman (2012) found that clinicians (social workers, specifically) who work primarily with veterans from the most recent conflicts are at greater risk for developing compassion fatigue and burnout. They found that working with OEF/OIF/OND veterans 50% or more of their time—scored highest on compassion fatigue and above the accepted level for burnout. Although the clinical responsibilities of social work and psychology are not necessarily the same, the findings of the current study, along with previous research, indicate and support the need for more heterogeneous caseloads, not only in terms of diagnosis, but also in terms of the demographic variables of the veterans, such as age, generation, and era in which they served. Clinicians in this study reported caseloads that consisted of more than 50% combat veterans, but no respondents indicated working primarily with veterans from the most recent conflicts. Although they work primarily

with combat veterans who have been diagnosed with PTSD, their caseloads are balanced in terms of the conflicts in which their clients have served.

Managing the Impact of Facilitating Trauma Therapy

Realizing that facilitating trauma therapy with combat Veterans who have been diagnosed with PTSD is important, but actively addressing that impact seems to be even more important for sustaining a rewarding career as a VA psychologist. Each participant in this study promoted active coping strategies, including healthy self-care behavior and strategic interventions with therapy clients. There does not appear to be any one approach to managing the impact of facilitating trauma therapy that works best. In fact, results indicate that it is important that clinicians develop individualized approaches to managing their personal and professional needs. This will help ensure lifestyles that are sustainable and rewarding.

Personal History of Trauma

Roughly half of the participants indicated they had personally experienced trauma, while the other half indicated they had not experienced personal trauma. They were each able to explain the impact their personal trauma (or lack thereof) has had on their current functioning, including their current work with traumatized veterans. Perhaps because those clinicians who have experienced trauma in their personal lives are acutely aware of the impact their own experiences can have on their clients, they have taken steps to adequately address the impact of their own experiences. Participants who had not experienced trauma themselves also recognize the impact their personal lives have had on their professional lives. They note resilience and appreciation as a result of their experiences.

It appears as though a personal experience of trauma was not significant in terms of impairing the clinicians' ability to continue to function as a therapist who provides trauma therapy with combat Veterans. Those who indicated a personal history of trauma did not appear to be any more or less able to provide services to their Veterans. Findings indicate that clinicians who have experienced trauma in their personal lives are as able to provide quality services, as are their peers who have not experienced trauma. More important than a history of personal trauma (or lack thereof) is the clinicians' awareness of the impact of their personal experiences and behaviors engaged in that are aimed at addressing the impact of personal experiences.

Personal Experiences Influence Professional Functioning

Therapists who work with combat veterans are cautioned to be aware of their own inner experiences in reaction to their work (Harrison & Westwood, 2009; Tyson, 2007). According to Tyson (2007) "it is vital for clinicians to be aware of how the global shattering of their clients' lives will inevitably alter their own professional and personal experience" (page 187). Consistent with previous research, results from the current study support the idea that mental health professionals need to be in tune with their own psychological needs and deficits and take action when appropriate. Therapists in the current study reported awareness of the impact their clinical work has on individuals, including themselves, who are involved with or interpersonally connected to, someone who has experienced trauma. They also spoke of the necessity of this awareness in clinical work. Awareness of these effects is important for these therapists' well-being and mental health. Awareness promotes self-protective and therapy-promoting action on the

part of the clinician that allows for sustainable connectedness between client and therapist and contributes to career longevity for the clinician.

Therapists also need to be aware of their own personal means of coping, organizational issues that have an impact on clinical work, and the social context within which the therapy process takes place (Saakvitne & Pearlman, 1996). Awareness of these factors is important for clinicians because increased awareness will allow for appropriate behaviors to address their impact. Results support this finding; clinicians who have successfully navigated careers with combat veterans have been able to understand the influence their personal lives and experiences have on their professional lives and experiences, have adopted coping skills and behaviors that adequately address their individual needs, and recognize VA culture and the needs of their Veteran clients. These qualities likely protect the clinicians, leaving them less vulnerable to negative consequences of therapy and more effective with their veterans.

Regardless of the specific behaviors or strategies used by these therapists, each has been able to successfully cope with the effects of their clinical work with combat veterans. Appropriate awareness of one's own internal states and the ways in which their clinical work may affect the clinician is evidenced in the results. These therapists realize their clinical work and their personal histories have the potential to affect them both personally and professionally. This awareness fosters active self-care and healthy coping strategies that have allowed for longevity and effectiveness in their careers.

Active Self-Care Practices

To function effectively as trauma therapists in the VA, it is important to respond in healthy ways to effects of facilitating trauma therapy. Awareness of internal activation

and reactions to client trauma is important, but certain behaviors must follow for the therapist to remain healthy. Therapists interviewed for this study realize the importance of self-care and it was overwhelmingly identified as an important, necessary aspect of the practice of psychology.

Research supports the emphasis on self-care in protecting against the development of vicarious trauma and secondary traumatic stress (Deighton, Gurris, Traue, 2007, Harrison & Westwood, 2009). More than the mere exposure to traumatic material of their clients, it is what therapists do in response to the content presented by their clients that leaves them either vulnerable to or protected from the potential consequences of facilitating therapy.

Each of the therapists interviewed in this study identified multiple self-care habits they use to address reactions to their work with trauma clients. Most indicated well-established habits from which they derive satisfaction and that meet their personal needs. Social support was identified as an important aspect of self-care. The clinicians in this study endorsed reliance on their social support systems to varying degrees, but all identified primary relationships that serve are supportive and valuable to their well-being.

Facilitating Trauma Therapy

Choosing an approach to trauma therapy seems to aid professional functioning for therapists who work with combat Veterans. Although the VA promotes manualized treatments such as Cognitive Processing Therapy and Prolonged Exposure Therapy, these approaches are not required for successful therapy outcomes. Therapists from this study use a variety of approaches with their combat Veterans and all have indicated success in their clinical work. More important than the specific approach or interventions used

seems to be a solid understanding of theory and intentional employment of specific interventions.

Participants in the current study identified a favored approach they use when working with trauma clients. Therapists identified several theoretical orientations that guide their clinical work. Although the theoretical approaches varied, they all serve as a guiding principle by which clinicians understand and explain their clients' experiences and through which they employ interventions. It was interesting to find that no single theoretical orientation or approach was more commonly endorsed than any other, but all were noted to be useful and effective for the both client change and therapist well-being. This seems to indicate that it is not as important which theory clinicians use to guide their work, so long as there is some framework that guides therapy and provides conceptual understanding for the client's issues and the therapeutic process.

Within each of the identified approaches identified by participants in the current study, empathy is understood to be an important component. To be able to connect emotionally with one's clients and understand their unique experiences is essential. However, empathy is understood to be a contributing factor to the development of negative reactions to conducting trauma therapy (Figley 1995, 2002a, 2002b). As therapy continues and empathic engagement progresses, therapists become increasingly susceptible to vicarious trauma and/or compassion fatigue. Paradoxically, it is through empathy that the therapeutic relationship and consequently, progress, occurs and yet, also through empathic engagement is a key mechanism by which the therapist becomes burdened by their clients' trauma (Jordan, 2010).

The therapists interviewed in this study recognize the essential nature of empathy with their clients. Although empathy is highly valued among participants, they also recognize the limitations of empathy in therapy. Several participants indicated that empathy is a necessary, but an insufficient component of therapy and cautioned against overreliance on it as a therapeutic model. Therapist appear to understand that it is important to be aware of the value of empathy, but not to rely too heavily upon it while conducting therapy.

Therapists in the current study gave no indication of impaired ability to maintain empathic engagement. Perhaps because of the intentional use of theory to guide their therapeutic interactions with Veterans, participants in this study have been able to protect themselves from the potential hazards of empathic engagement. The understanding that empathy is necessary but not sufficient for therapy may also keep these clinicians from relying too heavily on empathy alone, thereby achieving a balance between empathy and other means of connecting with clients and implementing change with them.

Recommendations for Practice

Results from the current study indicate that facilitating trauma therapy does seem to have an impact on the therapist, however, as mentioned previously the impact is not universally positive or negative. The therapists interviewed represent a group of clinicians who have successfully navigated these effects. Although, consistent with previous literature, the current results appear to support the claim that there are indeed personal and professional consequences for the therapist who facilitates trauma therapy, some findings appear to be contrary or ill-aligned to previous findings in the literature. Some of those findings are discussed below.

First, roughly one half of the participants indicated they had personally experienced trauma, while the other half denied such experiences. Having a personal history of trauma did not appear to influence clinicians' current functioning. The impact (or lack thereof) of previous personal trauma on therapists in this study, although not necessarily or directly contradictory of previous research, does not seem to support the relationship between personal trauma histories and compassion fatigue. However, previous research only suggests greater *susceptibility* to compassion fatigue for those with a history of trauma (Baird & Kracen, 2006). Results from the current study indicate that these therapists have been able to properly address and protect themselves from potential vulnerability that results from their experiences of trauma. Those clinicians who denied a personal history of trauma often noted the absence of personal trauma made them appreciative of what their current life circumstances and fostered their resilience and ability to work with combat veterans and their (Veterans') traumatic experiences.

Second, research suggests that the use of evidence-based approaches to therapy is a protective factor against the negative consequences of facilitating trauma therapy (e.g. burnout; Craig & Sprang, 2009). Related to this, the VA endorses and encourages the use of approaches such as Prolonged Exposure and Cognitive Processing Therapy, both of which are empirically supported. Three of the seven therapists indicated they used one of these cognitive approaches in their work with trauma. Other orientations such as Internal Family Systems, narrative therapy, and mindfulness were also endorsed. Given the attitudes of the VA system, it might be expected that more clinicians in this study would utilize VA-endorsed approaches to trauma therapy.

Third, the impact of facilitating trauma therapy was acknowledged almost universally by the therapists interviewed. However, it did not appear that knowledge of such things as vicarious trauma and compassion fatigue were acquired through formal graduate training. Some therapists indicated they had been to trainings as part of their professional career with the VA or had previously conducted research on the issue. It seems that although there is some awareness of the potential harmful effects of facilitating trauma therapy, there is limited education on the issue.

Finally, good self-care practices were universally endorsed by the participants and each identified several habits they use to cope with their clinical work. It was surprising to find that there was no mention of sleep hygiene or the importance of adequate rest by any of the therapists interviewed. Exercise was rarely mentioned and was not identified as a primary means of self-care or coping. Previous research would suggest that sleep and exercise would be more often identified as important aspects of self-care than results from this study indicate.

Directions for Future Research

The seven participants in the study were recruited primarily through email from the two primary VA facilities in the state of Iowa. The recruitment procedures and content of recruitment materials included a time limitation for participation responses. They also included a stipulation on the number of times the primary investigator may contact potential participants. These limitations were intended to minimize the amount of time potential participants would be burdened with emails and time away from their professional obligations. However, the possibility remains that potential participants may have needed additional reminders of the opportunity to participate, as many clinicians

have busy schedules and heavily trafficked email accounts. It is possible that with additional contact from the research team, that recruitment may have gone differently, perhaps completed more quickly.

Related to the recruitment procedures is the identity of the primary investigator and research team. The primary investigator completed two years of practicum experience at the Iowa City VA. Due to the size of the clinic, many of the potential participants were familiar with the primary investigator. This familiarity could have influenced participation, likely in one of two ways. First, familiarity with the primary investigator may have encouraged participation and facilitated more open and honest interviews. Second, familiarity with the primary investigator may have discouraged participation and limited or restricted responses during the interviews. Depending on any personal or professional concerns (e.g. confidentiality, privacy, triggering of traumatic memories, etc.), clinicians may have been swayed in one direction or the other in terms of participating in a study that was led by someone with whom they are familiar. Because the potential participants and actual participants were not asked about their thoughts and feelings on knowing the primary investigator it is difficult to determine the level and type of influence the relationship may have had on participation and responses.

The demographic characteristics of the participants are homogeneous in race and ethnicity, and all practice in the same geographic region of the United States. The participants have spent an average of 13 years working as psychologists within the VA and the mean age is 53.7 years. The shared demographics result in a homogenous population and results may not be generalizable to a wide range of people. Further, most of the participants are settled into their careers as psychologists and have had several

years to acquire the skills necessary to sustain a career that includes trauma therapy. It appears that the findings of the current study highlight successful coping strategies more than the impact of facilitating trauma therapy.

The research team consisted of three counseling psychology students of similar ethnicity, cultural background, and social class. The research team two Caucasian females and one Caucasian male. As counseling psychologists, the members tend to subscribe to a strengths-based approach to psychology. These demographic characteristics of the research team are important to consider in that they could influence the interpretation process. For example, the research team may view facilitating trauma therapy differently than someone who had served in the military and/or had combat experience. However, the members of the research team had experience and familiarity with each other, as they had previously conducted CQR together. The familiarity among the team members allowed for comfort and openness during discussions and improved receptivity to differing opinions and feedback.

The current study used a sample of participants from VA facilities in the state of Iowa. There was an average of 13 years of experience within the VA and most clinicians were in their mid- to late-forties and fifties. Further, the population studied was comprised of Caucasian individuals from similar cultural backgrounds. Given the homogenous demographic characteristics of the current sample, it may be beneficial to replicate the study with younger psychologists, perhaps including graduate students who are still in training, and more culturally and ethnically diverse clinicians.

Diversifying the study sample will further increase understanding of the protective nature of certain demographic variables such as age and experience and result in more

generalizable findings. By diversifying the ethnic and cultural demographics of the study sample, future research could uncover important contributions of variables such as race, ethnicity, culture, etc. on therapists' ability to effectively cope with the impact of facilitating trauma therapy. Cultural values that promote social support, self-care, and mental health could protect clinicians from the negative consequences of their work facilitating trauma therapy. Cultural values that inhibit or discourage self-disclosure, personal therapy, or other related self-care behaviors may leave individuals more vulnerable to the effects of their clinical work.

Increased focus on therapists who are still in training or who are early in their careers in the VA, for example, could reveal important developmental markers that promote or protect against adverse effects of trauma therapy for the clinician. Understanding developmental needs of clinicians who work with combat Veterans diagnosed with PTSD as they directly relate to concerns such as vicarious trauma, secondary traumatic stress, and burnout could improve training and career support for new clinicians to further protect and buffer against these effects.

Implications

Although the current literature seems to lack consensus regarding the exact nature of vicarious trauma and secondary traumatic stress, there does seem to be consistency in the finding that facilitating trauma therapy can affect the clinician if proper safeguards are not in place. Awareness of this potential is important for the mental health field.

Research

Continued research in this area is needed to provide clinicians working with combat Veterans in the VA and other researchers with conceptual clarity; raise awareness

of the issue and its potential impact on VA therapists and their clients who experience PTSD as a result of their combat experiences; and to expand on the populations investigated. This can be done through future studies that flesh out details of how issues such as vicarious trauma develop. For example, focusing on variables such as training, clinical supervision, and facility-level involvement could increase understanding of how protective factors are developed and fostered. There appears to be clear support for both risk factors and protective factors in the development of vicarious trauma, secondary traumatic stress, and burnout, but the field would benefit from improved understanding of the progression of these conditions. Further investigation of this topic will allow for the provision of improved services for both VA clinicians and their Veteran clients.

As VA therapists who work with Veterans diagnosed with PTSD become increasingly aware of and adopt greater understanding of the impact of facilitating trauma therapy, they will be increasingly able to address any adverse effects in healthy ways. To do this, findings from research must be embedded into training programs and clinical opportunities. In addition to being sources of guidance and information, providers and educators at all levels must serve as models and examples of healthy professional and personal practices.

With the release of the newest Diagnostic and Statistical Manual (DSM) come changes in the diagnostic criteria for PTSD. Most notably, the updated DSM includes the criterion for "repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g. first responders, collecting body parts; professionals repeatedly exposed to the details of child abuse)." The new criteria for

PTSD necessitate distinction between PTSD, STS, and VT. There is now more overlap between these concepts than there has been with previous diagnostic criteria for trauma.

With the current diagnostic criteria for PTSD, the distinction between STS/VT and PTSD appears to be even more questionable, challenging the validity of the concepts as distinct and standalone. Criterion A1 and A2 have been part of an ongoing debate in the field of psychology (Friedman et al., 2010). Part of this debate focuses on the issue of how broad or restricted the criteria, Criterion A1 specifically, needs to be. The recent version of the DSM appears to have adopted a broader view of the criterion, in part because of research that indicates PTSD symptoms do not develop unless the stressor or traumatic experience is sufficiently distressing (Friedman et al., 2010; Kilpatrick et al., 1998). The distinction between STS and PTSD is made based on Criterion A1. The newest diagnostic criteria for PTSD include the exposure requirements of STS (repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties). This modification to the diagnostic criteria eliminates the differentiation between STS and PTSD. Future research should address this issue and revisit the distinction of STS, and perhaps VT, from PTSD.

Training and Education

Given the reported impact of facilitating trauma therapy, the importance of healthy self-care behavior, training programs are encouraged to take a more active role in educating future therapists so they are prepared to face the potential challenges. Although psychologists-in-training may be aware of the importance of self-care, training should include more targeted information relating self-care and how it protects from the impact

of facilitating trauma therapy. This is especially true for those who are currently or who hope to work in the VA system and who intend to work with combat Veterans.

Providers who are currently working in the VA system may share many of the same qualities as the providers interviewed for this study that allow for successful functioning as professionals. Such individuals may serve as role models and guides for their peers and should be encouraged to so do. Current practitioners who have been successful in navigating the impact of their clinical work with combat Veterans diagnosed with PTSD could provide leadership, share their experiences and knowledge with others, and serve as advocates within the VA system for the health and well-being of providers. For those providers who lack the necessary level of awareness or perhaps have not yet established adequate self-care habits, the results of this study may serve as guidance and education on the importance of such things.

The current study found that although many of the therapists were familiar with the concepts of vicarious trauma and secondary traumatic stress, few indicated formal training on such issues. Those who had received any type of formal training did so after graduate school. Therapists-in-training as well as early career psychologists should be actively informed of the potential consequences of facilitating trauma therapy and prepared and/or trained on how to handle those consequences.

Graduate students and early-career psychologists need to be made aware of the consequences of their clinical work through formal training in the classroom as well as through clinical experiences. Professors, advisors, and clinical supervisors can not only promote awareness and offer their expertise through the process of academic and clinical training, but also model such behaviors in their own work. Further, opportunities to

openly discuss personal experiences resulting from professional encounters must be afforded to trainees. New and developing psychologists should be encouraged to seek out their own therapy in general, but particularly whenever personal experiences of trauma have occurred. Because individual trauma survivors should not be singled out and made to disclose their experiences, opportunities and encouragement to seek personal counseling should be promoted in the general culture of psychologist training programs and work environments for early-career psychologists.

It is known that self-care is an important part of a clinician's skill set, which should be fostered from an early point in training and supported throughout careers. There was little mention of systemic or facility-level training or support in this area as well. Because self-care can evolve and needs to be appropriate for each individual, it is possible that efforts to find what works may be an ongoing, ever-changing process. As such, facility-level involvement will not only serve to increase and foster awareness, but also encourage and support continued efforts on the part of clinicians to maintain good mental and physical health in order to best serve their client populations.

Though active modeling and fostering of opportunities, training programs can create a culture in which self-care is a cultural norm. Facilities such as the VA would benefit Veterans and clinicians by also creating and atmosphere in which clinician self-care is an active component of clinical work and the professional culture. If leaders, supervisors, clinicians, trainees, and support staff alike are regularly involved in self-care, the expectation and modeling of such values will likely be instilled at both the provider and system levels, thereby creating a climate where it is actively and consistently practiced.

Counseling psychology endorses a strengths-based view of mental health. Through that worldview, the findings of the current study serve to foster individually based, adaptive, and healthy self-care habits. Armed with the understanding that their clinical work has the potential to both positively and negatively affect them, counseling psychologists who work with combat Veterans in the VA can use their skills as clinicians not only to better serve their clients directly, but also indirectly by serving themselves. Established therapists in this population unanimously endorse the need for good self-care. They understand that individual clinicians need to find self-care habits that work specifically for each person and accept that there is no one-size-fits-all approach to self-care. As long as the methods are safe, healthy, and effective, they are good and should be used.

Conclusion

The current study sought to provide understanding of the impact of facilitating trauma therapy to combat veterans diagnosed with PTSD on clinicians working within the VA. The main finding of the current study indicates that trauma therapy with combat Veterans results in a bi-directional impact that requires constant monitoring, self-awareness, and self-reflection. Findings support previous research by highlighting the impact therapy has on the clinician providing it. The impact of facilitating trauma therapy or working with traumatized populations is not wholly positive or negative, but often both. The current study suggests that what clinicians serving this population do in response to hearing trauma narratives that is of key importance. Successful coping strategies and self-care behavior protect against the negative effects of repeated exposure to traumatic material and traumatized clients.

APPENDIX

INTERVIEW PROTOCOL

[After verbal consent is obtained by the participant]

Thank you for agreeing to be part of this study. This interview is about how therapists working with combat veterans are affected by their clinical work. If at any point my questions are unclear, please feel free to ask for clarification.

I am going to begin with a few general questions.

Demographics:

1. What is your age?
2. How would you describe your ethnicity?
3. How do you categorize/characterize your gender?
4. What is your level of education?
5. Did you ever serve in the military? If so, which branch and what was your rank? Dates of enlistment? Type of discharge? Ever in combat?
6. How long have you worked at the VA?
7. What percentage of your caseload includes combat veterans? OIF/OEF Veterans? PTSD diagnoses?
8. Who do you include in your primary support system at this time? Please describe each person's relationship to you.

Impact of Clinical Work with Combat Veterans

1. How would you describe your approach to trauma work with combat veterans?
2. What impact, if any, has your trauma work had on you professionally? Personally?
3. Describe how you feel after a session with a trauma client.

   a. Any noticeable/memorable thoughts? Emotions? Physical feelings?
   b. How do you typically process your trauma work?
4. What role, if any, does empathy play in your (trauma) work with combat veterans? How would you describe your empathic engagement with trauma clients?
5. Can you think of any clients that were particularly difficult to work with or had particularly difficult trauma narratives to hear? How did you deal with those clients/sessions?
6. Have you ever felt negatively affected by your clinical work with combat veterans/trauma clients? How did/do you address it?
7. Have you experienced trauma in your own life?
   a. Perceived impact on your clinical work?
8. What are your thoughts on trauma work and its (potential) impact on therapists in general?
9. What do you know about the concepts of vicarious trauma? Secondary traumatic stress?
   a. Any ideas on how these issues arise?
   b. Any advice for other therapists?

TABLE A1
Demographics

Pseudonym	Gender	% Combat Veterans	% OIF/OEF	% PTSD Diagnosis
1. Ruth	Female	85%	70%	90%
2. Paul	Male	90%	50%	100%
3. Bonnie	Female	90%	20%	80%
4. George	Male	60%	10%	60%
5. Lisa	Female	33%	“most”	100%
6. Brian	Male	70%	33-50%	85%
7. Alice	Female	70%	50%	60%

TABLE A2
Domains, Categories, Frequencies, and Illustrative Core Ideas

Domain/category	Illustrative core ideas	Frequency
1) Social Support a) All participants have an identifiable social support system.	Friends, family, and coworkers	General
2) Treatment a) Client factors influence therapist's approach to treatment.	Avoidance, superficiality, availability for treatment	Typical
b) Therapists develop a theoretical approach to facilitating therapy.	PE, Mindfulness, IFS, CB/CP, collaborative approach	General
3) Impact on Therapist a) The perceived effects of trauma work on therapists are mixed.	Startled response, awareness, distracted, angry, drained, emotional v. rewarding work, gratitude, motivated	General
b) Therapist factors influence their trauma work	Personal trauma history, sexual identity, understanding	Typical
c) Therapists have ethical responsibilities to their clients when facilitating trauma therapy.	Impairment, self-care, self-awareness	Typical
d) Therapists develop strategies to stay/remain effective.	Perspective taking, diversify work load, self-monitoring	Typical
4) Self-Care a) Trauma therapists encourage the use of self-care.	Develop support system, therapy	Typical
b) Self-care is individualized.	Consultation, self-awareness, meditation, hobbies, work-life balance	General

5) Empathy a) Empathy is essential for trauma work.	Promotes understanding, compassion, productivity in therapy	Typical
6) Challenges a) Trauma therapists experience a variety of challenges in their clinical work.	Details of trauma narratives, feeling ineffective as a therapist, client perception of competence	General
7) Knowledge of Concepts a) VT is not universally understood.	Developing from empathy v. one's own trauma history, being affected by clinical work v. being traumatized	General

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