Relational Social Work Practice with Combat Veterans

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Introduction

Relational social work is a practice model rich in social constructivist, relational-cultural, feminist, and interpersonal theories born out of the psychoanalytic object relations and self-psychology schools of thought (Tosone 2004). Despite theoretical variations, all these orientations share the foundational construct that human beings are inextricably embedded in their social environments and cannot be understood apart from the relational context in which they are immersed in (Aron 1996; DeYoung 2003; Jordan 2010; Miller and Stiver 1997; Wachtel 2007; Watts 2003). The context of combat powerfully and enduringly impacts the survivors who become clinical social work clients and therefore calls for the contextual sensitivity of relational practice.

Contemporary neuroscience, psychological, and social work research findings confirm that human beings are hardwired to form social attachments (Cozolino 2002; Fosha et al. 2009; Porges 2011; Shore 2001). Clinicians observe how desire for human bonding, connection, and mutuality fuels many of our strivings (Adler 1992; Aron 1996; Bowlby 1983; Mitchell 2000); Stern 2000). Many of these strivings also fuel the promotion of human welfare within our social and subcultural groups. In total, human beings make meaning, and create and maintain their sense of self through the context of their social relationships (Wrenn 2003). The dramatic change in the meanings and sense of self between combat and post-combat contexts creates an urgent need for a relationally attuned process to reestablish the combat veteran's sense of cohesion and relevance.

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J.B. Rosenberger (ed.), *Relational Social Work Practice with Diverse Populations*, Essential Clinical Social Work Series, DOI 10.1007/978-1-4614-6681-9_14,

Individuals learn to cope in the world by assigning rules, attitudes, and values to self and other. They develop plans for action through images of what relationships should be as well as for the ideal self (Adler 1992; Stolorow 2007; Watts 2003). Relational social work focuses on the healing nature of relationships through connection and co-creation of narratives and meanings (Aron 1996). This is the heart of relational social work, which adopts a client-centered non-pathological stance. The focus is not merely on symptoms catalogued in the Diagnostic Statistical Manual of Mental Disorders 4th Ed. (DSM-IV) (American Psychiatric Association 1994) but on difficulties arising from conflicts caused by disconnection, ruptures, and misattunements, in an individual's relational environment (Mitchell and Aron 1999). This relational environment includes group membership, which can be a product of shared heritage and/or shared significant life experiences.

Combat Veterans and the Social Work Perspective

Combat veterans, like members of other diverse subcultures, present with complex cultural layers derived from their war experience that impact all phases of clinical work. While clinical social work, embracing client in context, is especially suited to the required cultural competency and sensitivity in working with any group that is socially constructed, unique features of the military context, and combat in particular, are central to practice with this population. This is even more the case when, as is common, the clinician himself/herself is or has been a member of the military. The relational clinician is actively engaged in monitoring her own as well as her client's interaction of military socialization with experience in the civilian world. Attunement is specifically necessary to the veteran's symptoms, issues, and personal narrative, as an adaptation of that person to the environment of war (Goldstein et al. 2009). Awareness of the adaptations that are necessary to survive the culture of combat, coupled with the specific social work value of taking into account a person's present and past context (Tosone 2004), reframes events and helps redevelop new growth to promote optimism, hopefulness, and successful reintegration with a prewar, and perhaps enhanced, identity. The literature review and case illustration presented below support the importance of a relational social work perspective for this population.

Recent studies note that many veterans go outside of the Veterans Administration and military mental health settings in order to receive care (Hoge et al. 2006, 2004). Therefore, clinical social workers will encounter this population in settings that provide individual, family, and child treatment. Indeed, presenting problems and even initial assessments often do not directly reveal combat experience or link that experience to the problems for which help is sought. This is particularly true in when a veteran or his/her family member presents for clinical services that are not combat related; such as marital, child or substance abuse issues. The veteran may be attempting to compartmentalize that history in his/her life. Therefore the social work practitioner should routinely ask about military history in the initial assessment phase.

The Department of Defense estimates that 2.2 million men and women have served in the wars in Iraq and Afghanistan (Watson 2009). To simplify the reading of this material, the words combat veteran, soldier, or combatant will be used synonymously and are not meant to exclude marines, airmen, or seamen. Military culture remains steeped in masculine language, and it is impossible to avoid when trying to give the reader a sense of cultural competency (Sherman 2010). The use of him/his for the veteran and she/her for clinician also is used here to simplify the writing and is not intended to minimize the role women serve in the military or diminish their war experiences or to disregard the increasing number of male clinical social workers. It is beyond the scope of this chapter to discuss in detail military values and norms in each branch of service or issues related to gender, sexual orientation, or ethnicity. The focus is on competency in dealing with a client who has undergone adaptations in identity, values, and behaviors to survive deployment to a combat zone.

The material presented is also relevant to deployments to a noncombat zone. Peacekeeping and Homeland Security missions are similar to combat deployments. Soldiers typically will spend a long time away from family and friends, the conditions of the field are generally uncertain or harsh, there is a lack of privacy and unpredictable level of boredom mixed with threat, and a high chance of bearing witness to interpersonal violence (Adler et al. 2005; Castro 2004). While it is beyond the scope of this volume to address the clinical practice with family and children in reunification with their deployed family member, a social work perspective that focuses on the person's entire family system can recognize and assess issues related to family anxiety, anger, and resentment due to a combat deployment. These issues if remain unacknowledged or treated can create further isolation and disconnection for the combat survivor upon return home. Roles also undergo change, as does the power structure in the family regarding making decisions, which may further create relational and feelings of failure in combat survivor (Laser and Stephens 2011).

Cultural Adaptations to Survival in War

Hoge (2010) asserts that during the phases of engagement and assessment, it is more helpful to view any altered meanings and schemas as adaptive solutions to surviving combat, rather than focusing on the DSM-IV (APA 2000) framework of dissociation, arousal, hypervigilance, numbing, and avoidance as posttraumatic stress disorder (PTSD) symptoms. Viewing the symptoms merely as a disorder can create stigma and interfere with the veteran's ability to reintegrate with his prewar identity. Failing to understand the individual's personal adaptive strategies, however imperfectly they serve at the moment, will limit the clinician's ability to know the combat veteran's experience or to form a therapeutic alliance (Hoge 2010; Shay 2002). Such misalignment between clinician and client violates the mutual pursuit of understanding of relational social work practice and in turn may lead to impairment in psychological, social, and occupational functioning, risking inviting chronic complex posttraumatic stress disorder (PTSD) and other comorbid disorders

(Figley 1978; Van der Kolk et al. 1996). Within the relational principles of collaboration and co-construction of the therapeutic alliance, the clinician can proactively normalize, validate, and affirm to the client that they have had to develop new constructs for self-protection that cannot be easily switched off (Adler 1931/1992; Hoge 2010; Watts 2003). Of course there are veterans who do exhibit symptomatology beyond their combat adaptations; the caution here is against presumptively classifying all phenomena presented as evidence of psychopathological makeup.

The following adaptations should be understood in the context of the combat environment and the difficulty in adjusting upon return to civilian culture due to physiological changes that occur upon exposure to trauma (Castro 2004).

Normal adaptation to combat vs. symptoms in civilian context	
Tactical awareness of environment	Hypervigilance
Trust only in combat buddies	Emotional withdrawal from family, friends
Personal accountability	Over-controlling behaviors
Targeted aggression	Difficulty assessing appropriate level of threat
Armed for battle	Perceived need to be armed for danger
Emotional control	Anger/detachment
Mission operational security	Secretiveness
Individual responsibility	Guilt
Combat driving	Aggressive driving
Discipline	Ordering others/inflexibility

Military Culture and the Subculture of Combat

The military is a social construction formed for the purpose of protecting the dominant culture it represents (Shay 2002). All branches of the military share the same core value of commitment to serve the greater good of its society. This commitment requires the soldier to serve the prevailing government's ideological beliefs and unquestioningly carry out orders given by superiors. Technology, tactics, and demographics have changed over time, but what remains unchanged is the fundamental organizing principle that "one must do what's right, honorably and courageously" for self, comrade, and fellow Americans (Shay 1994, p. 5). These individuals enter into a social contract to secure and protect against the aggression of others. The social work clinician must set aside opinions of the military and of war in order to create the mutuality and co-constructive process of the therapeutic alliance. Transference by the veteran himself to a civilian or Veterans Administration social work practitioner also is active and powerful in the determination of the therapeutic engagement. The relational stance may need more explicit articulation and pursuit of the client's expectations than is typical of the initial clinical social work encounter. Many individuals called to serve in war do not always agree with the mission at hand, but do what is ordered because they took an oath to do so (Sherman 2010; Wachtel 2007).

Early in training, the military individual is re-socialized through the rigid rules of moral order, conventions, normative expectations, ethics, and social values. This acculturation intentionally and forcefully strips away the personal identity, so that the individual can become a member of a military cadre. The new service person undergoes a conversion experience, where the previous focus of life shifts to new collective organizing principles and relational schemas (Sherman 2010). These organizing principles and schemas focus on mission objectives, survival of self and other, and a sense of meaning in purpose derived from the oath to serve.

To assimilate into military culture, one must abandon the social construction of the concept of "I" for the collective good (Grossman and Christensen 2008). Modern military is structured so that each individual is dependent on the chain of command to provide for all their needs, supplies, and orders/responsibilities. This emphasizes that each person's survival is dependent on the others in the group (Shay 1994; Watson 2009). These men and women must suspend many beliefs of their ethnocultural and social groups of origin in order to commit government sanctioned actions, including killing or being killed, on behalf of their fellow Americans (Lifton 1973). This realignment of self-identity requires the construction of a personal meaning that they are doing what is right for the greater good. The construction of personal meaning to serve in combat may be further complicated if the person disagrees with the fundamental objective of the mission. In this case, attempts at meaning will be derived from the commitment they made to serve and the value they find in protecting their comrades in arms (Hoge 2010; Shay 2002; Sherman 2010). Failure to do so might result in rejection of support from the unit they are serving with or psychological decompensation when they are confronted with the realities of combat. The new constructions of relational schemas and meanings that emerge serve not only to acculturate the individual but as a necessary adaptation for survival once deployed to a war zone. Mitchell's (1988) statement that "I become the person I am in interaction with specific others…" (p. 276) is particularly reinforced for combat veterans who need to be aligned with the group to secure mutual survival. As a result, a combatant's newly formed view of the world may feel incommensurable with others outside of military culture (Shatan 1978).

Many men and women join the military due to a sense of patriotism and want to serve and protect others. However, many also join in the hopes of improving their life condition with education, employment, a family tradition, or a lack of alternative life plans. Some desire the structure and discipline, may seek to have basic needs met, experience a sense of belonging, or as a vehicle to gain citizenship (Sherman 2010). This may result in further inner conflicts over participating in, or witnessing, the horrors of interpersonal violence (Lifton 1973). These complex motivations are further arenas of relational exploration and clarification rather than presumption of meanings of which the clinical social worker needs to be aware of.

Training is an unconditional submission to the hierarchy of command for the maintenance of order occurs in other cultural groups where deference and respect to those deemed in authority is a primary value (Berzoff et al. 2008). As is the case in any rigid and closed cultural group, some soldiers may experience inner conflict

about betrayal by civilian authority, politicians, or commanders while trying not to break existing rules, norms, or standard operating procedures (Hoge 2010; Shay 1994). In other words, conscious submission does not quell all unconscious conflicts, even as it is endorsed as the means of survival.

The Intersubjective Context of War: Rationale for a Relational Social Work

Combat trauma originates in an intersubjective cultural context: interpersonal violence of one human is pitted against another (Janoff-Bulman 1992). Combat is personal in comparison to an act of nature: instead of fleeing from the threat of injury or possible death, a soldier is required to face down interpersonal aggression. In this extreme context, disconnection from others and self-identity after military service may be and inevitable by product. The experience of war breaks down the individual's attunement to previously shared meanings with people outside of the combat experience. It also derails previous systems of mutual regulation of self and self with other (Grossman and Christensen 2008; Janoff-Bulman 1992).

Combat trauma is the experience of "unbearable affect" and results in changes in meaning, purpose, values, beliefs, and worldview (Stolorow and Atwood 2002, p. 52). It destroys social trust, which is a key resource to healing (Shay 2002). Herman (1992) asserts that healing from war trauma depends on "communalization." Shay (1994) further clarifies that communilization, which is the reconnection to community membership post-combat, can only happen in an inter subjective context. Freud (1918) in Totem and Taboo, wrote about the communal social purification rituals performed for returning warriors to heal the taint of war Absolution was given not just through acknowledgment of the warrior's experience, but by the community not disavowing the violence and aggression that is endemic to any war so the returning soldier could be reconnected to society, without judgment (Bragin, 2010). In the current social context, the opportunity for this communalization and social purification occurs frequently in the clinical social work process where incorporation of context, past and future, is central. The relational social worker can help the veteran make explicit the words and affect of fragmented, disavowed, and intolerable parts of the combat experience in order to create a whole narrative (Bromberg 1998; Wrenn 2003). Disassociating memories and disavowing affects result in what Saari (2002) described as events that are unconstructed (without meaning), uninterpreted (without words), and unintegrated (without affect). The combat veteran needs to be able to tell his story safely to an empathic compassionate listener, who can be trusted to assist in authentically cocreating a narrative of his experience that is interwoven with pre-combat narratives surrounding self and community identity (Bragin 2010; Shay 1994).

Herman (1992) noted that combat veterans are experts in coping in a society that rejects its injured members, while they struggle with spiritual pain and personal loss. This is confounding to the returning combat veteran because emphasis during tours of duty on protecting injured members is not replicated in the civilian community. Especially when such injury is not visible, failures of support or appropriate

response takes on particularly virulent meaning. Bonanno (2004) underscores the importance of focusing on the individual's resilience and capacity to thrive after traumatic events, which expresses the clinical social work value of empowerment.

Relational theory focuses on the positive psychology of prevention, optimism, resilience, social conscious, meaning making, and a sense of community within relationships (Jordan 2010; Tosone 2004). Restorative application of these principles is a central relational clinical practice. Watts (2003), in discussing relational constructivist theories, noted that human beings are driven by the desire to share with and contribute as individuals to others. The veteran is emerging from a specific culture of prescribed ways of contributing and protecting others into a very different configuration of community. Relational social work emphasizes the core value of healing in context and with veterans must include disjuncture in context. Deconstruction as well as reconstruction of an individual's narrative is bidirectional; the relational clinical relationship's emphasis on mutuality in problem definition and context-embedded attunement to past and future allows interpersonal recognition, a primary self organizer, to be a vehicle for self-healing to occur (Aron 1999; Schamess 2011; Teicholz 2009). The military value of interdependence for survival and growth is in keeping with a relational social work perspective and can be emphasized to counteract infantilization in help receiving (Grossman and Christenson 2008; Herman 1992; Hoge 2010). Working in collaboration with this shared value, the relational social worker, generally embedded in the veteran's civilian social environment, can help the veteran relay, or translate, his new narrative and meanings to his family and community (Figley 1978; Janoff-Bulman 1992; Stolorow 2007). This value assists the clinician in focusing on a representation of what's wrong as not being something inside the combat survivor but rather being how he feels about his trauma experience and what it is like for him to be in the world afterward (Goldstein et al. 2009; Jordan 2010). A relational social work approach can be the fertile intersubjective ground, drenched with shared meanings, not only to create new future based narratives but also to reclaim mourned aspects of a prewar identity (Mitchell 2000; Stolorow and Atwood 2002).

Shattered Assumptions and Altered Schemas of Meaning: Barriers to Treatment

After the overwhelming experience of war, the combat veteran experiences a shattering of his assumptive world regarding safety, trust, and meaning (Janoff-Bulman 1992). Existential issues arise such as traumatic rage and grief, annihilation anxiety, a foreshortened sense of future, external locus of control, guilt and survivor guilt, suspiciousness that the universe is counterfeit, and a loss of meaning and purpose (Frankl 1996; Southwick et al. 2006). These worldviews serve as barriers to treatment, with their isolative and constrictive nature blocking a deepening of the clinical alliance (Lifton 1973; Shay 2002). The double problem of adapting to the new community ethos while maintaining a sense of good self for his combat experience creates and invitation to fractures self-cohesion and a depletion of original meaning.

The combat veteran faced with chronic disconnection, which in turn creates negative, fixed, and painful relational images, can create a state Miller (1989) describes as "condemned isolation." This state decreases energy, creating immobilization, confusion, and a negative self-image, causing his focus to be limited to regulating emotions, avoiding negative outcomes, and/or controlling interactions with others (Wilson et al. 2001). Life projects and meaningful pursuits take a back seat to self-regulating strategies designed to avoid reminders of his combat trauma (Tedeschi and Calhoun 2004). A combat veteran often constricts emotional experience so as not to show that which might be unacceptable or dangerous to others outside of his combat buddies, who he feels understand him (Van der Kolk et al. 1996). Disavowed affects may feel like inner defectiveness or badness if they emerge. This sense of defectiveness may further self-loathing, isolation, and shame that may be perceived as, or is real rejection of the veteran by his social group of origin (Janoff-Bulman 1992; Lifton 1973; Stolorow 2007).

Jordan (2010) discusses how society has the power to create and control images of shame in the prevailing culture. These images become a part of a person's relational images for self and others. In the Vietnam War, veterans, who for the most part were adolescents when drafted, were called "baby killers," marginalized and reviled, due to the sociopolitical atmosphere among the general public. They reported that they felt shunned by the World War II and Korean War veterans. Had this not been their experience, the social rupture could have been alleviated by being socially aligned with the groups that were welcomed and reintegrated in the larger societal context (Shay 2002). Fontana and Rosenheck (2005) noted that Vietnam veterans most often sought help due to existential issues, feeling not so much injured or subject to PTSD, but more as having lost a core sense of self or meaning. Finding a pathway to reintegration is a social work principle fused with clinical treatment: healing isolation and building trust must occur before deeper trauma work can begin (Stolorow 2007).

The strengths perspective of relational social work that seeks to locate and empower the functional value of defensive and coping strategies can assist the veteran in viewing himself as an expert in survival and agent of change in his life, but not a victim (Herman 1992). A veteran experiencing a foreshortened sense of future can be moved to act, rather than to fall into immobilization. New meanings can be created through support in encouraging redemptive acts, newly discovered competencies, and altruism (Fontana and Rosenheck 2005; Southwick et al. 2006). Clinical social work practice that underscores the importance of the encounter with an empathic other will help shift the emphasis from problems, symptoms, failures, and deficits toward strengths, goals, solutions, and possibilities (Goldstein et al. 2009).

Cultural Competence in Clinical Assessment and Treatment of Combat Veterans

The engagement phase is critical in clinical work with combat veterans. Many will not report difficulties during the phase called demobilization, upon when they are preparing for release and return home from a deployment. Many may come into

social work clinical services voluntarily, or be mandated to treatment in community mental health settings, due to marital or child problems, legal problems from substance abuse, or occupational problems (Laser and Stephens 2011). When initially seen, the clinical social worker should be cautious not to pathologize behaviors but rather focus on engagement with the individual around the nature of the presenting problem. Behaviors within any subculture may be seen as abnormal if the clinical practitioner is unaware of applicable cultural norms (Berzoff et al. 2008). In this case, combat training emphasizes the constriction of emotional expression and the value of limited self-disclosure. An equally cautious countertransference is expectable. This is the relational clinician's cultural context in the work with combat veterans and like all transference and countertransference is to be understood, not characterized as treatment resistance or problematic.

In the initial engagement process, seeking specific information rather than generalizing about the military or combat is crucial. For example, the clinician should try to find out what position, or Military Occupational Specialty (MOS), the veteran held. Rank structures (Enlisted, Warrant Officer, and Commissioned Officer) are important self-identifiers. The National Center for PTSD (www.ptsd.va.gov) is an excellent clinical resource for information regarding this population. A brief Internet search of the branch of service, unit, and combat theater the veteran served in helps the clinician conceptualize the deployment, without having to be too intrusive during the initial phase of contact. Familiarity with geographic or regions of the veteran's deployment will go a long way in the engagement process with a veteran (Watson 2009). Applying authenticity, the relational clinician does not pretend to have expert knowledge she does not have or to comparability of her own military experience with that of her client. At the same time, an effort to understand the "language" of the client can avert innocent mistakes like referring to a marine as a soldier or a navy seal or member of the air force. Specific designations are especially powerful in the military (Watson 2009), and clinician errors need to be acknowledged and corrections requested, which can be part of the mutual construction process.

The clinician needs to convey that power in the relationship is shared and that the veteran can be helped even if the clinician is not a member of the group (Goldstein et al. 2009). The empathic and not-knowing stances of relational practice let the veteran know the social worker is interested in learning, through the veteran's privileged knowledge, about the combat experience. Granting expertise to the client conveys reciprocity and tolerance for learning from someone else's experience. Authenticity of the inquiring stance dissipates suspiciousness and may reduce shame about asking for help. It is not unusual for a combat veteran to want to know he has positively impacted the clinician. The relational model endorses not overinterpreting countertransference: in the clinical context, in this case the military, interpersonal responsibility means difficulty accepting help without offering something of value in return (Figley 1978).

Sherman (2010) also underscores clinician in context, calling attention to how the returning soldier constantly must struggle with macro-level forces (prevailing social culture), mezzo-level forces (military culture), and micro-level forces (how he experiences of himself). The clinician represents the dominant group, be she military or civilian. When a veteran is experiencing grief or anger over feeling

marginalized or misunderstood by his family or community, the word civilian may connote frustration, sarcasm, disdain, and despair. This invites defensive countertransference and perhaps vain attempts at compensation, rather than empathic recognition of the authenticity of such feelings. The relational social worker must be able to bridge the divide between us (combat survivors) and them (civilians) with the therapeutic relationship. The relationship can be a template of here-and-now lived experience of reintegration into civilian life which requires modification of the subordination, stoicism, and restricted expression of affect regarding self and others instilled in combat experience (Grossman and Christensen, 2008; Hoge 2010).

Intake and Assessment

In the initial intake and assessment, the clinician should be aware of her eye contact, body language, and tone when acquiring history and presenting problems (Brandell 2011). Authenticity and emotional presence, free of pressure to accomplish a clinical mission, allow mutuality and co-construction of engagement that must precede articulation of a core treatment problem. If agencies require clinicians to use symptom checklists and scales during intake, the clinician should minimize note-taking that limits eye contact and weave the pursuit of specific information into a conversational tone. Thorough preparation by the clinician makes the exploration easier to conduct conversationally. A rigid Q and A conveys that the clinician, like society or the military, sees the veteran as just another number or as sick if they answer yes to symptoms on a checklist (Hoge 2010; Watson 2009). Practitioners with trauma, including combat trauma, value the creation of space for issues to emerge (Goldstein et al. 2009). In this space, the relational social worker can assess safety and trust before pursuing details. Allowing details of trauma to emerge too early can result in emotional flooding and retraumatization, often ending treatment (Van der Kolk et al. 1996).

Problem Formulation and Treatment Planning

Many veterans report problems remembering appointments due to short-term memory and concentration loss, difficulty leaving home during episodes of hypervigilance, unexpected job interviews, childcare, and the like. Clinical social workers need flexibility and open recognition of the increased demands of the veteran's transition. Immediate return to comfort and confidence may not be possible. As noted above, relational theory does not ascribe contextual reality factors automatically to resistance or transference. Of course these may be present, and accommodations with all clients are meaningful; in this population, the potential for attrition is exaggerated by ambivalence about chain of authority and the complexities of reentry into civilian life. Collaboration on managing factors that interfere with treatment consistency involves not only scheduling but phone check-ins if symptoms are too intense. Addressing these context factors openly builds attachment free from authoritarian pressure

(Erbes et al. 2009). The relational social worker measures holding a frame of consistency against transference linked to anger at the government or to negative feelings toward nonmilitary persons. Maintaining balance for the relational clinician includes discussing issues related to the veteran's ambivalence as well as real-life issues with a clinical supervisor or administrator (Erbes et al. 2009).

Clinical interventions will also depend on whether a veteran is still on active duty or may be called backup for another deployment due to a reserve obligation. Psychoeducation on the importance of a soldier's defenses, such as psychic numbing and the avoidance of processing grief and traumatic experiences in the combat zone, should be discussed (Tyson 2007). Explicitly acknowledging the value of maintaining these normal adaptations can convey to the veteran that the clinical social worker is not going to impose the processing of difficult content or minimize the value of what otherwise might be primitive coping defenses, if he will be redeployed. Given the potential of additional trauma exposure, the clinician should elicit what the veteran feels would be most helpful to him, so he does not break down defenses that he feels are necessary to survive in a combat situation again. In this case, it might be necessary to take a here-and-now, supportive approach that focuses on normalizing why he is having difficulty readjusting as well as the relative value of temporary adjustment, in order to improve his social and emotional functioning with family and community.

The Course of Treatment

Many specific issues require attention with combat veterans seeking clinical services. Regarding space, the veteran may not want to have his back to the door, will need a clear exit, and may be sensitive to outside noises. Time management also is vital. A core military value is promptness, and if a veteran is kept waiting in a crowded waiting room, he may assume the clinician does not observe this value and leave treatment. The same is of control over the end of any session: keeping to agreed times shares control. Withdrawal may indicate fear of being asked about his combat experience, such as questions regarding whether they killed someone in action or witnessed the same. The relational clinician, while not the blank screen, must be prepared in her own countertransference so as not to overreact, judge, or offer sympathy for behaviors necessary for survival in a war zone (Castro 2004; Hoge 2010).

Self-Disclosure. The issue of self-disclosure, always controversial, combined with the authenticity of the interpersonal in relational practice, has special salience with combat veterans. Contemporary neuroscience reaffirms that self-disclosure of a clinician's affective experience helps the client increase his capacity for self-regulation, which assists in the reconfiguration of internal representations that may have been altered through traumatic experience (Quillman 2011; Porges 2011). For the clinician, this self-disclosure must be purposeful and contained. Client and clinician both constrict or expand the other's emotional experience in the bidirectional process (Stolorow and Atwood 2002). In relational social work treatment, the clinician making

the implicit explicit should be to help the veteran move from the traumatic content per se to the discomfort of talking about it (DeYoung 2003), which resonates in all his interpersonal relationships.

Even positive relational moments can create intense defensive reactions and anxiety in the combat trauma survivor. The desire to dissociate and emotionally withdraw to ward off all feelings may be true for the clinician as well (Van der Kolk et al. 1996). As a relationship model for future possibilities of reconnection, the clinician must bring these things into awareness with empathy for the pull to disavow history. The veteran needs to see the clinician take risks and share her emotional experience in a non-defensive way to convey that the clinical relational space is a solid and the clinician is brave enough to contain his trauma narrative. Fosha (2000) states that in order for the clients to be willing to share their affects, the clinician must not only show the same but model that "affects are valuable, tolerable, enriching, and that they need not be draining, overwhelming, or shameful" (p. 214). Clinician "neutrality" (Mitchell 1988) can be an unbearable reminder of the veteran's experience with the civilian world in which he has perceived his affect was uncontainable by others and can trigger episodes of shame, rage, and dissociation, as there is no affective ground to which to anchor to (Stolorow 2007).

Rice and Greenberg (1984) suggest that e*mpathic prizing,* which is the unconditional positive regard the clinician has for her client, be made treatment specific, affirming the veteran's intrinsic worth and humanity. At the same time, affirmation may reveal ego deficits (DeYoung 2003; Wachtel 2007). Affirming positive qualities may trigger survivor guilt, rational guilt for behaviors in a war zone, or aspects of personality structure prior to combat experience. The relational clinician's emphasis on the here and now, including the bravery it takes to share difficult experience, can allow the veteran to become more aware of his adaptation to difficult circumstances rather than focus on affects like shame, guilt, and self-criticism (Stolorow 2007). As a corollary, the veteran's being apologetic, or hyper-focused on getting it right in the interaction with the clinician, may reveal a tendency for self-blame for any ruptures. A relational clinician will attend to her own part in any ruptures or misattunements (Mitchell and Aron 1999), indicating the mutuality of all interpersonal connection. Farber (2006) notes that new clinicians must not mistake authenticity in the relational approach for relentless self-disclosure or self-referencing. Silent listening is critical, with the gauge being intolerable withholding for the trauma survivor or clinician anxiety.

Transference Issues. A relational clinical perspective emphasizes what Hoffman (1994) refers to as *dialectical constructivism*, which posits that in a therapeutic relationship there is a reciprocal influence on both the parties subjectivity (Aron 1999). True neutrality, and uncontaminated transference, is not possible (Wachtel 2010). From this perspective, the classical concept of countertransference (the clinician's reaction to the client's transference) is not sufficient to capture the subjective interactions that occur in the bidirectional process. Mitchell and Aron (1999) argue that the term countertransference minimizes the impact of the clinician's behavior on the transference. Orange (1995) argues that the mutual reciprocal interaction of two subjectivities is better described as *co-transference*. Safran (2002) emphasizes that

in-depth exploration of the client's experience that unfolds in the therapeutic space should not focus on interpretations about generalized relational patterns. All these concepts underscore the relational principle that the clinician is not an objective observer in the interaction. Rather, interpersonal reconnection through affective sharing with others, who are not combat veterans, can be accomplished through the co-transference in the relationship (Bragin 2010; Shay 2002). By the clinician modeling observation of her internal processes and actions, in the relationship as they are happening, the veteran and clinician cocreate a template for relationships outside the treatment room. As with all work with trauma survivors, the clinician may experience secondary trauma or reactivated traumas of her own past, such as being the helpless observer, perpetrator, and enactor (Neumann and Gamble 1995). Supervision to avoid unconscious reenactments is part of trauma practice (Herman 1992).

Compassion Fatigue and Shared Trauma. Clinicians working with combat veterans are at risk for secondary traumatic stress reactions, variously referred to as *compassion fatigue* (CF) (Figley 2002), *secondary traumatic stress disorder* (STSD) (Stamm 1999), and *vicarious traumatization* (McCann and Pearlman 1990; Pearlman and Saakvitne 1995; Sabin-Farrell and Turpin 2003). Affected clinicians can experience a syndrome of symptoms, which may parallel their client's diagnosis of PTSD (Adams et al. 2006). While it is an unavoidable occupational hazard for mental health professionals who are empathically immersed in their client's trauma narrative, these reactions cause alterations in a clinician's self-identity, cognitive schemas, interpersonal relationships, physical health, job morale, worldview, and spirituality (Figley 2002; Hesse 2002; Tyson 2007).

Relational social work, which emphasizes the intersubjective field between clinician and client (Stolorow and Atwood 2002), may specifically invite vicarious traumatization (Rasmussen 2005). The co-construction of the trauma narrative confronts the relational social worker with her vulnerability and may challenge her attitudes about aggression and killing (Tyson 2007). Munroe (1991) research found that clinicians who have themselves been exposed to combat-related PTSD had significantly more intrusion and avoidance symptoms. A relational social worker unaware of her emerging symptoms, or alterations in her cognitive schemas, is at risk for rupturing her empathic connection that bridges the client between the worlds of war morality and civilian morality (Tyson 2007).

Clinicians providing treatment to returning combatants of the wars in Iraq and Afghanistan are at increased risk for compassion fatigue. This group of veterans is younger, subjected to severe trauma exposure from multiple deployments, may be less able to return to their prewar occupation due to the present economic situation as well as individual psychological or emotional injury (Barnett and Sherman 2011; McDevitt-Murphy et al. 2010). Negative effects can be minimized by organizational changes, increased supervision and training, as well as clinician's awareness of potential overidentification (Zimering et al. 2003). At the same time, Tedeschi and Calhoun (2004) discuss at length the concept of *posttraumatic growth* that emphasizes the positive effects on the psychological growth of the clinician and client. Finding meaning and purpose in the work with combat veterans can increase *compassion satisfaction* (Linley and Joseph 2007).

The construct of *shared trauma* speaks to primary reactivation in the relational clinician of experience of similar trauma (Tosone 2006). Tosone (2006) states that shared trauma transforms a clinician's self-concept and impacts the therapeutic intimacy in the clinical dyad. She noted that in the aftermath of the September 11, 2001, terrorist attacks on the World Trade Center, employing emotional distancing "felt intolerable and inauthentic" (p. 93). This may be a similar hazard to the many social work clinicians themselves recently serving in military combat for whom retriggering of trauma is a risk. Shared traumas alter professional boundaries regarding a clinician's depth of caring and concern for a client, both productive and defensive. Tosone et al. (2003) noted that shared trauma may cause a clinician to feel desensitized, lack empathy, have less tolerance, and experience more anger at clients who express fear and anxiety that they are themselves warding off. Both the client and therapist may be in the process of mourning actual and ambiguous losses (Tosone and Bialkin 2004).

Relational Social Work: A Case Illustration

Tom is a young, white, 23-year-old male, who was brought into the community mental health center by a fellow marine 4 months after he returned from serving 4 years in the Active Duty Marine Corps. Tom had two intense combat tours in Iraq. He reported that he joined the military in his senior year of High School after 9/11 because he felt "it was the right thing to do". When Tom had completed his 4 years of service, he signed up for the Ready Reserve Unit of the Marine Corps because he felt he had to "finish the mission for my buddies, and this is the only skill set I have." At the initial intake, Tom was guarded, exhibited psychomotor agitation, pressured speech, restricted affect, and constantly watched the door. He reported he was "pissed off about being here," and only came to get his buddy "off his back." His friend, who was also a client at the agency, was asked by Tom to stay for the first intake. He initially gave Tom's history and reported why he was worried about Tom, while Tom remained stone faced at attention at the edge of his seat. It had been a common occurrence in my experience for one combat veteran to bring another veteran in for help. As in Tom's case, highly resistant and suspicious, he needed a friend with similar experience to reassure him there was no stigma attached, a concern I normalized for him.

Tom did not report symptoms when he was demobilizing: he had 3 years left in his reserve obligation, and he didn't want to be seen as "crazy" or as someone who would "get someone else killed." He was living at home with his parents and younger siblings, which was difficult, as he felt "civilians don't get it." Tom reported He could not sleep or stop checking the doors and locks, making sure " the perimeter was secure." He did not exhibit any psychotic processes and did not report any early childhood trauma or losses. Tom saw another clinician the first month he was back, when he could not sleep. Tom complained the clinician was stone faced and wrote notes with little eye contact, going down to checklists and wanting details of his traumatic stressors, suggesting a psychiatrist consultation. Tom stated,

"I don't think I hated myself or anyone else more than in that moment." He had stormed out, afraid he might hurt the clinician. I expressed empathy and contextual normalization, saying that it made sense why he, or anyone else who had been in combat, would have felt enraged. This seemed to relax him and his psychomotor agitation began to decrease. Tom felt he could not connect with friends he had before the Marine Corps who were "living the fairy tale that if you work hard, and do good things, nothing bad happens to you." He could not relax in public places, imaging things that might happen, so he spent most of his time in his parent's basement. He only felt comfortable talking to his battle buddies with whom he felt he was not "a freak." He said it is easier to be in combat than be with his family, as "they just want to pretend the last few years didn't happen." Tom engaged more freely as I validated how his own "just world" beliefs and sense of safety and meaning had been shattered. He acknowledged drinking heavily and getting into fights, which prompted his friend to bring him for treatment.

Tom's symptoms, including alterations in his schemas surrounding trust, safety, and meaning, met the criteria for PTSD. His hypervigilance, hyperarousal, emotional withdrawal, and isolation were ego-syntonic for him – uncomfortable but necessary. Most troubling and angering was his inability to connect with anyone outside of the military. He stated his problem was making some kind of sense out of everything that happened. Tom had survivor guilt over members of his squad who were killed and felt rage in his perception that he was now "like an outcast, that everyone is afraid of."

Keeping with the social work principle of meeting a client where he is, I stated that only someone who had been to battle would know what it was like for him, where anyone would have had to change and do what was necessary to survive. I offered that if it was all right with him, we could work together on skills to help him tolerate the uncomfortable feelings, assuring him that he was not going to lose anything that he needed if he was redeployed: this remained in my mind due to his reserve obligation. I asked his permission to add some goals that I thought might be helpful, rather than telling him what he needed. I expressed a core concern that his present symptoms, if left unchecked, could become chronic.

I was very careful not to elicit too much traumatic combat content during the early stages stages of engagement and assessment. I asked background questions to get to know him, keeping the tone conversational and avoiding clinical terms or diagnoses. I expressed curiosity about his life before the Marine Corps, what meaning and purpose it had for him to join after 9/11, and then what his experience of being home now was like. I wanted him to navigate his narrative, knowing that I would not tread anywhere that felt dangerous. I noted that there were differences because I was not in the military and asked how was it to talk with me, someone who had not been to combat. I encouraged him to let me know anytime he felt I was not "*getting it*." I acknowledged that I appreciated his service and commitment. I emphasized that I could not possibly know more about Tom, or what was right for him, than he already knew himself because he had the skills, strength, and resilience to make it through two deployments. We talked about the tremendous resources it took for all service men and women to get through basic training and combat.

I asked Tom to look at our collaboration as a safe place where he could unpack his bags, since, in his own words, he really "hadn't unpacked" yet and that we would make sure we would pack it all backup before he left each session. This was to reassure him that if he took the risk in letting his guard down in here, that did not mean he had to drop those defenses down anywhere else before he was ready. I kept good eye contact, asked permission to jot down a few dates and names. Tom would "Yes, Ma'am" a lot, even after I let him know he did not need to be so formal. I referred to Tom as "Sergeant" until he let me know he wanted me to call him by his first name.

I made attempts to understand what went on in the region where Tom was deployed, to show him that I really wanted to "get it." He appeared relieved that I gained working knowledge of what was going on during the time he was there, without having to explain it all to me. I used my tone of voice, facial expressions, and body language to help Tom begin to experience and regulate more of his affect, which was constricted except when he was angry. When things outside the room startled him, I confirmed that the noise bothered me too. One night, we were the last in the building and Tom insisted he walk me to my car, which I agreed to, instead of exploring it as a transference reaction. I knew he genuinely felt responsible for others' safety, and he might experience more distress over my refusal of something he could give back.

Early on, I employed education about physiological effects of stress on the body and the necessary adaptations required by the military and combat. This opened up his ambivalent feelings toward his superiors in the military and his frustration of not being able to integrate back to his prewar identity, without disavowing his combat experience. Tom agonized that his skills as a sniper would not transfer to anything but law enforcement. He often felt discouraged due to limited openings for the police academy. Other criminal justice positions he felt he might like required a college education. When feeling hopeless about his prospects, Tom would bring in an application to work as an independent security contractor, or mercenary, in Iraq or Afghanistan. Although I felt this was a terrible idea, I worked hard to control my judgment and offered support and validation regarding how it must feel like he was on an alien planet here and life in the paramilitary might seem easier. When Tom would become angry at something I missed or forgot, I acknowledged my error, and he appreciated my accountability. At times, when his symptoms exacerbated, he would cancel an appointment at the last minute or not show. I explored this casually with him and he agreed that if he could not tolerate leaving home, he would check in via phone. I wanted to express investment in our work rather than rules. Absences decreased over time, and we noted his strength at coming in on days that he wanted to bolt.

I used language that might bridge differences by suggesting we team up, together, perhaps come up with a new mission objective based on current values and strengths. Tom's mission objective was finding a meaningful pursuit that could incorporate his combat experience, so that the "before war me, and after war me, could hang in the same body." I self disclosed to Tom that if I had gone through the same things, I would probably feel the same way and reminded him that as difficult as things were now, he was the same person who could function under far worse circumstances.

Tom said one day, after a long silence, that he was ready to talk about "s**t" that went down, because he felt I "had his back." He was afraid not only to burden me but that I would be "weirded out, scared, or think he was crazy." I let him know the walls in my office had pretty much heard it all, and there was nothing he could say that I couldn't bear to hear or change the way I felt about him. I was honest in responding that some things might be scary or freak me out but that I was not afraid of him or his anger. If he had the courage to bear going through it for us all even when he was afraid, then, at the very least, I could help him hold some of this stuff, so he didn't have to carry it alone.

Tom welled up for the first time, and we sat in silence for a long while. Tom stated he felt he was "keeping secrets", that made him feel "afraid, and full of shame and guilt". He painfully disclosed he was hearing gunfire or his name being shouted by dead friends, when exposed to even the most innocuous stimuli, like a brand of water his buddy was drinking when he was hit. He also said he could not stop looking at video and photos of graphic material from events when he almost died or others were killed and injured. He felt he was seriously "f**d up," but worse, "couldn't feel anything at all." To him that meant he couldn't feel "like a human being again." I let him know how much it meant that he would trust me enough to share this difficult material, that I did not think he was crazy or wrong, and he was grieving for himself and others, and trying to make sense of it all. I had Tom bring in the video and photos, some extremely graphic, but many were pictures of his squad, smiling, in all their gear. These photos elicited great pride in Tom and he had a wider range of affect when he shared them, which I drew his attention to.

As we sat and looked at the pictures and videos, I employed mindfulness techniques, psychic numbing and cognitive distancing for myself, so I could be present for Tom without exhibiting distress. I helped him frame that it is normal for anyone to feel numb or that it didn't feel real, because it is too much for anyone to get their head around. I asked him to notice where he felt it in his body to help him reduce dissociation.

Over several sessions of normalizing his reactions, and how it was for me to witness his experiences, he began to exhibit more grief, and he reported less self-loathing. Tom's symptoms of hyperarousal did increase as his numbing decreased, but we worked together to figure out which skills for distress tolerance worked best for him. Gradually, Tom stopped reviewing the images daily. He understood why he was hearing his buddies' voices, though he still struggled with survivor guilt. Tom had frequent nightmares of combat operations gone bad and once dreamt that I was there with him while he was trying to get to his wounded buddies. I let him know how important it was to me that he had taken me in enough to be part of the rescue efforts. Because I not only heard his narrative but also saw pictures and video, I began to have nightmares of combat, felt vigilant at times, and began to experience alterations in my worldview. I had to pay close attention to my positive transference and genuine feelings of care for him that might interfere with my challenging him or acknowledging things that we both might be avoiding. Both the positive and negative aspects of the trauma work with Tom transformed both the relationship and my own narrative over time.

After 1 year, while the work still oscillated between trauma and supportive work, Tom was reactivated to deploy to Iraq. He had just begun community college, decreased his drinking, spent less time isolating, and found himself better equipped "to deal with civilians" who in his mind were "not all bad" anymore. I was careful not to burden Tom with worry about his safety, as he complained his family did. I genuinely thanked him for his service to our country and explored the positive and negative feelings hearing me say that brought up. I controlled my own reactions of wanting to get him out of the deployment due to his PTSD but knew how he felt about "wimping out." I reminded him of his strengths and inner resilience. I realistically stated that more exposure such as his first tour would have an impact on his neurophysiological system, and we brainstormed ways for him to cope, by reviewing what worked and didn't work for him before. I struggled in supervision with what type of contact might be beneficial while he was in the combat theater and decided to let him know that he could reach out if he felt like it. He jokingly remarked, "you are coming with me cause I always hear s**t in my head that you might say when I am stressed out." I knew at that remark that he had internalized me as someone not only whom he could look to for support but who understood him.

Several months after he deployed, I began receiving urgent voice mails from Tom from a cell phone in Iraq. I became vigilant in answering my phone to unknown numbers and found myself searching the Internet to see if he had been injured in action. My own narrative had been changed by the bidirectional relationship and the care and concern that evolved from our collaborative alliance. When Tom finally reached me, his speech was pressured and agitated. Tom said he called because he was struggling with rage at his command and feeling isolated in his reserve unit, after the one guy he connected with was killed. He stated he hoped my voice might help. I used our relationship, and regulation of my affect, to attempt to anchor him by stating he had been in bad situations before, and capable at his job, while validating his anger at his superiors. Although I was anxious, I was careful to let him know that we would work together on it all when he returned. Knowing his dark sense of humor, I told him to not do anything stupid, as I wouldn't visit him in the brig. Tom seemed to calm after a few minutes of my reframing, and validating how hard it must be to not be able to mourn his buddy while under fire.

The conversation abruptly cut off, due to what turned out to be a rocket and mortar attack. It was impossible to find out that he was safe for several days until I received an email from him. Other than processing it with my supervisor, I felt alone and helpless in my experience of anxiety and intrusive recollecting of the sounds of incoming mortars, yelling, and ensuing chaos before the phone cut off. My symptoms were more than a countertransference reaction and required more than supervision. I sought personal help to process the traumatic experience I had shared with Tom, a relational clinical recommendation particularly in work with trauma (Herman 1992).

When Tom returned, his symptoms were greatly exacerbated and he quickly resumed treatment. We co-constructed the narrative around our shared experience of his deployment. I limited self-disclosure to my concern for him, not the symptoms I experienced. He gave me a piece of twisted shrapnel, as a "souvenir of our shared combat." He reported that being connected to me had helped him navigate back and forth twice between combat and home in a way that he didn't have to cut

off one part to exist in either place. He continues to remain engaged in treatment and able to grieve and work through his traumatic experiences. He also has become more amenable to my challenging cognitive distortions, such as his belief that he could have done more to save fellow marines that were killed. He adopted a survivor mission of reaching out to marines, or soldiers, he would meet at college and offer support, advice, or bringing them to the agency or to the VA for help.

Conclusion

The case of Tom illustrates how a clinical work utilizing a relational approach can help bridge the differences between a civilian clinician and combat survivor. Emphasis on a two-person perspective, in which differences are acknowledged and normalized with this population, can assist the returning soldier reintegrate back to his civilian environment through the co-construction of a future narrative that allows for the premilitary, military, and post-military aspects of identity to coexist. The process of the social work clinician, empathically responding to the combatant's real experience with real experiences of her own, is part of the mutual process that is direct and expressed in the treatment process, rather than artificially being relegated to transference and countertransference as a detached analysis. The therapeutic alliance becomes a template of safe interaction and connection to others, so that the veteran can create and share new meanings and adequately process grief and the traumatic experiences.

Study Questions

1. Describe how mutuality and co-construction of the core problem, as relational practice skills, are reflected in the case in this chapter. Describe how this does or does not reflect your own practice approach, now or previously.
2. Describe how the adaptations to a combat zone might be viewed in the classification organization of the DSM-IV. How would *context* be used to normalize defensive measures that have now become a problem.
3. Name two techniques the social work clinician used to promote a safe working space for the client. What role did self-disclosure play in engaging the resistant client?
4. Discuss how secondary trauma, or shared trauma, might impact you as the clinician? How would you address this issue with relational techniques?
5. Discuss the pros and cons of ongoing contact with past clients. Explain how the situation of redeployment of a combat veteran does or does not alter your view on ongoing contact.
6. Describe the role of internalization in the client's experience of the clinician being "with him" in redeployment and also in civilian life. What kind of impact does internalization have on how a relational clinician might anticipate and manage this type of experience?

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