

Institute for Clinical Social Work

Exploring Countertransference of Therapists Providing Treatment to Perpetrators of War
Atrocities

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By

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Abstract

The task of providing therapy to some of America's most heroic combat Veterans can be both rewarding and daunting. Addressing the physical and emotional wounds of war takes a dedication that most clinical social workers accept with pride. However, working with our nation's heroes who disclose being perpetrators of war atrocities can prove a more difficult task.

This qualitative research study shed light on the experience of countertransference as experienced by therapists whose patients have disclosed committing a war atrocity. In an attempt to understand and explain these reactions, a comprehensive literature review was presented within the perspective of relational theory. The relationship between the reported countertransference reactions and the treatment was then highlighted. This research suggested steps for improving the difficult task of providing therapy with this population and also providing useful support to those who work with these challenging patients. Ultimately, this research drew attention to how those reactions encourage and hinder treatment. The findings that emerge from this research suggest that there are commonly strong negative reactions to patients, hidden feelings of disconnection with those patients, and a deep therapist hunger to engage in sensationalism of patient's disclosures. This dissertation concludes by proposing recommendations that would promote healthy use of countertransference reactions within social work practice.

For Mychal, Kylin and Kendall

One cannot think of a better gift to give someone than your understanding, for with it comes acceptance and harmony. The sage accepts others as they are, and patiently assists and shares in their growth.

~ Lao Tzu

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List of Abbreviations

AVASW	Association of Veterans Administration Social Workers
CBT	Cognitive Behavioral Therapy
DARE	Drug Abuse Resistance Education
EMDR	Eye Movement Desensitization Reprocessing
ICSW	The Institute for Clinical Social Work
IPA	Interpretative Phenomenological Analysis
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OND	Operation New Dawn
PE	Prolonged Exposure
VA	Veteran's Administration

Chapter I

Introduction

General Statement of Purpose

The purpose of this phenomenological study was to understand the countertransference reactions of social workers who hear disclosures of war atrocities within the therapy room. During this initial stage in the research, the countertransference reactions to the disclosures were generally defined as the personal inner experience of the therapist and how that experience affected therapeutic treatment with combat veterans in the United States.

Motivation for Research

On a cold day in December, I sat across from my patient. He was an older African American gentleman in his 70s who had been married since he returned from Vietnam 40 years ago. He had retired from a good job and was in top health. He was a normal grandfather and community member. However, as he sat across from me, he said something that prompted my quest for understanding. He started his story with, "I am ashamed, but I know what it's like to own a slave."

While I sat with him, he disclosed that while in Vietnam, he had, like most GIs, participated in the booming sex trade. Barry (1995) recounted that buying women's

bodies, especially those of ethnic women, was sometimes a fascination for GIs. As my patient wrung his hands, he disclosed that he was given the opportunity to “buy” a prostitute for an entire year for the equivalent of 50 U.S. dollars. This would secure the girl for the GI and exclude her from selling herself to any other servicemen. This arrangement lasted for up to a year, during which time she would be at his beck and call. If the girl ran away during this year, the GI could pay 35 dollars to have her brother or another family member retrieve her. If that were not enough, the GI could pay an extra 20 dollars to have the woman killed, and a trinket of hers returned to him afterward. My patient reported that his girl had indeed ran away, but he chose not to pay the extra money to retrieve her.

This Veteran and I worked together for more than a year. Several times, we touched back on this subject, but it was far from fully processed by the time we ended.

Social work practice was born out of the need to help and empower those who are marginalized. Over the last century, social workers have been educated to advocate for the oppressed, and help them become healthy enough to thrive and eventually advocate for themselves (www.vasocialworkers.org). The experiences of perpetrators of war atrocities are often held in secret due to the reactions of others (Stapleton, 2007). If clinical social workers are to help eliminate this barrier in therapy with our Veterans, exploration into the conscious and unconscious reactions of social workers to these patients will be necessary to help further informed work. The ethical guidelines laid out by NASW (www.nasw.org) state:

Social workers should be alert to and avoid conflicts of interest that interfere with the

exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

Most social workers agree that it is unacceptable to discriminate against a potential client due to race, gender, age, or other demographics. But when discussing working with Veteran perpetrators, it may be less acknowledged that countertransference reactions, if left unexamined, may lead to conflicts of interest and bias, and could result in jeopardizing a patient's care (www.nasw.org). This study will help identify the process by which this phenomenon comes about.

The Veterans Administration (VA) employs more than 9,000 social workers nationwide. As such, a large number of clinical social workers provide services to our wartime Veterans ("NASW Center for Workforce Studies," 2011). There is therefore a high likelihood that a clinical social worker will encounter Veterans who have committed or been party to war atrocities. While this study informs practice for these social workers, it also highlights areas that need strengthening, such as training, consultation, and support for those workers. Lastly, this study contributes to the practice by highlighting the voices of clinicians. It will serve as a starting point for further exploration into tangential, unstudied areas of practice, thereby increasing the robust knowledge base of the practice.

Statement of the Problem

An estimated 1.7 million service members will return from conflicts in Iraq and Afghanistan. Of these, an estimated 18.5% will return with symptoms that may need clinical intervention (Burnam, Meredith, Tanielian, & Jaycox, 2009). Previous wars produced large numbers as well. World War II utilized 16 million American men and women, while Korea had 5.7 million Americans, Vietnam had 2.7 million, and during the Gulf War period, 650,000 servicemen and women protected our country. Since the military's birth, approximately 42 million Veterans have served in combat since the American Revolution (www.va.gov). In a culture with a strong belief in actively defending the country and protecting others, it is likely that the number of war Veterans will continue to increase.

As long as war has existed, so too have war abuses. Therefore, it is highly likely that a clinical social worker tasked to practice therapy with Veterans will encounter those who have been involved in these crimes. It is also likely that treating these patients could evoke a number of reactions in the social worker. Given that these crimes are often brutal, it is not uncommon for the social worker to have competing visions of the Veteran patient as hero and perpetrator. This may lead to negative countertransference (Brownmiller, 1975; Davies, 2004; Fenell & Weinhold, 2003).

Most social workers are fully aware that unprocessed or unrecognized countertransference can be detrimental to therapy and can profoundly affect the Veteran's therapeutic growth. Interviews with these social workers details the actual experiences in

sessions, and possibly highlights how these countertransference reactions either positively or negatively affect therapy.

Carl Rogers (1957) posited that unlike any other profession, social workers are able to create relationships that allow patients to feel safe expressing their feelings and attitudes. Clients can express themselves without feelings of guilt or shame, and without worrying that they will not be received with warmth and understanding (Rogers, 1957). Building a safe place for patients to grow and explore their beliefs is sometimes rewarded by the patient growing in their self-exploration, in and out of sessions. This linchpin of the relationship is the formation of a bond that allows patients to speak openly, honestly, and directly about concerns they might not be able to express to anyone else.

Research has shown that the relationship a client builds with a counselor provides the greatest possibility for change in a patient (Rogers, 1957). However, sometimes the material that the patient shares may bear a strong resemblance to the social worker's own experience, history, or morals. Most social workers understand that personal dynamics of this kind are unavoidable.

Countertransference is the term often used to describe reactions within the clinical setting that counselors may experience based on their own issues (Rogers, 1957; Davies, 2004). As such, it is important for a social worker to pay attention to these reactions, as they have the potential to hinder the relationship, and ultimately, the patient's healing process. Social workers who avoid specific topics run the risk of isolating or shaming their patients. Avoiding clients' issues may lead to patients believing that their behavior is deviant or wrong, which in turn can then lead to an irreparable rupture in the patient-

counselor relationship. There is a need for openness on the social worker's part, and it is imperative that clinicians who treat wartime Veterans be particularly aware of the likelihood of revelations of trauma.

Specific Objectives to be Achieved

Since this is the first study looking at the countertransference of social workers and Veteran perpetrators of war atrocities, its purpose was explorative. The overall objective was to bring awareness of the phenomenon and guide future research. Individual objectives included the following:

1. To describe the phenomenon of social worker countertransference reactions to Veteran perpetrators through interviews with these social workers . . .
2. To explore how the countertransference reaction, whatever that may be, is perceived to affect therapy . . .
3. To discover emerging themes, commonalities, and trends via data analysis, with the expectation that the social worker will have a similar reaction to that of working with non-Veteran perpetrators . . .
4. To help explain data findings and apply knowledge, thereby providing explanations and informing treatment . . .
5. To lay groundwork for further research in this understudied topic . . .

Questions to be Explored

The primary question for this paper is, “What is the nature of social worker’s countertransference reactions to combat Veterans who reveal perpetration of war atrocities?” Although this is the main research question, other questions will help demonstrate a richer answer to the research topic.

The varieties of war atrocities are limitless. Generally, war atrocities are defined as follows:

1. Murder . . .
2. Genocide . . .
3. Enslavement . . .
4. Torture . . .
5. Rape . . .
6. Persecutions on political, racial, and religious grounds . . .

Crimes committed during wartime, for this research, are defined as the following actions:

1. Driving under the influence . . .
2. Arson . . .
3. Drug charges . . .
4. Robbery . . .
5. Human trafficking . . .
6. Persecutions on political, racial and religious grounds

From this, the questions to be explored include:

1. Do the above align with your understanding?
2. There are various understandings of countertransference reactions. For the purpose of this research, such reactions are understood as conscious or unconscious reactions to patients in therapy. Does this align with your understanding?
3. Please recall a situation in which a Veteran disclosed being a perpetrator of a war atrocity.
4. What was it about this particular disclosure that caused you to have a difficult-to-define reaction?
5. What physical or emotional responses did you exhibit?
6. Can you describe how you first noticed this reaction?
7. Thinking of your countertransference reaction, can you speak to what you believe was the purpose of your response?
8. How do you believe those reactions impacted your patient?
9. How do you believe those reactions affected you?
10. Thinking of this particular example, how do you believe you may have used your countertransference reaction within the treatment room?
11. Can you speak to how ultimately your reaction impacted your relationship within the working alliance? Can you expand on that?

Operational Definitions of Major Concepts

Therapist.

The clinicians interviewed in this study were a diverse group. All held at least a master's degree in clinical social work, and they all practice in a clinical setting with Veterans. The VA defines a clinical social worker as a "professional having the ability to provide counseling and psychotherapy to individuals, groups and families" (www.usajobs.gov). This study only included social workers who actively worked with Veterans. To keep the data relevant to locality, I limited participants to those who practice in the United States.

Countertransference.

As described previously, this study identified countertransference as conscious or unconscious reactions to patients in therapy. These reactions derived from various aspects of the social worker's current and previous experience, not just those projected from the patient or co-created in session.

Combat Veteran.

The VA generally defines a combat Veteran as an individual who served in the active military forces, during a period of armed conflict (www.va.gov).

War crimes / atrocities.

According to Walzer (2000, p.42), “War is distinguishable from murder and massacre only when restrictions are established on the reach of battle.” As the definition of war atrocities is not clearly established, and some perpetrators whom social workers treat will not have been convicted or even accused of war crimes, this paper uses the terms “war crimes” and “atrocities” interchangeably. This is by no means exhaustive of the literature on war crimes but served the purpose for this paper. *Law of War Handbook*

(www.defense.gov) defines war crimes as follows:

Willful killing; Torture or inhuman treatment; Biological experiments; Willfully causing great suffering or serious injury to body or health; Compelling a prisoner of war to serve in the armed forces of his enemy; Willfully depriving a prisoner of war of his rights to a fair and regular trial; Maltreatment of dead bodies; Firing on localities which are undefended and without military significance; Use of civilian clothing by troops to conceal their military character during battle; Poisoning of wells or streams; Pillage or purposeless destruction; Compelling prisoners of war or civilians to perform prohibited labor; Killing without trial spies or other persons who have committed hostile acts; Violation of surrender terms. (Library of Congress; Military Legal Resources, 2005, pp. 208-209)

Included in this definition are other crimes equally as damaging to the image of the military, such as driving under the influence, arson, drug charges, robbery, and human trafficking.

Statement of Assumptions

Clinical experience and theoretical research led to a number of assumptions that impacted my interview process and data analysis for this study. Those assumptions were as follows:

1. The participants were motivated to share their experiences freely . . .
2. During the interview, the subject and interviewer might have been influenced by transference and countertransference reactions . . .
3. The participants might have encountered uncomfortable feelings or emotions that may be unearthed during the interview process . . .
4. The participants reported both negative and positive countertransference reactions in their practice with Veteran perpetrators . . .
5. Participants may have known their countertransference reactions consciously but may also not have been able to identify their reactions. This may have been coerced out in the interview process . . .
6. “Countertransference” is a word that had many meanings and was different for each subject . . .
7. Understanding one’s countertransference was important for effective therapy with Veteran perpetrator patients . . .
8. Gaps in education and experience may have contributed to negative countertransference reactions . . .
9. Participants may have been hesitant to discuss their countertransference reactions based on their theoretical standpoints or perceived moral values . . .

Chapter II

Literature Review

This study described the phenomenon of countertransference within the therapy room with Veterans who disclose their involvement in war atrocities with social workers. As this is a burgeoning topic within the field of social work, this study primarily intended to expand the understanding among social workers of countertransference reactions toward this Veteran population. This review references literature on violence, risk factors for perpetration, Veteran aggression, and countertransference through a relational-theory conceptualization. This conceptualization will lay the foundation of this exceptionally dynamic and underexplored topic.

The United States of America's military has a rich history. According to the Department of Defense (n.d.), in 1775, the Army, Navy, and Marine Corps were established as a result of the American Revolution. In the Journal of Congressional Record (1775), it was written that six companies of riflemen were to be developed and situated in several different states. Hence the birth of the United States soldier began with this oath:

I have, this day, voluntarily enlisted myself, as a soldier, in the American continental army, for one year, unless sooner discharged: And I do bind myself to conform, in all instances, to such rules and regulations, as are, or shall be, established for the government of the Army (Journal of Congressional Record, 1775).

Like other organized groups, servicemen and women are heterogeneous. Similarly, their reasons for joining the military, and their tasks while enlisted, vary greatly. For example, there is a clear distinction between a person who is drafted versus a person who volunteers for service, or similarly, one who joins for the idea of patriotism versus those who were coerced into the military as an alternative to punishment or imprisonment. There are also within-group differences among Veterans who share the same military culture. For example, there are clear distinctions among Veterans who served in combat and those who served in non-combat zones or during peacetime. Regardless of the reason for joining, it is stated that the contemporary United States has created the largest sustained ground-military operation since Vietnam (Hoge, Auchterlonie, & Milliken, 2006).

Part of the heterogeneity among Veterans relates to the categories with which members of this group identify themselves (Wertsch, 1991). Veterans may distinguish themselves by the branches of service they were in; their subgroups, such as where they completed basic training; their unit; the schools they have graduated from; or the job that they were assigned to. Scholars, politicians, and mainstream culture may refer to Veterans as former military personnel, heroes, soldiers, and so on. Veterans can also vary in their makeup. They can be men or women, old or young, educated or uneducated, and of all different ethnicities nationalities. This diversity was not always characteristic of Veterans, but has developed during the past 50 years (Haigh, Pfau, Fiferick, & Holl, (2006).

There is a continuous cultural debate on what a Veteran is, however. By statute, a Veteran is defined as a “person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable” (Scott, 2012, p. 4).

Basic training is an initial process of indoctrination and instruction, mandated for new recruits to help them adapt to their new environment. Similar to a foreigner acculturating to the U.S., recruits are taught a new language of acronyms, hierarchies, adopted values, beliefs, and customs of this new culture (Volkin, 2007). For some, when the acculturation process hitches or misaligns, adjustments in mental-health status are warranted.

Hall (2008) stated, “As counselors, we must first become aware of our own boundaries, biases and prejudices regarding the clientele we serve and then discover the unique issues, concerns and strengths that they bring into our counseling office” (p. 71). As this research study does, Hall challenged social workers to question a great many things, including:

1. Internalized perceptions . . .
2. Personal experiences with the military . . .
3. Political views . . .
4. Understanding of the concepts of honor, heroism, and loyalty . . .
5. Feelings on working with people who have willingly caused harm to others.

The United States is a warring country, and therefore social workers should recognize that service members make a commitment to not only their country and other servicemen, but also to make the world a safer place (Fenell & Weinhold, 2003).

Our Violent World

Since its inception, the armed forces have struggled to protect our country from threats of violence. As such, the current soldier's oath is to "protect the United States against enemies, foreign and domestic" (<http://www.history.army.mil>). To the lay person, the word "violence" might invoke physical altercations, verbal aggression, and possible emotional damage intended to destroy the ego of a person. The WHO defined violence as:

The intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. (The World Health Organization, 2002, p. 5)

The WHO carefully and purposely crafted their definitions to include guidelines of both physical force and power within a given situation. For example, psychological abuse that does not directly result in physical disability can nonetheless constitute an intentional use of maltreatment. Likewise, the WHO also categorized its definition of violence into three major categories: "self-directed harm; interpersonal violence; and collective violence" (WHO, 2002, p. 6). It is worth noting that the WHO specifically names armed conflict and genocide as correlations to violence. Troops engaging in stateside combat are recognized as utilizing collective violence with many differing motives such as pride in their country, exploitation of the country's resources, or violence used to maintain a balance of control and power (p.7).

Further, when defining crime, we must separate violent crime from nonviolent crimes. In 2012, the FBI's Uniform Crime Reporting Program compiled statistics for the almost 10,000 law enforcement agencies in the United States. These statistics include 28 defined offenses, subcategorized first into themes, and then again into violent and nonviolent arrests. Nonviolent crimes included forgery, gambling, weapon carrying, driving under the influence, arson, and drug violations. Violent crimes—crimes that involve force or threat of force—included murder, manslaughter, rape, human trafficking, and robbery (Federal Bureau of Investigation, 2012).

To briefly highlight some of the crime statistics compiled for this report, from 2003 until 2013 there were more than 12 million arrests. Drug-related arrests and those pertaining to driving while using intoxicants ranked highest. The majority of arrestees were male. Of those, 69% were white, 28% were black, and 3% involved other races. Of violent crimes, 1.2 million had been committed since 2003, and the largest percentage of those were aggravated assaults, followed by robbery, rape, and lastly murder (Federal Bureau of Investigation, 2012).

Risk Factors for Perpetration

Numerous layered factors influence a person's likelihood to participate in violence or to commit crimes. It is difficult to find a succinct, definitive, causal relationship between predisposing factors and perpetration. However, several studies have attempted to narrow these indicators. One large United Nations study explored factors associated with male perpetration of physical and sexual partner violence. Although this only gives a slight

view on a small part of communal violence, the worldwide study's comprehensive data is useful in highlighting predisposing trends. From this nationwide study, Fulu, Warner, Miedema, Jewks, Roselli, and Lang (2013) found that men were predisposed to partner violence given the presence of certain classic disparities, including "depression, financial or work related stress, low levels of education and childhood experiences of violence" (p. 69). However, the rape of women who were not partners of the men (essentially strangers) bore a strong association to the men having multiple sex partners, beliefs of gender inequality, and utilization of the local sex trade. Likewise, men who engaged in other violent crimes (e.g., fights and weapon use) were more likely to be perpetrators of rape to both female and male counterparts (p. 78).

Social workers may encounter Veterans who engaged in or are perpetrators of atrocities. Because of this, it is important for social workers to be aware that certain common factors are strongly and consistently linked to violence perpetration, including mood instability, atypical sexual behavior, troubled childhoods, aggression, and disregard for gender equality. Of the men surveyed for the United Nations study, 10% to 62% (based on country) reported raping a girl or woman, with more than half of the rapes committed before the perpetrators were of the age of 20 (p. 80).

The current prevalence of nationwide violence and crimes is staggering. Issues of lawlessness are so prevalent that national conventions have been convened, research has been funded, and law enforcement agencies have been created to help curb our society's fascination with cruelties. War is sometimes seen as a necessary evil, with a tenuous line between barbarity and legitimate disputes. As such, virtually every nation has placed

rules and regulations on the conduct of its soldiers during battle. In the fifth century, Sun Tzu suggested in *The Art of War* that although war was necessary, rules of engagement were also required. He warned soldiers to “treat prisoners of war well and care for them All soldiers taken must be cared for with magnanimity and sincerity” (Tzu, 1994, p. 173). Plato previously extended this idea to striving for a friendly correction of the enemy, versus total destruction, during war (Plato & Bryan, 1898).

Geneva Convention articles addressing the protocols for armed combat first date to 1864. However, the best-known versions of these articles are actually revisions, resulting from the disclosure of horrific war crimes during the Nuremburg trials (Tusa & Tusa, 2010). The Nuremburg trials prosecuted Nazi perpetrators who participated in mass execution of Jewish citizens, inhuman scientific studies, and other crimes against humanity. The trials attempted to give some structure to what is acceptable within combat, and to punish those who cross the line and commit atrocities. Even our former President Jimmy Carter (2002) addressed how war breaks down people and makes them more inclined to perpetrate crime:

In order for us human beings to commit ourselves personally to the inhumanity of war, we find it necessary first to dehumanize our opponents, which is in itself a violation of the beliefs of all religions. Once we characterize our adversaries as beyond the scope of God's mercy and grace, their lives lose all value. We deny personal responsibility when we plant landmines and, days or years later, a stranger to us—often a child—is crippled or killed. From a great distance, we launch bombs or missiles with almost total impunity, and never want to know the number or identity of

the victims (J. Carter, Nobel Lecture, December 10, 2002).

War Crimes and Atrocities

War and violence are often intertwined in a relationship that includes the idea of survival, aggression, pride, and sacrifice. When soldiers talk about their experiences of war, they may discuss topics like the loss of a friend, personal injuries, times where it was either “me or the other guy,” or memories of times they enjoyed with friends with whom they lost contact after returning stateside. However, Veteran perpetrators may also talk about experiences including willing participation in torture, the sex trade, drug smuggling, embezzlement, kidnapping, or dehumanization—thereby adding a complicated layer to the treatment environment for therapists.

To continue the path of violence and war, anthropologist Philippe Bourgois (2001) gave an ethnographic account of his experiences in post-war El Salvador. In his findings, he created stunning pictures of violence in the country during the year 1980. He illuminated stories of interpersonal violent acts such as the death of hundreds of community members every month at the hands of death squads and the Salvadorian military. Bourgois retold stories of soldiers destroying crops and livestock and torturing commoners.

In one instance, Bourgois ran for his life alongside the peasants he lived among, fleeing for two weeks until finding safety. One of the most chilling accounts involves his experience with infanticide. When hiding from government troops with others in a cave, Bourgois witnessed a mother suffocate her two wailing babies so that she and her

companions would not be found by the soldiers. As an embedded anthropologist, Bourgois attempted to experience culture in as pure a form as possible. It is likely that he may continue to carry visions of the deeply disturbing images he witnessed.

Many Veterans have been on both sides of Bourgois' experiences. Sometimes they are the powerful troops. Other times they are the people hiding in the thickets, hoping to stay alive another day. That type of violence, and constant victim / victimized role reversal, informs how social workers view Veterans as either aggressors or victims. As the Veteran tells war-related stories, conflicting feelings of identification, sorrow, and revelation may be introduced into the room.

War is violent, tumultuous, and mentally injurious. As discussed, the laws during combat differ from those concerning civilian altercations and crimes. Heinemann's (1986) fictional book *Paco's Story* gave insight on a Vietnam Veteran named Paco who, after witnessing the gang rape and execution of a teenage peasant girl, states, "We looked at her and we looked at ourselves, drawing breath again and again, and knew that this was the moment of evil, that we would never live the same" (p. 184). Although this is a fictional tale, stories like it are not uncommon in the offices of clinical social workers working with combat Veterans. Many social workers counsel on PTSD related to Veterans' experiences with combat, losing buddies, or of being forced to kill. However, while Veterans might bring experiences of war atrocities into their sessions, these experiences often go undiscussed. Combat PTSD can be a shroud that deflects a more shame-filled experience. Oftentimes a social worker is first to earn the trust of having the Veteran disclose their perpetrations.

War atrocities have existed as long as war itself. As such, it is important to provide short, salient depictions of war atrocities that have transpired throughout the history of war. Brownmiller (1975) observed that war, rape, pillage, and plunder occur frequently throughout military history. Brownmiller stated that when Constantinople fell in 1204, the spoils of war included taking women along with land.

During the Vietnam War, the Mỹ Lai massacre became notorious for its vicious murder of unarmed civilian men, women, children, and infants. Many of the women were raped and mutilated. One Army officer, Lt. William Calley, made a formal apology 40 years after the incident:

There is not a day that goes by that I do not feel remorse for what happened that day in Mỹ Lai. I feel remorse for the Vietnamese who were killed, for their families, for the American soldiers involved and their families. I am very sorry. (*Seattle Times* staff, 2009, para. 2).

More recently, Sowden and Stewart (2011) presented a paper at an ethics symposium, where they recounted a soldier's chilling account of his platoon killing an innocent Afghan teenager:

Yeah, an innocent dude. They planned and went through with it. I knew about it. Didn't believe they were going to do it. Then it happened. Pretty much the whole platoon knows about it. It's OK with all of them pretty much. Except me—I want to do something about it. The only problem is I don't feel safe here telling anyone. The guy who did it is the golden boy in the company who can never do anything wrong and it's my word against theirs (p. 3).

The soldier who gave his account later experienced two other violent engagements, one of which he directly participated in.

In 2007, decorated U.S. Army Ranger John Needham reported witnessing numerous atrocities committed by his fellow soldiers while serving in Iraq. He reported seeing Iraqi citizens detained, questioned, and killed. In one instance, he witnessed a man die while a soldier peeled the skin off the man's face. Needham alleged the abuse of children as young as 14, and in one gruesome paragraph, he detailed his fellow soldiers being visibly excited about killing a man and pulling his brains out (Duell, 2011). A subsequent investigation found that no war crimes were committed. Needham's own life met a tragic end, when he killed his girlfriend and then overdosed on pain pills.

The Fort Carson Army base in Colorado Springs, Colorado has been plagued by similar disturbing news. The local newspaper, the *Gazette* created a two-part series called "Casualties of War" (2010), examining the soldiers of the Second Battalion, Twelfth Infantry Regiment, who participated in brawls, beatings, rapes, drunk driving, drug deals, domestic violence, shootings, stabbings, kidnapping, and suicides at a rate of 112 times that of local violent crime.

Sowden and Stewart (2011) maintained that egregious acts and ethical violations erode the trust between the military and its client, the American people. Some suggest that servicemen and women commit and bear witness to horrific crimes due to group dynamics and peer pressure. Simply put, if one member of the group engages in appalling behavior, it creates a pseudo-world in which such behavior will be accepted. This has

been discussed by authors to help explain why the rules of war are so vastly different than those of the civilian world (Kish-Gephart, Harrison, & Trevino, 2010).

Others assert that we have focused too much on combat Veterans as victims. In her work on atrocities in Vietnam, Weaver (2006) clearly argued that “American atrocities of the war have used the ‘victimized Veteran’ to represent the U.S. itself as a victim of Vietnam rather than the aggressor” (p. 5). If this is indeed true, clinicians should focus on helping Veterans deal with this split in how they see themselves. If social workers are the gatekeepers, it is of the utmost importance to understand countertransference reactions to thoughts of combat Veterans as not only victims, but perpetrators.

Countertransference

The idea of countertransference is not new to the study of psychoanalysis. There have been several discussions by psychoanalysts who assert that countertransference, at its basic level, consists of the attitudes or emotional reactions toward a client (Heimann, 1950; Little, 1951; Racker, 1957). This section examines the concept of psychoanalytic countertransference from a relational theory lens, in order to explore how the concept is understood and utilized.

Looking at early drive-theory definitions of countertransference, Freud addresses it briefly in his works. Freud stated that analysts should be aware of the countertransference that arises based on the patient’s unconscious feelings, and that since analysts are indeed human, they can easily let their own emotions influence the patient (Laplanche & Pontalis, 1973). To Freud, countertransference was something to be managed and never

disclosed within therapy. In this case, the wellspring of countertransference in social workers should lead them directly to their own therapy, since they were unable to remain neutral. Laplanche and Pontalis (1973) state, “No psychoanalyst goes further than his own complex and internal resistances permit” (p. 92). It is believed that Freud did not elaborate on the subject because the analyst having a strong countertransference reaction was a form of failure in allowing the patient to free-associate. Some say that Freud spent little attention on the subject because he feared it would result in less acceptance of the newly emerging science of psychoanalysis (Cooper-White, 2002). Although Freud did not spend an inordinate amount of time exploring the concept of the social worker’s countertransference reactions, it has been addressed in contemporary literature.

Relational Theory

Many have attributed a relational turn in psychoanalysis to Stephen A. Mitchell and his seminal works (Aron, 1996, 2003; 2002; Benjamin, 1988, 1990, 1995; Mitchell 1988). When developing his theory, Mitchell integrated aspects from several other developmental theories and created a richer, more inclusive model of the interaction between social worker and patient within the treatment room. In describing his relational matrix, Mitchell (1988) touched on the relevant concepts of theorists like Freud, Bowlby, Sullivan, Fairbairn, Klein, and Winnicott. Although Mitchell (1988) had very clear ideas about how his theory differs from others, he amassed the theory’s strength by highlighting the integration of previous classical theorists.

In a chapter titled, “Clinical Implications of the Developmental Tilt and Penelope’s Loom,” Mitchell (1988) skillfully summarized many of the above theorists’ concepts to compare how they relate differently to the relational system with the patient. To draw attention to a few, Mitchell suggested that within Freud’s theory, the analyzed and the analyst are in a system that replicates “stuck” points from developmental conflicts in infancy. Comparatively, Mitchell (1988) charged that Fairbairn’s theory might say that the interaction between the patient and social worker is a recreating of the social worker working to be the “good object.” However, Mitchell (1988) elucidated that the relational system is both part of the past (remediating historical deficits) and also about utilizing the here-and-now relationship to help address interpersonal difficulties as an adult.

Mitchell (1988) asserted that theories such as self-psychology and object relations are more indicative of a developmental-arrest model, which adds aspects of relational connectedness while staying linked to drive theory. The relational-conflict model represents melding elements of the theories mentioned above with a seriously different premise, namely that disturbances in early bonds influence subsequent relationships, and the child builds an interpersonal world with the bricks of those earlier experiences. Analysis, in this theory, functions as a moment-by-moment transactional mechanism used to rework the patient’s troubling family attachments, loyalties, and subjective culture within the current relational model (Mitchell, 1988).

This theory tasks clinicians to challenge how they hypothesize the presentation of a patient and how things are enacted in the office. In relational theory, clinicians do not locate the patient’s difficulty in their “infantile failures.” They see them as adult

expressions of needs. Likewise, the expression of desire is a type of success within the therapy in and of itself (Mitchell, 1988).

Working with Veteran perpetrators is often best explained in relational terms. Some Veterans admittedly joined the military to flee dysfunctional homes or behavior or, on the opposite end, to participate in the violent heroism of protecting one's country. Either way, when a Veteran perpetrator enters treatment, most often the issues are related to interpersonal complexities (in youth, adulthood, or both), intrapsychic difficulties, and a range of trauma reactions that damage past coping mechanisms and change the landscape of current coping. Utilizing a relational theoretical perspective when working with Veterans allows past fears of connection (due to shame, fear, and guilt) to unfold in the healing process. Sitting with a Veteran perpetrator involves both the Veteran's current and past experiences, as well as the social worker's fears, beliefs, and reactions. Relational theory gives way to accomplishing and illuminating these aspects to facilitate growth (Mitchell, 1988).

Relational theory and countertransference.

As discussed previously, the most basic unit of focus in relational theory is the relationship. Whether the relationship between the patient and others, or the patient within the treatment room, the relationship is most often the vehicle of therapeutic action. Likewise, relational practitioners may look at the interpersonal effectiveness of patients and their coping strategies. This two-person model differs from most others that preceded in the anchored belief of using a relational environment as an experiential learning tool.

In this dynamic, the medium of the relationship is utilized to help identify historical enactments and to provide an interactive platform for identifying these patterns.

Relational formation examines how each person within the dyad, social worker and patient, co-create their environment and influence each other both consciously and unconsciously. In some previous theories, countertransference was seen as a hindrance to free thought, but in this perspective, the importance of analyst subjectivity is highlighted (Benjamin, 1988).

Whereas transference in this milieu examines the patient's patterns of relating to the social worker (based on their interactions, expectations, and coping throughout their lives), countertransference is not simply the reaction that the social worker has to these archaic psychic structures. Rather, countertransference is a fluid exchange of action-reaction between the patient and social worker. Internal and external psychic growth results from the integration of this therapeutic apparatus while also preserving the patient's idea of autonomous self. These enactments are difficult for both the social worker and patient to explore, but they are the lynchpins in negotiating therapeutic impasses, representations, and reactions within the dance of therapy. These enactments in turn help to reconstruct past structures of interpersonal functioning (Aron, 2003).

Aron (1991) revealed another layer of the patient and social-worker matrix that went underexplored in many past theories. Aron posited that within the treatment dyad, "patients seek to connect to their analyst . . . to probe beneath their professional façade . . . much in the same way that children seek to connect and penetrate their parent's inner world" (p. 29). If this is indeed true, it highlights that the relational theory's take on

countertransference is not only examined for the social worker's reaction, but also a cyclical transactional exchange. Countertransference is seen as a kernel of knowledge to examine within the context of the relational system.

Continuing with the exploration of social-worker subjectivity, previous theories focused on the social worker being an objective, sometimes even a neutral, detached apparatus in the room with little input for fear of interrupting the patient's free thought (Freud, 1923). Within the relational lens, countertransference asks both the social worker and patient to identify each other's subjectivity. Conversely, patients have fantasies of their social worker and their interpretations. Cyclically, social workers have their own fantasies and interpretations of patients and how they may view the social worker. Both of these dynamics glean a picture of the inner workings of the session and how they are integrated for both parties.

As subsequent sections of this dissertation will examine, for a social worker working with a Veteran perpetrator, how failing to address the challenges of relating within session can constrict any progress in linkage based on the probable shame and guilt of the offense. Stated simply, if social workers are unable to look at how they affect patients and how patients affect them, the opportunity to bridge psychic growth for the Veteran might go unrealized.

In his paper, Aron (1991) describes a social worker being the patient's under-recognized "self-object." Aron also raised an important point about the relational view of transference-countertransference. In this two-person bidirectional model, neither the patient nor the social worker is free of biases. The transference that the patient deposits

into the room is equally built on the role of the social worker in the room. Although Benjamin addressed a baby's first attachment (and anxiety), it is apt for a relational view of transference-countertransference. Aron (1991) posited that, "She is also a secure presence to walk away from, a setter of limits, an optimal frustrator and a shockingly real outside otherness. She is an external reality" (p. 24).

Because these are strong roles for any person to play, countertransference reactions cannot be divorced from the analytic process. Many relational theorists have commented on the need for countertransference to be utilized in session because of the subjectivity the social worker carries into the treatment room (Ringstrom, 2010; Bromberg, 1996; Hoffman, 1983). In such instances, countertransference within the room is pivotal because the relationship is didactic and interactional. Each person (the patient and social worker) takes cues from the other and adjusts accordingly. Some of these cues are processed and accessible, and some are unformulated but still present in session. Beebe and Lachmann (2003) quoted a premise that:

This implicit and explicit processing of each other, coupled with outmoded patterns of relating for the patient is the crux of treatment. No moment can be written off as purely the patient's transferences or projections, or as purely the analyst's countertransferences or projective identifications. Furthermore, at every moment there is the potential to organize (or not reorganize) expectations of intimacy, trust, mutuality, repair of disruptions, as well as to disconfirm (or not disconfirm) rigid archaic expectations. Both analyst and patient contribute to this process (p. 9).

Relational theory and aggression.

When a patient walks into the office, an unspoken agreement exists that the space (and its social worker) will be emotionally perceptive, open, and willing to enter the patient's world of reality. It is assumed to be a place of safety. Foxe (2004) called her analytic space the "safety of my hospitality" (p. 244). Social workers are bound by laws that were developed to create a space that will prevent harm to those on the couch. Sometimes, however, the threat of safety comes not only from the humanness of the social worker and their possible "secret delinquencies," as Slochower (2003) called them, but rather from the patient themselves, (p. 452).

Mitchell (1988) encouraged relational thinkers to process clinical data through the lens of the relational matrix and the social theory of the mind. Both the patient's abject world and the world of the social worker intertwine together within the room. As such, the world of the patient (past identifications, repeated enactments, failed and successful journeys) pushes into the room, reckoning for the understanding of the social worker. In turn, those same associations for the social worker burgeon within the dyad. What happens relationally when a patient introduces aggression into the safety of the room?

Although the occurrence of aggressive feelings between the patient and social worker is indeed a relevant topic and one under-addressed in psychoanalytical research, this section of the dissertation is concerned with how one might explain (or extrapolate) the experience of the social worker who continues, week to week, to sit with patients who present perpetration as part of their social matrices.

The romance between humanity and aggression has long been a study of psychoanalytic inquiry (Freud, 1923; Klein, 1932; Kohut, 1971). Working with someone who has a history of cruelty, atrocity, and evil can cause even the most objective social worker to pause. However, for a relational social worker, no separable subjectivity exists. Therapists must endure with the patient's history while also attending to their own reactions. Grand (2008) stated that we cannot shut out the violence brought into analysis nor can successful therapy be achieved without defining the subject of the atrocity (and the patient perpetrator) as it sits, leaden, within the therapy dyad. Sometimes patients will resist talking about their inner worlds due to the fear of enacting previous judgments, biases, and hatred they experienced when previously disclosing to others. Likewise, Grand (2008) suggests social workers must be aware of a "slippage into cruelty" (p. 681) during intense work with these patients.

Foxe (2004) shared a poignant story of what it was like for her (as a woman of German-Jewish descent) to complete a particularly difficult session with her patient of German-Nazi descent. In her case illustration, she discussed her unasked questions, pregnant pauses, feelings of hatred, and enactments of her own childhood interpersonal narratives coming into the room. She described how she both colluded and bore against the patient (and the subsequent treatment), and how by acknowledging barriers between them, a rich therapeutic experience took place. At the apex of the session, she shared her parallel feelings—that she did not want the patient to disclose his history, and in turn he did not want to disclose either—which created a new shared space of openness and also a bit of trepidation. He closed the session by stating, "I hope none of my people ever hurt

any of your people” (p. 284). It would be naïve to believe that all relational therapies would address the patient’s identification with his or her horrific past, but it is a pointed example of how a relational social worker could use self-disclosure as a way to discuss enactments and move through past remembrances to possibly create a new experience.

Relational theory and dissociation.

Traditional views of dissociation, at their most basic, surround patients splitting off a part of themselves that is psychically dangerous, and repressing it into the unconscious in hopes to annihilate its self-destructive possibility. This inevitably results in the psychogenic inability to integrate the self (Freud, 1923; Ferenczi, 1949; McDougall, 1926; Janet, 1930).

Relational theorists have a differing view of dissociative organization. Unlike classical theory, dissociation is seen to be dialectical. Dissociation, in a psychically healthy person, is a normative process in which the tool to suppress feared destructive elements also serves to functionally help the mind shut out over-stimulating aspects of daily life (Bromberg, 1996, 2006). Pathological dissociation often motivates patients to seek treatment and would classically be addressed as a central univariate focus of therapy. Relational theory seeks to understand not only how the patient splits off parts, but also how the patient uses them effectively. To add another dimension, relational theory is also constructed to utilize the therapeutic dyad so to experience an active engagement of both aspects between both the patient and the social worker. In practical terms, a social worker working with a Veteran perpetrator would be aware of the patient’s dissociation of the

possible shame and guilt of wartime acts, but would also acknowledge how splitting off that part has allowed the Veteran to effectively play a normative role in society (such as husband, father, and friend).

The healing process for dissociation, not unlike classical theory, focuses on integration of the fragmented self-states. However, the interpersonal spirit of relational theory guides thought to helping patients, as Bromberg stated, “live a life with both authenticity and self-awareness . . . and with an ongoing dialect between separateness and unity of one’s self states . . . allowing each to function without foreclosing communication and negotiation between them” (Bromberg, 1996, p. 514).

Returning again to the Veteran perpetrator, helping the patient unify both selves without the total negation of the other provides a harrowing yet profound goal. Davies and Frawley (1991) similarly identified that when working with maladaptive dissociative patients, healing comes from helping them work with archaic object meanings through the transference-countertransference paradigm, and in so doing allows patients (who were formally limited by their narrow tools for coping) to rework through other possible configurations within the safety of the therapeutic environment.

Since humans have an ability to be both one and many, dissociative self-states are fluid and ever-changing, dependent on the variant. For a relational social worker, this requires a special set of skills to hone the ability to remain attuned to such changes. If the believed goal of growth is to help the patient widen the ability to think and process past and present interactions, then the patient’s concrete awareness of the social worker is also a focus of attention.

Helping patients rework fragmentations within their multiple self-states requires that social workers also identify their dissociative self-states. Perhaps the social worker is dealing with external variants such as the sip of acrid coffee, or a nagging backache, or internal stimuli such as reactions to the patient's vivid details or the patient's facial expression. Either scenario requires the social worker to both utilize that disconnection within session and also simultaneously hold the reactive flow of interaction in the room—a phenomenon that Foxe (2004) called “dissociation with a secondary gain” (p.239). As such, perhaps the aforementioned scenario leads to the social worker being unattuned. Ringstrom (2010) suggested that analysts may be concerned with their disconnections, curious about where they and their patients disjoined, and may work to be active in taking apart their own subjectivity (such as nonverbal communication as well as direct verbal interpretations that may allay ill feelings about the patient). Davies and Frawley (1991) concluded that a relational stance on dissociated patients requires social workers to pay close attention to their own reactions and unpack this data to be utilized in formulating interpretations within the therapeutic relationship.

Working with our nation's heroes can be both arduous and rewarding. Their therapeutic needs are dynamic and ever-changing as each war brings new experiences to process. Social work has been at the front line of capturing new and creative ways to explain experiences like countertransference, PTSD, violence, and social-worker connections in treatment. Haley (1974) wrote a short article suggesting that social workers working with Vietnam Veterans who disclose atrocities should be keen to their natural responses. Although no study data was produced from this article, it is a great

starting point. There is a great deficit in this area of exploration. Given the rise in suicide rates and burnout with clinicians, this study will have long-lasting effects that not only benefit the patient in symptom reduction, but also the clinician in maintaining healthy, informed treatment.

Chapter III

Study Methodology

The primary objective of this study was to describe the phenomenon of countertransference for clinicians providing therapy to Veteran perpetrators. Since this was the first study looking at the countertransference of social workers to Veteran perpetrators, its purpose was explorative. Through analysis, this study aimed to identify the specific themes as they emerged in the data, as well as the commonalities in treatment and trends identified among clinicians. Given that this is an understudied topic, another goal was to lay the groundwork for further research. The overarching objective was to describe this experience of countertransference in order to understand it and bring awareness to this phenomenon, providing a guide for future research.

Due to the limits of this study, the clinician's ultimate treatment plan with the patient was not the primary focus. Additionally, identifying the progress of countertransference reactions over time was not part of this study. This study was limited to a series of interviews and did not assess the longevity of countertransference. Not intended to be exhaustively comprehensive, this study sought to illuminate the countertransference phenomenon and possibly lay the groundwork for future studies.

Qualitative research intends to find explanations of social phenomenon. It may seek to understand why a person behaves a certain way or what a person feels during a certain event. It seeks to describe social trends as they occur naturally and to understand a situation holistically (Corbin & Strauss, 2008; Creswell, 2007). Data collection is usually time-consuming and in the case of this study, it included verbal interviews meant to glean, from a specific population, information about how they experience Veterans who are perpetrators.

Creswell and Miller discussed that several accepted research methodologies guide social-science researchers: phenomenological, ethnographical, grounded theory, and case study. This study looked more toward internal experience, and more inductively examined the language, personal stance, and subjective experience of the participant (Creswell & Miller, 1997). As such, an interpretative qualitative research method was the best fit for this study. It has often been stated that qualitative research fails to produce generalizable data because samples are often small and not randomized. However, in cases with few participants or a more narrowed experience, generalizability to a wider population is not the aim (Creswell & Miller, 1997).

According to Merriam-Webster.com (2013), “phenomenology” literally means “the study of phenomena.” In a phenomenological design, the researcher works to explain something that happens or exists in the world that is experienced but not fully understood. For this particular study, two research methods were applicable—phenomenological and grounded theory—to elicit rich data concerning the experiences of

counselors within the therapy office. However, certain differences in these two theories helped this researcher determine which method best lent itself to this study.

Grounded theory hopes to gather the participant's observations about a phenomenon while creating new knowledge and, out of occurring themes, develop a subsequent theory. In this type of research, the goal is to study how the social process of one thing (e.g., working with a dying patient) happens in the context of another (e.g., the stages of a grieving process) (Walker & Myrick, 2006; Corbin & Strauss, 1990; Glaser, 1992). A grounded-theory lens has the goal of soliciting feedback of the experience, examining trends, and attempting to create a theory from these observations.

Interpretative Phenomenological Analysis (IPA) was introduced in 1996 and is an inductive approach fairly new to psychology research. Like both grounded theory and phenomenological theory, IPA strives to identify the participant's experience. However, IPA is most concerned with the meanings which those experiences hold for the participants. It explores the individual's personal perception or account of an event. As such, exploration depends on the researcher's conception of how to make sense of that participant's experience, and this exploration is often referred to as an interpretative activity (Smith, 1996). IPA combines parts of phenomenology, hermeneutics, and ideography.

In essence, within IPA the researcher works to decode the participant's experience and participants in turn attempt to decode their own experiences. Smith (2011) termed this interactional dynamic as "engaging in a double hermeneutic" (p. 10). IPA strives to explore the lived experience of participants, seeing them as the experts in their

understanding, and aiming to capture the meanings that participants assign to their experiences (Smith, 1996). To view the data through a relational lens, IPA fits very well into this structure, given that every social worker practices differently. This particular study design elucidated the themes, opinions, and realities of the social worker's day-to-day experience with more depth.

Using the prior example of working with the dying patient and exploring within an IPA orientation, one may ask what the experience of loss was for the social worker, including not only how the therapist experienced working with the patient, but how the therapist processed that dying patient, what sense she or he made of the grieving process, and what that may look like in the clinical setting. Whereas if this were looked at through the grounded-theory lens, the goal would be to solicit the experience, look at trends, and attempt to create a theory from the data. Although it is assumed that there is a commonality in how social workers are affected by a dying patient, IPA does not take this for granted and examines each phenomenon deeply and dynamically.

Research Sample

The population studied are social workers who administer therapy to Veterans. This study explored institutional settings such as VA hospitals, community clinics, or private practices. The plan was to utilize the Association of Veterans Administration Social Workers (<http://www.vasocialworkers.org>) to recruit participants. The AVASW was established in 1979 and is now a nationwide organization of almost 300 social workers

(Association of VA Social Workers, 2013). As such, the AVASW offered a wide, rich collective from which to gather information.

An additional source, The Institute for Clinical Social Work (ICSW), was established in 1981 to serve the needs of social workers who strive to expand their education for clinical practice. Several years ago, the ICSW developed a Military and Veterans Social Work Specialization geared toward clinicians who work with both military and Veteran populations. This specialization explores topics such as war trauma and the patient-treatment process (www.icsw.edu). As such, tapping into this specialized population of social workers was ideal for gathering participants who have direct, relevant experience. I sent emails to colleagues, asking them to share information about this study with other social workers who worked with Veterans.

In the past, reaching these participants would be done face to face, by phone, or as recently as several years ago, via emails or surveys. Today, however, online video and visual interviews have become more viable methods of reaching distant study participants. As with any type of data-collection method, there are notable benefits and concerns for using videoconferencing as a suitable vehicle for qualitative interviews (Sullivan, 2012).

Skype is one of the most notable multi-method data-gathering systems. This was the token system used in this discussion, as well as with the research sample. One benefit of Skype is its ease of use. As Carter (n.d.) notated, after downloading the software, choosing your Skype username, and getting familiarized with the system, Skype is ready

for use. It also has a recording feature and is compatible with numerous transcription programs, which can be extremely beneficial in the accuracy of data and theme selection.

Although Skype can be used with video or without, for the purpose of this study, the video option was used. This allowed for a synchronous environments in which the researcher and participant participated in a reciprocal reactionary process, similar to those that would transpire in face-to-face meetings (Carter, n.d.). As an IPA study, it was essential for the researcher to note eye movements, frowns, and other non-verbal cues volleyed between researcher and participant. Also, as Sullivan (2012) highlighted, participants may be more comfortable in the setting of their own space (at home, in the office, or on a smartphone), and personal settings may assist in the fluidity of conversation. Skype also allowed the researcher to access a varied data set from different locations, thereby increasing the sample to a wider range.

Inversely, using modern technology tools like Skype for interviewing entails certain drawbacks. For example, Internet and hardware requirements could cause technical difficulties that disrupt or even end interviews. Saumure and Given (2012) cautioned that disconnection may result in a loss of data, as well as rapport, and can decrease the sense of trust and engagement with the researcher. Overall however, for this study the benefits of videoconferencing outweighed the potential deficits and gave the researcher a richer, more accessible sample base.

Initial contact with potential respondents took place through electronic recruitment flyers. The flyers listed contact information for the researcher, and once contacted by

an interested participant, the system outlined in the study's design section commenced, as seen in Appendix D.

Participants were required to have a master's degree in social work, hold a current clinical license, and practice in a therapeutic capacity. Although social workers are trained in a variety of theories, each participant was acclimated to the study and its particular definition of countertransference, which was expected to offset theoretical differences.

The researcher limited the number of participants who were newly practicing or retired, in favor of participants with significant, recent experience working with Veteran populations. This allowed for richer data and ruled out those who lacked substantial experience with countertransference. Interview participants needed more than one year of practice and / or were within one year of ending active practice. The participant also needed to have been actively engaged in therapy with one Veteran for a minimum of three months.

The researcher interviewed four participants recruited from the AVASW, the ICSW, and colleague referrals. With purposive sampling as the goal, the researcher recruited participants who had experienced the countertransference phenomenon. Research suggests that for this type of study, three or four thoroughly interviewed participants are an average size, but this study was on the larger end of the spectrum to increase the validity and reliability of the data (Morse, 2000; Smith & Osborn, 2003; Starks & Trinidad, 2007).

The researcher sent out initial paper requests or email correspondence (depending on the access granted), soliciting members to participate in the study. Based on the response level, face-to-face or electronically assisted interviews (Skype or other such means) were used to complete semi-structured interviews. Given the data that was gleaned during these interviews, additional follow-up interviews were scheduled.

Research Design

The first step involved the president of the ASWVA posting an invitation to the research on its main website with an explanation of all inclusion and exclusion criteria. Additionally, the researcher accepted referrals from ICSW faculty and students, as well as personal coworkers.

Those who responded by email or phone received a welcome letter and directions to complete an electronic demographic survey. The basic demographics included the following:

1. Race . . .
2. Age . . .
3. Gender . . .
4. Level of education . . .
5. Years of practice . . .
6. Type of social work generalization and frequency of performance of therapy . . .
7. Level of license . . .
8. Primary practice setting . . .

9. Employment status . . .

10. State of practice . . .

Clinicians who did not meet the criteria for the study (for example, those who did not practice psychotherapy) received a letter of thanks for their desire to participate. For those who had not completed their survey, two additional reminders were mailed or emailed. Once the survey was returned, the participant received the consent form for review and the researcher set up a subsequent appointment at a time convenient for the participant, as seen in Appendix C.

After review of the consent form, as included in the initial communication, the researcher fielded questions regarding the researcher's credentials and field of interest or work, as a means of building rapport so that the respondent felt comfortable sharing ideas. The researcher asked participants about any concerns, such as nervousness about being recorded or questions that lingered from the original interest letter.

As the question of countertransference with Veteran perpetrators can elicit negative reactions in the participant (due to fear, shame, or guilt), the researcher continuously monitored the effect of the interview on each respondent. The researcher, as a relational theorist using IPA, responded not only the respondent's verbal expressions, but also their non-verbal cues, noting when a participant felt uncomfortable with a particular line of questioning or misunderstood a question.

In order to be proactive in finding the strong and weak points of the interview process, the researcher conducted a pilot interview with a colleague via Skype. Minor improvements were then made to the interview guide, interviewing style, and process.

Each study participant was contacted individually by email or phone to set up a time and date for conducting the Skype interview. Each interview was promptly transcribed verbatim and read several times by the researcher. The field notes on impressions were also reviewed several times to denote any impressions that may have been gleaned during the interview. After the raw material was thoroughly reviewed, the process began of picking out similarities, laying out themes, and connecting those themes. All of these data were recorded and kept. As the preliminary analysis of the data began, the researcher remained in regular consultation with the dissertation chair to guide the review and analysis process.

After the first interview was completed and the data processed, subsequent interviews began and proceeded in a similar fashion. The researcher kept a list of themes during those interviews, but did not allow those themes to guide the interview, as the IPA approach strives for the interview to mold and flow from the respondent's point of view. When all interviews were completed, a universal table of themes was created. A review of the draft of results was performed to delineate the themes that emerged from analysis, and the researcher subsequently solicited participants' feedback and reflections. After the analysis and member checks were completed, the researcher completed a final draft of the results, along with a statement of consideration as to how these implications inform practice.

Data Collection Methods and Sources

In terms of practical application, when a potential participant indicated interest in participating, the researcher sent a welcome email soliciting the participant to fill out an email-demographics form within 48 hours. If appropriate for the study, the participant received a request for an appointment time and an email copy of the consent form. The researcher then scheduled and contacted the participant at the agreed-upon time.

Each interview began with a final, in-depth review of the consent form. During this stage of the interview, the researcher asked the participant to sign the consent and either fax or email a scanned copy of it. If the researcher did not receive consent within three days, a gentle reminder was sent. If their consent was not given within a week of the second request, it was assumed that the participant was no longer interested. This was the same process for unreturned requests for demographic sheets and / or appointment times.

The four participants who responded engaged in two semi-structured interviews all through Skype, lasting approximately 90 minutes. During the first interview, participants were asked about their experiences, and how they coped and used those experiences in session. This dialog followed the loose interview schedule and prompts. The participant was asked to speak slowly and clearly so that notes could be written to use along with recording. At the end of the interviews, the participant was asked to share any of their thoughts, questions, or experiences during the interview. This was included in the final data. Digital recordings of the Skype interview were gathered as data. Likewise, paper notes of the researcher's observations were gathered and made available in a notebook. There was also a transcription of the recording saved on a local computer.

Mishler (1979) noted, “The choice among (ideological realities) depends on the purpose of the investigator and the focus of the investigation” (p. 10). This suggests a co-created reality exists between researcher and participant as they conduct interviews. Given the sensitive nature of the material, the source of data (as well as how it is gathered) deserves attention. It is widely accepted that the IPA researcher commits to loosely semi-structured interviews in which an initial prompt script may be developed, but this is merely for the benefit of starting conversation, not as a prescriptive question-and-answer tool (Biggerstaff & Thompson, 2008; Smith & Osborn, 2003; Starks & Trinidad, 2007). Some of the most common methods used by IPA researchers include taking written notes during the interview, making video recordings, and making voice-only recordings. Each method has benefits and deficits, but to the researcher, the combination of the transcript material, as well as the interpretation of reactions inside of the interview, remains most important. In this study, the researcher noted in a personal notebook whenever she assisted the participant in exploring their reactions, non-verbal reactions, pregnant pauses, visual reactions to the questions, and emphasis on words. This gave a true relational framework to how the material was birthed during the interview.

Plan for Data Analysis

Smith and Osborn (2003) posited that the goal for data analysis in IPA research is to stay focused on the meaning of the experience excavated in the interview, and to aim to understand the content and complexity of that meaning versus measuring its frequency. If a researcher wants to understand the psychological world of a participant, then the

researcher should focus on both what the participant feels is relevant, and why it is relevant to the participant.

IPA analysts can review and summarize their data in many nuanced ways. Generally, researchers are guided to remain ever vigilant when collecting data, to make sure that they interpersonally engage with interviewees. As such, it is suggested that notes be written during the interview, including the researcher's descriptive comments on the interview, emotional responses (from the respondent and the researcher), key phrases, descriptions, and linguistic musings (Smith & Osborn, 2003; Fade, 2004; Cooper, Fleischer, & Cotton, 2012).

Below are the steps that the researcher took to collect data and create rich, related summaries:

1. After completing the first interview, the interview was transcribed verbatim . . .
2. The transcript was read in totality several times . . .
3. During each review, using the Microsoft comment function, the researcher noted what may be interesting or significant, such as pronoun use by the respondent, pregnant pauses, body shifts and / or changes in topic . . .
4. From these common themes, the researcher formulated broader clusters of themes that could be named so to represent a superordinate theme . . .
5. Naming this overarching theme provided an identifier that could be used to label similar themes within the transcript. This aided not only in organization, but also helped create a master list . . .

6. The researcher reviewed the superordinate themes and subthemes and, when necessary, pruned themes that were outliers or that lent no rich evidence, to keep the criteria succinct . . .
7. Major themes from the previous interview and the next participant interview were utilized and integrated into the current data analysis . . .
8. Each superordinate theme was written up as a narrative, exploring the shared experiences between the interviews . . .
9. A final table of superordinate themes was constructed, reviewed, and finalized . . .
10. Regular contact was kept with the dissertation chair to consult on areas that were difficult to navigate . . .

Through careful attention to the respondent's reflections, noting nonverbal communication, and bracketing the researcher's own conceptions, the researcher maintained a clear view of the experience of social workers working with Veterans who disclosed perpetrating war atrocities. Since the topic is sensitive, IPA allowed for the exploration of the clinician's responses in greater complexity than a phenomenological interview.

Ethical Considerations

The researcher understood the importance of protecting interviewees from experiencing undue harm via their participation. Participation in this study was voluntary and the following items were addressed to help each interviewee decide whether to participate:

1. The interviewer's name, identification, and affiliation as a student were given to participants . . .
2. A brief summary and explanation of the purpose of the study was outlined . . .
3. The interviewee was then asked to participate, but it was made clear that participation was completely voluntary and that there was no penalty for declining to participate . . .
4. A consent form was given to the participant and once signed, it was cataloged. The participant was given a copy for their records . . .
5. Participants had the right to withdraw from the study at any time without penalty . . .
6. Participants received an explanation of the qualitative-research method, which included the expectation of one to two interviews lasting up to 90 minutes each. Participation would end with the last scheduled interview . . .
7. The researcher explained that participants' privacy would be maintained. The notes and transcribed sessions were locked in a file to prevent the disclosure of potentially identifying information . . .
8. An explanation of the risks such as emotional distress, loss of privacy, or unforeseen risks were addressed, and the participant had a chance to ask questions about the process . . .
9. The researcher detailed the benefits of the study, such as improved understanding of research, self-exploration, and the chance to add to knowledge in the psychotherapy field . . .

10. Participants were directed to contact the researcher or the IRB with any questions about participants' rights . . .
11. The researcher addressed how participants could withdraw from the study, as well as how they may be excluded . . .
12. In the event that distressful emotions arose out of the subject's participation, the researcher explained how appropriate referrals for assistance would be made . . .
13. It was agreed that any identifying information regarding participants would be disguised, and the researcher asked participants to not disclose their patients' identifying information. Likewise, the researcher was diligent in protecting the identifying information of the study in published reports . . .

Validation Strategies

Researchers have long debated how to best validate qualitative data. Widely disparaged as a soft science, qualitative research, including IPA research, has widely gone unaccepted among the research community (Denzin & Lincoln, 1994; Lindlof, 1995; Silverman, 2000). Since qualitative research strives to capture the lived experience of the participant, it is often hard to set rigid data standards. For example, the sociocultural expression of joy cannot be calculated by standard quantitative methods. A quantitative study could use a survey to extrapolate how often a respondent reports feeling joy, but would not capture participants' observations of what they feel when they experience joy.

Denzin and Lincoln (1994) posited that “qualitative researchers study things in their natural settings, attempting to make sense of phenomenon in terms of the meaning people bring to them” (p. 2). Lincoln and Guba (1985) urged qualitative researchers to not feel that they are “guilty of producing ‘sloppy’ research by merely engaging in subjective observations” (p. 289). To assist with cohesion between qualitative researchers and translatable terms with quantitative methods, the aforementioned theorists worked to develop a validation method that identifies trustworthy research data versus using quantitative lingo. Even though the theorists later updated the correlative titles, the original standards of trustworthiness are still widely used. These titles roughly parallel the following: “Credibility (internal validity); Transferability (external validity); Dependability (reliability); Confirmability (objectivity)” (Guba & Lincoln, 1994, p. 114).

In this study, the researcher used several techniques to assure trustworthiness of the collected data. Credibility ensures that the findings reflect the study’s objective. To attend to this, the researcher engaged in continuous peer or dissertation supervision, including in-depth discussion about the research process. This helped avoid any unnoticed or unintended derailments that would jeopardize the credibility of data. After the second interview, to increase the chance that collected data accurately aligned with participant experience, the participant reviewed the summarized data and indicated whether the themes aligned with what they reported.

Transferability in qualitative research is sometimes considered unattainable. Nonetheless, it is important to have an in-depth description of participant experiences, to inform possible situations with other people, groups, or environments. The dependability

of a method hinges on the evaluation of whether data support findings. Although IPA is an interpretative research perspective, it may harvest less fixed data, instead producing a summary of shared experience within the data.

In this study, another researcher, independent of the study, reviewed the collected material, summarized the material, and compared that summary to the researcher's preliminary findings. This methodology intended to increase the understanding of the project between quantitative readers, and also to give strength to collected data and highlighted understandings. Lastly, techniques for establishing confirmability retained a thorough audit trail (Lincoln & Guba, 1985), which included process notes, tapings, and transcripts of the interview, including the researcher's personal notes, margin writings, and research musings.

Limitations of the Research Plan

Although the above-mentioned research methodology was carefully prepared and thoroughly implemented, this study has certain limitations. Two of the most notable limitations were generalizability and longitudinal effects. The population of this experimental group was a small sample and only included female participants. As such, it did not represent the majority of clinicians' experiences. The research design was not intended to produce wide-sweeping results, but to learn emerging information on an under-researched topic. This liability was accepted at the outset. However, the benefits of this exciting phenomenological data outweighed the limitations. For future research, it

would be beneficial for the study to be more longitudinal or perhaps in vivo after a number of therapy sessions.

As this is an IPA study, it should be noted that since the interview was conducted by the author specifically, there was unavoidable subjectivity on the part of the participants, as well as researcher bias. This could be improved by the participant being interviewed by multiple examiners to decrease the likelihood of interviewer influence. Although time and budget limitations may make it impractical, it would also be beneficial to examine how clinicians' long-term thinking may change after the interviews. Relevant data material may be uncovered.

Role and Background of the Researcher

Users of IPA widely believe that one cannot completely divorce the researcher from the researched. As previously discussed, an inherent understanding exists that the participant is being researched by a researcher, who is researching along with the participant. IPA researchers talk of "staying reflexive" as one means to maintain awareness of the researcher's footprint within the relational matrix of the interview (Finlay & Gough, 2003; Willig, 2001; Nicholson, 2003). The explicit role of the researcher, in addition to harvesting data and understanding the nature of human beings, is to remain acutely aware of themselves and their degree of willingness to examine the activation of their own influence. Thus researchers accept their responsibility to witness, accept themselves as being secondary participants in the room, and to think critically, sincerely, and candidly about the research experience.

In terms of background, the researcher in the study was an African American wife and mother of two school-age children. The researcher has worked exclusively with Veterans for more than seven years. During these years, the researcher noticed that different social workers respond differently to items brought up in treatment. The researcher hoped to further examine these differences in response, and to shed light on why some clinicians find it difficult to work with wartime Veteran perpetrators.

Chapter IV

Results

This chapter presents the results of the study, identifying social-worker countertransference reactions toward patients who disclose war atrocities during therapy. It will begin with a detailed description of what the researcher experienced when sitting with each participant during interviews, and how the real nature of the analysis was captured. The results are organized around main themes and sub-themes derived from the analysis of the raw data.

Understanding the dynamics of each participant was crucial. Without highlighting the relational aspect of the interviewer-interviewee relationship, the understanding of the data and results are severely limited. This chart begins gives a specific description of the participants' demographics.

Table 1.

<u>Participant</u>	<u>Age</u>	<u>Gender</u>	<u>Ethnicity</u>
Jalena	34	Female	Other
Catherine	30	Female	Caucasian
Lindsey	39	Female	Caucasian
Sharon	44	Female	African American

Table 1, continued.

<u>Participant</u>	<u>Years of Practice</u>	<u>Highest Degree Completed</u>	<u>State Licensure</u>	<u>Theoretical Orientation</u>	<u>Place of Work</u>
Jalena	2 to 10	Masters	New Mexico	Integrative	VA community- based outpatient clinic
Catherine	2 to 10	Masters	Illinois	Integrative	VA community Vet Center
Lindsey	2 to 10	Masters	North Carolina	Cognitive Behavioral	United States Army
Sharon	15 to 20	Masters	Virginia	Cognitive Behavioral	VA community- based outpatient clinic

The research included a total of eight Skype interviews. As suggested in IPA, the sample was fairly homogenous. It included four women of differing backgrounds. All the

women were over the age of 30, with at least two years of experience (the average was more than five years), and a master's degree in social work. Their state licensure was within their practicing state, except for one participant who had a license in New Mexico but practiced in a neighboring state. All worked at divisions of the VA except for one who was on active duty in the Army. All identified with a particular theoretical orientation but were trained and practiced fluently in a number of methods.

Personal Reflections

As a social worker who practices through a relational lens, the researcher's interactions with participants deserve attention. While sitting with each participant through the interviews, a unique relational dynamic occurred for both the researcher and the participant. Participants brought themselves into the room, not only in a clinical sense, but also personally. Even though the interviews were not therapy sessions, enactments of therapy occurred very early in the interviews. At times the researcher had to be reminded of her role as researcher, versus therapist. A conscious reorientation toward the role of researcher, as opposed to therapist or confidant, became necessary. As part of the collected data, the researcher noted the reciprocal interplay between herself and each interviewee, and how that shaped the progress, content, and tone of the interview. The following section provides details of each participant: who they are, and what it was like interacting with them in the interview. Interpretations such as facial expressions, gestures, and dialog are described, and categorization of the data follows these brief descriptions of participants.

Jalena

Introduction.

Jalena is a 34-year-old female (race identified as “Other” on the demographic sheet) living in New Mexico. The interview began with introductions. Jalena shared that she was single and had two daughters, both under the age of 8. The fact the researcher also had young children appeared to help Jalena relax, as the researcher noted that Jalena’s shoulders released and she put her hand under her chin in a mellowed gesture. When talking about her education history, Jalena reported knowing that she wanted to be a social worker from a young age. She obtained her BSW and then immediately began MSW studies. Before working as a clinical social worker, Jalena provided case management for underprivileged children and families in the community, but she was not satisfied with this choice of career. She stated, “I did case management for a long time and I had enough. That was not my niche.”

Jalena currently works full-time at an outpatient clinic. This is an offshoot of the main VA hospital that was set up to increase treatment opportunities for rural Veterans. Jalena’s primary treatment groups are new Iraq and Afghanistan Veterans. She provides a majority of behavioral treatments that are recommended by the VA. She also provides longer treatment modalities.

Portrait within the interview room.

As the interview began, Jalena was relaxed and her smile dimpled as she searched the computer screen. She smiled warmly as technical difficulties disrupted the flow of

conversation and reconnection was made several times. She described herself openly and talked with pride about her two daughters. When she described where she grew up and practiced, she sheepishly joked that she “hadn’t gone far” in terms of exploring outside of her sleepy town. Her tone denoted shame at not moving far from her childhood home.

This sentiment continued as she described her hometown as extremely racially and economically separated. As she shifted in her seat, she told about those on one side of the tracks who were socioeconomically depressed, versus the other side that housed the wealthy vacationers and snowbirds. She shared that the city was divided by a train way and she literally grew up on the difficult side of the tracks. Almost as a side note, she described her side of the town as having rampant crime and child abuse and noted that this was area she worked in before she began with the VA.

As we casually discussed Jalena’s background—talking about why she started working at child-welfare agencies and where she was from—her voice hitched and she began to well up with tears. It was unexpected and surprising, almost as if she had been asked a deeper question than just describing the area where she grew up. She immediately broke eye contact and began looking at the floor as she tried to compose herself. As she spoke, she began to cry more. “Growing up in my hometown wasn’t easy,” she said. “Can we pass all that? It was just very difficult.”

The role of researcher became counterbalanced as ideas of how to re-engage Jalena flooded in. She denied interest in ending or postponing the interview, but the reciprocal relationship became strained. The result was a broken and awkward 15 minutes of discussion as I floundered, searching for how to best react to Jalena’s emotional discord.

Her behavior was now incongruent with her reported mood, and it made it difficult to decide how to proceed. The moment felt oddly voyeuristic and I felt laden with guilt that she was in pain due to the interview. In an effort to soothe her, I reassured her and normalized that it was often difficult as a social worker to navigate personal landmines and that there was no shame in her reaction.

As she became less tearful, the discussion progressed, and Jalena discussed the links between one's self and therapy work. She described using check-ins with herself and her patients as a method to keep her patients focused on their trauma when emotional landmines occurred. This focus on the "other" was a semi-dissociative stance she utilized to create distance and not be drawn into the triggering stories which would then threaten to disrupt her therapeutic strength.

I do a lot of trying to just remove myself from the discussions I run in my head. I try to focus on their situation. It's not mine. I just make sure I'm checking in with the patient and their own feelings and not trying to input mine within the session. (Jalena)

She worried that her triggered countertransference would deskill her. The clinician within me was engaged and aware enough to bring the association into the room. I reassured Jalena that the interview space via Skype was safe and containing. Slowly her angst faded and she stopped rolling and re-rolling her tissue. She responded openly to questions about her presence in the treatment room and commented that when she is in the therapy room, she realizes that she releases her anxiety by fidgeting in her seat, which was similar to what she was doing in our interview. Several seconds later, when she

began to laugh, the researcher began to relax also. Both the researcher and the interviewee had ridden the crest of anxiety together.

At the 45-minute mark, she became more engaged with the interview and returned to her experience with her disclosure patient. She described how she interacted with him on topics such as their children, parenting, and relationships, and these descriptions seemed to help assuage her worries about being a good, attuned social worker.

Personally, I guess that it's almost reassuring that I'm doing what I like, and I'm doing my job well. But it's more of the ego . . . it's nice to know that out of everybody that they've known in their life . . . they were able to go that far with me as their social worker. (Jalena)

However, contradictory to this, during the end of our first interview, it was evident that Jalena was unable to completely trust the researcher or the interview process. She answered politely to questions but her responses were clipped. At one point, she responded in a manner that probably felt similar to her gently prompting her patient to “wrap it up” at the end of the session. She ended the interview with a wide, relieved smile and agreed to the second interview.

At the outset of the second interview, Jalena seemed reluctant to talk. When asked about her experience of discomfort in the last interview using a scale, she reported it was an eight or nine. The intention was to check in about what came into the room during the first interview and identify the transference that is inevitably present at all times. She again began to shift her body when asked about her level of self-care after our previous interview. She described that she went out to dinner with her friends as a coping

mechanism. She had effectively drawn on her ability to create a safe space with her friends. When questioned about how she processed and got her mind to a level spot, she responded, “I had to kind of stop and think about why I had that reaction. Why was it so hard? Basically, why I was so thrown off?”

Although she reported processing the exchange that night, Jalena began avoiding the interview itself. She had changed the meeting time and date several times. And now during the interview, her facial expressions were flat and despondent. She had enacted another coping strategy. She distanced herself by doing the interview in the family room of her father’s house. It was impossible to maintain her full attention during parts of the interview, as her children appeared on the Skype screen twice. Her children clearly felt her unconscious distress. At one point, she put her daughter between herself and the Skype screen, creating a physical barrier.

When asked if the interview was upsetting her, Jalena said no, but she missed questions and absentmindedly had side conversations with her family. She had checked out of her connection with the researcher. Toward the end of the interview, she was asked to elaborate on her story of her patient’s dangling anxiety and feeling unable to help him. Jalena described feeling as though she was being drawn into trying to rescue the Veteran. She concluded that she realized she could not rescue him and that her role was to give him tips and support. When the researcher noted that her therapy sounded a lot like the current interview, she agreed. The researcher was able to process with Jalena the link between transaction and reaction within the interview setting, and what it might be like when she becomes overwhelmed by trauma.

Working with Jalena was fascinating, and she was different from the other participants. Although we reviewed the definition of atrocities and she confirmed her understanding, the disclosure that she shared was about a young child who was injured and left by a soldier. While the story conveyed the pain of a soldier having to abandon a child roughly his own child's age, it did not denote that an atrocity was committed. Although she met the criteria for the study and she provided pertinent data to the question of clinicians treating war perpetrators, it was apparent in reviewing the data that her choice of story did not fit the study criteria.

Jalena made a unique contribution in that her interviews gave clues about herself and her unconscious processing. Jalena found it significantly difficult to understand her own personal transference within our interviews, but it was clear that when she is sitting with her patient she works to be present and caring. Her reaction toward the researcher was at first unbearable, as she felt disarmed. As the interview continued, she struggled to gain her equilibrium, but with time, she stated she wanted to continue her participation. In the findings section I will further address the understanding of Jalena's interplay within the interview.

Catherine

Introduction.

Catherine is a 30-year-old Caucasian female with a witty sense of humor. She is married and her husband is also a social worker. Unlike some of the participants, Catherine is not a Veteran and none of her family members has served. Catherine

currently works at a VA satellite counseling program called the Vet Center. The population of the Vet Center is exclusively comprised of combat Veterans and those who have suffered military sexual trauma. The majority of her patients are male Vietnam Veterans. Although she would like to practice more long-term therapy, she primarily does short-term and group treatment.

Catherine began her social work career when she was 21. After receiving her bachelor's, she began working at a women's shelter. While there, she was allowed to sit in on peer consultation meetings. This sparked her desire to pursue the profession. Catherine has an extensive training history, which she and the researcher reviewed at the beginning of both interviews. Catherine has completed several VA internships, worked at a women's shelter, and volunteered with a community-outreach program for people with severe mental illness. Her diversity of training is one of her best clinical assets. "I've worked in housing," she said. "I've done a lot of outpatient, therapy in people's homes, and psych rehab."

Portrait within the interview room.

Catherine rocked forward slightly as she described being allowed to sit in on the consultation sessions at the women's shelter even though she was not finished with her program yet. The tone of her voice rose as she described the owner of the facility as a Rogerian social worker and "very psychodynamically trained." When she left the organization to pursue her MSW, her experience at the women's shelter sparked her interest in psychodynamic work and she took as many psychodynamic classes in her

program as possible. Her voice was proud when she recounted this interest and how it played a major role in why she was so drawn to participate in the study. The researcher also had an interest in analytic work, and noted that such interest is scarcely talked about in traditional social work circles.

Catherine's surroundings on Skype were stark, including only a window, a food bowl for a cat, and an exercise glider. A window showed the hustle and bustle of the city she lived in. Several times during our interview, there was an almost deafening blare of police and fire-department sirens. Catherine sat squarely in front of her computer, appearing totally engaged and present. One of the first things the researcher noticed was that Catherine's life had been extremely packed within in her youthful 30 years.

Catherine's interviews proved to be as dynamic and layered as her career history. Her clinical knowledge was fascinating, as was her personal history. This petite woman had moved around several states during school and internships, showing immense fortitude in the process. She was scrappy and funny. When she became passionate about a topic, she gestured quickly with her hands. The researcher wondered what it would be like to be in session with her. Would she be quiet and reserved or open and direct? Ultimately the researcher assumed that Catherine acclimated to whatever was needed by the patient during that session.

During the interviews, Catherine explained her need to develop a tough skin and the ability to rebound from constant patient questions about her age, experience, and ability to perform her job, due to her youthful appearance. During the second interview, she touched the base of her neck (a gesture she did when she was talking about herself). With

pride in her voice, she discussed using herself within the therapy room to build and solidify rapport with patients. She summarized, “But to me, the core of therapy really goes back to the use of self by the social worker, and I think you just can’t forget that.”

Although the interviews ran just as smoothly, they included several major surprises. For example, Catherine identified heavily with OEF / OIF / OND (Operation Enduring Freedom / Operation Iraqi Freedom / Operation New Dawn) Veterans, as she is part of that generation. This was intriguing, as the researcher identified with Vietnam Veterans because they comprised the majority of her workload at the VA. Catherine used her cultural knowledge of that generation within in therapy, but most often she was conscious of her own experience and did not let her own visions of patients cloud their individualism. Whereas some clinicians have parents who grew up in the same era as most Vietnam Vets, Catherine had to draw on different experiences. Her father is native German and did not come to the United States until he was an adult.

My father is German. He grew up in Germany so he had dual citizenship and he was here in the U.S. for college, so he couldn’t get drafted. He wasn’t part of the counterculture movement that Vietnam vets like to talk about: “Those damn hippies.” I don’t see my father in either of those categories at all. He grew up in Germany right after World War II, so there’s guilt, but it’s a Nazi guilt that is very, very strong in his generation. (Catherine)

This upbringing made it very difficult for Catherine to feel bonded with Vietnam Veterans and when she was challenged by them to prove her expertise, she felt disconnected, and in some ways was unable to feel empathy for those patients. Her

annoyance was evident as she recounted having to sidestep questions about her competency when Veterans tried to relate to her as a “daughter or granddaughter.”

I think it’s important to pick your boundaries. I will not tell patients how old I am even

though they ask me all the time because I look young. They’ll say, “What are you, 16?” and I humorously reply, “Don’t you know it’s rude to ask a woman her age?” This usually actually rebuffs them, or I let them guess. Sometimes it gets creepy.”

(Catherine)

On one occasion, her discomfort with Vietnam Veterans compounded when she was substituting for another social worker’s group. While outside the door, Catherine heard men in the group joke about gang raping her. Horrified, she backed away from the room but eventually went in to conduct the session. This highlighted a pattern of her fighting to be respected as a seasoned clinician and how she also steels herself against unsafe situations. She described a Veteran with whom she was conducting therapy absentmindedly bringing a weapon out of his pants while trying to find a telephone number. She talked about being comfortable with the violence if she “knows the Veteran” and can use it within session.

Catherine has a surprising physiological reaction when she sees blood. Whether in a movie, on TV, or direct experience, Catherine passes out when she sees blood or gore. She described the first time she passed out, during a high-school DARE (Drug Abuse Resistance Education) presentation, and another instance while watching a combat

movie. Although she passes out when confronted with the trauma personally, she feels completely comfortable listening to soldiers' stories.

Catherine's devotion to the profession could have roots in the fact that her sister was a victim of rape and her father-in-law was killed by a drunk driver (drinking is a common coping mechanism for Veterans with PTSD). Feeling powerless, she chose a profession where she could symbolically help the family members whom she previously had no ability to assist. This was an example of Catherine's struggle with her counter-phobic drive. Interviewing Catherine emphasized what makes the art of therapy so beautiful. She personified a clinician who is able to use herself within session, and also able to make correlations of how her reactions form.

Lindsey

Introduction.

Lindsey is a 39-year-old Caucasian female recently married with one child. An active duty social worker with the United States Army, Lindsey is also a combat Veteran. She shared what it's like to be both the healer and the healed, both social worker and behavioral-health patient.

Lindsey currently works on her local military base, where she sees patients. She is due to process out of the military within the next three months, and is working to close all of her cases. Lindsey only provides evidenced-based treatments such as EMDR (eye movement desensitization reprocessing), CBT (cognitive behavioral therapy), and PE (prolonged exposure). She readily admits that this form of treatment keeps her at a safe

emotional distance. Her client population is exclusively active duty, comprised of both combat and non-combat soldiers with behavioral health issues.

Portrait within the interview room.

Talking with Lindsey was disarming. She had positioned her phone so that she had to look down at her screen—an angle that had an almost menacing effect. Although feminine with long hair dangling around her face, Lindsey’s countenance was so rigid that it was very easy to imagine her in uniform, directing units. Her wide smile sometimes contrasted with the stories she recounted. At times that smile became tense as if to cover her emotions, such as when she described her disclosing patient.

She began this discussion by very sternly stating that she was acting as her own entity, in no way representing the United States Army. Lindsey was fiercely protective of “her soldiers” and, like in her own day-to-day work, she held the researcher at bay with flat, general answers until trust began to develop during the interview. She reiterated four times during her first interview that her role was to protect the soldiers, and she practiced that by being non-judgmental. However, in a turn of projection, while sitting with Lindsey the researcher felt judgmental toward her answers and how much she revealed. She talked about herself in vague, cleansed descriptors, and she unconsciously refused to share her patient’s disclosure during our interview. She felt as though she was being disloyal by telling her Veteran’s story.

Lindsey recounted that in therapy she regularly told soldiers not to say anything she would have to legally report, and encouraged them to only speak in hypothetical terms. The researcher asked what it was like to sit with a patient, trying to be non-judgmental

while at the same time having to judge if the action was worthy of military legal punishment. Lindsey responded that it was one of the most difficult parts of her job.

Lindsey waited until the second interview to disclose the atrocity that originally prompted her to join the study. She explained that her avoidance was because she felt that the story of this Veteran was not “my story to tell.” Although the researcher allowed Lindsey the time and space to feel that she could talk openly, the first interview ended with the researcher feeling frustrated and that matters were unresolved, a reflection of what it must be like for Lindsey to be unable to truly join with her patients.

Lindsey’s active-duty experience was fascinating and there were hopes that she would represent this population of social workers. Because of this, the interviews went over the stated time, but they were productive in allowing Lindsey to share her experience. There were times where the researcher struggled to understand the military culture of an active-duty social worker. It was hard to visualize Lindsey’s requirement to judge of her fellow soldiers and how this conflicted with her own distressing combat experiences. She struggled with over-identifying and utilized peer consult to keep her connected when she sometimes lost perspective. Her position as therapist and cohort seemed endlessly frustrating as she was also triggered by what was shared. As such, she was on an active regimen of antidepressants which reciprocally made her unfit for some deployments.

Once trust was established during our interviews, Lindsey talked openly about the juxtaposition of her career as a soldier and her status as an emotionally wounded healer. Although she never really showed much emotion or even facial expression, the interview

proved relationally enlightening as she ultimately shared feeling burned out as a military social worker and discussed her decision to retire due to medical and mental health issues.

It's funny because I was building my resume and in the summary, I put "enthusiastic \ licensed clinical social worker." You're always excited when you're a new social worker and I don't want to go in as an already burnt-out social worker. I can't put "not a bitter social worker yet," so "enthusiastic" is a better word. (Lindsey)

At one point during the Skype interviews, Lindsey's demeanor became intense. When she laughed, her whole face lit up, but when she talked, her voice was commanding and clipped, but also confident and relatable. During our interview, there were moments in which she relaxed. Her serenity of being on her farm (where the interview was conducted) could almost be felt, even through Skype. Her interview was enjoyable because it piqued interest about what it would be like to be a social worker on active duty. Her interview also touched on the strength it takes to survive in battle zones.

Sharon

Introduction.

Sharon is a 44-year-old African American. She has two teenage daughters and in addition to her work, she and her husband co-pastor their church. Sharon has an infectious sense of humor that she shared many times in the interview. The minute the first interview began, Sharon put the researcher at ease. Her Skype background included a fireplace with a mantle full of pictures of her family. The glow of the fire elicited a

desire to talk and stay for hours. Sharon's warmth was matched only by her devotion for her patients.

Like Catherine, before joining the VA, Sharon was already seasoned as a social worker. She worked as a social-work supervisor in hospital services including the emergency room, acute rehab, and obstetrics. In 2008, she began to search for more hands-on patient care and joined the VA to provide direct short-term and long-term therapy.

I remained undecided for two years. I thought I would be in public administration but I didn't like it. After two years of kind of floating around, my father said, "Okay, you have to make up your mind." I took one social-work class and I fell in love. I received my bachelor's in social work from a local college. (Sharon)

Portrait within the interview room.

For the researcher, the interviews with Sharon were by far the most enjoyable. Not coincidentally, the researcher felt most connected with Sharon, out of all the other participants. In retrospect, this connection owed to associations that the researcher shared with Sharon as Black women who grew up in the same area, with the same field of study, and having two daughters. Both researcher and participant shared the struggles of race and gender bias working at the VA. Both women experienced the same triad of discrimination: female, black, and civilian. Although this is not uncommon, Sharon's sensitivity to the discrimination could be attributed to the dynamic of living and practicing in a small, rural town in the Deep South. Unlike other more progressive areas,

in her current location Sharon still battles to be taken seriously as a woman in her practice. This actually increases her empathy for the difficult stories of the Veterans in her office.

Sharon was unapologetically open and shared how one traumatic incident in particular shaped her interest in social work. When Sharon visited an out-of-town family as a teenager, a close cousin sexually assaulted her. She kept the incident secret until she was an adult and her father passed away. She worried that the disclosure would destroy her father and the family. Sharon worked through much of the broken trust in the family system, as well as its impact on the early part of her marriage. She recounted how the healing process allowed her to now empathize with soldiers who feel like the “family” system of the military failed them, a common experience for combat Veterans. It was not difficult to get Sharon to tap into her countertransference as she was very insightful about her reactions. She attributed this to having written a “soul-healing” book that she published several years ago.

Sharon’s father was a retired lieutenant colonel who spent 21 years in the army and served in the Korean War. Being the daughter of a soldier helped her to relate not only to the Veterans in her office, but also to those Veterans’ family members, who moved locations which each new deployment. Additionally, her father served as an inspector general, which was distinguished and uncommon for an African American male of his time. During an interview with a particularly discriminatory patient, she used her father's stature to ease the conversation and gain respect from the Veteran, who remains in treatment with Sharon.

As Sharon shared lively accounts of interactions with patients, she often leaned back in comfort and laughed deeply. Her laugh seemed to vibrate through her entire body and her blush turned her face the shade of red clay. She summarized how she worked through her own sexual trauma in her youth and that this led to her empathy for others. Her strict parental upbringing (and trauma) led to “wild” college years, and then her journey of settling down into the person she is now. This impacted her countertransference because having made what she felt were mistakes, she could identify with people who are the underdogs, similar to those disclosing Veterans who have been isolated and marginalized. Her warmth in that area is one of her greatest clinical gifts.

The comfort of Sharon’s therapy space was evident from the first interview. She has tried to create a loving clinical practice and, emphasizing the issue of inclusion, has provided this to her disclosing Veterans. She did so in an attempt to accept her broken patients in a way she wished she or her father had been unapologetically accepted. As she shared the story of her Veteran, she exuded a sense of self confidence that she had achieved her goals of supporting the Veterans she reveres, while also being aware of and using herself in the room.

Results

Smith and Osborn (2003) stated that IPA is not a prescriptive methodology. Rather, it is a personal journey that is tied to the researcher and participant. As such, the starting point for this analysis involved the interview video and recorded audio. The latter of these was typed into a transcript following the interviews. The researcher re-watched the videos

and compared them to the thoughts and notations made in the margins of the transcripts. The transcripts were then read through again without the video, and processed line-by-line for key points and inferences. At this point, the annotations on the transcript were reviewed and then scaled down to concepts that captured the essence of each interview. Primary themes and subordinate themes were then analyzed. Some themes clustered together while others were discarded because they did not capture the richness of the data. Once completed, sticky notes were moved around around to determine the final table of master themes. Table 2 is a short excerpt of burgeoning concepts, notations, and early analysis.

Table 2.

<p>V: What do you think the source of your reaction was?</p>	<p><i>I think she notices the parallel</i></p>
<p>J: I guess our own values. Why would you want to put your little girl in that situation? Why would you want to do with our children? It is very different from what we're hearing as far as what the soldiers are experiencing over there. And witnessing what little kids go through while they're over there. I guess it's more of a reaction against our own moral judgment.</p>	<p><i>in his story and hers and it affects her reaction to him.</i></p>
<p>V: What are those morals for you? What were your thoughts you were raised with in terms of kids and family?</p>	<p><i>I wonder if she's speaking her angst as a mother. Or perhaps she's talking about herself as a kid and the fact that she used her "potential" to make it out of her impoverished youth.</i></p>
<p>N: Especially because before I did this, my work was with children, I always want to make sure that their basic needs are all met, making sure that they grow into the potential that they should. So the number one thing is their safety and their protection, and this completely went against that.</p>	

This is an example of the next stage involving returning to the text and video and using the other margin to process and take the analysis to a deeper, richer level.

Table 3.

BURGENONING THEME	DIALOG	INTEPRETATION
<p>Personal narrative</p> <p>Reenactments within the therapeutic alliance</p>	<p>V: What do you think the source of your reaction was?</p> <p>J: I guess our own values. Why would you want to put your little girl in that situation? Why would you want to do with our children? It is very different from what we're hearing as far as what the soldiers are experiencing over there. And witnessing what little kids do while they're over there. I guess it's more of a reaction against our own moral judgment.</p>	<p><i>She notices the parallel in his story and it affects her reaction to him.</i></p>

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In the third stage of analysis, the emergent themes are reviewed and organized into overarching superordinate themes in order to give fluid movements of the data and personal narratives, the following example shows:

Table 4.

<p><i>She notices the parallel in his story and it affects her reaction to him.</i></p>	<p>Personal narrative</p> <p>Reenactments within the therapeutic alliance</p>	<p>Social worker as a person</p>
<p><i>I wonder if she's speaking to her angst as a mother. Or perhaps she's talking about herself as a kid and the fact that she used her "potential" to make it out of her impoverished youth.</i></p>	<p>The wounded healer</p>	

This process of analysis applied to every participant interview. After each interview, the researcher reviewed emergent themes and musings from the verbatim transcript and grouped them into a superordinate theme. The IPA approach suggests that interviewers have the option of keeping a loose sheet of themes with them as they interview each participant, or they can start fresh with each interview. The researcher did not use an outline and interviewed each participant with as little bias as possible. As such, the

researcher only created the final master list of themes after analysis of all the interviews.

The master themes that surfaced were as follows: the social worker as a person, empathic attunement, insulating the patients against our reactions, and feelings in secret.

Superordinate and Subordinate Themes

1. Social worker as a person

1.1 Personal story

1.2 Wounded healers

1.3 Self-care

2. Empathetic attunement

2.1 Use of self as an instrument

2.2 A worthy battle buddy

3. Insulating the patients against our own countertransference reactions

3.1 Trauma buffet

3.2 "I've heard everything"

4. Feelings in secret

4.1 Pride

4.2 Disgust

4.3 Ambivalence

4.4 Hunger

Superordinate theme 1: Social worker as a person.

The first theme from data collection involved the importance of participants acknowledging themselves as people and as social workers. At this point, the researcher would be remiss not to note that unconscious processes bring participants to volunteer for studies. This is a critical component to countertransference reactions.

Each social worker explored how they utilize the two-person model of therapy. All counted themselves as a part of the therapeutic dynamic. Some integrated themselves into the relationship more than others, but the link was very clear. When clinicians step into a room with a patient, they bring their personal selves, and there is little way to disjoin that. This dynamic developed into three subthemes: personal story, wounded healers, and self-care.

Subordinate theme 1.1 Personal story.

Whether creating lines of communication with racists or the need to protect abused children, all participants noted the importance of their personal experiences in working with soldiers and Veterans. Upbringing and morals help shape the relationship with the patient and becomes part of the countertransference reaction.

Jalena's story of the disclosed atrocity was about disadvantaged and vulnerable children. This story reflects her values and her experience, which unconsciously impacted the story she chose to tell. Her personal countertransference reaction about vulnerable children prevented her from sharing a true account of a patient's disclosure, but rather prompted her to disclose a topic with which she struggles, namely, abandonment and the

semi-processed feelings about not being protected from abuse she sustained within her family as a child. As Jalena said:

I guess our own values are the source of our reaction. Why would the people in that country put a little girl in that situation? Why would you want to do that? I remember recalling during our session that that little girl was the same age as my little girl. I guess we have our own values as far as what we should be doing with our children. It's very different from what we're hearing as far as what the soldiers are experiencing over there. Witnessing what little kids go through over there during all this time? I guess it's more of a reaction against the soldier's own moral judgment. (Jalena)

Jalena's reactions within the interview and with the researcher revealed Jalena's feelings of shame, guilt, and damage in terms of self-visualization. Although Jalena agreed to continue, her participation afterwards remained muted and disconnected. The researcher noticed Jalena looking down at her lap and nervously twisting a napkin as a means of "pushing through" her commitment to the interview. This links to Jalena's admitted childhood sexual abuse and parallel mechanism of "pushing through" fear and discomfort by staying in the community where she was assaulted, and where sexual abuse is rampant. In essence, she picked a story of abandonment versus a war atrocity (e.g., rape) as a way to participate, but also as a way to psychically protect herself from the horror that would have accompanied description of a true war atrocity.

Like Jalena, Catherine's countertransference reactions resulted from her background. Being the child of a German immigrant colors how Catherine views culture. Her upbringing and spiritual connectedness triggered her when her Veteran disclosed.

Catherine shared how she noticed her moral values clashing with the action of the perpetrating Veteran.

I do feel like in war, it's your job and you're doing your job. But I guess maybe my reaction was at a fundamental level. I don't believe humans should kill each other. That's my spiritual belief. It's the values that I grew up with. (Catherine)

Lindsey's countertransference reaction stemmed from areas different than the other participants. Being an active-duty social worker immediately tied her reactions to the soldiers as comrades and also to visions of herself. Soldiers' stories were her stories. This was best conveyed in her description of herself.

I joined the army in 2004 as a medic. I didn't know much about the army, but I was a single mom and I thought it sounded like a good idea. Then I deployed to Iraq in '05/'06 as a medic. After that, I was ready to get out of the army and I said if they gave me a non-deploying unit in Hawaii, I'd stay, and they did. So as a social worker I don't know if I experience a lot of countertransference. Maybe because I'm in the military and have deployed, maybe that's the countertransference and that's why I don't react horrified? It helps me understand how it got to the point where you'd choose to do that and feel like a monster afterwards. (Lindsey)

Sharon's reaction during disclosure was intertwined with a history of fighting stereotypes, for herself and for her father, who faced open discrimination when he was in the military. Sharon acknowledged that her countertransference reactions, especially toward older Veterans, were formed from her father's military experience.

I came to work at the VA because my father is a retired lieutenant colonel from the

army who served 21 years. He enlisted in the Korean War, so he'll be 88 this summer. I grew up hearing how things happened that were unfair and unjust. As a young black officer in a segregated army, my dad faced many challenges. But then I started working with the VA and started seeing patients that served during that particular era where there was a lot of segregation. Our country was in total disarray during the Vietnam War. All these feelings kind of spilled over and I started sensing and feeling the same thing. I even had a Caucasian Veteran gripe about African American NCOs [non-commissioned officers] until I showed him a picture of my father and all his medals. He then had to give respect. (Sharon)

One of the strengths of this study was that all the clinicians carried a different motivation for beginning their practice with Veterans. Some related it to their passion for the work, some because of their individual connection with the military. Either way, each has chosen to work and give themselves to the therapy process with Veterans and active-duty service members.

Subordinate theme 1.2 Wounded healers.

Another common theme was that each social worker recognized her own individual struggles. Sometimes those struggles were mastered, and some were still being processed, but all the participants used their own experiences to tap into their empathy and enrich the therapeutic relationship.

When Jalena began to open up about how her childhood led her to work with Veterans, emotions surfaced around her own difficult upbringing. She could identify how after

personal therapy, she was able to recognize the transactional dynamics happening in the room. However, Jalena's quickness to disclose and her unaligned affect point to her being overly interconnected with the story, versus her reaction to her combat Veteran perpetrator's disclosure.

I first started working in child services in my hometown, which is a little sleepy town. But there's a huge discrepancy between the poor and individuals who are retired and pretty well-off. To be honest with you, it's in the lower socioeconomic level that there's a lot of child abuse and neglect, so the jobs with children are available. Growing up and working in the same area wasn't easy. Can we pass all that? (. . . begins to cry . . .) I am aware of my own stuff. I know that when I feel strongly about something, there's usually a reason for that. I try to stay aware of that and the stuff I have to work on, and keeping that in check within myself. I worked on that in my own therapy. (Jalena)

Although extremely dedicated to working with and for her Veterans, Catherine's blood phobia created a unique set of countertransference reactions to her Veteran's disclosure stories and the general combat experience of war.

I really don't like gore. I will actually pass out if I see a lot of blood in a movie. I couldn't be a nurse or doctor. I've passed out in public a couple of times. One time when I was in high school, they did an assembly on not drinking and driving. They brought in an ER nurse with slides of someone impaled on a light post. I passed out in the middle of the assembly. I've also passed out seeing blood from my hand if I cut it.

I don't have a moral objection to seeing blood on a movie screen, I just can't look at it.

It's an odd physiological reaction. In therapy, I can listen and read about it. I might have a reaction like, "Oh, that's really gross," but I don't get faint or lightheaded when the Veterans talk about it. (Catherine)

As Lindsey explored how she reacts toward perpetrating Veterans, she struggled to see herself as both the healer and wounded. Her experience leading troops forced her to make nearly impossible decisions in regards to atrocities, taking a toll on her mental health.

I love the army but I have other things I want to do. I'm actually struggling with depression myself. So as my responsibilities and rank are getting higher, I'm finding it harder to take care of myself. I haven't had any episodes. I still do patient care. I've been cleared. They're always looking at you if you have a mental-health diagnosis, but I was just managing it. But at what costs? I have to take three different medications and have a therapy light with me. If I have to do all this stuff to maintain myself, how am I going to take care of a brigade? (Lindsey)

Sharon shared how her painful experiences with trauma and sensitive family dynamics directly affected her reactions to disclosing Veterans.

It depends on the situation. I myself had some childhood sexual abuse, so when I work with military sexual trauma, I could have a different reaction. For instance, if a patient either wasn't supported after they told someone or they had that same guilt associated with it when it wasn't their intention, of course it was the perpetrator's. And I could feel there was some countertransference there. (Sharon)

There were significant areas of each participant's own mental health that affected treatment. Areas like family history, personal hurdles, or the pain of others paved a way for the social worker to join with their patient

Subordinate theme 1.3 self-care.

As any social worker can attest, the idea of self-care is of utmost importance to the health of clinicians. It is especially crucial when working with high-burnout-potential professions associated with trauma. Clinicians use a myriad of techniques such as meditation, reading, music, and social time to deal with trauma. However, what was apparent with these participants was that self-care was sometimes put on the back burner in order to attend to the Veterans. Most of the participating clinicians had a very small bag of tools that they used to care for themselves regularly.

Jalena's coping plan was deficient in helping her take care of herself and she admittedly reported that stressors of work and reactions to disclosures bled over into her home life.

I process while driving on my way home. I have an hour drive, so that's always helped me. It puts me into perspective going into work and it gets me back into a different perspective after work. But during the day, session after session after session, you're just moving with the flow and you don't do self-care at that time. I'll go and talk with my coworker if something gets to me, but that's pretty much it. There is really no time. Once I get back home, I just flip to whatever is next. But I have to care for myself and turn back into mom. No matter what. (Jalena)

Like Jalena, Catherine uses the commute home to process the day. However, Catherine also tries to add short breaks in her day when she is significantly bothered by a case. She lacked the ability to communicate with other staff members because she did not feel the genuine bond that is needed to discuss personal responses to her patients. However, she can confide in her husband who is also a social worker.

I process in the car because I have an hour-and-20-minute drive. It depends on what mood I'm in whether I want to hear people talking like NPR or just music. Sometimes I just talk myself through the patients I saw. I just kind of describe the case to myself and it sort of helps me get it off my chest. That is me taking care of my body. It's also really important to end my session on time because I do 50-minute sessions and take my break in-between. Some of my coworkers do a full hour back-to-back. I could not do that. I will do a brief meditation between if I feel I need to, or have a snack, something to consciously boost myself back up. (Catherine)

Unlike the other participants, Lindsey's lack of self-care extended beyond staffing cases and outside activities. Although she worked tirelessly for years serving soldiers, she worried about being professionally looked down upon for using self-care measures. She remarked that this kind of luxury was seen as frivolous and selfish. This lack of support for self-care directly led to her decision to leave the army.

I'm finding it harder and harder to take care of myself. My self-care was taking away from my officership. I wouldn't be useful to the army. Sometimes there's only one behavioral health officer and sometimes they're the only provider for hundreds and hundreds of soldiers. I'm going to do that. But fortunately right now we have enough

people that that they can easily replace me. (Lindsey)

Sharon was the most resourceful and consistent in utilizing self-care. She had all the normal suggested components including staffing support, exercise, avenues to process, and a strong relationship with her spiritual beliefs as a deacon. Sharon's work-related tension was markedly decreased because of this.

After a particularly difficult patient or day, I walk with my coworker who I've really grown to appreciate. She's a psychologist. When things get me stressed, we walk. We walk up four inclines and two hills a day. Or I make some hot green tea and I put on different music that I like. Some days it's Lalah Hathaway, it just depends. It's always something mellow so I'm able to decompress enough to write my treatment notes. (Sharon)

All four clinicians endorsed one method of self-care: a long drive to decompress and reflect. Both Jalena and Catherine have hour-plus drives home, and actively used that time to process patients, situations, and in some ways, to serve as their own case consultant. Both Lindsey and Sharon have a shorter drive, but Lindsey spent time driving from work to her farm and Sharon would drive around the block until she was able to decompress enough to function in her roles at home.

Superordinate theme 2: Empathic attunement.

The second theme that developed was empathic attunement. As seasoned clinicians, the participants understood the reciprocal role of therapy. In addition to the patient feeling heard, it is also important to bring oneself into the room. All participants looked at their

offices as nooks of safety and calm, and held them as a major component of why Veterans were able to open up. The clinicians considered it equally important to present themselves as a caring, interested, pseudo-coach in the process. Three subthemes emerged: the use of self, self as an instrument, and worthy battle buddy.

Subordinate theme 2.1 Use of self as an instrument.

Each clinician had a method of using herself as a tool within therapy. For some, it involved mentally rejoining the patient throughout the session when the mind wandered. For others, the self-as-tool pertained to reflective guidance of the patient. Still others actually used their physical body and movements as a means of connection.

Unlike areas of self-care, Jalena felt that her ability to be a tool of healing for her patients was skillful. She was able to listen to the Veteran's physiological needs while modeling her own. Her tool was the ability to separate herself and determinedly focus on the disclosing Veteran, who usually felt unheard and shamed in other areas.

Personally, I talk myself out of feelings related to or parallel to the Veterans' situation. To do this, I focus on keeping myself physically still, then maybe the patient will not be cued into any of my movements and stay with whatever they're talking about. In times where they're going into intense emotions and it's difficult for them, I stop doing anything that would distract them from their emotion. So if I make any movements or any kind of noise, that's going to distract them, especially with him, because he liked to use humor as a distraction a lot. I wanted to make sure anything that I did was not going to pull him out of his own distressing emotions. (Jalena)

Catherine sometimes felt that her youthful features offset her level of expertise and years of experience. However, she uses this to encourage the Veteran to feel safe about testing her, so she can then show her strength and ability to contain their disclosure.

Sometimes I feel like the Veterans test me. They have said, “I don’t know if you can handle it [the disclosure].” So they see if I pass the test. I don’t know if I have with him yet. I think once we know each other better, I could kind of use myself within the therapy. I don’t feel like we’re at that point. In other patients, I like to give people feedback about how they come across to me within session. Talking about their assets and things like that. I sort of give people a reality check or a refrain on something they’re saying. When I hear you say that, it makes me think of this. (Catherine)

Given Lindsey’s unique position, she uses herself as a pseudo-tuning fork. She taps into the emotion of the discloser. However, she also has to be a tool for the military—to explore, examine, and decide if the atrocity disclosed by the soldier will be charged as a crime. To mitigate this, Lindsey tries her best to create a safe space through non-judgment and openness.

My countertransference is more like, I can understand your atrocity if you give me the context of what you did. I take the judgment part out of it. I take the horror out of it. And whatever you tell me, if you can make it make sense to me, they can usually come up with their own therapeutic answers. Collateral damage is probably the easiest for me to walk around because everyone knows that that happens. People know that innocent people do get killed in war. That happens to a soldier, they accidentally or unintentionally harm a lot of people—especially children because a lot of the times

children have bombs strapped to them and are running toward them. So I stay non-judgmental with a lot of compassion and sadness. (Lindsey)

The use of self varies from clinician to clinician. Sharon used herself as a tool to confront a disclosing patient's bigotry. She built rapport, and then trust, and eventually was able to process the Veteran's biases, which were pivotal points of treatment.

He said, "Well, I hope you didn't take offense. I hope you didn't get upset." I was like, "No, I didn't. I didn't really get upset," when, you know, of course I did. But I didn't want to tell him, because we had worked so hard to get where we were. He didn't say, "Well hey, I'm not comfortable because you're Black," you know what I'm saying? He didn't know how to take me at first. He was kind of, "Oh, you got a lot of stuff on your wall. Are you going to be able to help me?" We worked it out. After the 12th session, he hugged me, and said thanks. So I use myself. I guess I use a lot of myself. I share some of myself, if you will. (Sharon)

Each participant had strong skills that she brought to the table. For Jalena, it was her understanding. Catherine used her age and self-disclosure to build rapport. Lindsey empathized. Sharon, like Catherine, used unchangeable characteristics as a means of creating trust bonds that are particularly hard for offenders to create.

Subordinate theme 2.2 A worthy battle buddy.

Since this study concerned social workers who worked with combat survivors, each social worker described a situation of an individual Veteran's war experience. All participants attested to their need to be emotionally strong, genuinely authentic, and

generously accepting when hearing about war experiences. This, from the Veteran's perspective, is a qualifier before they disclose things that may shame or horrify them. The social workers needed to provide a durable holding environment before the Veteran fully opened. Each participant admitted to purposely working hard to "pass the test" of the Veteran before work even began. Each participant shared their own experiences of having to pass the test to be what one participant called "a battle buddy," meaning that the social worker must gain the trust and have the "back" of the Veteran as they fight the emotional battle together, side by side.

Jalena highlighted a well-known thought among VA clinicians, that the level of burnout and attrition of social workers is a serious issue. It is not uncommon for a patient to go through multiple medical providers within a treatment year. Being a battle buddy for Jalena signifies creating safety, security, and reliability.

The system bumps Veterans around through so many people. Clinicians don't stay at the VA. They always end up leaving. So building rapport with them is very crucial because they worry that you're going to leave. Why should I tell you this if you're not going to stick around or you're part of the system? It's kind of reassuring for me and nice to know that out of everybody that they've known in their life, they were comfortable enough to tell their story and were able to go that far with me as their social worker. (Jalena)

Catherine's comfort with being a battle buddy was limited, as she was still working on processing and gaining trust and building rapport with her disclosing patient.

It was important for him to kind of be in control and lay that on me and see if I could

take it. I think that's inherent in military culture. I mean, it starts in boot camp and never ends as far as I can tell. You constantly test people and you test yourself. And you check out limits and you see what's the most that you can take. So I think that's kind of how they get to know me. By testing me. I'm not sure I always passed.

(. . . laughing . . .). (Catherine)

Lindsey has an advantage of knowing what it is like to create an environment safe enough for her fellow comrades to disclose. Lindsey takes her responsibility extremely seriously and shows a level of compassion surpassed only by her dedication to her fellow soldiers.

I think any time you work with someone through something, you gain experience.

There are just things you just can't learn in a book. It just takes experience [referring to her deployment]. So I think I definitely have learned. When I hear a story that so-and-so did something, I'm not quick to judge why they did that. You don't know how people are going to react until they're in the situation. I understand that and they know I understand. (Lindsey)

Sharon has been tested multiple times by her patients, who deem her a worthy battle buddy. She gained her disclosing patient's trust, but also created a psychological safety bunker that only someone in the emotional trenches with a patient can create.

After he finally disclosed to me what he did and I didn't judge, I kept myself as calm and as neutral as possible, of course. After that, he felt safe. Sometimes they'll ask me, "Are you able to know this information?" I'm like, "Yes, I am. I've heard it all." So they kind of test you in a way. With that particular guy? Now we have been in

session or seeing each other for almost a year. (Sharon)

The title of “battle buddy” is not easily gained. Each social worker were tried and tested, as a means of securing the trust of patients, who as perpetrators already feel marginalized. While some participants were seasoned in this regard, others were still preparing to take on the responsibility of having someone’s full trust.

Superordinate 3: Insulating the patients against our own countertransference reactions.

The third theme that emerged was the need to protect patients from social workers’ own reactions. Ask any social worker about dedication to their patients and it will be very clear that social workers give their all and meet patients “where they are.” However, even with the utmost care and respect for their patients, there are times when social workers encounter negative countertransference reactions. This was no different for the four participants in this study. Each enjoyed her job and felt effective, but also had specific patients or stories that triggered reactions. All the participants found ways to combat feelings of horror, indifference, and sometimes outright disgust, in order to provide a safe holding environment for patients. Through this theme, three subthemes developed: trauma buffet, “I’ve heard everything,” and feelings in secret.

Subordinate theme 3.1: Trauma buffet.

When asked to pick a trauma story, 100% of the participants responded in some derivative of, “Which trauma do you want to hear about?” One participant stated that she

had several atrocity stories to choose from. This seems standard when working within a VA system, as well as with Veterans with multiple deployments and experiences. Below are the cases shared by participants as the most significant patient disclosures.

For Jalena, her Veteran's story hit close to home as she picked a story that relayed abandonment.

When I first started with him, it was very hard to get to the point. He started off saying that in this instance, it was a suicide bomber and it was a car coming in. They just came in really fast. They were telling them to stop. "You have to stop, identify yourselves. Who are you?" They wouldn't stop. So they engaged fire. They shot the engine. The bomb didn't go off, but there was a little girl inside the car.

There were two individuals in the car, two males. One was I think an uncle and one was the father of the little girl. The little girl had gotten injured from one of the pieces of shrapnel from the engine block. Some shrapnel came by and it severed her leg. So, it was only hanging by a piece of skin. And so he tried to go over there and tried to do what he could for her. His thing was, she was about the same age as his daughter and he went through some depersonalization in that moment. Everything stopped and it was just him and her at a point. And so there was a time after that . . . he doesn't know how long he was there. He doesn't know how long he was holding her. He doesn't know how long he was trying to work on her. He just remembers the next thing. His superior came up and was cussing at him, yelling at him, "Let's go. We've got to get out of here." He wanted to get her to go to the hospital or whatever, but he left never knowing what really happened. (Jalena)

Jalena's recounting of her patient's disclosure was strained and mechanical, strikingly similar to how she described using herself within the room. She became completely still. She attributed this to numbing, as she identified in many ways with the disclosure. Although Jalena's contribution was extremely valuable, her experience highlights that countertransference can be colored by personal stories that shape perceptions, even those that would cause a clinician to pick a non-atrocity disclosure account. Catherine's experience was different in that her patient disclosed mass murder.

He is an Iraq Veteran who's a marine and he was talking about some of the different missions that he went on. He talked about one particular mission where a bunch of them helicoptered into a village in the middle of the night. Their instructions were just to go kill anyone carrying a gun or some kind of weapon. And he basically decided, along with the guys around him—and this was not something that came down from their command—that they were just going to kill whoever. He talked about killing a lot of woman and a lot of children. He talked about how much he enjoyed it. At the end he said, "You know, toward the end of the mission, I kind of started to feel bad, but not really because the adrenaline high was so great that I just, like, I really enjoyed it and we got a lot of bad guys, so I felt good about it." (Catherine)

At the outset of the interview, Catherine recounted having several disclosures that could be shared within the interview. She picked this particular incident because it was fresh (within a week) in her mind. However, it was difficult for Catherine to process this because of her disgust, not so far below the surface, of not only military killings, but those of innocent civilians.

Lindsey not only had the traumas of her disclosing patients, but her own trauma gave her a particular perspective on trauma stories. Lindsey's Veteran admitted to killing an unarmed civilian child.

Because I've been in the military 10 years, people told me disclosures previous to me becoming a social worker. So it wasn't a shock when I heard it in session, but in the therapeutic setting, something someone has disclosed can be considered a UCMJ [Uniform Code of Military Justice] violation or a crime. So this was a close-combat incident. Not a shooting. It was where they were getting shot at, ducking into a house, and ended up just instinctively protecting themselves in a way that was detrimental to the health of the person standing in there. They shot an innocent child that was walking down the street. He admitted he would not do it again, that he didn't have to do it, there were better ways. He knew he didn't have to do it and he struggled with that. But ultimately he was able to forgive himself because in the context of everything as we worked it out, he's not a bad person. He did feel bad about it. But he was really tormented also. So he had to let go of the torment in order for him to get his life back. Because you can't undo the past. (Lindsey)

Lindsey's trauma buffet was particularly large due to her own experiences. Because of this, her narration of the incident was numb and matter of fact. The whitewashing of her atrocity story served as a way of separating her trauma from theirs.

Sharon had two very different trauma disclosure stories and chose which to discuss by weighing which had more of an impact on her. She picked a disclosure of a perpetration of a willful murder.

This Veteran, an OEF / OIF Veteran, went on two deployments to Iraq. The second deployment, he shot a civilian. Just point-blank shot him in the head. The reason why he did that, he said, was that they were on a convoy, and their group decided to go a different direction than where they were instructed to go. So when they were going down this particular road, they noticed that there was a lot of flies, and vermin, just a lot of stuff. And they approached the side of the road and looked over this embankment, they saw these huge oil tanks filled with dead Iraqi civilians that were decomposing. Mothers, babies, men, boys, girls.

He said that it was like something in him snapped where he didn't care anymore about the enemy. He had no feelings for them. So I don't know how much longer after he saw those dead bodies that they went out on another patrol. There were a lot of people approaching him. And one particular guy he identified or he thought was one of the militia or one that was not an Iraqi soldier. So he just didn't care. He pulled out the gun and he shot him point-blank in the head. So that was a war crime. He went against all rules of engagement and everything. (Sharon)

For Sharon and other clinicians, the experience of a disclosure is a frequent enough occurrence that she had trouble deciding between which incidents stuck with or disturbed her most.

Subordinate theme 3.2 “I’ve heard everything.”

One particularly interesting theme was that the participants were able to predict when a disclosure was going to happen. Some hints were body language, and some were

phenomenon that the social worker could not quite explain. This was a talent they utilized in treatment. Jalena was the only clinician that did not claim this ability, and she was unsure why she could not. Catherine, however, was very clear in noticing the “signs.”

Over the course of the interview, I began to think a disclosure like this was probably coming. I don't want to say that I profile people, but I look at their demographics and then I sort of think, “All right, the chances of this are pretty high.” (Catherine)

This skill of foresight allows the social worker to emotionally prepare, thereby preventing feelings of judgment toward the patient. Lindsey's trauma stories were a bit more extensive than the other clinicians.

The collateral damage is probably easier to walk around because everyone knows that that happens. People know that innocent people do get killed in war and when that happens to a soldier, when they accidentally or unintentionally harm a lot of people—especially children, because a lot of times over there, children have got bombs strapped to them and are running up to them. I just try to have a lot of compassion but also sadness.

Most soldiers don't go over there just wanting to cause harm and destruction. I think the only way [being a combat vet] works against me is sometimes I don't see the obvious—sometimes I'll overlook some of the risks. That's why I like having my supervisor because sometimes she will say, “Well, objectively, he's got an alcohol problem. He has homicidal urges toward his boss and probably is shooting at the range.” So I think that's where sometimes it's good to have somebody outside of the situation who hasn't seen it all. (Lindsey)

Lindsey's multiple experiences with combat and disclosures created a feeling of compassion that she uses to understand and predict experiences that may lead to an exposure. Sharon described how she was able to detect a forthcoming disclosure through the patient's behavioral changes.

I know it's coming if there are specific things they want to say. They might say, "Don't write this down." So that's when I know that an atrocity or war crime is going to come up. I've heard it all. (Sharon)

Sharon keyed into being able to predict a disclosure by the tone and mannerisms of the Veteran during a session. Being extremely attuned with the Veteran helped to solidify the burgeoning connection. As the demographic for this study included clinicians with more than one year of treatment experience, all participants were seasoned clinicians who could predict patient disclosures, based on patient cues, subsequently allowing for trust and healing. These clinicians have mastered the advanced tool of sharpening the skills of staying attuned and intuitively aware with patients.

Superordinate theme 4: Feelings in secret.

Each clinician valued and respected the patients with whom they worked. Each participant exhibited remarkable care and worked to create an environment in which patients felt understood, wanted, and accepted. However, in our interviews, participants disclosed their own feelings that they hid from the Veterans, including ambivalence, pride, disgust, and hunger. Given the personal nature of the feelings shared during our

interviews, each participant's undisclosed feelings cannot be generalized and are recounted verbatim.

Jalena noted that the feeling she has most frequently is pride in her patients and the hard work they do with her. Parallel to that, Jalena's idea of self-image was strongly linked to her ability to serve and connect with these difficult patients.

I think the reason why I'm there is to get them to be able to open up and go into something horrific. The ones that don't want to go there are a little harder to encourage and build up to that. I feel like I am being more productive, so I guess if they're able to do that, then I guess it's easier for me to feel like I'm doing my job. (Jalena)

The link of pride is so strong that Jalena finds it difficult to detach her work from home and her worth as a clinician outside of her patients. As previously mentioned, her competent work with disclosers surfaces and assuage fears from her youth, such as disappointment and absence of safety.

Personally, I guess that it's almost like it's kind of reassuring to me. I'm doing my job well. It's an ego thing. It's nice to know that out of everybody that they've known in their life, they're not comfortable in talking about any of it, and they were able to go that far with me as their social worker. (Jalena)

Although it was clear that Catherine loves her work, she has also worked hard to cover feelings of anger linked to her sister's rape and her father-in-law's death at the hands of a drunk driver. "Oh yes, I definitely get disgusted," she said. "I think particularly when I hear Vets talk about crimes against women, like gang-raping them or something of that

kind. It hits a little closer to home.” Catherine’s disgust owes to her morals and upbringing, which clash with some of the illegal activities disclosed by the soldiers.

It’s not my job to sit there and go, “Oh, my god, I am so disgusted by what you did.”

So I think of it as I’m giving them what they need by listening and by not having that reaction. But then I need to have it later on. (Catherine)

Catherine struggled with this ambivalence. “Well, I wish I could say I was more horrified by it,” she said, “but at this point, I’ve heard it so many times that I was just kind of like, ‘Yeah. I wasn’t really surprised.’” Ambivalence was also an emotion Lindsey found difficult to counter. Her dual role made it extremely hard to stay present, not only for her Vets but also for herself. Her distancing constitutes a dissociation that helped her find space between being a soldier and being a social worker.

So as a social worker, I don’t know if countertransference occurs. Maybe because I am military and because I have been deployed, maybe that’s the countertransference. I don’t react horrified. It helps me understand how it got to the point where [the veteran] chose to do that. I have worked with a few perpetrators, but nothing, nothing against children and nothing really horrific. (Lindsey)

Lindsey also shared a type of hunger that was not uncommon among other participants. She explored the social workers’ voyeuristic desire to hear additional juicy details, in perhaps a counterphobic attempt at mastery within self and job.

There is a hunger [regarding a disclosure]. I get excited. I think that my reaction is usually, “Tell me more; tell me more,” but I have to hold myself back a little bit. If I’m

really excited to hear this story, I have to remember that it may be a story I don't want to open. (Lindsey)

Sharon's emotion in secret was her ambivalence about her patient and his disclosure. Inside Sharon positive and negative feelings coexisted in relation to her disclosing patient. "Numb," she said. "I'm numb. Somebody walks in and they're like, 'I'm getting ready to cut my wrist,' and I'm like, 'Okay. Right. Triage, get ready because we're going to have some sutures.'"

Sharon shared that she tires of the stories and the unending crises often presented with a post-traumatic stress diagnosis. To stay lighthearted, she joked about her identification with mental-health issues.

A patient comes in and says, "You know, I'm just so depressed." And I'm like, "Well, guess what? Join the club." Or, "I'm angry." "Well, guess what? Me too." You know what I'm saying? Let's talk about who's angrier, you or me. (Sharon)

Inevitably, all the clinicians reported experiences that were both similar and markedly different. Whether it was all participants sharing the similarity of their own traumas or areas where they diverged, the rich experience of the clinicians helped to shed light on how each one experiences countertransference when sitting with disclosing Veterans. Sharon's sentiment of social workers who work within the military care-system stated it best:

So you got to say, "Okay, let me get ready for this trauma." And then you see them again next week, or you look at the list, and the next patient has checked in. I'm like, "Golly, can a sister get a no-show?" (Sharon)

Summary

The purpose of this study was to examine social-worker countertransference reactions when engaging in therapy with combat Veterans who disclose committing war crimes. In particular, this study focused on the nature of those reactions, the social worker's response to the reactions, and the use of those reactions within therapy. This was achieved through the review of the transcripts and video using IPA analysis. The study included four female participants, one an active-duty social worker who had previously deployed and three that worked for the VA within their community-based outpatient clinics. This chapter described each participant and her interview.

In this type of study, it is pertinent that one can visualize themselves in the interview in the same way as the researcher, who worked to understand and visualize the meaning each social worker assigned to experiences with a disclosing Veteran. This ultimately allowed for a greater understanding of the main themes of social workers as people dedicated to insulating patients against clinician reactions and feelings in secret.

Chapter V

Findings, Implications, and Conclusions

This section will examine and discuss the key findings in relation to contemporary theory. Additional topics will include significance of this study, the clinical and theoretical implications of the results, suggestions for future research, and reflections. The following findings were discovered and will be presented in more detail in this chapter:

1. We are wounded healers . . .
2. The need to feel skilled . . .
3. The threat of disgust . . .
4. Battling ambivalence . . .
5. Hunger for more . . .
6. A worthy battle buddy . . .
7. The phenomenon of self-care . . .

We Are Wounded Healers

Being someone's social worker is, in many ways, an honor. A patient allows the social worker to access places within the patient that feel broken. It becomes the social worker's job to assist the patient on the road to healing. A social worker's skills acquired through

schooling must also be layered with “street smarts” and life experiences. However, all participants shared that these life experiences also trigger their own emotions.

Research points to the fact that a social worker’s countertransference reactions are affected by the clinician’s own psychological health. Beatty (2001) stated that roughly 60% of studied social workers said that their own therapy affected their career choice, and 90% of participants experienced at least one life event such as a childhood trauma, loss, or dysfunction in families.

For Jalena, this was very real. She disclosed her previous therapy for issues related to childhood sexual trauma. This coping may have been helpful in the past, but at an unconscious level, it triggered her decision to participate in the research study. While recounting her history, she stopped the interview briefly to regain composure after being triggered while discussing the death of a child during her patient’s disclosure. This was exemplified in her statement, “You can’t ignore the countertransference. Especially when it pairs.”

Catherine shared an index trauma that was not specifically her own but nevertheless molded her reactions with patients. These traumas directly affected her work with Veterans who were sex offenders or alcoholics, as she found that her countertransference, including feelings of disdain, disrupted sessions.

Sharon’s childhood experience of being the youngest girl, and excluded from activities due to her parents’ overprotective nature, helped her have a particularly soft spot for patients who were the “underdogs,” or who were raised with constricted social development. She understood why some people were shy and reserved in social

situations. This works very well with combat soldiers who suffer from PTSD or social anxiety, in which cases isolation is a main mode for coping. Richardson, Sheenan, and Bambling (2009) suggested that motivations to provide therapy like Sharon's indicate an attempt to come to terms with one's own psychological conflicts through practicing therapy. This is consistent with contemporary theories that those in the profession of therapy usually have personal, difficult experiences that create a desire to mentally help others.

Not all clinicians are wounded from things in their personal lives. Sometimes the environment that they practice in plays a role. Catherine reported a reaction of fear and anger when she recounted overhearing the men of a group therapy session jokingly talk about gang-raping her.

My male coworker overheard it and checked in with me afterwards. He was like, "Are you okay? That's the worst thing I ever heard someone say." And I didn't have a reaction to it. I was just like, 'Yeah, that's what it's like to be a woman.' (Catherine)

Although she had no previous personal experience of rape, Catherine's trauma related to sexual assault increased. She was able to intuit that her experience colored her countertransference reactions toward older men in large groups. For cases like this, Zeddies (1999) suggested that if social workers are haunted by their own unresolved disavowed psychological issues, regardless of the circumstance, then it is the social worker's duty to seek therapeutic support. Catherine acknowledged this and sought consultation.

Lindsey was more detached and mechanical as she discussed her deployment to Iraq and subsequent social-work degree. She recounted that as a medic she dealt with healing the soldier's physical wounds, but thought it might be easier to heal their emotional wounds. However, in the unique position as a true wounded healer, she found she had to split her loyalties.

Sowden and Stewart discussed this dynamic in their 2011 article, "The Dilemma of Competing Loyalties in the Profession of Arms." The authors explained that if we revisit the army's definition of loyalty, it is directly counterintuitive of how emotions of loyalty naturally operate for civilians. They stated that for people similar to Lindsey, "Loyalty landmines cut deeper into the psyche and can distort existing schemas in such a way that it creates perverse moral disorientation on a subconscious level of psychological processing" (p. 22).

Although Sowden and Stewart (2011) attempted to highlight this phenomenon in non-helping professions such as social work, it readily applies to Lindsey's attempt at distancing herself emotionally by the conduction of "hypothetical" therapy sessions. It also explains her reluctance to tell the story of the Veteran during the interview because it was her way of handling the difficult task of melding the two competing allegiances. "It's not my specific story to tell," she said. "It's kind of like telling somebody else's story. I guess it's a respect thing. The details of his story, I feel like they're not mine to tell." She did, however, share the story during the second interview. For her, balancing her soldier's brokenness with her own provided an everyday struggle.

Contemporary literature supports the idea of a wounded healer, and holds that people enter social work for a number of personal reasons. However, literature has also shown that via this desire, the need to work on self sometimes creeps into the session. Additionally, using Catherine as an example, it is important to point out that sometimes trauma reactions are formed from the dangers of the treatment environment. Examination of this will be pertinent to further exploration.

The Need to Feel Skilled

All clinical social workers have licensure requirements that ensure the highest quality of knowledge given to their patients. Each participant completed these criteria and were up-to-date on their licensure requirements. Hypothetically, all the participants take pride in being equipped to practice confidently and with expertise. However, in practice, this was only true for some of them. Jalena found it difficult to fully embrace her skill. She struggled to take pride or ownership in the hands-on work done with the patients, as she felt it was self-indulgent and de-emphasized the patient's movement toward emotional growth.

This supports research that suggests social workers working with perpetrators feel shame when praising themselves and thus rarely do so (Sussman, 1992). A poignant example of this was when Jalena retold a story of her patient's emotional milestones. She smiled as she recounted the story, but quickly caught herself and stopped smiling. She explained that she was putting the spotlight to herself versus the patient, and that this was unacceptable. She felt that social workers should be humble. "We want to bring ourselves

down a little bit and not get our heads too high in the sky,” she explained. However, Jalena felt comfortable taking pride in her skill to create a safe environment for the patient. She stated that it was important for her to remember that. “No, I’m not a Veteran,” she said. “I’ve not personally been in war. But being confident in my skills, I can normally get them to . . . warm up.”

In contrast, Lindsey and Sharon talked openly about their effectiveness. They were not boastful, but they believed that it was a deep privilege to witness and be the catalyst of client growth. Norcross and Farber (2005) reported that when social workers feel fulfilled by their work and proud of their efforts on behalf of their patients, they feel reassured that they are in the right profession. Both Lindsey and Sharon ascribed to this phenomenon. McCann (2011) called social work a “mystical experience in the living lab of psychotherapy” (p. 9), and agreed that professional pride is a protective factor against social workers’ potential ineffectiveness.

Although Catherine struggled to feel as though she was optimally effective in her work (because of issues like age and gender), she found pride in her ability to teach the Veterans how to connect with themselves. With a population of combat Veterans who suffer from PTSD, she has the necessary skill of helping patients get grounded and stay present.

I do a lot of [self] mindfulness, like really scanning my body and noticing where I feel stuff. I also do a lot of grounding exercises with people, especially if they're dissociating. So I really like to kind of sit there and go, “I’m sitting in my chair and my feet are in my shoes,” and kind of go through that in my head. (Catherine)

With this level of awareness, Catherine models and teaches her patients how to do the same. Currently, literature fails to fully highlight the different experiences of social workers who do not feel as comfortable in self-representation and effectiveness in practice, or how this affects their reactions to patients.

The Threat of Disgust

Experiencing disgust for their patients often disturbs clinicians. As social workers, creating a safe space within the therapy room is usually the primary task in making clients feel safe and cared for. However, participants expressed that a significant feeling of anger and horror accompanied therapeutic feelings.

The phenomenon of these feelings is touched on by Winnicott (1949), who began the discussion of social-worker anger. He warned that, “We must not deny those feelings otherwise the therapy becomes adapted to us” (p. 74). This was difficult to process for Catherine as her feelings of disgust were complex. “It’s not my job to sit there and say, ‘Oh my god, I am so disgusted by what you did,’” she said. However, most social workers are able to identify their countertransference reactions, which ultimately benefits treatment—an idea that this study supports.

Additionally, this study found that when the patient disavowed evil, it directly triggered the act of disavowal within the social workers. Pope and Tabachnick (1993) pointed to the phenomenon that patients seem to connect to social workers’ own fantasies of violence, hatred, and desire to act out. These are feelings that most social workers shield fiercely. Sharon wrapped her arms around herself as she admitted that the patient

she thought was a “nice wholesome man” had “turned into a guiltless killer.” She felt not only disgusted by the patient’s actions, but also by her own reactions.

Relationally, the countertransference feelings of sitting with a disclosing war criminal are complex. These feelings are transacting every moment in the therapy room, but for some social workers, the feelings are never disclosed. Without the support of consultation, feelings may remain only partially processed. Yet, those feelings represent a humanness of the profession. The social worker can be a protector for the patient, and sometimes change roles to represent other entities that the patients disown. Although this can be frightening and sometimes emotionally overwhelming, these social workers continue to give of themselves for the healing of the broken soldiers sitting across the room.

Battling Ambivalence

Data from this study showed the importance of clinicians identifying themselves as having a strong inner or moral conscious. Thomas (2011) explained that the idea of therapeutic alliance and collaboration rests on the trust and strength the practitioner provides. Lindsey explained that her fortitude allowed her military division to trust her to be competent and strong. This served her well while on active duty.

The data also showed that sources of social-worker strength centered around the values that the women associated with themselves, be they spiritual, religious, relating to family upbringing, or derived from life experiences. The study’s findings elucidated that

to enter the field of therapy, practitioners must possess the ability to build alliances, be empathic and less reactive, and resist the attitude of shaming.

This proved difficult because although participants used words like “pride” and “honorable,” they also used words like “repulsed” and “monster,” and described how they felt their Veterans sadistically enjoyed describing atrocities. As stated above, even when social workers feel skilled in their jobs, they still encounter feelings that are hard to integrate (Winnicott 1949; Pope & Tabachnick, 1993; Orange, 2006).

Some of the stories that the participants recounted were gory and painful, cruel and callous. Some directly challenged the social worker’s moral beliefs. Catherine reported that she morally bristled at the idea that people kill people, but was able to temper it by understanding the necessity of the act of war and weighing that with her spiritual beliefs. Aron (1999) posited that discordance with the patient may provide a unique and important treatment perspective. For example, Catherine’s moral compass was vastly different than her patient’s, this discordance lent the opportunity for the social worker to become more curious about the experience for the patient.

Each social worker had her own way of balancing the plethora of her reactions. Whether it was staying completely still—like Sharon, Catherine, and Jalena—the participants employed many techniques to emotionally remove themselves from the office, making room for the emotional expanse of the Veteran’s disclosure. Sowden and Stewart (2011) tried to describe this phenomenon in suggesting that social workers have to narrow their view of patients, so that the atrocities do not overwhelm the clinicians and they are able to move on in their difficult job.

Hunger for More

Some researchers have attributed entrance into the profession as a manifestation of the social worker's own unconscious narcissistic desires, and that social workers also have the conscious tendency to give too much of themselves, or even martyr themselves, to fit patients' relational needs (McCann, 2011; Sussman, 1992; Richardson et al., 2009; Beatty, 2012). Clinicians working with combat soldiers do not mind being an emotional container for the perpetrator and at times find that they voyeuristically participate in the stories of gore and inhumanity. All participants commented that they could predict a disclosure, and that this excited them. Lindsey mentioned a satisfaction in hearing a disclosure, and Jalena shared that non-disclosing patients tended to be less exciting.

Lansen (1991) explained that social workers who worked with Holocaust survivors sometimes became so psychologically hungry that they looked for and solicited more and more sensational stories from their patients, asking needless questions about the war. Although his theory was geared toward the social workers of Holocaust survivors, this finding still aligned with the participants' experiences in this study. Lindsey chuckled as she talked about sitting with the Veteran in her office and desiring to hear more of his story, but at the same time, having the dilemma that doing so would possibly lead to disclosure of actions she had to report. She seemed a bit disappointed and torn at the same time. Catherine reported that in session, she battles her own ego to not seek pleasure in the horror of the disclosures.

Lansen (1991) also examined discernable patterns of behavior that his Holocaust-survivor social workers exhibited, in direct similarity to the experience of this study's

participants. Lansen posited that some social workers often found themselves drifting into different roles with the patients. These included, “negative nurturing parent; negative controlling parent or taking up the good child psych persona” (p. 55).

As a “negative nurturing parent,” the social worker wants to protect the patient from ever hurting again. This develops out of fear and guilt that there is little more can be done for the patient (Lansen, 1991). Lindsey carried this burden, as she worked in an environment of command. She was in charge of mentally and physically protecting her fellow soldier-patients, but felt unable to do so.

The “negative controlling parent” becomes infuriated with the patient for complaining about a situation, or when the patient bestows upon the social worker the role of their prosecutor. A memorable part of Sharon’s interview came when she described listening to a patient “drone on” about his problems and anger. She said to herself, “I’m angry too, you’re not the only one. Why don’t we put our notes together and see who’s angrier?” The joviality of her tone alluded to being both caring but also annoyed with the patient’s complaints.

There are also times when patients’ needs prompt the social worker to respond as the “good child.” Jalena became frustrated when finding herself trying to never displease her patient. She noticed that when the patient disclosed, she witnessed herself rocking more visibly in an attempt to soothe the patient and simultaneously take care of herself. She did this even though it interrupted the flow of allowing the Veteran to be curious about his suffering.

Personally, I think it’s just talking myself out of feeling like I’m related to the

situation or parallel. So I focus on keeping myself still and then maybe the patient won't be cued into any of my movements and stay with whatever he's talking about.

(Jalena)

Lansen (1991) concluded that in order to give the healthiest treatment possible, the social worker should acknowledge these personal sympathetic feelings that may be promoted from the patient. Social workers can also play the role of a "the fearful child," feeling unable to cope with horrible patient stories and ashamed that they have never had the gruesome experiences themselves. In some cases, the social worker may begin to see their patient as beyond saving and hence become exasperated in working with the patient. Although this was not a phenomenon expressed by participants in this study, Ceccarelli (2005) suggested that when social workers take such positions, they fail the patient by acting out, versus helping the patient work through and process situations.

Navigating the emotional landmines of Veteran war criminals can be harrowing, and in some cases, over-intriguing for the social worker. While Lansen (1991) theorized that a well-run therapy would allow the social worker to judge the patient's needs, he also warned that it is only balanced when the social worker also keeps emotional distance. It was found that creating distance was complicated by the voyeuristic hunger to know more, and to solicit the Veteran to disclose more. When the patient does not have more to disclose, it leaves the social worker unsatisfied. This indulgence leads to the social worker to assume different roles in the therapy office, in attempts to simultaneously manage two different hungers: the hunger to hear and the hunger to help.

A Worthy Battle Buddy

This particular theme was universal among the participants, but it also resonated with the researcher. A psychodynamic patient with whom I spent more than two years shared that he saw me as a worthy battle buddy. He explained a battle buddy as someone he could trust, who had his best interest at heart, and who would support and protect him.

This was an amazing honor for him to give me.

Being a protector for patients is often needed to help regulate the onslaught of feelings and emotions introduced in therapy. This sentiment is supported by current literature that posits that within therapy, the social worker is the most important instrument for healing (Richardson et al., 2009; Rogers 1957; Beatty 2001). However, this knowledge can now be expanded to encompass the nuanced dynamics of social workers (in this case, all female) protecting not only combat soldiers but also combat criminals. The strength needed to accomplish this is crucial for using oneself as a competent instrument for healing.

All participants described the moment where they began to break down the delicate walls of the Veterans with whom they worked. One of the most poignant examples came when Jalena described her pride in being the lone confidant of her Veteran, the one he had chosen to sit with in his most vulnerable psychological zone. Jalena reported being proud like the parent of a child who had “walked for the first time.” Lindsey and Sharon both spoke about being tested and awarded this status. Lansen (1991) stated, “Social workers contain, absorb, restrict and restrain” (p. 4), and pointed out that patients deposit

their fears, excitement, evil, and love within the social worker, hoping the social worker can endure those feelings of abnormality and shame.

However, not every participant described their experiences in the same way. Catherine felt controlled by the patient, that she was being tested to see if she could withstand the horror of his disclosure. Unlike the other participants, Catherine stated that she did not know if she “passed the test [to be a battle buddy]” and that she imagined she has not yet done so, because she is still being tested by her disclosing patient. She said she sometimes wondered how much pressure she could take from the Veteran. As described during her group experience, social workers regularly walk into the therapy room unaware of what to expect that day from the patient. Unlike the other participants, Catherine felt that this unpredictability sometimes threatened to unbalance and crumble one’s idea of self as a social worker.

On the other hand, Lindsey felt her experience in the field gave her a certain advantage when working with combat vets. She too had seen trauma, and had made the same life-or-death decisions. Lindsey was a worthy battle buddy because she was an actual fellow combat soldier.

Lansen (1991) guided social workers to sympathize with the patient but at the same time create distance so the practitioner does not “fall into the problem of concurring assumed solidarity and becoming an accomplice” (p. 2). Lindsey tried to combat this by not judging a fellow soldier’s actions. She felt no one could understand split-second combat decisions unless “you are there.” Surprisingly, she sought counterbalance by staffing all cases with a coworker who could objectively point out when Lindsey’s

collusion obscured the soldier's actions. "Sometimes I'll overlook some of the risks," Lindsey said. "That's why I like having my supervisor. Sometimes I'll take the word of the client and not be as objective as probably I should." This points to the findings that while it is beneficial to have a social worker who has been in combat, such a situation can threaten objectivity if the clinician is not in regular consultation with a peer or supervisor.

For most social workers, things done in therapy are geared toward helping the patient feel comfortable and safe enough to engage in a reciprocal dialog. From the way that the office is decorated to the social worker's seated position, everything relays the message to the patient that they are safe and cared for in the dyad of shared therapy. Most participants saw themselves as strong and able to emotionally protect the Veteran alongside themselves in the trenches of treatment.

The Phenomenon of Self-Care

The ability to self-care is sometimes difficult for social workers. Whether because of workplace politics or an overloaded panel of patients, self-care usually takes a back seat to patient care. Social workers accompany their patients on some of the most intense, emotionally painful journeys imaginable (Thomas, 2011). According to Pipher (2003), although practitioners often go into this field understanding the emotional cost of the work, they also enjoy the challenges and obstacles. "Although the work can be frustrating and demanding and puts you in peril, it's one of the best jobs around. It's fun if you can stand it" (pp. 137-138).

This level of connection and intimacy can leave clinicians open to feelings of helplessness, which can affect one's job to operate efficiently. This is why literature stresses the need for self-care. Beatty (2001) reported a number of theories about self-care, including the normative phrase, "Don't take it home with you," but literature lacks examples of how to do that efficiently. In this study's findings, all the women had a similar but also nuanced way to provide self-care. They all used their long commutes (one hour or more) to process the day's patients and sessions. This afforded them the opportunity to decompress with ample time to change hats when they returned home to their families.

Lindsey found it hard to self-care, for reasons different than those often suggested in the literature (e.g., lack of time or burnout). She found it hard to self-care because she had a whole unit—hundreds of soldiers—depending on her. As she put it, "My self-care was taking away from my officership." She felt like every time she tried to take time for herself, and attend to her own therapy, she cheated the army and failed the soldiers under her officership. Subsequently when she was "no longer needed" because the army was downsizing, she took the opportunity to leave and focus on herself. Perhaps it was difficult to not over-identify and repeat her own military trauma every day.

Ceccarelli (2005) theorized that in these situations, we are tempted to repeat what we have suffered. Lindsey's own pain led her to social work. Curiosity of the minds of others ultimately reveals one's own curiosity of oneself. This study showed that Lindsey's inability to self-care led to her quitting her job, not only in therapy, but with the army

altogether—a large action of self-care, in and of itself. This important point was emphasized poignantly in the study.

Sharon had one of the most structured self-care mechanisms of all the participants. She would go on walks with her coworker if she had a particularly difficult patient. This served as both a tool for processing and also for exercise, which was one of her self-care goals. She also brewed herself tea, listened to music, and was able to compose herself enough to write the summary note from the session. Consistent with Thomas (2011), Sharon's coping mechanisms are sufficient to gain "emotional separation" by keeping herself differentiated from the patient. Although Sharon has a short drive home, she would, like the others, stay in the car until the day's happenings were resolved. She reported that when an issue was particularly difficult, she would sometimes drive mindfully around her subdivision several times. Thomas (2011) would maintain that Sharon's emotional separation was a method of buffering herself against the "negative effect of empathetic engagement" (p. 2).

Likewise, Catherine's self-care method included mindfulness for herself within session.

I really don't want to say I cultivate it [initiating self-care] exactly, but I really check for it and sort of stay in my body, while I'm sitting with somebody and really just try and pay attention to that. (Catherine)

All participants found creative ways to deal with the stressors of helping Veterans. Each participant employed these tools with regularity, to avoid becoming vulnerable and

ineffective as clinicians. With consultation, support, and self-care, the clinicians can continue to provide support for the Veteran perpetrator.

Summary of Interpretation of Findings

The findings of this study helped to explain social-worker reactions to disclosing war Veterans. As a cohort of military specialized social workers, all participants reported areas where they felt competent, proud, deskilled, and overwhelmed. Being human and understanding that some of the rawest emotions present themselves within the therapy room helps to balance the difficult job of caring for themselves as clinicians.

Each participant was asked to share a story of a disclosed atrocity. Each chose a story that differed from the others. The findings of this project have underscored that each participant picked a story that had a personal flavor, meaning, or an idea that was important to express in the interviews. It was shown that this directly related to their own parallel traumas, interests, fears, or skilled areas. Lansen (1991) normalized that social workers have feelings of guilt, rage, dread, horror, grief, and shame—and that social workers enact the defenses of numbing and denial to counteract those feelings. The findings of this study illuminated the need for more research that emphasizes this phenomenon.

Chapter VI

Conclusion

Theoretical Implications

This study contributes to the existing understanding of the relational dynamics of countertransference by specifically targeting the countertransference reactions of therapists engaged in therapy with war criminals who disclose atrocities. When looking at these reactions, it is best to view them in terms of a relational model. Relational theory suggests that disturbances in the early bonds shape the interpersonal world of the human being (Mitchell, 1988). To expand on this, the study closely conceptualizes how those interpersonal and professional bonds of the clinician directly affect the therapist's corresponding reactions within the dyad of counseling. In this section, the theoretical implications will be categorized in four main sections: employing defenses, the idea of "we," hunger, and a worthy partner.

Employing defenses.

The researcher assumed that each participant would openly share her reactions to Veteran disclosures during the Skype interview. Specifically, the researcher expected to hear classic struggles of bonding with patients and periodic disconnection. This supposition was partially true in that three of four participants talked freely about their

experiences with countertransference and shared specific standout instances. However, Jalena, although initially motivated to share her experience, was drawn into her own trauma while talking about parallels between her childhood abuse and the soldier's story about the death of a child. Jalena quickly shut down and remained guarded through the rest of the first interview, as well as the entirety of the second interview.

Jalena felt overwhelmingly disturbed by her own activation, which prevented her from being fully present during the interview. Her trauma reaction was so strong that she could be seen dissociating from the experience. She began to steel herself and look down at the floor as she detached from her immediate surroundings, which, at this point, consisted of the Skype screen. Although the researcher attempted to repair the relational chasm, Jalena never emotionally returned to the interview. This research tells us that wounded healers (the phenomenon of therapists needing to organize their own psychological growth) will react to the projections of their patient's powerlessness, and that this can allow triggering to surface within the therapist. Subsequently, the research showed that these dynamics were managed outside of the therapy room by all participants, to protect the patient, as well as the therapists' sense of self.

However, although one might assume that Jalena's reaction was a negative coping strategy, Blomberg's (1996) hypothesized that such reactions might be psychically healthy. Perhaps Jalena engaged certain tools to suppress the destructive elements of her activation during the interview. The research showed that Jalena's coping allowed her to shut out overstimulating aspects of the interview, so that these feelings would not disrupt her most important job: being a psychically stable mother when she returned home. As

this study found, therapists need to feel capable in the presence of a serious personal disruption within the therapist in the shared space. If not, the space will become unsafe.

As a result of attempting to defend against the horrors of disclosures and return to bearable work, therapists like Jalena will enact defenses like those she successfully used during her childhood trauma. For Jalena, her goal turned from sharing her countertransference reactions to focusing on returning home emotionally unbroken so that her dynamic with her children, family, and loved ones would remain safe and containing. This affirmed the idea that therapists sometimes become wounded healers and despite this, they have an innate desire to feel skilled in their lives and practices. This study showed that all participating clinicians were aware of triggers and knew the benefit of seeking help.

In summary, the course of this study made clear that although therapists generally remain strong in the field to maintain themselves and provide fortitude for the patient, there has to be consideration for therapists with sexual or other trauma. Just by the nature of topics discussed, careful attention this activation can lead to therapists feeling de-skilled with their patients. The chance of losing skill and difficult enactments will prove detrimental to effective treatment if not resolved.

The idea of “we.”

All therapists confirmed that they relationally felt the reciprocal tug of reactions between themselves and their patients within the therapy room. Benjamin (1988) suggested that the transference that patients bring into the room is equally built on the

reactions deposited by the therapist. This was clearly shown to be true within the study results. Participants described volleying feelings of hunger, disgust, and ambivalence within the room.

This dynamic was exemplified by Catherine. Her negative countertransference reaction was so strong that it disrupted the dyad between her and the patient. Relationally, therapists with innate moral aversions against murder or other atrocities will bristle against the horror that these patients disclose, much like Catherine did. The results of this study elucidate that all of the participant's reactions were directly guided by their moral beliefs and what they personally carried into the sessions. These findings prove that although therapists can sometimes have negative personal narratives or disruptive reactions that cause clinical hindrances, these reactions, if properly managed, can improve the relationship of "we" with their patient.

Hunger.

Given the patient population, all therapists reported not being stunned by soldiers disclosing painful, gut-wrenching, and saddening stories. Relationally, all therapists created personal methods of distancing themselves from psychological harm and attempted to use self-care as a mechanism to assist in withstanding the horror of the disclosures. The researcher originally hypothesized that countertransference reactions would be so heavy that therapists would be relieved when patients did not disclose. However, this proved untrue. Findings showed that therapists felt the opposite.

Three of four participants directly addressed the hunger for knowing more about the patient's disclosed atrocities. Two respondents commented that working with other patients without atrocity stories became mundane and "boring." The researcher's assumption that a therapist would flee from negative countertransference reactions proved false. Instead, interviewees embraced these reactions.

Each therapist had been working with veterans for more than a year by the time of the interviews. Relationally, clinicians had heard many battle stories and through this level of "trial by fire" they had become stronger regarding containment under extreme duress. In fact, the more complex the disclosure, the more therapists enjoy the challenge of working with disclosing patients. This is because these disclosures tap into feelings of excitement and focus for the therapist. It was also found that therapists, if left unmonitored, may give into their thirst for tantalization, which can affect clinical work with patients who proved a less clinical challenge for containment. In summation, therapists' voyeuristic positions sitting with patients are fed by the hunger to know more. This thirst also strengthens therapists' tolerance for hearing hard stories and maintaining the alliance.

A worthy partner.

This study proved that therapists working with combat perpetrators have a unique task, requiring therapists to maintain healthy empathy for the perpetrating veteran but also providing containment against dangerous enactments. These enactments, such as unbearable shame, are recreated while simultaneously supporting the healing growth of the veteran's autonomous self. Aron (1991) proposed that patients actively seek to

personally know their therapists just as the therapist actively seeks to know them. In the context of this study, such active seeking proves dubious. Therapists need to be advised of the perils of falling into the sensationalism of the atrocity and becoming an accomplice or colluding with the patient (Lansen, 1999; Lansen, 2011; Foxe, 2004).

Whereas one participant, Lindsey, found it difficult to separate herself from colluding with her fellow combat soldiers, all other therapists reported the ability to stay objectively removed. All participated in peer support and case presentation to maintain the balance of conspiring versus empathizing with the patient. Even Lindsey was able to recognize her partial bias and offset it through constant supervision with a fellow combat-soldier psychiatrist.

Mastering this ability to balance the relational dynamics within session led to three of four therapists receiving the title of “battle buddy,” a term used by patients to denote extreme trust in a therapist’s ability to emotionally serve and protect the patient. In session, therapists benefit by employing these skills and contributing healthy containment to their disclosing patients. All participants took pride in their “battle buddy” status.

In summary, four theoretical implications affected therapists: employing defenses, the idea of “we,” hunger, and a worthy partner. This study found that participants attributed their status as seasoned clinicians to their ability to identify and discuss their countertransference reactions toward patient disclosures. Each participant found areas where she utilized the countertransference reaction positively, as well as areas where feeling skilled were challenged. It is important that therapists find ways to heal personal triggers that result from patient disclosures, and battle their feelings of ambivalence and

hatred toward patients and their actions. Therapists must also temper their thirst for sensationalizing the stories and avoid the pitfall of slipping into cruelty (Grand, 2008), as opposed to staying focused on healing the perpetrator of the atrocity. Clinicians achieve this focus through self-care acts such as exercise, family connection, support of friends, and consultation on tough cases.

Lastly, here is perhaps one of the largest implications in this study. Therapists who can overcome their initial fears of working with Veteran populations can gain a respected role in treatment, and perhaps become so trusted as a vehicle of healing to earn the title “battle buddy.” Relationally, Lachmann (2000) suggested that therapists recognize the moments to rework or reorganize feelings within the room as well as to address rigid archaic strongholds. This study highlighted characteristics of this category of therapist and also drew attention to how countertransference within the room contributes to this.

Clinical implications.

Results from this study explore countertransference reactions of therapists while providing treatment to combat veteran perpetrators. This research found that treatment with war criminals differs from traditional treatment for issues such as depression and PTSD because of accompanying feelings of guilt, shame, and the illegality of the actions that precipitated the disclosures. Treatment for a patient who has somnolence issues and flashbacks will be different than a patient who has committed crimes that will jeopardize his career or freedom. With this, therapists working with this population have special challenges that we would be remiss not to address.

This study revealed that therapists will experience confusion when confronting their own ambivalence and the disturbing emotions that occur when working with combat veteran perpetrators. Feelings of disgust and repulsion can threaten to destroy the therapeutic relationship. Hence, clinicians who treat this population should be aware of common countertransference reactions. This includes myriad competing feelings, the increased chance of personal triggering, and the need to pay special attention to the surfacing of these aspects within treatment. Likewise, as shown, therapists will likely be triggered in some way by their work with this population. Given this finding, clinical social workers and all other clinicians should engage in their own psychotherapy. Personal psychotherapy is effective for clinicians when struggling with countertransference (Richardson, Sheenan, & Bambling (2009). This awareness can help therapists working with combat veteran perpetrators feel more skilled, empathetic, and capable of handling the unique treatment needs of this population. That being said, there are also implications that can be addressed within social work education.

Training implications.

Many social work education programs—whether bachelor’s, master’s, or doctoral—are proficient in helping burgeoning professionals learn the tools needed to practice confidently and effectively. However, as demonstrated by the women in the study, a basic understanding of countertransference and related practice implications does not sufficiently cover the dynamics of in-session reactions to veteran perpetrators. Since the increasing return of combat veterans, some schools have made special efforts to discuss

the challenges of working with veterans and sometimes also combat veterans. This is extremely beneficial. However, in researching local programs in the Houston area, no programs offered specific training for clinicians working with this specific population.

Likewise, social work programs would benefit from focusing more on this topic. The far-reaching impact of war atrocities impacts not only perpetrators but also their spouses, children, workplaces and, as described, relational dynamics such as within the therapy room. Supporting clinicians in learning about the pitfalls and stressors of working with combat veteran perpetrators can help fight the universal feeling of lack of skill that each participant expressed.

Systemic implications.

Although one participant was an active-duty social worker, all others practiced within the Veteran Administration system. The suggestions for this population of clinicians would include supportive programs such as monthly provider calls or meetings addressing this particular population, or regular educational products that review the current treatment theory for offending combat veterans, as the social-work community pays little attention to current theories on countertransference reactions with this population.

This study underscored that active-duty social workers must contend with split loyalties. Having a therapist who feels that she can fully engage with patients without fear of jeopardizing patients' livelihoods is a basic tenant of effective therapy. The current solution of having a code for talking about atrocities with the patient so that

reporting does not have to interfere with treatment dissolves trust with the patient and efficacy for the therapist.

However, at the same time, the VA has been giving more attention to marginalized needs of populations such as women veterans, the LGBT community, and those who experience sexual trauma during their service. The VA recognizes that clinicians treating these subpopulations need particular support. However, the system fails to educate clinicians who may support the subpopulation of combat veterans who, for example, are themselves perpetrators. Concentrated education and support for clinicians in the military and within the Veterans administration system would prove beneficial.

Larger administration implications.

One additional area that could utilize continual support is financial contributions to the organizations that employ clinicians who serve these populations. Funding to organizations like the military, VA, and community programs would help provide needed training programs. Likewise, it is important to continue current support for our returning soldiers. Government-funded programs such as educational support for veterans returning to school and vocational rehabilitation programs help clinicians provide psychosocial coping. Sometimes this coping is needed in conjunction with therapy to help veterans return to fully functioning civilian lives.

This study highlighted the vast experience of social workers working with combat veteran perpetrators who disclose atrocities. This study identified areas of growth for supporting these clinicians with the difficult task of providing informed treatment. The

women in this study brought much knowledge to their profession. By staffing cases with other mental health professionals or even discussing their experiences within this study, they have done a great service to highlight and continue discussion and education about therapist reactions within the treatment room.

Implications for Social Work

The study of social-worker reactions benefits the areas of training and supervision. Below are examples of how such study may improve social-work practice.

Graduate programs better preparing students for the perils of the profession.

Although it is unlikely that a specialization for the treatment of military professionals will be fully developed in schools, students should still learn about the emotional fortitude necessary to stay present during patient disclosure. Perhaps some classes could focus on high-risk populations and plan self-care / support systems. This would teach students to identify and utilize supports when in the field. Many of the participants in this study felt that they had to process material without support, which ultimately led to burnout.

Social workers working with Veteran perpetrators should have consultation and support.

Often, the systems of peer support that the population of social workers explored in the study were faulty. This should be a major part of any program, but especially for those who work with Veteran perpetrators.

Guidelines for therapy by those on active duty should be reviewed.

Active-duty social workers face the conundrum of split loyalties. Having a social worker who feels that she can fully engage with patients without fear of costing patients their livelihoods is a basic tenant of effective therapy. We need a code for talking about atrocities with the patient, so that reporting does not have to interfere with treatment. We could thereby avoid adverse effects such as dissolution in trust with the patient and efficacy for the social worker.

Strengths and Limitations

This study has offered an evaluative perspective on the countertransference reactions of social workers when participating in treatment with Veterans, particularly combat Veteran perpetrators. The strengths of this study were the diversity of the social workers. Although there was homogeneity regarding gender and experience level, all practiced in different states and in varying jobs. This allowed the study to compare and contrast the different elements of the women. Likewise, diversity in terms of race gave a unique view of how issues of origin impacted treatment.

The openness of the participants to explore their reactions was the strongest part of this study. Each participant allowed the interviewer to prod and probe with questions of practice, as well as areas of perceived skill and lack thereof. Most of all, each participant brought to light the varied dynamics of social workers.

As with any research study, there were limitations. One limitation pertained to the participants. This sample population possibly did not represent a sufficiently large variety of those who work with Veteran perpetrators. Although the research was an average sample size for the type of research done, there were some issues with homogeneity. Having interviewed all female social workers may not have given the widest range of data. Another limitation was the inability to sit face-to-face with the participants. For a relational social worker, watching and talking with someone through video media is never as good as sitting with the person face-to-face. Not being able to interview the participants in a shared space may have limited the researcher to explore non-verbal communications and made it more difficult to build rapport.

Suggestions for Future Research

The findings of the current study have demonstrated the fortitude and strength of men and women who work with this population. It highlighted the many interpersonal struggles that social workers encounter and how skilled social workers are able to identify and use countertransference reactions within session. It recognized the paramount importance of identification of the unconscious countertransference reaction between the patient and therapist. It also found that dynamics for future studies could

include the reactions that develop between researcher and participant. Future studies would benefit from encouraging therapists to seek their own treatment when working with veteran perpetrators so that a system could be in place for therapists like Jalena, whose countertransference jeopardized the quality of even her study participation. Future research would benefit from looking at what role gender plays in processing countertransference reactions. Perhaps some of the reactions would be markedly different. Looking more thoroughly at the role, and mental coping, of active-duty social workers would also benefit the profession. Examining the counterintuitive reactions of military social workers with competing loyalties will be a great asset to the knowledge base.

Lastly, future research would benefit from gaining information about patients' reactions to clinicians. This study was primarily focused on the dynamic from the social worker's standpoint. Insight could be gained for the profession by identifying how patients viewed social workers as they disclosed.

Researcher's Reflections

During this journey, I have gained so much insight into the world of social workers and hence myself. It was sometimes very invigorating knowing that the struggles I faced are similar to others. This reinforced the work that I have done over the years and soothed my angst about how I react within session with this population.

Through this research, I also learned that some of the pitfalls of our profession include overextending ourselves, giving into the titillating stories, and indulging ourselves in

patients' emotional conflicts. The emotionally successful social workers in this study created an ethos of self-care. It encouraged me to set up regular consultation at my own office.

During the first round of interviews, I had to actively remind myself that my participants were not my clients. When Jalena broke into sobs, I worked hard to not slip into my social worker role. Doing so would taint the comrade-to-comrade bonds that were made. Creating a power differential would have been disastrous to gaining truthful, unadulterated feedback.

One participant was so enjoyable that I began to fantasize about talking with her after the study. Her sense of humor and relieving demeanor created a safe environment for her patients, and I found myself wanting that also. At the end of our last interview, I mentioned that her patients must feel very in tune with her and that I believed her patients knew without a doubt that they were cared for. I hope that my patients feel that way about my therapy space as well.

The data that emerged from this study will hopefully help other social workers verbalize their reactions and process them and their role more efficiently. The hope is that this study will encourage discussion on working with this population, and add to the growing knowledge about provider experience. Until these reactions can be regularly and openly discussed, the profession will lack insight into how therapists cope with perpetrator therapy. Not only would this strengthen social work practice, it can also be multidisciplinary, used to help inform other professions such as psychiatry, psychology,

and family-dynamic practices. Understanding this phenomenon stretches beyond the social-work population. That is one of the reasons I enjoyed this research so much.

Conclusion

This study began with an unprocessed question of how colleagues reacted when they encountered Veterans who admitted war atrocities. This study found that social workers are oftentimes wounded healers. It found that all of the participants had areas that needed psychic growth or examination. However, it also found that utilizing these reactions properly can produce rich and meaningful experiences of therapy for the Veterans.

All participants agreed that being able to provide quality care to their patients is an utmost priority. Each participant had areas where she felt proficient and skilled but also had areas where she felt unable to perform skillfully. The social workers usually utilized consultation in terms of supervision or staffing cases to support their choices in therapy and validate actions.

An additional finding was that clinicians who worked with this difficult population struggled with feelings of ambivalence. There were also prevalent feelings of pride and simultaneously disgust. This is not to say that social workers do not care for the Veteran patients, but that war perpetrators bring up myriad reactions during sessions.

Often, skilled social workers are sufficiently in tune with their patients to predict when a disclosure will be made. This allows the practitioner to be ready and prepared, if needed, to contain the patient during the disclosure. It was also found that social workers with this specific population hunger for more details. As disclosures were made, Veterans

appreciated having a safe space in which to confide with their therapists. For therapists, being the protector of the vulnerable Veteran sometimes led to the utmost honor of “battle buddy,” the trusted companion with whom the Veteran can fight the psychological battle.

Lastly, it was found that self-care was acknowledged by each participant, but some found it more difficult than others to practice. For some, it was being able to tap into their own mindfulness in and out of session. For others, it was setting up a system of diet and exercise. But for some, the idea of self-care was riddled with guilt. The idea of taking care of oneself was seen as extravagant and selfish. In this case, self-care was discarded, which resulted in termination of work in the field.

This study is vital to the specialty of social workers who work with the armed forces and the unique situation that this evokes. Working with returning combat Veterans requires a look at the specific relational matrix that comes about in these types of therapy. Whether it is the lack of post-master’s training on the harrows of the profession or the naiveté that those in the helping profession, it is very clear that we are not fully aware of our reactions and how they are used in session. Feelings of guilt, trust, frustration, and pride are all in line with participant accounts.

The findings are significant because this population challenges the current social-work knowledge base. Although similar to former studies of perpetrators, it can barely be generalized to this population. This is a subset of common civilian life, which is then a subset of military service, which is then focused on combat Veterans and their attempts at healing from atrocities that are unknown to most people. The social worker is the

overanalyzing mother, nationalist supporter, and protester against human injustices.

Social workers both love and dislike the perpetrating Veterans. As the social workers sort their feelings, they also simultaneously work hard to provide the Veteran with the most caring and welcoming therapy possible. The job of a combat soldier's social worker is long and mine-filled, but many buckle down and ride along with the soldier on the journey to healing, and many find it to be the most rewarding position imaginable.

Appendix A
Initial Survey

Appendix A: Initial Survey

Please complete the following survey. Circle your answers.

1. Have you, in the last year, treated a combat Veteran who disclosed war atrocities?
 - a. Yes
 - b. No – if not, please stop here and contact researcher

2. Of those combat Veterans, have you actively engaged in therapy with at least one Veteran for a minimum of 3 months?
 - a. Yes
 - b. No – If not, please stop here and contact researcher.

3. How many years of clinical practice experience do you possess?
 - a. Less than 2 years – please stop here and return packet to researcher
 - b. 2 to 10 years
 - c. 10 to 15 years
 - d. 15 to 20 years
 - e. Greater than 20 years

4. Are you a Licensed Clinical Social Worker or equivalent?
 - a. Yes – Please indicate the state _____
 - b. No – please stop here and return packet to researcher

5. What gender do you most identify with?

- a. Male
- b. Female
- c. Other

6. Your age:

- a. Under 20
- b. 21-30
- c. 31-40
- d. 41-50
- e. 51-60
- f. 61-70
- g. Above 70

7. Your ethnicity:

- a. White
- b. African-American
- c. Asian/Pacific Islander
- d. Hispanic/Latino
- e. Other

8. Your highest degree completed:

- a. Masters
- b. Doctorate

9. Theoretical orientation you most identify with:

- a. Psychodynamic (and/or Psychoanalytic)
- b. Cognitive Behavioral (and/or Behavioral)
- c. Humanistic (and/or Existential)
- d. Integrative (and/or other)

10. Where do you work with Veterans

- a. Veterans Administration
- b. Private Practice
- c. Clinic
- d. Other

Appendix B
Interview Schedule

Appendix B: Interview Schedule

Interview schedule categories adapted from (Phillips, 2004)

Base Questions

1. The definition of atrocities is limitless. Generally, war crimes are defined as

- Murder
- Genocide
- Enslavement
- Torture
- Rape
- Persecutions on political, racial and religious grounds

2. Crimes during war, for this research, are defined as actions including:

- Driving under the influence
- Arson
- Drug charges
- Robbery
- Human trafficking

Do these align with your understanding?

- a. Probe: If no, what does the expression “war atrocities” mean to you?
- b. Probe: How was this idea formed for you?

3. There are also various understandings of countertransference reactions. I define it as: the conscious and or unconscious reactions to the patient in therapy. Does this align with your understanding?

a. Probe: If no, what does the concept of countertransference reactions mean to you?

b. Probe: How was this idea formed for you?

4. Please recall a particular patient and/or situation where the Veteran disclosed being a perpetrator of a war atrocity.

a. Probe: Can you share that experience with me?

b. Prompt: Keep this person and situation in mind when answering the following questions.

Identifying the source of Countertransference Reactions (CTR)

5. What was it about this particular disclosure that caused you to have a difficult to define reaction?

a. Probe: What was it about the Veteran disclosing this that made you develop a reaction to what they described? Can you expound on that more?

Exploring the Countertransference Reaction

6. What physical and/or emotional responses were you able to notice that you exhibited?

a. Probe: Have you had thoughts or feelings that manifest themselves in dreams, physical sensations or behavior inside the session? Can you discuss that more?

b. Probe: Did you act in a manner that was unusual or inauthentic for you? Talk more about this, please.

7. Thinking of your response, will you describe how you first noticed this reaction?
 - a. Prompt: How did you know that you had a markedly abnormal reaction?

Investigating the Function of the Countertransference Reaction.

8. Thinking of your countertransference reaction, can you speak to what you believe was the purpose of your response?
 - a. Probe: Did it help you to be able to understand enactments for you or the patient within the room, for example? Why?

Assessing the Impact of the Countertransference Reaction

9. How do you believe those reactions impacted your patient?
 - a. Prompt: How do you believe those reactions were perceived by your patient?
10. How do you believe those reactions affected you?
 - a. Probe: Did it highlight past trauma's or life experiences that may need more attention? Can you speak more to that phenomenon?
 - b. Probe: Did it illuminate areas of growth or strength? How so?

Clinical Use of the Countertransference Reaction

11. Thinking of this particular example how do you believe you may have used your countertransference reaction within the treatment room?
 - a. Probe: Did you disclose your CTR? Can you speak to that?

12. Can you speak to how ultimately your reaction impacted your relationship within the working alliance? Can you expand on that?

Appendix C
ICSW Consent Form

Appendix C: ICSW Consent Form

Institute for Clinical Social Work

Research Information and Consent for Participation in Social Behavioral Research

THE OTHER DON'T ASK, DON'T TELL: EXPLORING
COUNTERTRANSFERENCE REACTIONS AMONG CLINICAL SOCIAL
WORKERS PROVIDING THERAPY TO PERPERTRATORS OF WAR
ATROCITIES.

I, _____, acting for myself, agree to take part in the research entitled Exploring Countertransference Reactions Among Clinical Social Workers Providing Therapy to Perpetrators of War Atrocities.

This work will be carried out by Vivian Jennings-Miller, LCSW under the supervision of Dr. James Lampe.

This work is conducted under the auspices of the Institute for Clinical Social Work; At Robert Morris Center, 401 South State Street; Suite 822, Chicago IL 60605; (312) 935-4232.

➤ PURPOSE AND BACKGROUND

The purpose of this research is to examine how social workers react when working with Veterans who disclose their involvement war time atrocities. You are being asked to

participate because you are a Clinical Social Worker who provides therapy to this population.

➤ **PROCEDURES**

If you agree to be in this study, you will participate in the following:

- Two 90-minute interviews by Skype.
- One 60-minute interview for follow-up and data checking.

We will set up a time to meet that is convenient with your schedule.

➤ **BENEFITS**

There is likely no direct benefit to you from participating in this study. However, the information that you provide may help develop stronger, more informed practices for social workers working with this population.

➤ **COST**

You will not be paid for your participation in this study.

➤ **RISKS**

Because of the personal nature of the interviews, there is a possibility that you might find the interview distressing. In the unlikely event that some of the interview questions make you uncomfortable or upset, you are always free to decline to answer or to stop your participation at any time. Should you feel discomfort after participating, I will be able to provide a list of community resources local to you that can be helpful should counseling needs related to the above occur. Likewise, this research will yield to the Texas rules of duty to report abuse, neglect or unethical activity.

➤ **PRIVACY AND CONFIDENTIALITY**

Reasonable efforts will be made to keep the personal information in your research record private and confidential. Any identifiable information obtained in connection with this study will remain confidential and will be disclosed only with your permission or as required by law.

Your name will not be used in any written reports or publications which result from this research, unless you have given explicit permission for us to do this. Data will be kept for five years after the study is complete and then destroyed.

➤ **SUBJECT ASSURANCES**

By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue this study at any time without penalty or loss of benefits. My relationship with the staff of the ICSW will not be affected in any way, now or in the future, if I refuse to take part or if I begin the study then withdraw.

If I have any questions about the research methods, I can contact Vivian Jennings-Miller, LCSW or James Lampe, Ph.D. at this phone number (409)986-2960 or (773)665-1380 respectively.

If I have any questions about my rights as a research subject, I may contact Dr. John Ridings, Chair of the Institutional Review Board; ICSW; At Robert Morris Center, 401 South State Street; Suite 822, Chicago IL 60605; (312)935-4232.

➤ **DOCUMENTATION OF CONSENT**

I have read this form and I agree to take part in this study as it is explained in this consent form.

Signature of Participant Date

I certify that I have explained the research to _____ and believe that they understand and that they have agreed to participate freely. I agree to answer any additional questions when they arise during the research or afterwards

Signature of Researcher Date

Appendix D
Recruitment Flyer

Appendix D: Recruitment Flyer

**VOLUNTEERS NEEDED FOR
RESEARCH INTERVIEWS ON:
YOUR COUNTERTRANSFERENCE
REACTIONS WHEN PROVIDING THERAPY
TO COMBAT VETERAN PERPERTRATORS**

We are looking for volunteers to participate in speaking about their reactions when counseling combat Veterans who are also perpetrators. As a participant in this research, you would be asked to: recall some experiences from your own clinical practice and answer some questions about them. There will be two interviews and a possible third (if needed) lasting approximately 60-90

minutes. The deadline for participation is November 1st 2015.

Your input will be used to inform our Social Work practice!

Feel free to contact me if interested:

Vivian Jennings-Miller, LCSW at dissertationvjm@gmail.com or

phone/text (832)221-3126.

Your experience is very important to us and will be kept strictly confidential

(used only for the purposes of research for this project).

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