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Shared Trauma and Resiliency Among Military Mental Health Veterans: A Heuristic Inquiry

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Abstract

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Tashina Lynn Miller

MSW, Wichita State University, 2008

BSW, University of Kansas, 2005

Dissertation Submitted in Partial Fulfillment

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Abstract

With the wars in Iraq and Afghanistan lasting over a decade, hundreds of military mental health providers have deployed to hostile environments and some on multiple occasions. Military mental healthcare providers can experience symptoms of acute and chronic stress resulting from exposures to horrific events while caring for soldiers in a deployed environment. Indeed, in treating these soldiers, clinicians may continue to experience the same traumatic events as their clients. The purpose of this phenomenological study was to understand and describe shared trauma and resilience for military mental health professionals who have deployed. The concept of shared trauma was defined as the experiences providers faced as they attempted to deliver clinical services while simultaneously addressing the same issue within their own lives. The concept of resilience was explored as how stressful situations were interpreted in relation to individuals' overall life experiences. The principle research question for this study examined how military mental health providers described dilemmas faced as they attempted to navigate the personal and professional aspects of shared trauma. This study utilized a purposive sample of 7 military mental health veterans who deployed during Operation Iraqi Freedom and Operation Enduring Freedom. Data were collected through semi-structured interviews and analyzed using Moustakas's 5 steps of heuristic analysis. Key findings indicated participants' interpretations of experiences involved posttraumatic growth, lessons learned, and changes in belief systems. Findings of this study can assist military mental health leaders in developing support and protection programs to assist this overwhelmed population, ensuring service members receive the proper care they are entitled.

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Dedication

I dedicate this work to my loving family. I could not have completed this academic journey or pursued my career without the continuous love and support from my husband and son.

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Chapter 1: Introduction to the Study

Introduction

The mounting evidence demonstrating that the wars in Iraq and Afghanistan differ significantly from previous U.S. conflicts is irrefutable (Flynn & Hassan, 2010). The frequency of deployments, types of injuries, and ambiguous frontlines have all combined, culminating in a crisis within society (Flynn & Hassan, 2010). The invisible wounds of these conflicts are more prevalent than physical injuries (Flynn & Hassan, 2010). With approximately 1.7 million service members deployed to Iraq and Afghanistan, the RAND Corporation estimates that more than 500,000 will develop some degree of combat stress disorder, which, if left untreated, could last a lifetime (Flynn & Hassan, 2010). After a decade of conflict, more than 2 million men and women have served in more than 3 million combat tours to Iraq and Afghanistan, and there is still no end in sight (Bowen & Martin, 2011).

Throughout the history of U.S. foreign conflicts, mental health professionals have played a frontline role in maintaining the fighting force (Pols & Oak, 2007). In the current world climate, where there seems to be no end to conflict and terrorism, clinicians will continue to experience the same traumatic events as their clients (Tyson, 2007). Military mental health practitioners (MMHP) are vital to preserving the fighting force, being expected to assist others in battle while simultaneously dealing with their own emotional challenges (Miller & Warner, 2013). In conjunction with this concept of shared traumatic experience, the theory of resilience further examines the meanings individuals

place on stressful events as they try to understand experienced trauma within their overall life experience (Bartone, 2006).

Within current literature, a gap exists in understanding the full effects of shared trauma and resilience for mental health clinicians (Tosone, McTighe, Bauwens, & Naturale, 2011). Despite the presence of scholarly literature examining shared trauma, there has been no published conceptualization found regarding this theory within the population of military mental health practitioners (Miller & Warner, 2013). Military experts estimate that the United States will remain in some conflict over the next two decades (Flynn & Hassan, 2010). This exploration of military mental health is not meant to be an endorsement of war; rather, it is an attempt to ensure adequate services to military personnel (Flynn & Hassan, 2010).

With the wars in Iraq and Afghanistan lasting over a decade, hundreds of MMHP have deployed to hostile environments, some on multiple occasions (Linnerooth, Mrdjenovich, & Moore, 2011). Military mental health practitioners experience a variety of environmental, physical, and emotional stressors while working along the frontlines of conflict (Linnerooth et al., 2011). Healthcare professionals serving in the military are at high risk for anxiety, posttraumatic stress symptoms, and alcohol misuse (Gibbons, Shafer, Aramanda, Hickling, & Benedek, 2012). Military healthcare providers can experience symptoms of acute and chronic stress resulting from exposure to horrific events while caring for soldiers in a deployed environment (Gibbons et al., 2013). An increased presence of MMHP in combat, through frequent deployments, has forced this subset of professionals to perform roles outside typical clinical services, to address

uncommon ethical dilemmas, to work in unfavorable conditions with some level of risk to personal safety, and to function in some degree of professional isolation (Miller & Warner, 2013). While deployed, MMHP live under the same conditions as combatants, leading to risk of compassion fatigue and the development of their own stress-related problems (Miller & Warner, 2013). Despite the resiliency techniques this group may possess due to training and experience, burnout is high in this profession (Linnerooth et al., 2011).

This study was conducted in an attempt to add to the body of knowledge needed to address the concepts of shared trauma and resilience by exploring themes identified by military mental health practitioners who have experienced deployment during Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF). The concepts of shared trauma as described by Tosone et al. (2011) and resiliency as defined by Bartone (2006) are combined to form a conceptual framework providing a foundation for this exploration. *Shared trauma* is defined as a concept capturing the experience that clinicians have in striving to provide services to individuals undergoing trauma while simultaneously addressing the same issues within their own lives (Tosone et al., 2011). The concept of *resilience* relates to how stressful situations are interpreted or made sense of in the context of one's overall life experience (Bartone, 2006). The purpose of this study was to gain an in-depth understanding of the meaning MMHP ascribe to their deployment experience. In this exploration, I attempted to address the gap in the literature related to this phenomenon, producing a richer understanding and ability to support this population. Obtaining in-depth knowledge of this issue will assist in the development of

support and protection programs to assist the military's limited number of mental health professionals, ultimately ensuring that service members receive the proper care they deserve (Linnerooth et al., 2011).

Background

In the current global climate of conflicts and terrorist acts, there is a growing societal focus on the impact of catastrophic environments on both combatants and those in noncombatant roles (Tyson, 2007). These events have made it paramount to gain a better understanding of the phenomenon of deployed MMHP in an attempt to assist this group in treating combat survivors during decades of war (Tyson, 2007). A review of relevant literature illuminated issues of acute/chronic stress experienced by clinicians in shared traumatic realities, yet there continues to be limited understanding of the full impact faced by MMHP who deploy (Gibbons et al., 2013; Linnerooth et al., 2011). In addition, it remains unclear which circumstances and attributes contribute to the effects of posttraumatic stress symptoms versus posttraumatic growth and resilience within the population of MMHP (Gibbons et al., 2013). As military mental health professionals continue to play a frontline role in preserving the fighting force (Miller & Warner, 2013), it becomes prudent to consider MMHP deployments to allow better understanding of this phenomenon and development of programs to support this field of practitioners.

A number of studies have explored shared trauma in the post-9/11 environment (Gibbons et al., 2013; McCauley et al., 2012; Miller & Warner, 2013; Tosone et al., 2011; Tosone et al., 2012; Tyson, 2007). In the literature review section, I examine these studies in detail; overall, the totality of effects on clinicians working with the OIF/OEF

population has yet to be thoroughly explored (Voss-Horrell, Holohan, Didion, & Vance, 2011). Traumatized veterans of the Iraq and Afghanistan conflicts will require mental health support across the lifespan, with MMHP shouldering a significant amount of this burden (Linnerooth et al., 2011). In the currently evolving literature, shared trauma is found to produce both acute/chronic stress reactions and positive awareness allowing for posttraumatic growth and resilience (Tosone et al., 2012). While the field of trauma research has evolved to consider factors of resiliency, resilience is a common phenomenon that is often overlooked (Schok et al., 2010). Further research is necessary to enable quantification of the possibility of positive results of combat in an attempt to fully understand the reason for growth and resilience among some veterans (Gallaway et al., 2011). At the time of this study, there was no found literature examining the relationship between shared trauma and resiliency in MMHP who have deployed.

A limited amount of research has been conducted concerning the unique stressors and rewards experienced by mental health practitioners working with veterans and the potential impact on performance, job satisfaction, and emotional well-being (Linnerooth et al., 2011; Voss-Horrell et al., 2011). Exploration of this subject has revealed that clinicians who treat clients with combat-related stress scored significantly higher than peers on cognitive intrusion and avoidance behavior scales (Linnerooth et al., 2011). McCauley et al. (2012) examined British deployed clinicians in regard to their deployment position, engagement with colleagues, challenges faced, and responses. Findings suggest that while MMHP experienced various stressors, their overall concern during deployment was the success of the mission through achieving clinical goals

(McCauley et al., 2012). Challenges for deployed clinicians were found to include ethical difficulties, professional and personal obstacles, and bonding with colleagues (McCauley et al., 2012). Identifying with one's unit or group was related to increased motivation and improvement of performance during deployment (McCauley et al., 2012). Clinicians reported using a variety of intra- and interpersonal strategies throughout their deployment to overcome these stressors (McCauley et al., 2012). Overall, clinicians indicated that working with the military population can be a rewarding professional experience; however, risk factors of secondary traumatic stress and shared trauma must be addressed to maximize the positive benefits of these shared experiences (Voss-Horrell et al., 2011).

Furthermore, Miller and Warner (2013) examined how MMHP experience reintegration back into families and jobs upon return from deployment, as well as how these professionals cope with their own postdeployment issues. Deployment was described by participants as a freeing experience due to having the right skill, at the right time, in the right place (Miller & Warner, 2013). Military mental health professionals described the use of a homogeneous set of behaviors to care for their own personal well-being during deployment (Miller & Warner, 2013). The choices of coping strategies were consistent and involved exercise, maintaining faith, and staying in contact with friends and family (Miller & Warner, 2013). In an examination of postdeployment effects, prior knowledge of deployment's psychological impact did not prevent these professionals from experiencing adjustment challenges (Miller & Warner, 2013). Results showed that 81% of MMHP noticed some level of dysfunction in their lives at home, work, or both upon return from deployment (Miller & Warner, 2013).

Additional research within the field has studied the varied healthcare provider responses to trauma by examining perceptions of control, self-efficacy, and postevent coping strategies in military nurses and physicians deployed to combat regions (Gibbons et al., 2013). Consensus among providers indicated that there are no predictabilities during deployment (Gibbons et al., 2013). The providers who reported being successful in managing stress were ones who focused on the structure they could create to ensure positive outcomes for service members (Gibbons et al., 2013). To cope with potentially traumatic events, some providers compartmentalized, while others described working through thoughts and feelings in social groups or solitary self-reflection periods (Gibbons et al., 2013). The need to develop strategies to care for the emotional health of active-duty providers has been identified; however, little is known about clinicians' cognitive and behavioral coping during deployment and while returning home (Gibbons et al., 2013). While research has influenced interventions used with combat troops experiencing psychological problems, the impact of current conflicts on health care providers remains ignored in the midst of legitimate occupational concern (Gibbons et al., 2013).

Throughout the past decade of conflict, MMHP have proven to be an essential component in maintaining the fighting force of several nations (McCauley et al., 2012; Miller & Warner, 2013). As a result, MMHP will continue to be integrated into military units across the globe (McCauley et al., 2012; Miller & Warner, 2013). Within current literature, a gap exists in understanding clinicians who experience trauma both personally and professionally (Tosone et al., 2011). Despite the presence of scholarly literature exploring the concept of shared trauma, there has been no published conceptualization

found in relation to this event (Baum, 2010). Additionally, there continues to be a lack of understanding regarding the components that influence resiliency within the military community (Gibbons et al., 2013). Current research (McCauley et al., 2012; Miller & Warner, 2013), has failed to clearly isolate meanings MMHP assigned to their deployment experience. In addition, there is little evidence to demonstrate the cognitive impact of deployment on those in the mental health field (Gibbons et al., 2013). Overall, the need exists for increased clarity concerning the concepts of shared trauma and resilience among MMHP who deploy. Due to these gaps in the literature, this study's primary focus was exploring meanings MMHP ascribe to their deployment experience in an attempt to better understand this phenomenon.

Problem Statement

Military mental health deployments involve a complex set of circumstances, with the full effects of these events being unknown (Gibbons et al., 2013; Linnerooth et al., 2011). Practitioners who experience catastrophic environmental events can find themselves impacted on intrapsychic, interpersonal, and communal levels, leading to alterations of self and world views (Tosone et al., 2012). Similar to trauma clients, practitioners who experience shared trauma may exhibit disturbances in cognitions, emotions, and maintaining hope (Geller, Madsen, & Ohrenstein, 2004). Acute and chronic stress reactions may result from the trauma witnessed by healthcare providers in a deployed environment (Gibbons et al., 2013).

In contrast, resilience has been suggested as an underestimated factor for those who experience traumatic events (Tosone et al., 2011). The underlying mechanism within

the concept of hardiness resilience involves how stressful events are understood or made sense of in the context of one's life experiences (Bartone, 2006). Assigning meaning to life experiences is perhaps the single most critical issue in developing resiliency, as the perception of understanding the purpose of one's pain can help in avoiding negative emotions that a trauma mindset may produce (Osran et al., 2010). Further research is needed to explore factors that allow military members to remain resilient in the face of traumatic events (Gibbons et al., 2013). Addressing shared trauma and resilience within the selected population is paramount in order to support a limited number of professionals who are trying to assist combat survivors throughout a decade of war (Tyson, 2007). In this study, I attempted to enhance the body of knowledge needed to address the phenomenon of MMHP deployments by exploring themes identified by veteran practitioners who served during OIF/OEF and the impact of this experience on their professional as well as personal lives.

Purpose of Study

The purpose of this phenomenological study was to better describe the experience of MMHP who deployed during OIF/OEF. I used the concept of *shared trauma* in an attempt to capture the experience of clinicians striving to provide services while simultaneously addressing the same issues within their own lives (Tosone et al., 2011). Using the concept of *resilience*, I examined how stressful situations were interpreted or made sense of in the context of one's overall life experience (Bartone, 2006). This research was directly related to shared trauma and resilience through the

phenomenological examination of meanings military practitioners assigned to their deployment and shared reality experiences.

Research Questions

The principal research questions for this investigation were:

RQ1—Central research question/qualitative: How do military mental health providers describe difficulties faced as they attempted to navigate the personal aspects of trauma?

RQ2—Central research question/qualitative: How do military mental health providers describe difficulties faced as they attempted to navigate the professional aspects of shared trauma?

These questions contained multiple overlapping phenomena, which required explicit attention in order to understand the main phenomenon as a whole. Therefore, the following subquestions were posed:

RQ3—Qualitative: What meanings do military mental health providers choose to assign to their shared trauma experiences?

RQ4—Qualitative: What were the most difficult psychological aspects of deployment for military mental health clinicians?

RQ5—Qualitative: How did the clinicians attempt to care for themselves while simultaneously caring for others during deployment and the 6 months following return from deployment?

Conceptual Framework

The concepts of shared trauma as described by Tosone et al. (2011) and resiliency as defined by Bartone (2006) were combined to form a conceptual framework to provide a foundation for this exploration. Shared trauma is an emerging theory within the field of trauma that is used to explain the concept and effects of clinicians caring for clients while simultaneously experiencing the same situations personally (Tosone et al., 2011). Military mental health practitioners are essential to maintaining the fighting force, being required to support others in combat while simultaneously dealing with their own emotional difficulties during deployment (Miller & Warner, 2013). During shared trauma experiences, clinicians may suffer from both primary trauma experiences and the secondary trauma of therapeutic exposure (Dekel, 2010). There is an urgent need within the military mental health field to better understand the concept of shared trauma and develop interventions that will mitigate the degrading effects of working within the military population (Tyson, 2007). Research within the field of trauma has found that assigning meaning to life events through trying to understand the purpose of one's pain can assist in avoiding negative emotions that a trauma mindset can produce (Osran et al., 2010). Furthermore, the ability to designate meaning in life experiences is perhaps the most critical factor in developing resiliency (Osran et al., 2010). The theory of resilience lies in conjunction with the concept of shared trauma by examining the meanings individuals place on stressful events as they attempt to understand the trauma within their overall life experience (Bartone, 2006). This study examined a population of veteran

MMHP within the frameworks of shared trauma and resilience in an attempt to provide a conceptualization of the phenomenon of deployment for these practitioners.

Military Mental Health

Witnessing effects of combat such as death, destruction, and unexpected and at times continuous threats to one's life can potentially lead to mental health problems (Pols & Oak, 2007; Reger, 2006). Throughout the 20th century, mental health clinicians offered their assistance to the military in an attempt to mitigate the effects of the traumatic events inherent in conflict (Pols & Oak, 2007). Throughout the history of the profession, when mental health professionals have been perceived as contributing to maintaining the fighting force, their influences have been appreciated (Pols & Oak, 2007).

While most Army brigades have several physicians assigned to the element, there is usually only one mental health provider (Linnerooth et al., 20011). Furthermore, an increased presence of MMHP in battle has forced these professionals to perform roles outside typical clinical services, to address uncharacteristic ethical dilemmas, to work in unfavorable and dangerous environments, and often to operate in some degree of professional isolation (Miller & Warner, 2013). Military mental health professionals often serve at Forward Operating Bases (FOB), living next to combat units and functioning in the important role of preserving the fighting force (Miller & Warner, 2013). During deployment, these practitioners are required to support others in combat while simultaneously dealing with their own emotional challenges (Miller & Warner, 2013). Military mental health professionals are soldiers first and practitioners second; while MMHP deployment experiences are unique, their credentials do not diminish their

role as soldiers (Miller & Warner, 2013). Stories of MMHP deployments are often inspirational and heroic; however, MMHP have frequently been unknown and ignored within current scholarly literature (Miller & Warner, 2013).

Shared Trauma

The conceptual framework for this study involved shared trauma, which has received increasing attention in the scholarly literature since the terror attacks of 9/11 (Baum, 2010). Even though clinicians have been working and living in the same communities as their clients since the beginning of the profession, the term *shared trauma* was only recently recognized within the literature in response to the terror attacks on 9/11 (Tosone, Nuttman-Shwartz, & Stephens, 2012). Researchers currently use the term *shared trauma* to describe situations where clients and therapist are exposed to the same collective disaster (Baum, 2010). While most literature post-9/11 presents the concept of shared trauma as new, review of scholarly works indicates the first known references to this phenomenon in two studies produced in the mid-20th century (Baum, 2010).

Conditions of shared trauma were written about as early as the 1940s and 1950s; however, it would be several additional decades before the phenomenon would be fully recognized (Baum, 2010). Schmideberg (1942) offered a brief analysis of the impact that threat of injury or death had on psychoanalysts and their clients (Baum, 2010). Killian (1952) explored the dilemmas faced by clinicians as they navigated the personal and professional aspects of a disaster (Baum, 2010). Both researchers focused on this double trauma; however, neither of these studies gave this event a name (Baum, 2010). It was

not until the Gulf War in 1991 that this phenomenon was named using the terms *shared traumatic reality* and *shared reality* (Tosone et al., 2012). As therapists found themselves in the same sealed rooms wearing gas masks along with their clients, both seeking shelter from chemical attack, this shared reality was acknowledged (Baum, 2010). The concepts of compassion fatigue, burnout, secondary trauma, and vicarious traumatization all paved the way for *shared trauma* theory and exploration (Baum, 2010; Tosone et al., 2012).

The definition of shared trauma was found to have the following four features: (a) disaster is a collective trauma, b) communal disaster is a current one, c) both the client and the therapist belong to the community, and 4) the provider suffers double exposure both professionally and personally (Baum, 2010). Furthermore, shared trauma was found to produce blurred boundaries in the professional realm, causing workers distress due to loss of familiar work settings and unsuitability of most alternative settings (Baum, 2010). Operationally, shared trauma is defined as the affective, cognitive, behavioral, and multimodal responses providers experience as a result of dual exposure to the same trauma as their clients (Tosone et al., 2012). In the currently evolving literature, shared trauma has been found to result in adverse effects presenting as acute stress reactions, as well as positive effects allowing for posttraumatic growth and resilience (Tosone et al., 2012).

Resiliency

The majority of U.S. soldiers desire to do the right thing and seek to perceive their mission as worthwhile (Bartone, 2005). In an analysis of how individuals perceive events, Frankl (1960) asserted that human beings have the power to choose their meaning

and that some are perhaps better than others at constructing positive meanings (Bartone, 2005). The underlying mechanism within the concept of hardiness resilience involves how stressful experiences are perceived or made sense of in the context of one's life experiences (Bartone, 2006). Hardy individuals recognize stressful experiences as an expected aspect of existence and part of life, which makes the overall challenge worthwhile (Bartone, 2006). Research related to hardiness has focused on the positive effects of resilience and the tendency to remain healthy under stress (Bartone, 2005; Lo Bue, Taverniers, Mylle, & Euwema, 2013). Hardiness has been found to reduce the impact of stressful life experiences on mental and physical health (Lo Bue et al., 2013). Furthermore, previous research has demonstrated that hardiness predicts fewer posttraumatic stress symptoms in soldiers exposed to a variety of stressors (Bartone, 2005; Escolas, Pitts, Safer, & Bartone, 2013; Lo Bue et al., 2013).

Psychological hardiness was first described in the literature by Kobasa (1979) as a characteristic that distinguished those who became ill under pressure from those who remained healthy (Escolas et al., 2013; Lo Bue et al., 2013). Hardiness is theoretically grounded in existential philosophy and was explored by psychologists including Frankl (1960), Binswanger (1963), and Heidegger (1986; Bartone, 2006). The hardiness concept encompasses the meaning of life, the acceptance that it may involve hardships, and courage to live life fully despite its challenges (Bartone, 2006). Overall, hardiness is seen as a core characteristic that affects resilience (Escolas et al., 2013).

According to Frankl (1960), despair is suffering without meaning (Osran et al., 2010). Furthermore, while all events have meaning, humans always have a choice

whether or not to find it (Osran et al., 2010). Under the hardiness approach, the use of resiliency allows for the placement of deployment experiences in a meaningful context that may resonate with veterans (Osran et al., 2010). The ability to assign meaning in life experiences is possibly the most crucial factor in developing resiliency (Osran et al., 2010). When individuals are able to assign purpose to suffering, they often find an absence of the negative emotions that a trauma mindset can produce (Osran et al., 2010). The ability to assign meaning to traumatic events does not guarantee a symptom-free event (Larner & Blow, 2011). Rather, evidence suggests that meaning making assists in determining whether a memory is stored as traumatic or simply stressful (Larner & Blow, 2011).

Nature of the Study

The focus of this research was understanding a human phenomenon and how MMHP experience this phenomenon. This goal fit with the philosophy and intentions of the interpretive paradigm (Ajjawi & Higgs, 2007). Within the interpretive model, meanings are constructed by human beings in their own unique ways, depending on context, frames of reference, and personal perception (Ajjawi & Higgs, 2007). What is relevant and meaningful among MMHP who have deployed depends on the situation (Ajjawi & Higgs, 2007). Attempting to isolate or measure such an experience would have involved ignoring the complexity and consequences of the phenomenon (Ajjawi & Higgs, 2007). The interpretive paradigm was found to be most suitable for this research due to its potential to create new understandings of the multidimensional human phenomena of deployed MMHP (Ajjawi & Higgs, 2007).

The approach for this study was qualitative. Qualitative research is consistent with gaining an in-depth understanding of a phenomenon, which was the primary focus of this dissertation. This phenomenological study was conducted in order to obtain a better understanding and description of the lived experiences of shared trauma and resilience in relation to MMHP who deployed during OIF/OEF. The heuristic phenomenological method of inquiry was employed to examine in-depth lived experiences from the source of the individual (Kafle, 2011). Shared trauma was defined as a concept capturing the experience of clinicians attempting to provide services to individuals experiencing trauma while simultaneously addressing the same issues within their own lives (Tosone et al., 2011). The concept of resilience is described in terms of how stressful situations are interpreted or made sense of in the context of one's overall life experience (Bartone, 2006).

Heuristic inquiry was used in relation to this topic, as I questioned my personal experience of this event and the essential experience of others who lived this phenomenon. The heuristic discipline involves gaining understanding beneath one's subjective experience by finding the objective nature realized by an individual (Kafle, 2011). Heuristic phenomenology was used to reveal the world as experienced by participants through their life stories (Kafle, 2011). In addition, hermeneutics allowed for exploration of participants' experiences, with further analysis based on my personal experience with the phenomenon (Ajjawi & Higgs, 2007). The purpose of this heuristic research was to examine information-rich cases in an attempt to provide a comprehensive description of the experience being investigated (Ajjawi & Higgs, 2007).

When conducting phenomenological research, purposive sampling of information-rich cases is recommended (Kafle, 2011). The use of purposive sampling allowed for analysis of cases that manifested the selected experience profoundly (Ajjawi & Higgs, 2007). In an investigation of these information-rich cases, this study attempted to create insights and in-depth understandings rather than empirical generalizations (Kafle, 2011). The application of interviews with a small number of individuals followed the traditional interpretive model of inquiry (Ajjawi & Higgs, 2007). The intended participant group was individuals who previously served on Active Duty, National Guard, or Reserve components and were deployed for 4 months or more to Forward Operating Bases (FOB) in active combat zones as mental health professionals during OIF/OEF. Individuals were selected based on how intensely their experience demonstrated the selected phenomenon, along with demographic factors to ensure a mixture of gender, age, service affiliation, and professional discipline. A sample size of (N = 7) individuals was selected purposefully for interviews. The originally purposed sample size of (N =10) individuals was an approximation and remained flexible to ensure that saturation had been reached. The purposed sample size of (N =10) participants was reduced to (N =7) due to difficulties in finding willing individuals who fit within the defined population. This reduction in sample size is further discussed within the study's limitations in Chapter 5.

Data were collected through semistructured interviews, and analysis involved Moustakas's (1990) five steps of heuristic analysis. Moustakas described five principles within the heuristic process: immersion, incubation, illumination, explication, and

creative synthesis. *Immersion* involved organizing the data set into the text, iterative reading of the text, and preliminary interpretation (Ajjawi &Higgs, 2007). *Incubation* occurred through time of quiet contemplation, allowing for precise and profound awareness of meanings (Patton, 2002). *Illumination* involved attempting to link literature and reconstruct interpretation into stories (Ajjawi & Higgs, 2007). In the *explication* phase, full comprehension of the experience began to emerge through self-dialogue and reflection, producing patterns and discovered relationships (Patton, 2002). Finally, *creative synthesis* consisted of bringing the pieces of emerging patterns together, allowing for new perspectives and implications (Patton, 2002).

Definitions

Shared trauma: For the purposes of this study, shared trauma was defined as a concept used in an effort to capture the experience of clinicians attempting to provide services to individuals experiencing trauma while simultaneously addressing the same issues within their own lives (Tosone et al., 2011).

Resilience/Resiliency: For the purposes of this study, resilience and resiliency were interchangeable terms defined in terms of how stressful situations are interpreted or made sense of in the context of one's overall life experience (Bartone, 2006).

Military mental health professionals (MMHP): For the purposes of this study, military mental health professionals (MMHP) consisted of social workers, psychologists, and psychiatrists assigned to provide mental health services along the frontlines of combat (Miller & Warner, 2013).

Operation Iraqi Freedom (OIF): For the purposes of this study, OIF was defined as operations beginning with U.S. military forces deploying to Iraq in March 2003, including the period of Operation New Dawn, which indicated a shift in mission to one of advising roles. On December 15, 2011, the United States marked the official end to the war in Iraq (Torreon, 2012).

Operation Enduring Freedom (OEF): For the purposes of this study, OEF was defined as operations beginning with U.S. military forces deployed on October 7, 2001 and continues to encompass ongoing missions in Afghanistan and other nations (Torreon, 2012).

Assumptions

For the purpose of this study, it was assumed that the selected MMHP responded honestly during interviews. In addition, the assumption was made that the respondents' memories and descriptions of the events were accurate perceptions of the participants. For the purposes of this phenomenological study, the perceptions of the participants were considered valid as their understanding of the truth during the experience. No documents were collected to verify statements made by individuals during the interview. It was also assumed that the participants' reports of meanings associated with deployment were accurate, as individuals are knowledgeable of their own histories. Finally, it was assumed that participants found through purposive sampling were honest when describing their status as veterans of OIF/OEF within the profession of mental health when directly asked. No documentation was collected for verification in relation to these certifications.

Scope and Delimitations

This study limited the sample population to MMHP who served on Active Duty, National Guard, or Reserve components and deployed for 4 months or more to Forward Operating Bases (FOB) in active combat zones as mental health professionals during OIF/OEF. This study also confined itself to interviewing a sample size of (N =6), limiting the generalizability of the findings. Additionally, resilience in this study was defined in terms of how stressful situations are interpreted or made sense of in the context of one's overall life experience (Bartone, 2006); however, the presence of this concept was not known prior to the exploration. Prior to the interview, an individual might have reported that he or she experienced an event of deployment and shared trauma, with the absence or presence of resilience remaining unknown prior to the data collection and analysis process.

In an attempt to address the transferability of this study, individuals were selected based on how intensely their experience demonstrated the selected phenomenon, along with demographic factors to ensure a mixture of gender, age, service affiliation, and professional discipline. Furthermore, to increase the odds of transference into future works, detailed descriptions of data collection and analysis as well as a rich narrative of the experiences of the participants are provided in Chapters 4-5.

Limitations

The following limitations have the ability to influence this research. This phenomenological inquiry explored the lived experiences of deployed MMHP; however, the results are not generalizable to a larger population. The results of this research can

only be used to describe military mental health deployments as they apply to the participants. While this investigation is intended as a meaningful and an important part of the puzzle, it only represents one piece, offering a glimpse into the selected phenomenon. Furthermore, heuristic inquiry necessitates an awareness to be used as protection from imposing the researcher's assumptions or biases (Laverty, 2003). While biases and assumptions are embedded in the research and are essential to the interpretive process, I have provided considerable thought to my own experience and offers claims to how my position relates to the issue being explored (Laverty, 2003). The use of this methodology required the ability to be reflective, insightful, and constantly open to experience (Laverty, 2003). In addition, the interview process only works within an environment of safety and trust, which was established at the onset and maintained throughout the exploration (Laverty, 2003). Establishment of rapport offered a free exchange of information and allowed for the use of rich descriptions (Kafle, 2011).

The research process dictated that the principal data collector was both the researcher and a member of the same profession as the participants. I experienced a 9-month deployment during OEF (2012 to 2013), serving as an active duty clinical social worker in the U.S. Army. There are several advantages and disadvantages in this dual role. First, my role as an MMHP allowed for the facilitation of trust and confidence within the researcher/participant relationship, providing for the establishment of rapport (Ajjawi & Higgs, 2007). In addition, I was already fluent in jargon participants used (Ajjawi & Higgs, 2007). In contrast, prior knowledge of the professional language and deployment experience allowed me the ability to make assumptions that the same

meaning was ascribed to the words for both individuals (Ajjawi & Higgs, 2007). To address disadvantages, I attempted to maintain hermeneutic alertness by taking a step back and reflecting on meanings and context rather than accepting preconceptions (Ajjawi & Higgs, 2007). The self of the researcher existed throughout the research process through understanding the phenomenon in increasing depth, allowing for increased self-awareness simultaneously (Patton, 2002). Heuristic inquiry allowed for the progression of creative self-processes and discovery (Patton, 2002). Throughout this exploration, the focus of heuristic inquiry was maintained as disclosing truth through exhaustive self-search and dialogues with others, creating a comprehensive knowledge of the lived experience (Patton, 2002).

In the execution of this heuristic inquiry, the methodology followed and reflected the chosen interpretive paradigm, allowing it to be carried throughout the project (Laverty, 2003). The completion of this heuristic research involved an engaging process that required focus toward the phenomenon as a central concern (Kafle, 2011). In an effort to strengthen the study's rigor, this hermeneutic investigation employed various stages of analysis, allowing for patterns to emerge along with an examination of how interpretation arises from the data (Laverty, 2003). To ensure quality of this phenomenological research; the use of systematic methods of data collection was ensured along with transparency and consistency in operating within traditions of the chosen model (Ajjawi & Higgs, 2007). Credibility and trustworthiness were achieved by ensuring the faithfulness of descriptions through the use of member checking (Ajjawi &

Higgs, 2007). Finally, authenticity was safeguarded through my presentation of varying perceptions (Ajjawi & Higgs, 2007).

Significance

The significance of this study derives from the need, within the current global climate, for mental health professionals to continue to serve clients within dangerous environments while struggling with the same traumatic experience (Tyson, 2007). Throughout the past decade of conflict, MMHP have proven to be an essential component in maintaining the fighting force of several nations (McCauley et al., 2012; Miller & Warner, 2013). As a result, MMHP will continue to be integrated into military units across the globe (McCauley et al., 2012; Miller & Warner, 2013). As the RAND Corporation estimates that more than 500,000 OIF/OEF veterans will develop some degree of combat stress disorder, MMHP will continue to shoulder the responsibility of caring for these heroes (Flynn & Hassan, 2010).

This investigation was unique due to its focus on an underresearched area of the phenomenon of shared trauma and resilience within the selected group (Baum, 2010). The results of this study provide significant insights into the phenomenon of shared trauma and resilience within the group of deployed military mental health providers. There remains a gap in research regarding the effects clinicians experience while delivering mental health services to troops (Miller & Warner, 2013). Additionally, there is an urgent need within the mental health profession to continue to develop interventions that will help in mitigating degrading effects for clinicians working with the military population (Tyson, 2007). Further knowledge of this phenomenon will assist in the

development of support and protection programs for the military's limited number of mental health professionals, ensuring that service members receive the proper care they deserve (Linnerooth et al., 2011). A review of the relevant literature suggests that the inquiry was unique in its analysis of shared trauma and resilience in MMHP that deployed during OIF/OEF. The implications for positive social change include a better understanding of military mental health deployment and the impact this experience has on military practitioners, providing the potential to minimize adverse outcomes and maximize potential resilience.

Summary

Military mental health deployments are complex events with multiple causes and effects representing interconnected relationships that are difficult to determine. Similar to trauma clients, practitioners who experience shared trauma may exhibit disturbances in cognitions, emotions, and maintaining hope (Geller et al., 2004). In contrast, resilience has also emerged as an underestimated factor for those who experience traumatic events (Tosone et al., 2011). The concept of resilience remains limitedly explored through scholarly literature and is defined as the ability to bounce back or grow from traumatic events. At the time of this study, it was difficult to identify the personal and professional impact combat deployments have on MMHP (Miller & Warner, 2013). This investigation contributes to the body of knowledge needed to describe the phenomenon of deployment described by MMHP and the impact of this experience on their professional and personal perception of lived meaning.

The purpose of this phenomenological study was to describe shared trauma and resilience better in relation to MMHP who deployed during OIF/OEF. Shared trauma is a concept used in an effort to capture the experience of clinicians striving to provide services to individuals undergoing trauma while simultaneously addressing the same issues within their own lives (Tosone et al., 2011). The concept of resilience explored how stressful situations are interpreted or made sense of in the context of one's overall life experience (Bartone, 2006). This study was directly related to shared trauma and resilience through the phenomenological analysis of meanings military practitioners ascribe to their deployment and shared reality experiences.

The focus of this research was understanding a human phenomenon and how military practitioners experience this phenomenon. This goal fit with the philosophy and intentions of the interpretive paradigm (Ajjawi & Higgs, 2007). Through use of the interpretive paradigm, meanings are constructed by human beings in their own unique ways (Ajjawi & Higgs, 2007). Attempting to isolate or measure the knowledge of deployed MMHP would have involved ignoring the complexity and consequences of the phenomenon (Ajjawi & Higgs, 2007). The interpretive paradigm was selected as most suitable for this research, as it allowed for the creation of new understandings of this complex and multidimensional human phenomenon (Ajjawi & Higgs, 2007). The phenomenological method of inquiry placed researcher and participant in a position to co-construct the multiple realities of the selected event. Furthermore, heuristic inquiry allowed for exploration of participants' experiences with further interpretation by me based on my personal experience with the phenomenon (Ajjawi & Higgs, 2007).

This study was an attempt to broaden the knowledge base and understanding relating to the deployment of MMHP. Examination of the relevant literature suggested that this was unique research on U.S. MMHP who deployed during OIF/OEF in relation to shared trauma and resilience. Positive social change implications include a better understanding of military mental health deployments, of the impact of this experience on military practitioners, and of the potential to minimize negative influences and maximize potential resiliency as well as posttraumatic growth.

Chapter 2: Literature Review

Introduction

After a decade of conflict, more than 2 million men and women have served more than 3 million combat tours to Iraq and Afghanistan, and there is still no clear end in sight (Bowen & Martin, 2011). With the wars in Iraq and Afghanistan lasting over a decade cumulatively, hundreds of MMHP have deployed to hostile environments, some on multiple occasions (Linnerooth et al., 2011). Military mental health practitioners (MMHP) experience a variety of environmental, physical, and emotional stressors while deployed along the frontlines of battle (Linnerooth et al., 2011). Treating veterans and service members in the midst of an ongoing conflict presents MMHP with unique opportunities and challenges that have not been present to such a degree in past decades (Voss-Horrell et al., 2011). The effects on clinicians who work with the Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) population has yet to be thoroughly investigated (Voss-Horrell et al., 2011). Further research is needed regarding the risk and resiliency factors for clinicians working with traumatized OIF/OEF veterans, given the probability of this group growing with no foreseeable end to global conflicts and terrorist events (Flynn & Hassan, 2011; Voss-Horrell et al., 2011)

Individuals serving as healthcare providers in the military are at increased risk for anxiety, posttraumatic stress symptoms, and alcohol misuse (Gibbons et al., 2013). Acute and chronic stress reactions may result from exposures to traumatic events witnessed by healthcare providers in deployed environments (Gibbons et al., 2013). Through recent war and terror events, it is evident that mental health practitioners not only help survivors

in coping with trauma, but also under certain circumstances experience the same threats (Dekel, 2010). During shared trauma experiences, clinicians may suffer from both primary trauma experiences and the secondary trauma of therapeutic exposure (Dekel, 2010). Military mental health practitioners are vital to preserving the fighting force, being expected to support others in combat while simultaneously dealing with their own challenges during deployment (Miller & Warner, 2013). In conjunction with this concept of shared traumatic experience, the theory of resilience further examines the meanings individuals place on stressful events as they attempt to understand experienced trauma within their overall life experience (Bartone, 2006). In the review of current scholarly literature, little is known about practitioners who experience trauma personally and professionally (Tosone et al., 2011). There is an urgent need within the military mental health field to better understand this phenomenon and develop interventions that will mitigate the degrading effects on clinicians of working within the military community (Tyson, 2007). Thus, this study explored the meanings MMHP ascribe to their deployment experiences to better understand this underexamined phenomenon.

Literature Search

Search of articles indexed in PsycINFO using the keywords *secondary trauma* yielded 53 articles; during examination of these reports, the concept of shared trauma was discovered. Additionally, a PsycINFO search using the keywords *military psychology* produced 2,207 results. In an attempt to further refine the intended research subject, I conducted a search of peer-reviewed articles indexed in PsycINFO, SocINDEX, PsycARTICLES, ERIC, MEDLINE, and CINAHL Plus, within the last 5 years, using the

keywords *shared trauma*, *shared traumatic reality*, *resilience and military*, *military*, *social work*, *military psychologist*, and *military mental health* that yielded a total of 252 unique citations. Due to the limited amount of literature found under the search words of *military mental health*, *military*, *social work*, and *military psychologist*, this search was expanded to 10-year period, resulting in 13 additional citations. A total of 61 citations were reviewed in their entirety. Additional articles were identified through cited reference and methodology searches.

A review of relevant literature provided the current knowledge base related to deployment of MMHP along with the concepts of shared trauma and resiliency. This literature review revealed that deployment experiences of MMHP since the terror attacks on 9/11 have been largely unexamined (Miller & Warner, 2013). Examination of soldiers returning from combat and the prevalence of posttraumatic stress disorder (PTSD) has been prevalent in research; however, limited research has inspected the concepts of noncombatants and deployments for MMHP (Miller & Warner, 2013). The discovered need was for clarity of the concepts of shared trauma and resilience among MMHP who deployed during OIF/OEF. Reviewed literature did not examine the concepts of shared trauma and resilience in relation to veteran OIF/OEF mental health clinicians (Miller & Warner, 2013). In addition, there was no published conceptualization found regarding shared trauma theory related to the military mental health population (Baum, 2010). Through review of the literature, it became my assessment that it was impossible to isolate the concepts of shared trauma and resilience for quantitative research until there

was further exploration of the selected phenomenon through qualitative inquiry; therefore, the phenomenological paradigm was chosen for this study (Kafle, 2011).

Theoretical Foundation

The concepts of shared trauma as described by Tosone et al. (2011) and resiliency as defined by Bartone (2006) are combined to form a conceptual framework providing a foundation for this research. Shared trauma is an emerging theory within the field of trauma studies which is used in an attempt to explain the concept and effects of clinicians caring for clients dealing with trauma while simultaneously experiencing the same situation personally (Tosone et al., 2011). Military mental health practitioners play a vital role in preserving the military's fighting forces and are expected to assist others in battle while simultaneously dealing with their own emotional challenges during deployment (Miller & Warner, 2013). During shared trauma experiences, clinicians may suffer from both primary trauma experiences and the secondary trauma of therapeutic exposure (Dekel, 2010). There is an urgent need within the military mental health field to better understand the concept of shared trauma and develop interventions to mitigate the degrading effects of working within the military population for clinicians (Tyson, 2007). Research within the field of trauma has found that assigning meaning to life experiences through attempting to understand the purpose of one's suffering can help in avoiding negative emotions that a trauma mindset can produce (Osran et al., 2010). Furthermore, the ability to designate meaning in life experiences may be the most crucial factor in developing resiliency (Osran et al., 2010). The theory of resilience lies in conjunction with the concept of shared trauma by examining the meanings individuals place on

stressful events as they attempt to understand the trauma within their overall life experience (Bartone, 2006). This study examined a population of veteran MMHP within the frameworks of shared trauma and resilience in an attempt to provide a conceptualization of the phenomenon of deployment for these practitioners.

The following literature review begins with a brief outline of the history of shared trauma, as well as an examination of this theory in relation to noncombatants, clinicians, and military healthcare providers. An analysis of the evolution of resilience and the concept of hardiness is also presented. Resiliency is explored within the context of trauma and military conflicts. Finally, the profession of military mental health is examined in relation to the concepts of shared trauma and resilience.

Literature Review

Shared Trauma

The theoretical framework for this study was grounded in the concept of shared trauma, which has received increasing attention in the literature since the terror attacks of 9/11 (Baum, 2010). Even though clinicians have been working and living in the same communities as their clients since the beginning of the profession, the term *shared trauma* is newly implemented within the scholarly literature (Tosone et al., 2012). In current literature, the term *shared trauma* has emerged to describe situations where clients and therapist are exposed to the same collective disaster (Baum, 2010). While most literature post-9/11 presents the concept of shared trauma as new, review of scholarly works indicates that the first known references to this event are found in two studies produced in the mid-20th century (Baum, 2010).

Situations of shared trauma were written about as early as the 1940s and 1950s; however, several decades would pass prior to this phenomenon being fully recognized (Baum, 2010). Schmideberg's (1942) study offered a brief analysis of the impact threat of injury and death had on the researcher in her role as psychoanalyst (Baum, 2010). Additionally, Killian (1952) explored the dilemmas faced by clinicians as they navigated the personal and professional aspects of a communal disaster (Baum, 2010). Both researchers focused on this double trauma; however, neither of these studies gave this phenomenon a name (Baum, 2010). Some 40 years later, in 1986, Raphael observed how psychotherapists, who are members of communities experiencing disasters, in turn become victims (Baum, 2010). It was not until the Gulf War in 1991 that this phenomenon was named using the terms *shared traumatic reality* and *shared reality* (Baum, 2010; Tosone et al., 2012). As therapists sat in the same sealed rooms along with their clients with gas masks at their faces, both seeking shelter from chemical attack, there was finally acknowledgment of this shared reality (Baum, 2010). In contrast, Knug, Nixon, and Vicent (1996) observed that although the same trauma could be experienced both by the practitioner and client, the pressure for the clinician to perform was so great that providers would forget they were part of the community (Baum, 2010). It was not until Wee and Myers (2002) suggested that professionals in shared reality situations experienced intense distress regarding their family members that the concept of shared trauma re-emerged (Baum, 2010).

The aforementioned shift in the theoretical construct was influenced by the trauma work of the 1990s, which focused on the intense stress experienced by providers

who work with trauma clients (Baum, 2010). The concepts of compassion fatigue, burnout, secondary trauma, and vicarious traumatization all paved the way for shared trauma theory (Baum, 2010; Tosone et al., 2012). The first of these conceptualized terms was *burnout*, which described the pathological process of developing emotional exhaustion due to the psychological strain of working within helping professions (Tosone et al., 2012). In 1995, Figley presented the term *compassion fatigue* into the literature to describe the cumulative effects of stress resulting from working in a caring role (Tosone et al., 2012). In addition, the term *secondary stress* was introduced to operationalize situations where stress occurs suddenly and is caused by listening to a client's expression of trauma (Tosone et al., 2012). Vicarious trauma took these concepts a step further by examining the cognitive and emotional transformations that result from direct engagement with trauma clients (Tosone et al., 2012).

After the terror attacks of 9/11, there was a call among the professions for a more exact concept to capture the experience of clinicians striving to provide services related to trauma while attempting to address the same issues in their own lives (Tosone et al., 2012). In terms of approach post 9/11, the operational expression to describe this dual trauma was *shared trauma* (Baum, 2010; Tosone et al., 2012). This change in name reflected a shift in the conceptualization of the impact of shared trauma; however, every writer on the subject continues to speak to the definition of a single disaster, ignoring experiences of multiple disasters (Baum, 2010).

The concept of shared trauma was found to have the following four components: a) disaster is a collective trauma, b) communal disaster is a current one, c) both the client

and the therapist belong to the community, and d) the provider suffers double exposure both professionally and personally (Baum, 2010). Under these circumstances, shared trauma was found to produce blurred boundaries in the professional realm, causing workers distress due to loss of familiar work settings, loss of usual work roles, and unsuitability of most alternative settings (Baum, 2010). Furthermore, shared trauma was operationalized as the affective, cognitive, behavioral, and multimodal responses providers experience as a result of dual exposure to the same trauma as their clients (Tosone et al., 2012). In the currently evolving literature, shared trauma was found to produce adverse effects, presenting as acute/chronic stress reactions and the less explored manifestations of posttraumatic growth and resilience (Tosone et al., 2012).

Throughout the course of their work, mental health practitioners are exposed to clients' perceptions and reactions to trauma (Dekel, 2010). Recent war and terror events have demonstrated that mental health practitioners not only assist survivors in coping with trauma, but also are threatened by the same conditions in certain situations (Dekel, 2010). In most of these circumstances, providers suffer from both primary trauma experiences and secondary trauma of therapeutic exposure (Dekel, 2010). Shared trauma includes the symptoms of compassion fatigue, secondary traumatic stress disorder, and vicarious traumatization but also further involves the effects of primary trauma on the therapist in shared traumatic situations (Tyson, 2007). The effects of shared trauma can encompass a variety of posttraumatic symptoms, including headaches, breathing difficulties, intrusive memories, hypervigilance, difficulty with trust, emotional numbing, and alterations in self-identity and cognitive schemas (Dekel, 2010; Tyson, 2007). During

shared trauma experiences, therapists report feelings of impairment in their ability to help, an increase in work-related stress, and feelings of being unprepared for the situation (Dekel, 2010). Therapists often perceive their role as more complicated due to being placed outside their conventional role as the other and therefore being unable to exercise rational judgment (Dekel, 2010; Tosone et al., 2012). Shared trauma can be further complicated due to the clinician and the patient being forced to mourn actual or ambiguous loss (Tyson, 2007). Similar to trauma victims, clinicians may begin to view the world through the lens of trauma over time, changing their beliefs about safety and reacting to events with suspicion, anger, and fear (Dekel, 2010). In the post-9/11 landscape, there have emerged two groups after traumatic events: the direct survivors of victims or combatants and the distant survivors of those who have borne witness (Tyson, 2007). In particular situations, clinicians experience admission into both groups simultaneously.

Noncombatants and Trauma

The conflicts in Iraq and Afghanistan have been the largest since the Vietnam War and have included the deployment of approximately 2 million U.S. service members (Peterson et al., 2010). During this decade of war, many soldiers have experienced traumatic events (Peterson et al., 2010). One of the most examined relationships in research has been the relationship between posttraumatic stress disorders (PTSD) and exposure to combat-related trauma (Peterson et al., 2010). While combat stress reactions have been investigated, there is a limited amount of literature examining what this context means for members of noncombat-related occupations.

Throughout the history of the U.S. military, noncombatants have served on or near the frontlines of war (Peterson et al., 2010). Peterson et al. (2010) examined noncombatants, exploring whether deployment locations are associated with reports of combat trauma, depression, PTSD, and other mental health outcomes. This study examined active-duty U.S. Air Force noncombatants ($N = 5,367$) who completed a Post-Deployment Health Assessment upon return from the Iraq combat zone ($N = 4,408$) and the noncombat zone ($N = 959$) of Qatar (Peterson et al., 2010). The inquiry used the retrospective analysis of archived data collected from Air Force service members who had been deployed to Iraq and Qatar from 2005 through 2007 (Peterson et al., 2010). Findings suggest that deployment to a war zone increases mental health problems, even for noncombatants (Peterson et al., 2010). Further interpretation of results indicated that, in some cases, noncombatants are more likely to develop PTSD than their combatant peers (Peterson et al., 2010). Further examination remains necessary, as the following limitations were noted: demographic variables of participants in each group were similar, the population only included active-duty Air Force personnel, and the number of combat events was based on self-report (Peterson et al., 2010). While there is an overabundance of literature in relation to the effects of war on those military members in combat roles, there continues to be a gap in relation to noncombat roles.

Shared Trauma and Mental Health

Bearing witness to traumatic stories can result in the clinician's emotional turmoil, known as *secondary trauma* (Geller, Madsen, & Ohrenstein, 2004). More specifically, working with survivors of trauma can produce indisputable negative effects on

practitioners (Ting, Jacobson, Sanders, Bride, & Harrington, 2005). The terror attacks of 9/11 further compounded secondary trauma as therapists themselves were personally processing the impact of those events (Geller et al., 2004). Mental health practitioners have taken an increasingly vital role in response to disasters and other large-scale traumatic events including terrorist attacks, school shootings, and natural disasters (Tosone et al., 2011). Concepts describing secondary trauma do not capture the impact that collective catastrophic events can have on mental health professionals living and working in hazardous conditions (Tosone et al., 2011). Despite emerging literature in relation to traumatic experiences and clinicians, no measure has been constructed to understand this distinct construct (Tosone et al., 2011).

One study, within the field of trauma, attempted to measure shared trauma through the utilization of the Quality of Professional Practice Survey to determine the relationship between shared traumatic stress and PTSD (Tosone et al., 2011). Random sampling was utilized, in the geographical location of post 9/11 Manhattan, to send surveys to 1,297 potential participants (Tosone et al., 2011). There were 507 surveys returned; however, 26 were excluded due to members being retired from clinical practice, leaving a final sample of 481 (Tosone, 2011). This study found participants tended to experience more trauma as a direct result of insecure attachment and previous life history of traumatic events (Tosone et al., 2011). Furthermore, a positive relationship was demonstrated between potentially traumatic events and resilience (Tosone et al., 2011). Overall, findings underscored the comparability between PTSD and secondary trauma suggesting the importance of taking into account dual exposure to trauma when clinicians

are living and working in dangerous environments (Tosone et al., 2011). Due to the predetermined locational boundaries, the findings may not be generalizable to mental health practitioners outside the geographic sample group of Manhattan (Tosone et al., 2011). Despite rejuvenated interest in this concept, little is known about clinicians who experience shared traumatic realities, and even fewer studies have examined risk factors and resiliency associated with shared trauma (Tosone et al., 2011).

In the aftermath of domestic and natural disasters, providers have expressed a desire to find a balance between apprehensions for safety, professional, personal, and family's needs (Faust, Black, Abrahams, Warner, & Bellando, 2008). Research in this area has attempted to define shared trauma in relation to existing secondary trauma constructs, as well as, examine the impact on the therapist regarding personal and professional alterations, which may result from double exposure (Tosone et al., 2012). Tosone et al. (2012) employed a literature review and case vignettes from clinicians in Israel to illustrate the transformative changes that mental health professionals may undergo, as a result, of dual exposure to trauma (Tosone et al., 2012). In addition, Faust et al. (2008) studied shared trauma in relation to four clinicians who practiced and resided in New Orleans after hurricane Katrina. Shared trauma was found to make professionals less open, distracted, and more protective of self (Faust et al., 2008). Lessons learned from these explorations included the necessity of utilizing the resiliency techniques of self-care prior to assisting others, as well as, expressing one's own trauma narrative (Faust et al., 2008; Tosone et al., 2012). Findings suggest agencies should provide the necessary education, supervision, and support to mitigate the negative effects of shared

trauma (Tosone et al., 2012). These literature reviews and incorporated case vinaigrettes reveal prior research in the area of shared trauma while offering an examination of resiliency within a trauma environment; however, further investigation is necessary for attempting to define this phenomenon (Tosone et al., 2012).

Shared Trauma and Military Healthcare

Military healthcare professionals hold one of the most difficult positions within the field (Linnerooth et al., 2011). Research conducted examining the military healthcare profession has explored the unique stressors and rewards experienced while working with veterans, as well as, the potential impact on performance, job satisfaction, and emotional well-being (Linnerooth et al., 2011; Voss-Horrell et al., 2011). These examinations have used literature reviews, surveys, and personal experiences to support and further describe the challenges for clinicians treating veterans of OIF/OEF (Linnerooth et al., 2011; Voss-Horrell et al., 2011). Exploration on this subject has found; clinicians, who treat clients with combat-related stress, scored significantly higher than peers when screened for cognitive intrusion and avoidance behaviors (Linnerooth et al., 2011). Techniques intended to ameliorate the risk, of working with the OIF/OEF population were; utilization of self-care practices and the presence of a supportive peer group (Voss-Horrell et al., 2011). Caseload management was also recommended as an essential resiliency factor as; attempting to manage individuals who suffer from pre-existing psychiatric conditions and are then subjected to additional trauma, make for a tremendously stressful and at risk caseload (Linnerooth et al., 2011). Overall, clinicians report working with the military population can be an extremely rewarding professional experience; however, risk factors

of primary and secondary traumatic stress must be addressed to maximize the positive benefits of these shared experiences (Voss-Horrell et al., 2011). Future implications note traumatized veterans of the Iraq, and Afghanistan wars will require support across the lifespan with military clinicians shouldering a significant amount of the burdens (Linnerooth et al., 2011).

Additional research within the field of trauma has explored the varied healthcare provider response to traumas by examining perceptions of control, self-efficacy, and post-event coping strategies in military nurses and physicians (Gibbons et al., 2013). Gibbons et al. (2013) investigation employed a purposive sample of 20 deployed military healthcare providers to complete a descriptive questionnaire, Posttraumatic Stress Disorder Checklist, the General Self-Efficacy Scale, and recorded semi-structured interviews (Gibbons et al., 2013). Descriptive exploratory design and descriptive interpretive approach were used to organize and analyze the cognitive-behavioral factors of interest (Gibbons et al., 2013). Providers indicated there are zero predictabilities while deployed (Gibbons et al., 2013). In addition, when asked to describe a traumatic event, providers often described a situation which involved injury or threat to others and not themselves (Gibbons et al., 2013). The providers who were reportedly successful in managing stress were ones who focused on the structure they could create to ensure positive outcomes for service members (Gibbons et al., 2013). To cope with potentially traumatic events some providers were found to compartmentalize while others described working through thoughts and feelings in social groups or solitary self-reflection periods (Gibbons et al., 2013). Overall, healthcare providers reported they knew what worked for

them, and they successfully employed these strategies while deployed (Gibbons et al., 2013). Findings suggest a need to train medical personnel in psychological first aid and resiliency concepts as they appear helpful in mitigating responses to stress in relation to combat exposures (Gibbons et al., 2013).

Review of relevant literature suggests there can be positive, as well as, negative effects for clinicians working within the military community (Voss-Horrell et al., 2011). There is a need to develop strategies to care for the psychological health of active duty providers; however, little is known about clinicians coping during deployment and while returning home (Gibbons et al., 2013). Previous research has influenced interventions that are utilized for combat troops with emotional problems; however, the impact of current conflicts on healthcare providers has been overlooked in the midst of legitimate occupational risk and concern (Gibbons et al., 2013). It remains unclear if the current mental health modalities used adequately address the unique stressors and aspects of healthcare professionals and whether this subpopulation needs to be treated differently (Gibbons et al., 2013). A gap remains regarding the scholarly understanding of cognitive and behavioral techniques used by deployed healthcare providers to cope with potentially traumatic events (Gibbons et al., 2013). Research examining the concept of shared trauma within the field of military healthcare is beginning to emerge; however, there continues to be a lack of information and understanding of this theoretical framework.

Resilience

Trauma research has long focused on the pathological outcomes, in particular posttraumatic stress disorder (PTSD), when considering individual's reactions to adverse

events (Dutton & Greene, 2010; Greene, 2010; Lee, Sudom, & Zamorski, 2013; Levine, Laufer, Stein, Hamama-Raz, & Solomon, 2009). However, this diagnosis is not experienced by most survivors (Dutton & Greene, 2010; Greene, 2010; Lee, Sudom, & Zamorski, 2013; Levine, Laufer, Stein, Hamama-Raz, & Solomon, 2009). The National Comorbidity Survey found exposure rates to trauma exceed 50 percent, yet lifetime PTSD rates are approximated at 7.8 percent (Levine et al., 2009). While many people suffer from physical and mental illnesses following exposure to stressful experiences, many others demonstrate remarkable resilience by reaming healthy despite facing traumatic events (Barton, 2006). In contrast to the mass of literature focusing on the mental health problems of deployed veterans, most veterans report more positive than negative results from their war experiences (Dutton & Greene, 2010; Laner & Blow, 2011; Schok, Kleber & Lensvelt-Mulders, 2010). Additionally, high levels of resilience have been found to be most protective during high levels of combat exposure (Lee et al., 2013). While resiliency is proposed as a standard reaction, research suggests the level of perceived trauma and enduring recovery from distressing events is variant by individual (Greene, 2010). Furthermore, the search for meaning after a traumatic event has been found to be a universal task which may occur naturally or through clinical intervention (Greene, 2010).

The field of resiliency literature has been evolving over several decades, which began with a focus in child development and expanded to include traumatic events (Dutton & Greene, 2010). Through this evolution, no single coherent framework has emerged to guide resiliency research (Dutton & Greene, 2010). In addition, there is a

long history of debate regarding the meaning and concept of resilience (Dutton & Greene, 2010). These controversies examine if the concept of resilience should be defined as a quality, process, outcome, development, multifaceted or one-dimensional, should it encompass healing or resistance, or external verses internal resources (Dutton & Greene, 2010).

The conceptualization of resilience varies through disciplines and practices (McGeary, 2011). Brief reviews of the most common definitions often provide some depth to how one can interpret this concept (McGeary, 2011). The most general and widely used definitions of resiliency describe the preservation and recovery of premorbid functioning (Laner & Blow, 2011; McGeary, 2011). The Latin roots of the word resilience include salire "to jump" and resilere "to spring back" and can be used as support for a strict definition of this concept (McGeary, 2011, p.603). Masten (1994) described resilience as a pattern of adapting despite risk, acute stressors, and or chronic adversity (Greene, 2010). Furthermore, resilience has been examined as an individual trait which evolves over time (Greene, 2010). The International Federation of Red Cross and Red Crescent Societies define resilience through a survival lens of adapting, recovery, and risk reduction (McGeary, 2011). In addition, Fraser (1997) offered resilience as an adaption to traumatic events (Greene, 2010).

Review of resiliency literature identified the following three waves of resiliency research (Greene, 2010). The first resiliency explorations attempted to explain traits that enable individuals to overcome adversity (Greene, 2010). These variables are protective factors and include positive temperament and self-esteem, supportive family, and positive

social environment (Greene, 2010). Additionally, several personality factors have been acknowledged as protective to include: hardiness, due to assessing threatening situations as less distressing, internal locus of control, and altruism (Dutton & Greene, 2010). Resilience has been defined in the literature as a factor of character, disposition, and endowment which offers protection when exposed to adverse events (Dutton & Greene, 2010). Furthermore, literature regarding resilience has consistently found that personality characteristics including hardiness, persistence, and acceptance of life, self-esteem, and social support are associated with lower posttraumatic stress (Dutton & Greene, 2010; Lee et al., 2013). The second wave of resiliency exploration has investigated the process of adapting by examining the level of recovery and long term effects (Greene, 2010). This process has been defined as the presence of factors that operate to either resist occurrences of or to recover from adverse results (Dutton & Greene, 2010). Resilience observed as a process of adaption has been operationalized as: self-enhancement, positive cognitions, coping styles, and spirituality (Dutton & Greene, 2010; Laner & Blow, 2011; Lee et al., 2013). The adaptation attributes of personal competence, stress tolerance, acceptance of change, personal control, and spiritual orientation are all associated with less suicidal ideation, lower alcohol consumption, fewer depressive symptoms, lower reports of PTSD, and decreased medical complaints within the military population (Lee et al., 2013). Finally, the third and current wave of resilience research has focused on how people grow and transform from adverse events (Greene, 2010). Current literature examining the concept of resilience suggests recovery from traumatic events can produce posttraumatic growth (PTG) resulting in the development of positive outcomes after the

traumatic event; however, this relationship between PTG and resilience is still unclear (Dutton & Greene, 2010).

Through review of the literature, there appears to be two different styles of coping which contribute to resilient outcomes (Mancini & Bonanno, 2009). The first, pragmatic coping, involves a set of highly specific coping demands (Mancini & Bonanno, 2009). In order to successfully meet these demands often requires a whatever it takes and goal oriented approach (Mancini & Bonanno, 2009). The second, flexible adaptation, involves the ability to shape and adapt one's behaviors to the demands of any given stressors (Mancini & Bonanno, 2009). Additionally, self-perception was found to influence coping associated with resilience (Mancini & Bonanno, 2009). Traumatized individuals commonly report symptoms of self-damaging or inferior self-perceptions (Mancini & Bonanno, 2009). In contrast, resilient individuals often report minimal changes to their sense of self (Mancini & Bonanno, 2009).

In an examination of the concept of resiliency, argument has been made that resilience is a mixed occurrence that defies simple characterization; however, resiliency factors have also been found to converge along similar mechanisms (Mancini & Bonanno, 2009). Furthermore, while individuals may hold components aligned with resilience whether individuals exhibit these factors can only be determined by their level of adjustment after a traumatic event (Mancini & Bonanno, 2009). Resilience has been distinguished from the two other prevailing patterns of reactions following trauma, chronic dysfunction and recovery from symptoms which gradually subside (Mancini & Bonanno, 2009). Individuals who exhibit resilience progress with their lives following

traumatic events with limited or no visible disruptions (Mancini & Bonanno, 2009). A resilient response does not imply that these individuals experience no distress related to trauma rather, through these symptoms their overall level of functioning remains stable (Mancini & Bonanno, 2009).

Hardiness Resilience

The majority of United States soldier's desire to do the right thing and seek to perceive their mission is worthwhile (Bartone, 2005). Frankl (1960) asserted human beings have the ability to choose their meaning and some of us perhaps are better at constructing positive meanings (Bartone, 2005). Research related to hardiness has focused on the positive effects of resilience and the tendency to remain healthy under stress (Bartone, 2005; Lo Bue, Taverniers, Mylle, & Euwema, 2013). Hardiness was found to reduce the impact of stressful life experiences on mental and physical health (Lo Bue et al., 2013). Furthermore, previous research demonstrated that hardiness predicts fewer posttraumatic stress symptoms in soldiers exposed to a variety of stressors (Bartone, 2005; Escolas, Pitts, Safer, & Bartone, 2013; Lo Bue et al., 2013). The underlying mechanism within the hardiness resiliency process involves how stressful events are perceived or made sense of in the context of one's life experiences (Bartone, 2006). Hardiness is a character trait which develops early in life and remains relatively stable over time, although it is seen as trainable under certain conditions (Bartone, 2006). Hardy persons have been found to possess the following traits: a grounded sense of life and work commitment, feelings of control, and are more open to change (Bartone, 2006; Escolas et al., 2013). Hardy individuals were found to perceive stressful experiences as

an expected aspect of existence and part of life which makes the overall challenge worthwhile (Bartone, 2006).

Psychological hardiness was first described in the literature by Kobasa (1979) as a characteristic that distinguished those who became ill under pressure versus those who remained healthy (Escolas et al., 2013; Lo Bue et al., 2013). Bartone (2006) asserts, hardiness is theoretically grounded in existential philosophy and has been investigated by psychologist to include; Frankl (1960), Binswanger (1963), and Heidegger (1986). Hardiness encompasses the meaning of life, the acceptance that it may involve hardships, and courage to live life fully despite its challenges (Bartone, 2006). Hardiness is a core personal quality that affects resilience (Escolas et al., 2013). A critical aspect of the hardiness resiliency mechanism involves the interpretation, or meaning people attach to events around them and how these link within their entire life experience (Bartone, 2006). Hardy individuals typically perceive events as worthwhile, something they can exert control over, and opportunities to learn and grow (Bartone, 2006). The key power of hardiness to buffer stressful experiences seems to be the particular interpretations of the events as assigned by the individual (Bartone, 2006).

Frankl (1960) made the observation that war hits the core of individuals' existential meaning; however, through great pain there can also be great meaning (Osran, Smee, Sreenivasan, & Weinberger, 2010). The psychological trauma of military deployment is very different from other traumas such as natural disasters, accidents, or illnesses (Larner & Blow, 2011). The presence of an asymmetrical battlefield, threat of invisible Improvised Explosive Devices (IED), and indirect fire of motors and rockets

into Froward Operating Bases (FOB) have created a war of unique stressors even on the relatively safe bases (Osran et al., 2010). In addition, OIF/OEF veterans have experienced multiple combat deployments which pile trauma over time making for a unique trauma schema unexplored in the scholarly literature, with most research focusing on a single traumatic event (Laner & Blow, 2010). The current United States military population comprises an all-volunteer force that willingly faces traumatic events with the knowledge of these possibilities in an attempt to defend their country rather than as victims of random experiences (Laner & Blow, 2011). This concept of experiencing a greater sense of self was found to have therapeutic value for some returning veterans (Osran et al., 2010). When facing experiences of over a decade of war, hardiness resilience offers hope that life has meaning in all experiences, even trauma (Osran et al., 2010).

According to Frankl (1960), despair is suffering without meaning (Osran et al., 2010). Furthermore, while all events have meaning, humans always have a choice whether or not to find it (Osran et al., 2010). Under the hardiness approach, resiliency places the deployment experience in a meaningful file-context which may resonate with veterans (Osran et al., 2010). Meaning in life experiences possibly are the most crucial factor in developing resiliency; the perception of understanding the purpose of one's suffering can assist in avoiding negative emotions that a trauma mindset can produce (Osran et al., 2010). The ability to assign meaning to traumatic events will not guarantee a symptom free event; rather, evidence suggests meaning making assist in determining whether a memory is stored as traumatic or simply stressful (Laner & Blow, 2011).

Resilience and Trauma

During the last two decades, literature and research on resilience have taken the focus away from the circumstances of failure and shifted the investigation to situations and factors which allow individuals to overcome adversity (Pulvirenti & Mason, 2011). Processes of memory and storytelling have been found to be significant actions allowing individuals to make meaning of traumatic life experiences (Cohen, Meek, & Lieberman, 2010). Additionally, resiliency research has found that characteristics of resilience in one domain of an individual's life, such as academia, do not always translate to resilience in other domains, such as emotional aspects (Pulvirenti & Mason, 2011). Under this concept, individuals do not just have resilience indefinitely; it is something to strive continuously to obtain (Pulvirenti & Mason, 2011).

When examining individuals who experienced traumatic life events; the stories of survivors present as sources of hope and strength. These individuals are living proof of the sheer desire for humans to survive (Cohen et al., 2010). These are not stories of extraordinary individuals, rather just how remarkable people can be (Cohen et al., 2010). The hardiness of trauma survivors was found to lie in the ongoing transformation process directly relating to the long-term effects and search for meaning after exposure to trauma (Cohen et al., 2010). In resiliency research, specific to refugee women and holocaust survivors; individuals moved on rather than bouncing back from experienced trauma (Cohen et al., 2010; Pulvirenti & Mason, 2011). Furthermore, resilience was described as an ongoing process of adaptation (Pulvirenti & Mason, 2011). Within this field of resiliency research, Cohen et al. (2010) utilized a mixed method structured interview

protocol with a population of holocaust survivors to assess aspects of their life experiences which assisted in the mitigation and protection from the adverse effect of the experience. Findings suggest the process of memory and storytelling are integral parts of life for human beings allowing individuals to make meaning of life experiences (Cohen et al., 2010). Overall, it was determined that survivors have two post trauma memories; those of injustice and survival which often combine to create an identity of survivorship (Cohen et al., 2010).

Military and Resilience

Resilience has been defined as; the ability to maintain healthy functioning across time and in the face of traumatic events (Howell, 2012; Lee et al., 2013; Schok et al., 2010). Through further exploration, resilience was shown to be a common phenomenon that is often overlooked (Schok et al., 2010). An ever growing body of research suggests that processing traumatic events can result in growth and psychological benefits (Gibbons et al., 2013; Schok et al., 2010). In 2010, the Army released a report on mental health asserting; the treatment oriented approach has been primarily reactive and in contrast, there should be a proactive movement through preventative measures (Howell, 2012). This Army report indicated prevention through resiliency training as the preferred method for addressing mental health concerns (Howell, 2012). The belief in the ability to prevent PTSD through resilience techniques can be both socially and economically beneficial within the military (Howell, 2012). The military is in need of resilient individuals who can withstand the effects of a wide range of stressors both in the short term, for performance and in the long-term, for retention (Lee et al., 2013). Meaning

making has been posed as a core mechanism in relation to resilience and posttraumatic growth within the veteran population; however, a gap remains in the understanding of how deployed military members cope and grow from their experiences (Laner & Blow, 2011).

In the field of stress and trauma, there is growing interest in the capacity of resilience to allow individuals to heal from painful events (Schok et al., 2010). The purpose of Schok et al. (2010) study was to examine whether the specific personal resources of self-esteem, optimism, and perceived control, in combination with the latent variable called ‘resilience,' are associated with cognitive processing of war-zone experiences. A cross-sectional study used a sample of 3000 Dutch veterans who deployed during war and peacekeeping missions (Schok et al., 2010). Questionnaires consisting of the Aftercare Questionnaire of the Royal Army in the Netherlands, Impact Event Scale, Meaning of War Scale, Benefit Finding Scale, Rosenberg Self-Esteem, and Lift Orientation Test were administered to the sample (Schok et al., 2010). The cross-sectional design of this study limited the conclusions related to causality amongst the variables (Schok et al., 2010). Findings indicated high resilience resulted in less distrust in others and the world, more personal growth, and fewer intrusions and avoidance after deployment (Schok et al., 2010). Resilience was also related to an individual's ability to process and construct meaning to one's experience (Schok et al., 2010). In addition, when attempting to understand the cognitive process of meaning making, two constructs were identified (Schok et al., 2010). First, people try to understand the event to define what

happened (Schok et al., 2010). Second, individuals try to comprehend the personal significance of the event (Schok et al., 2010).

Military resiliency research has also considered how potentially traumatic events are individually manifested (Schaubroek, Riolli, Peng, & Spain, 2011). This subgroup of research has focused on identifying factors that distinguish those who cope effectively with traumatic events (Schaubroek et al., 2011). Schaubroek et al. (2011) studied the interaction between combat exposures and characteristics associated with stress resilient individuals. This exploration focused on positive psychological capital incorporating various traits found to represent emotional resilience including self-efficacy, optimism, and hope (Schaubroek et al., 2011). The study's sample consisted of 648 soldiers assigned to nine deployed combat units with military personnel voluntarily completing anonymous questionnaires (Schaubroek et al., 2011). Additionally, Pietrzak, Johnson, Goldstein, Malley, and Southwick (2009) completed an analysis of 272 Reserve and National Guard OIF/OEF veterans through a mail survey to assess traumatic stress, depressive symptoms, resilience, and social support. Through these explorations, resiliency scores were found to be comparable to those in the civilian outpatient population of primary care patients (Pietrzak et al., 2009). Findings also indicated respondents diagnosed with PTSD scored significantly lower on resilience and social support screening tools (Pietrzak et al., 2009). Traumatic stress and depressive symptoms were negatively associated with increased reports of personal control and positive acceptance of change (Pietrzak et al., 2009). Furthermore, findings suggest, positive psychological capital served as an essential aspect in determining those individuals who were more adaptive in stressful situations

(Schaubroek et al., 2011). Overall, results submit, interventions to strengthen psychological resilience assist in the reduction of traumatic stress and depressive symptoms in OIF/OEF veterans (Pietrzak et al., 2009).

An additional review examining perceptions of military deployment among veterans found more positive than negative effects (Gallaway, Millikan, & Bell, 2011). Gallaway et al. (2011) studied a sample of 2,775 soldiers assigned to an infantry brigade combat team (Gallaway et al., 2011). Participants completed an anonymous survey assessing combat exposures, attitudes, and climate within the unit (Gallaway et al., 2011). Among these participants, 1,834 reported combat deployments and related posttraumatic growth (PTG) (Gallaway et al., 2011). These individuals were selected to participate in further examination of the posttraumatic growth concept. Findings suggest soldiers with the highest number of combat experiences had significantly higher posttraumatic growth (Gallaway et al., 2011). Further research is necessary to enable quantification of the positive perceptions of combat experiences in an attempt to fully understand the reason for growth among these veterans (Gallaway et al., 2011).

Military Mental Health

Throughout the 20th Century, mental health clinicians have offered their assistance to the military in an attempt to mitigate the effects of the traumatic events inherent in combat (Pols & Oak, 2007). Military officials have long displayed ambivalence toward involvement of mental health providers in military affairs (Pols & Oak, 2007). Prevalent stigma within the military has often labeled soldiers suffering from psychiatric symptoms as cowards and weak (Pols & Oak, 2007). Furthermore, military

officials have only shown interest in psychiatric symptoms when such occurrences are recognized to affect the accomplishment of the mission (Pols & Oak, 2007). Throughout the history of the profession, it has been demonstrated that when mental health professionals are perceived to contribute to preserving the fighting force their contributions have been appreciated (Pols & Oak, 2007).

During World War I and II screening programs were initiated, within the military, based on the theoretical view that vulnerability for nervous breakdowns was related to stable factors including; genetic makeup, temperament, and childhood experience (Pols & Oak, 2007). In 1944, the screening process was disbanded due to the failure of the process along with the military facing pressure regarding the need for manpower during World War II (Pols & Oak, 2007). In addition, during World War I, the initial stages of the terminology shell shock were being developed (Pols & Oak, 2007). Shell shock was presented as an emotional reaction to combat rather than the expression of a predisposition mental illness (Pols & Oak, 2007). Aware that screening for possible mental illness would not prevent psychiatric problems; the military mental health community shifted its focus to the management of psychological distress during deployment (Pols & Oak, 2007). Under this theory, treatment should commence as soon as possible, be applied near the service member, and be implemented in simple forms of psychotherapy and optimism (Pols & Oak, 2007). These principles continue to form the theoretical model for mental health care in combat by maintaining the readiness and battlefield numbers through the reduction in the impact of traumatic events (Chappelle & Lumley, 2006).

While it is normal for soldiers to experience stress reactions during combat operations,' military doctrine directs leaders to address these potential responses (Reger, 2006). In recognition of these potential reactions, the Army utilizes Combat Stress Control (CSC) teams with the mission of, preventing stress related problems, intervening rapidly, and returning soldiers to duty (Reger, 2006). Additionally, CSC teams attempt to prevent long term psychological symptoms, including the development of PTSD (Reger, 2006). Combat Stress Control units are mobile mental health teams which support the Brigade mental health assets, in the prevention and treatment of Combat Operational Stress Reactions (COSR's) (Reger, 2006). In support of the Army Medical Departments mission, experience has shown that CSC and Brigade behavioral health assets in combat can have positive impacts on preserving the fighting force (Reger, 2006). Providing mental health services in theater, as close to combat units as possible, provides service members the best chance of returning home free from psychological and emotional problems (Miller & Warner, 2013).

While most Army Brigades have several physicians assigned to the element, there is usually only one mental health provider (Linnerooth et al., 2011). In many of these cases, there will be only one MMHP among other helping professionals or entirely alone (Tallant & Ryberg, 2004). Furthermore, these positions are usually staffed by junior officers (Tallant & Ryberg, 2004). The limited availability of resources during these assignments often requires the clinician to develop a wide range of services (Tallant & Ryberg, 2004). MMHP experiences while unique do not diminish their role as soldiers (Miller & Warner, 2013). MMHP stories of deployment are often inspirational and

heroic; however, have frequently been unknown and ignored within current scholarly literature (Miller & Warner, 2013).

Military Mental Health Professionals and Deployment

When examining the psychological outcomes of war and trauma, a multitude of studies have shown that many survivors of war suffer from psychological distress (Lev-Wiesel, Goldblatt, Eisikovits, & Admi, 2012). There is a limited amount of research which explores the concepts of resilience, and even fewer studies examine the relationship of shared trauma and clinicians in regard to positive trauma related meaning (Lev-Wiesel et al., 2012). Furthermore, there is little scholarly literature focusing on the phenomenon of MMHP, who deploy (McCauley et al., 2012; Miller & Warner, 2013). The few exploratory studies completed in this field have attempted to develop a better understanding of the occupational and personal aspects of mental health and healthcare providers while practicing within hazardous environments (McCauley et al., 2012; Miller & Warner, 2013).

Prior research has examined posttraumatic stress symptoms and vicarious traumatization verses posttraumatic growth among Israeli practitioners in a shared war reality (Lev-Wiesel et al., 2012). This investigation gathered a convenience sample of 204 practitioners (76 nurses and 128 social workers) 2 months after the war (Lev-Wiesel et al., 2012). All participants were residents and employees in the Haifa area and were administered a self-report questionnaire (Lev-Wiesel et al., 2012). This study found the following factors contributed to feelings of worthiness: being responsible for others, the acknowledgment of the dependence of trauma clients, and working with colleagues (Lev-

Wiesel et al., 2012). Furthermore, professional expectations in their role of being required at times of crisis also became a resource for growth (Lev-Wiesel et al., 2012). In this shared war reality, challenges served as catalysts in discovering new strengths and meanings (Lev-Wiesel et al., 2012). The investigation found nurses scored higher on posttraumatic growth scales compared with their social work colleagues (Lev-Wiesel et al., 2012). In addition, strength of personal resources was found to contribute to the reduction of vicarious traumatization (Lev-Wiesel et al., 2012). While this study was limited due to lack of comparison groups; the examination was able to compare two professional groups, finding similarities in each professions code of ethics, as well as, differences in roles and emotional involvement within a shared trauma reality (Lev-Wiesel et al., 2012).

In addition, McCauley et al. (2012) studied 10 British MMHP, both commissioned and non-commissioned officers, who recently returned from deployment using a qualitative semi-structured interview protocol to gather data. The focus of this study was to develop increased understanding of the experiences of British deployed clinicians, their deployment role, engagement with colleagues, challenges faced, and responses (McCauley et al., 2012). Participants included psychiatrist, psychiatric nurses, and noncommissioned mental health service members across the Iraq conflict from 2003-2005 (McCauley et al., 2012). This study used the grounded theory methodological approach. Findings suggest while practitioners experienced various stressors; their overall concern was success of the mission through achieving clinical goals (McCauley et al., 2012). Challenges for these professionals were found to include, ethical difficulties,

professional and personal obstacles, and bonding with colleagues (McCauley et al., 2012). Clinicians were found to utilize a variety of intra and inter-personal strategies in an attempt to manage these stressors (McCauley et al., 2012). Identifying with one's unit or group was found to increase motivation and improve performance during deployment (McCauley et al., 2012). Due to the number of participants involved, this study is limited in its generalizability. Future research is needed to explore the experiences of commissioned and non-commission officers separately (McCauley et al., 2012). Additionally, the participant's indication that they found their work rewarding within the deployed environment can link into existing trauma and resilience research, as well as, guide future exploration within this phenomenon.

Finally, Miller and Warner (2013) examined how MMHP experience reintegration back into families and jobs upon return from deployment, as well as, how these professionals cope with their own post deployment issues. Post deployment experiences of MMHP were examined using the qualitative inquiry approach (Miller & Warner, 2013). A two phase sampling design was employed and consisted of snowball and convenience sampling. A total of 27 individuals including social workers, psychiatrist, and psychologist were interviewed to explore deployment and post deployment experiences (Miller & Warner, 2013). The standardized interview protocol used addressed experiences of MMHP in the six core areas of career, role after 9/11, personal care, deployment, skills, ethics, and relationships (Miller & Warner, 2013). Many MMHP spoke of their time during deployment as assignment driven with their key role of supporting the accomplishment of the unit's mission (Miller &Warner, 2013).

Deployment was described by participants as a freeing experience due to being the right skill, at the right time, in the right place (Miller & Warner, 2013). Findings further suggest, prior knowledge of deployments psychological impact did not prevent these professional from experiencing adjustment challenges (Miller & Warner, 2013). Results indicated that 81% of MMHP noticed some level of dysfunction in their lives at home, work, or both upon return from deployment (Miller & Warner, 2013). Examined MMHP described the utilization of a homogeneous set of behaviors to care for their own personal well-being (Miller & Warner, 2013). The choices of coping strategies were consistent and involved exercise, maintaining faith, and staying in contact with friends and family (Miller & Warner, 2013). Additionally, MMHP reported they sought post-deployment counsel from peers rather than pursuing official mental health services (Miller & Warner, 2013).

Throughout the past decade of conflict, MMHP have proven to be a vital component in maintaining the fighting force of several nations (McCauley et al., 2012; Miller & Warner, 2013). As a result, MMHP will continue to be integrated into military units across the globe (McCauley et al., 2012; Miller & Warner, 2013). Continued deployment to shared traumatic conditions dictates a need for further research to understand the phenomenon of deployed MMHP. Even though the field of trauma research has evolved to consider the factors of resiliency and shared trauma, these ideas continue to be under examined within the scholarly literature (Schok et al., 2010). While meaning making has been posed as a core mechanism in relation to posttraumatic growth

within the veteran population, a gap remains in understanding the meanings MMHP ascribe to their deployment experience (Laner & Blow, 2011).

Summary

Clinical MMHP hold one of the most difficult positions within the field (Linnerooth et al., 2011). Treating service members during an ongoing war provides professionals with opportunities and challenges that have not been present in decades (Voss et al., 2011). In the post 9/11 landscape, there have emerged two groups after traumatic events; the immediate survivors of victims or combatants along with the distant survivors of those who bear witness (Tyson, 2007). In particular circumstances, MMHP are aligned in both groups simultaneously. While there is a plethora of literature in relation to the effects of war on service members in combat roles; there is a gap in relation to noncombatants and more specifically MMHP.

In the currently evolving literature, shared trauma was found to produce adverse effects presenting as acute/chronic stress reactions, as well as, positive psychological consequences of posttraumatic growth and resilience (Tosone et al., 2012). Though the field of trauma research has evolved to examine factors of resiliency; the concept of resilience continues to be under examined (Schok et al., 2010). The concept of resilience remains limitedly explored through scholarly literature and is defined as the ability to bounce back or grow from traumatic events. Further exploration is necessary to enable quantification of perceptions of positive combat experiences in an attempt to understand the reason for resilience in certain veteran populations (Gallaway et al., 2011). At the

time of this study, there was no known research examining the relationship between shared trauma, resiliency, and MMHP, who have deployed during OIF/OEF.

Within current literature, a gap exists in understanding clinicians who experience trauma both personally and professionally (Tosone et al., 2011). Despite the presence of scholarly literature exploring the concept of shared trauma, there is still no published conceptualization found regarding this phenomenon (Baum, 2010). The existing research failed to satisfactory isolate shared trauma and resilience for the population of MMHP. In addition, there was little evidence to demonstrate the impact and overall meanings of deployment during OIF/OEF for those in the mental health field. Due to these gaps in the literature, this studies primary focus was on MMHP, who deployed and exploring meanings ascribed to this lived experience in an attempt to better understand the selected phenomenon. To explore this unique point of view and lived experience, the interpretive paradigm was chosen and carried out through the utilization of phenomenological inquiry.

Chapter 3: Research Method

Introduction

The purpose of this phenomenological study was to describe military mental health deployments within the frameworks of shared trauma and resilience. The concepts of shared trauma as described by Tosone et al. (2011) and resiliency as defined by Bartone (2006) were combined to form a conceptual framework to provide a foundation for this research. Shared trauma was defined as a concept developed to capture the experience of clinicians striving to provide services to individuals experiencing trauma while simultaneously addressing the same issues within their own lives (Tosone et al., 2011). The concept of resilience was defined in terms of how stressful situations are interpreted or made sense of in the context of one's overall life experience (Bartone, 2006). The phenomenological paradigm was used to obtain perspectives and provide information-rich descriptions of the phenomenon of deployed mental health providers. The implications for positive social change include better understanding of military mental health deployments and the impact of these events on providers, along with the potential to minimize adverse effects while maximizing posttraumatic growth and resiliency.

An examination of current literature suggests that shared trauma can result in both positive and negative cognitions resulting in symptoms of posttraumatic stress, as well as resilience. Similar to trauma clients, practitioners who experience shared trauma may exhibit disturbances in perceptions, emotions, and maintaining hope (Geller et al., 2004). In contrast, it has been suggested that resilience is the ability to maintain stability despite

traumatic events and in certain situations even grow from these experiences (Tosone et al., 2011). This investigation built upon the qualitative study by McCauley et al. (2012), who employed an exploratory grounded theory analysis to gain greater insight into the occupational and personal nature of providing mental healthcare while deployed. McCauley et al. (2012) examined 10 British military mental health professionals (MMHP) who had recently returned from deployment using a qualitative semistructured interview protocol to gather data. Findings suggested that while practitioners experienced various deployment stressors, their overall concern was success of the mission through achieving clinical goals (McCauley et al., 2012). Challenges for these professionals were found to include ethical difficulties, professional and personal obstacles, and bonding with colleagues (McCauley et al., 2012). Identifying with one's unit or group was found to increase motivation and improve performance during deployment (McCauley et al., 2012). Clinicians were found to use a variety of intra- and interpersonal strategies in an attempt to manage these stressors (McCauley et al., 2012). Overall, the McCauley et al. (2012) study failed to address meanings clinicians assigned to their deployment experience, resulting in a continued gap in knowledge regarding shared trauma and resiliency within this population.

Research Design

This examination used the phenomenological model, employing empirical methods to develop an understanding of human experience from a unique point of view. Phenomenological inquiry was used in an attempt to understand the hidden meanings and essences of experiences by gathering the participants' words and descriptions of events

observed (Kafle, 2011; Patton, 2002). The purpose of this phenomenological investigation was to discover the meaning of a particular lived experience (Englander, 2012). The phenomenological method of research allows the potential to explore in-depth lived experiences from the source of the individual (Kafle, 2011). In addition, this phenomenological inquiry uses the researcher as a fundamental tool, providing essential understandings of the methodology and the particular phenomenon being examined (Kafle, 2011).

Heuristic inquiry was used in relation to this topic, as I questioned my personal experience of this event and the fundamental experience of others who lived this phenomenon. The heuristic discipline of phenomenology involves an attempt to gain understanding beneath one's subjective experience by finding the objective nature realized by an individual (Kafle, 2011). Heuristic phenomenology was employed to reveal the world as experienced by participants through their life stories (Kafle, 2011). Hermeneutics allowed for exploration of MMHP experiences with further analysis by me based on my personal experience with the phenomenon (Ajjawi & Higgs, 2007). The focus of this heuristic exploration was providing rich textual descriptions of military mental health deployments (Ajjawi & Higgs, 2007).

This phenomenological study used in-depth interviews of MMHP who were veterans of Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF). This work represents an exploration of the perceptions and experiences of individuals who lived the event of deployment as MMHP. The primary methods of data collection were Skype and telephone interviews using the semistructured interviewing approach, which was

designed to evoke a comprehensive exploration of the phenomenon. The following research questions were proposed for this phenomenological study:

RQ1—Central research question/qualitative: How do military mental health providers describe dilemmas faced as they try to navigate the personal aspects of shared trauma?

RQ2—Central research question/qualitative: How do military mental health providers describe dilemmas faced as they try to navigate the professional aspects of shared trauma?

These questions contained multiple overlapping phenomena, which required explicit attention in order to understand the main phenomenon as a whole. Therefore, the following subquestions were posed:

RQ3—Qualitative: What meanings do military mental health providers choose to assign to their shared trauma experiences?

RQ4—Qualitative: What were the most difficult psychological aspects of deployment for military mental health clinicians?

RQ5—Qualitative: How did the clinicians attempt to care for themselves while simultaneously caring for others during deployment and the 6 months following return from deployment?

The intended participant group was individuals who previously served on Active Duty, National Guard, or Reserve components and were deployed for 6 months or more to Forward Operating Bases (FOB) in active combat zones as mental health professionals during OIF/OEF. Due to the difficulty in finding willing participants, some of the

population limiters had to be adjusted. For example, during the recruitment period, it was discovered that prior to 2006, Air Force and National Guard components deployed for 4 to 5 months; therefore, a change request was sent to the IRB for approval to adjust the defined duration of deployment from 6 to 4 months. Purposive sampling was used in an attempt to obtain a participant group that would provide information-rich cases. Investigation of information-rich cases was employed to create insights and in-depth understandings rather than empirical generalizations (Kafle, 2011). The number of participants for this study was (N =7).

Data analysis used Moustakas's (1990) five steps of heuristic analysis. Moustakas described five principles within the heuristic analysis process: immersion, incubation, illumination, explication, and creative synthesis (Patton, 2002). Immersion included organizing the data set into text and preliminary interpretation (Ajjawi &Higgs, 2007). Incubation involved quiet contemplation allowing for clear and profound awareness of meanings to develop (Patton, 2002). Illumination entailed linking the reviewed literature and interpretations, reconstructing these data into stories (Ajjawi & Higgs, 2007). In the explication phase, full comprehension of the experience began to emerge through self-dialogue and reflection (Patton, 2002). Finally, creative synthesis encompassed bringing the pieces of emerging patterns together, allowing for new perspectives and implications (Patton, 2002).

The focus of this research was understanding a human phenomenon and how MMHP experience this phenomenon. This goal fit with the philosophy and intentions of the interpretive paradigm (Ajjawi & Higgs, 2007). The interpretive paradigm is grounded

in the concept of idealism, with the central goal of interpreting the social world (Ajjawi & Higgs, 2007). Within the interpretive paradigm, meanings are constructed by human beings in their own unique ways depending on context, frames of reference, and personal perception (Ajjawi & Higgs, 2007). What is useful, meaningful, and relevant among MMHP who have deployed depends on the situation (Ajjawi & Higgs, 2007). Attempting to isolate or measure such an experience would have ignored the complexity, reality, and consequences of this phenomenon (Ajjawi & Higgs, 2007). The interpretive paradigm was selected as most suitable for this research due to its potential to create new understandings of the complex and multidimensional human phenomena of deployed MMHP (Ajjawi & Higgs, 2007). In addition, research seeking to understand the nature of the experience of deployed mental health professionals lent itself to phenomenological research, as the focus of phenomenology is lived experience (Ajjawi & Higgs, 2007). Furthermore, hermeneutics allowed for exploration of participants' experiences with further analysis by me based on my personal experience with the phenomenon (Ajjawi & Higgs, 2007). Finally, Moustakas's (1990) five principles of immersion, incubation, illumination, explication, and creative synthesis provided for a systematic review and report of gathered data (Patton, 2002).

Role of Researcher

The selected research process dictated that the principal data collector was both the researcher and a member of the same profession as the participants. Furthermore, I experienced a 9-month deployment during OEF (2012 to 2013), serving as an Active Duty Clinical Social Worker as a junior officer in the U.S. Army. There were several

advantages and disadvantages in this dual role. First, my role as a MMHP facilitated trust and confidence within the researcher/participant relationship, allowing for the establishment of rapport (Ajjawi & Higgs, 2007). In addition, I was already fluent in jargon participants might use (Ajjawi & Higgs, 2007). In contrast, prior knowledge of the professional language and deployment experience allowed for the assumption that the same meaning would be ascribed to words by both individuals (Ajjawi & Higgs, 2007). To address disadvantages, I attempted to maintain hermeneutic alertness, which allowed me, as a researcher, to take a step back and reflect on meanings and context rather than accepting preconceptions (Ajjawi & Higgs, 2007). While the self of the researcher exists throughout this research, the process of heuristic inquiry allowed for the progression of increased self-awareness and discovery (Patton, 2002). The focus of this heuristic inquiry was disclosing truth through exhaustive self-search and dialogues with others, creating a comprehensive knowledge of the lived experience (Patton, 2002).

Methodology

Sampling Strategy and Participant Selection

While there is no set method when conducting phenomenological research, purposive sampling of information-rich cases is recommended (Kafle, 2011). Purposive sampling was operationalized by examining cases that manifest the selected phenomenon profoundly (Ajjawi & Higgs, 2007). Exploration of information-rich cases allowed for presentation of insights and in-depth understandings rather than empirical generalizations (Kafle, 2011). When it came to selecting participants for this phenomenological study, exploration occurred concerning whether a participant had experienced the selected

experience intensely (Englander, 2012). Additionally, implementation of multiple interviews with a small number of individuals followed the traditional interpretive paradigm approach (Ajjawi & Higgs, 2007).

The purpose of this qualitative inquiry was to focus in depth on individual experiences within the phenomenon of military mental health deployments relating to shared trauma and resilience. The focus of this investigation was expressing the meaning of the phenomenon profoundly through sampling a small number of individuals who had experienced deployment as MMHP during OIF/OEF. The participant group was defined as individuals who previously served on Active Duty, National Guard, or Reserve components and deployed for 4 months or more to Forward Operating Bases (FOB) in active combat zones as mental health professionals during OIF/OEF. Individuals were selected based on how intensely their experience demonstrated the selected phenomenon, along with demographic factors to ensure a mixture of gender, age, service affiliation, and professional discipline. A sample size of (N =7) individuals was selected purposefully for interviews. Individuals were recruited through networking with current colleagues and past professional acquaintances to identify potential research participants. Potential participants were contacted via email with all pertinent information, including the purpose of the study, how information would be used, research procedures, confidentiality procedures, risks and benefits of participation, and informed consent.

In considering sampling size within phenomenological research, Englander (2012) asserted that a phenomenological study should begin with exploring the question of what the experience is like, rather than more quantitative questions of how much or

how many. This fundamental difference requires a different perspective on the issue of representativeness within qualitative studies (Englander, 2012). Phenomenological research does not focus on knowing how many or how often an exposure has occurred; rather, it focuses on meanings individuals discern from particular lived experiences (Englander, 2012). In phenomenological research, representativeness cannot be evaluated on the basis of sampling method, as the goal is general knowledge about the phenomenon (Englander, 2012). The task for the phenomenological researcher is to find members who report having experienced the selected event (Englander, 2012). Large sample sizes are often used in legitimizing research activity; the question of sample size is a persistent problem within qualitative research (Englander, 2012). Historically, foundational research within the field of psychology was conducted with a small number of subjects (Englander, 2012). Central figures within psychology such as Freud, Piaget, and Skinner developed theories based on research involving a limited number of subjects (Englander, 2012). The field of human science suggests that researchers use at least three participants for phenomenological inquiry (Englander, 2012). In Husserlian phenomenology, generality can be achieved through being present in the data, in contrast to how generality is viewed for quantitative studies (Englander, 2012). Small sample sizes can provide sufficient and accurate information as long as members possess a certain degree of expertise about the phenomenon of interest (Guest, Bunce, & Johnson, 2006).

In qualitative explorations, purposive sampling is often used as a form of nonprobabilistic sampling, and sample size is typically based on saturation (Guest et al.,

2006). Saturation is the point at which no new information or themes emerge from the data (Guest et al., 2006). The idea of saturation is helpful on a conceptual level; however, it provides little guidance for determining sample size prior to data collection (Guest et al., 2006). Morse (1994) recommended at least six participants for phenomenological studies to reach saturation (Guest et al., 2006), whereas Creswell (1998) placed a range from five to 25 interviews for phenomenological studies (Guest et al., 2006). Prior research in the field of military mental health has employed the grounded theory approach with a sample size of 10 clinicians. In addition, Guest et al. (2006) found that saturation occurred within the first 12 interviews and that basic elements of metathemes emerged as early as the first six interviews. The proposed research is interested in high-level, overarching themes; therefore, an approximate sample of 10 participants was purposed as sufficient to develop meaningful patterns and useful interpretations (Guest et al., 2006). The purposed sample size of (N =10) individuals was an approximation and remained flexible to ensure that saturation had been reached. Due to the difficulty in finding willing participants, some of the population parameters had to be adjusted. In the specific case of participants, the sampling size was adjusted from 10 to seven contributors, continuing to allow for metathemes to emerge from this exploration. These changes are discussed further in the limitations of this study, and areas in which research could continue are suggested.

Data Collection Procedures

The purpose of this phenomenological research was to examine cases from which the study could gain a great deal of knowledge, producing a dense description of events

being investigated (Ajjawi & Higgs, 2007). Interviewing has become the main data collection procedure most closely associated with qualitative exploration (Englander, 2012). Interviewing is used as a powerful method to produce understanding of human situations due to its ability to provide access to the lived world of participants who describe experiences in their own words (Kvale, 2012). Additionally, interviews focus on obtaining descriptions of participants' lived world in relation to interpretation of the meaning of the selected phenomena (Kvale, 2012). Phenomenological researchers often use interviews as a data collection tool due to their interest in the meaning of an event as it is experienced by members (Englander, 2012). For this investigation, the collection of stories from others was used in an attempt to discover meaning of the selected phenomenon (Englander, 2012). During this heuristic inquiry, participants were selected based on their ability to illuminate the phenomenon of MMHP who deployed during OIF/OEF. Interviews were essential tools when collecting data for this exploration and served two distinct purposes (Ajjawi & Higgs, 2007). First, interviews served as a means for exploring and gathering stories of lived experiences (Ajjawi & Higgs, 2007). Furthermore, interviews assisted in developing a conversational relationship with the participant (Ajjawi & Higgs, 2007).

Semistructured in-depth interviews of previously deployed MMHP were conducted in person when possible. Interviews were conducted via video conferencing and telephonic communication; conversations were recorded onto audio tape with the informed consent of the participant. Semistructured interviews were focused on obtaining descriptions of the living world with respect to interpreting the meaning of the selected

event (Kvale, 2012). This researcher prepared a set of open-ended questions allowing for the use of a semistructured interview protocol. Through open-ended questions, the interviewer focused the topic of research while allowing the participants to bring to the forefront the dimensions they found important (Kvale, 2012). Prior to data collection, I developed an interview protocol which was piloted with professionals within the field of military mental health. The interview protocol offered a procedural level of interviewing to include: opening and closing statements, informed consent, and field tested open-ended questions (Jacobs & Furgerson, 2012) (See Appendix A).

When conducting phenomenological interviews England (2012) offerd; asking for a description of the situation is vital in the attempt to discover meaning of a phenomenon as, the situation provides a context and meanings are context dependent. The utilized interview protocol encouraged participants to describe as precisely as possible their experience, feelings, and reaction (Kvale, 2012). The focus was on in-depth descriptions that demonstrate diversity and difference within the phenomenon, rather than directing one to fixed categorizations (Kvale, 2012). While exploring the situation offered both context and meaning, the actual situation for different participants varied; this factor is what separates this qualitative phenomenological research from traditional quantitative experimental designs (Englander, 2012). The focus of the interviews was to gain as complete of a description as possible of the lived experience (Englander, 2012). The interview questions use for this exploration are as follows:

1. Please describe your deployment experience and be as specific and detailed as possible.

Possible Probes:

a. What were the environmental conditions of your deployment?
b. What was your mission throughout the deployment experience?
c. What was your professional role throughout the deployment experience?
d. What was your typical caseload throughout your deployment?
e. What were the most difficult situations you experienced during deployment?

2. How did you attempt to care for yourself during deployment?
3. How did you attempt to care for yourself for the 6 months following deployment?
4. What kind of impact has this experience had on your life?

Possible Probes:

a. What lessons, if any, have you drawn from this experience?
b. How, if at all, have you been changed by your deployment experience?
c. What meaning (s) have you placed on your deployment experience?

5. Is there anything else you would like this researcher to know?

While open-ended questions guided the participants, the questions used allowed individuals the opportunity to focus on the areas of their own choosing. The lengths of the primary interviews were approximately 30 minutes in duration. Follow up interviews were intended to be conducted if themes emerged which were not addressed during the first meeting. The plan for adverse events involving research participants consisted of

ceasing data collection and offering the participant a referral for the opportunity to debrief. During data collection, no participants expressed adverse reactions resulting in no need to follow the preplanned protocol.

In addition to interviews, the following three categories of field notes were logged throughout the process. First, a transcript file was kept with the raw data from interviews (Ajjawi & Higgs, 2007). Additionally, a personal file was kept with a chronological account of interviewees and locations, reflection notes, and methodology issues (Ajjawi & Higgs, 2007). Finally, an analytical file was produced to provide a detailed recording of ideas that emerged throughout the data collection process (Ajjawi & Higgs, 2007). Transcriptions were produced by me and re-verified through comparison with the audio version and member checking.

Data Analysis and Interpretation Plan

The analysis of interviews was conducted through Moustakas (1990) five steps of heuristic analysis. Moustakas first step of immersion was accomplished through the following actions. First, audio recordings of interviews were transcribed and examined in comparison with original recordings, organizing data sets into text. The next step involved iterative reading and study of the text fully to immerse myself within the collected data (Ajjawi & Higgs, 2007). Finally, I began to render preliminary interpretation by writing notes and memos in the margins of transcripts to help with coding (Ajjawi & Higgs, 2007). During Moustakas second step of incubation, I participated in contemplation and review of transcripts allowing for a precise interpretation of data, themes, and coding to emerge (Patton, 2002). Hand coding was

used as a means to delineate and organize ideas and codes throughout this data analysis process. Hand coding facilitated greater familiarization of the interview data and assisted with in-depth knowledge throughout the analysis process, aligning data analysis procedures with the selected method of heuristic inquiry (McCauley et al., 2012). The third step of illumination was utilized to link the literature review to the reconstruction and interpretations of the data into stories (Ajjawi & Higgs, 2007). Explication required compiling and incorporating the transcript file, personal file, and analytical file to create patterns and relationships. Finally, creative synthesis was used to produce discussion and findings resulting from the analysis.

Throughout all stages of the data analysis process there was ongoing interpretation of the text, continually examining pre-research assumptions by comparing and contrasting pre-conceptions with emerging findings (Ajjawi & Higgs, 2007). Additionally, the data analysis process used continuous cross-checking of interpretations with the original transcripts to ensure faithfulness to the participant's constructs (Ajjawi & Higgs, 2007). The aforementioned data analysis process utilized the hermeneutic circle to assist in the interpretation of data. The hermeneutic circle used an interpretation process which examined the movement between parts of data and the whole of understanding the phenomenon, providing each context to give meaning to the other in a circular relationship (Ajjawi & Higgs, 2007). In using this type of analysis, I remained open to questions that arose during the study (Ajjawi & Higgs, 2007; Kvale, 2012). Understanding emerged during dialogue between me and the text produced from interviews (Ajjawi & Higgs, 2007). The analysis occurred in the gradual construction of

insight on the part of the researcher as the text is viewed and reviewed (Ajjawi & Higgs, 2007). These themes were then combined to yield an information rich description of military mental health deployment presented in detail in Chapter 5.

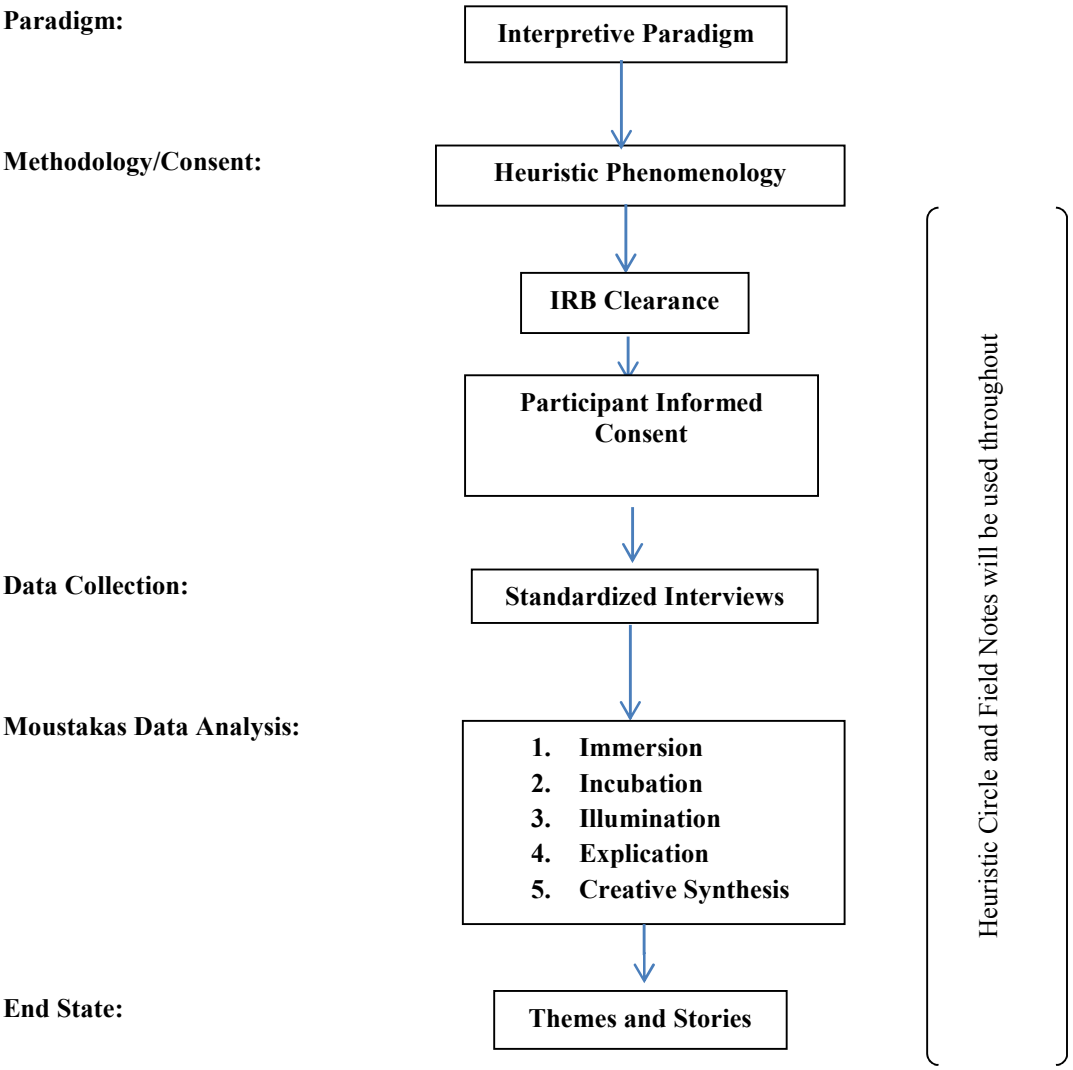

Figure 1. Overview of methods approach.

Issues of Trustworthiness

In the examination of the validity and reliability of qualitative research, the terms of trustworthiness, orientation, strength, richness, and depth were employed (Kafle, 2011). Orientation refered to the involvement of the researcher within the environment being studied (Kafle, 2011). I brought orientation to the study through the experience of deployment as a mental health clinician during OEF (2012-2013). Strength defineed the ability of the text to represent the core intention of meanings expressed through participant's stories (Kafle, 2011). Strength was established by using member checking throughout the data analysis process. Richness is described as the aesthetic quality of the generated text (Kafle, 2011). I used rich descriptions to produce a text that draws the reader into the selected phenomenon. Finally, depth was demonstrated in the ability to penetrate and express the best intentions of the participants (Kafle, 2011). Member checking was also used in relation to emerging themes and coding to ensure depth. In addition, analytical rigor within qualitative research was established through the ability to capture every case whether they confirm or refute themes (Kafle, 2011). Analytical rigor was addressed by including all emerging themes despite variation of findings. The intent of this qualitative research was not too widely generalize results rather, to explain the meaning of an event in-depth (Creswell, 2013). Thus, the sample size of (N =7) allowed for an in-depth exploration into the selected phenomenon; however, does not allow findings to be generalized outside the studied population.

Validity in qualitative research was achieved through tools I utilized to check for accuracy of findings. To ensure the validity, I documented the steps and procedures

followed as detailed as possible. Furthermore, reliability procedures included checking transcripts to ensure no obvious mistakes and no drift in the definition of codes. To increase validity, this qualitative study used member checking through taking final reports back to participants, along with using detailed and contextual descriptions throughout the exploration (Laverty, 2003). Member checking was employed through a process in which participants confirmed data and interpretations. Through this process, emerging themes, interpretations, and conclusions were verified by having the participants examine and approve ideas or explanations generated by the researcher (Laverty, 2003). This study additionally focused on transferability as a goal to generate scholarly literature that has the ability to facilitate future research. To increase the odds of transference into future works, detailed descriptions of data collection and analysis, as well as, a rich narrative of the experiences of the participants are provided in Chapter 5.

In an effort to strengthen the studies rigor, this hermeneutic investigation employed multiple stages of review allowing for patterns to emerge along with an examination of how interpretation arises from the data (Laverty, 2003). Ajjawi & Higgs (2007) study asserted, to further ensure quality of phenomenological inquiries studies require the use of systematic methods of data collection along with transparency, and consistency in working within traditions of the chosen paradigm (Ajjawi & Higgs, 2007). This study utilized systematic methods of data collection and analysis along with consistency in operating within the traditions of the interpretive paradigm to ensure a rigorous examination of the phenomenon. Furthermore, authenticity has been

demonstrated through presenting varying viewpoints in a balanced manner (Ajjawi & Higgs, 2007).

Informed Consent and Ethical Considerations

Ethical approval for this research was obtained from the Walden University Institutional Review Board (IRB). The primary ethical concerns, when conducting this qualitative exploration, were the importance of masking identities, clarifying purpose and procedure before beginning, obtaining informed consent, and sharing findings with members (Kafle, 2011). Informed consent was defined as a "voluntary and revocable agreement of a competent individual to participate in a research procedure based on adequate understanding of its nature, purpose, and implications" (Ajjawi & Higgs, 2007, p.620). Informed consent covered the following categories: disclosure, comprehension, competence, confidentiality, and voluntariness (Ajjawi & Higgs, 2007). To ensure confidentiality, each participant was assigned a number for data collection, analysis, and discussion. All participants were provided information sheets outlining the goals of the research and process allowing for informed consent. In addition, all members were afforded the opportunity to ask questions and told they have the ability to withdraw at any time without adverse consequence. A signed participant consent form was obtained from each participant prior to data collection (see appendix B). Furthermore, there were no existing power relations between the researcher and contributors which could be perceived as coercion.

During the introduction to the interview, participants were reminded that they were taking part in research along with a review of the purpose, procedures, and

confidentiality. The participants were also reinformed that the summary of this research was completed to fulfill a portion of this researcher's doctorate in philosophy degree from Walden University. There were limited anticipated risks or discomforts for participants in this research. Anticipated risk involved the minor discomforts that can be encountered in daily life, such as stress or becoming upset. Participation within this study did not pose a risk to individual's safety or wellbeing.

Summary

With the wars in Iraq and Afghanistan lasting over a decade, hundreds of MMHP have deployed to hostile environments and some on multiple occasions (Linnerooth, Mrdjenovich, & Moore, 2011). Military mental health professionals experience a variety of environmental, physical, and emotional stressors while being required to work along the frontlines of battle (Linnerooth et al., 2011). Individuals serving as healthcare providers in the military are at high risk for anxiety, posttraumatic stress symptoms, and alcohol misuse (Gibbons, Shafer, Aramanda, Hickling, & Benedek, 2012). At the time of this study, a gap exists in understanding clinicians who experience trauma both personally and professionally (Tosone et al., 2011). Despite the presence of scholarly literature exploring the concept of shared trauma, there is still no published conceptualization found regarding this phenomenon (Baum, 2010). In the currently evolving literature, shared trauma has been found to produce negative effects presenting as acute/chronic stress reactions, as well as, positive psychological consequences of posttraumatic growth and resilience (Tosone et al., 2012). The concept of resilience remains limitedly explored through scholarly literature and is the ability to bounce back

or grow from traumatic events. Further investigation is necessary to enable quantification of perceptions of positive combat experiences in an attempt to understand the reason for resilience in certain veteran populations (Gallaway et al., 2011). At the time of this study, there was no found literature examining the relationship between shared trauma, resiliency, and MMHP, who have deployed. This study contributes to the field of military mental health through gaining knowledge which needed to address the lack of understanding in relation to MMHP, who deploy by exploring the themes identified by these clinicians regarding the impact on their professional, as well as, personal lives.

The purpose of this phenomenological study was to describe OIF/OEF deployments of MMHP better within the frameworks of shared trauma and resilience. Shared trauma was defined as the concept which attempts to capture the experience of clinicians striving to provide services while simultaneously addressing the same issues within their own lives (Tosone et al., 2011). The concept of resilience was well-defined as how stressful situations get interpreted or made sense of in the context of one's overall life experience (Bartone, 2006). This study used the phenomenological paradigm to employ empirical methods to develop an understanding of lived experience (Patton, 2002) Phenomenology was utilized in an attempt to understand the hidden meanings and essences of the selected experience (Kafle, 2011).

The method of data collection employed was semistructured in-depth interviews, involving a series of open-ended questions (available in full in Appendix A) in an attempt to gain greater insight through a comprehensive exploration of MMHP, who deployed.

The inductive analysis model as described by Moustakas (1990) was used for data analysis. The following research questions were posed for this phenomenological study:

RQI-Central Research Question/Qualitative: How do military mental health providers describe dilemmas faced as they attempted to navigate the personal aspects of shared trauma?

RQ2-Central research Question/Qualitative: How do military mental health providers describe dilemmas faces as they attempted to navigate the professional aspects of shared trauma?

These questions contained multiple overlapping phenomena, which required explicit attention in order to understand the main phenomenon as a whole. Therefore, the following sub questions were explored:

RQ3-Qualitative: What meanings do military mental health providers choose to assign to their shared trauma experiences?

RQ4-Qualitative: What were the most difficult psychological aspects of deployment for military mental health clinicians?

RQ5-Qualitative: How did the clinician attempt to care for themselves while simultaneously caring for others during deployment and the 6 months following return from deployment?

The participant group was defined as individuals who previously served on Active Duty, National Guard, or Reserve components and deployed for 4 months or more to Forward Operating Bases (FOB) in active combat zones as mental health professionals during OIF/OEF. Individuals were selected based on, how intensely their experience

demonstrated the selected phenomenon, along with demographic factors to ensure a mixture of gender, age, service affiliation, and professional discipline. The focus, of this research, was to describe the meanings ascribed to the phenomenon in-depth through the use of sampling a small number of individuals who have experienced deployment as MMHP in OIF/OEF. Purposive sampling allowed for examination of cases which manifest the reviewed phenomenon profoundly (Ajjawi & Higgs, 2007). A sample size of (N =7) individuals were selected purposefully, for interviews, to achieve saturation of overarching themes within this lived experience. The purposed sample size of (N =10) individuals was an approximation and remained flexible to ensure saturation has been reached. Due to the difficulty in finding willing participants, the sampling size was adjusted from 10 to 7 participants, continuing to allow for meta-themes to emerge from this exploration. These changes are discussed further in the limitations.

Data analysis was conducted through Moustakas (1990) five steps of heuristic analysis. Moustakas describeed the following five principles within the analysis process; immersion, incubation, illumination, explication, and creative synthesis (Patton, 2002). Immersion involved organizing the data set into text and preliminary interpretation (Ajjawi &Higgs, 2007). Incubation was achieved through quiet contemplation producing clear and profound awareness of meanings (Patton, 2002). Illumination attempted to link literature and reconstructs interpretation into stories (Ajjawi & Higgs, 2007). Explication required full awareness of the experience which began to emerge through self-dialogue and reflection (Patton, 2002). Finally, creative synthesis brought the pieces of emerging patterns together (Patton, 2002).

Based on the review of the relevant literature, this study was unique in its examination of United States MMHP, who deployed during OIF/OEF in relation to the concepts of shared trauma and resilience. Through the utilization of heuristic inquiry and Moustakas analysis process, the focus was placed on military mental health deployments in an attempt to learn more about the phenomenon assisting with future research and new insights. The implications for positive social change include a better understanding of deployments for mental health professionals, illumination of the impact this experience has on these clinicians, and the potential to minimize the adverse effects and maximize the potential for posttraumatic growth and resilience.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to describe deployments of MMHP during OIF/OEF within the frameworks of shared trauma and resilience. The phenomenological paradigm was used to capture these stories, providing information-rich summaries and a description of the phenomenon of MMHP deployments during OIF/OEF (Kafle, 2011). This qualitative analysis allowed MMHP the opportunity to tell a story that few know about. The implications for social change include an enhanced understanding of deployments for mental health professionals and illumination of the impact this experience has on these clinicians. This study's findings also have the potential to assist in the development of programs to minimize the adverse effects of deployment while maximizing the potential for posttraumatic growth and resilience.

This chapter presents the findings of interviews with MMHP who deployed for at least 4 months to a combat zone during OIF/OEF. This work represents an exploration of the perceptions and meanings assigned by individuals who lived the phenomenon, resulting in the information-rich description of MMHP deployments offered in Chapter 5. In addition, heuristic inquiry was used, allowing for examination of my individual experience of being a deployed practitioner in conjunction with others who lived this phenomenon.

The method of data collection used was semistructured, in-depth interviews involving a series of open-ended questions (available in full in Appendix A) designed to evoke a comprehensive exploration of MMHP deployments and meaning these

individuals assigned to their experience. The data collection and structures of inquiry used during the in-depth interviews provided the basis for the data analyzed in this chapter, as well as resulting themes.

The following research questions formed the foundational background for the in-depth interviews conducted during this phenomenological inquiry:

RQ1—Central research question/qualitative: How do military mental health providers describe dilemmas faced as they attempt to navigate the personal aspects of shared trauma?

RQ2—Central research question/qualitative: How do military mental health providers describe dilemmas faced as they attempt to navigate the professional aspects of shared trauma?

These questions contained multiple overlapping phenomena, which required explicit attention in order to understand the main phenomenon as a whole. Therefore, the following subquestions were explored:

RQ3—Qualitative: What meanings do military mental health providers choose to assign to their shared trauma experiences?

RQ4—Qualitative: What were the most difficult psychological aspects of deployment for military mental health clinicians?

RQ5—Qualitative: How did the clinicians attempt to care for themselves while simultaneously caring for others during deployment and the 6 months following return from deployment?

Included in this chapter is a description of the process by which I collected, stored, and analyzed the data. The participant population identified for this study was seven MMHP who deployed for 4 months to a combat zone during OIF/OEF. Interviews were conducted via video conferencing and through telephone conversations. The format of the interviews was semistructured, with participants answering five main questions related to their deployment experiences. An interview guide was used for in-depth interviews to ensure consistency in the interview process (see Appendix A). Probing questions, described in Chapter 3, were also used to explore topics further. All participants were allowed to answer the questions in any manner and style they saw fit, with an ample time of 60 minutes. The longest interview lasted for 37 minutes, while the shortest interview lasted for 11 minutes. The average time for the in-depth interviews was 24 minutes. I created a file for each participant that contained brief demographic data, informed consent, and interview transcriptions. I organized the files according to each participant's designated case number from 1 to 7. The printed data, along with the transcript file, personal file, analytical file, and code book, remained locked in a file cabinet at my residence that only I had access to. Interviews were audio taped, with the consent of the participants, and transferred to my computer for transcription using the InqScribe program (InqScribe, 2.2.1). Electronic media and word documents were saved under the participant's assigned case number and stored on my password-protected computer to maintain confidentiality.

Pilot Study

Pilot interviews were completed to ensure that the purposed interview tool had the ability to discern information regarding this exploration's defined research questions. The intent of the pilot test was solely to assist in further refinement of the interview protocol. Pilot study interviews were conducted in person and audio taped at the consent of the participant. Participants were peers of mine who consented to participate in the pilot study with the prior knowledge that the data collected during this pilot test would not be analyzed for the purposes of this study (see Appendix C). The format of the interviews was semistructured, with participants answering five main questions related to their deployment experiences. An interview guide was used for in-depth interviews to ensure consistency in the interview process (see Appendix A). Probing questions, described in Chapter 3, were also used to explore topics further. All participants were allowed to answer the questions in any manner and style they saw fit, with an ample time frame of 60 minutes. The longest interview lasted for 36 minutes, while the shortest interview lasted for 18 minutes. The average time for the in-depth interviews was 25 minutes. I created a file for each pilot participant that contained brief demographic data, the informed consent, and interview transcriptions. I organized the files according to each participant's designated case number from 1 to 2. This printed data remained locked in a file cabinet at my residence that only I had access to. Audio recordings from the interviews were transferred to my computer for transcription using the InqScribe program (InqScribe, 2.2.1). Electronic media and word documents were saved under the pilot participant's assigned case number and stored on my password-protected computer to

maintain confidentiality. The transcriptions of test pilot participants were reviewed in order to examine emerging themes related to the defined research questions. The pilot test interviews produced initial metathemes related to the research questions; therefore, no changes were made to the interview protocol.

Demographics

The population was defined as individuals who had previously served on Active Duty, National Guard, or Reserve components and had deployed for 4 months or more to Forward Operating Bases (FOB) in active combat zones as mental health professionals during OIF/OEF. The recruitment of participants entailed contacting peers to inquire about possible colleagues who fit the defined population parameters. The recruitment of participants in this study took approximately 2 months. The email inquiry was sent or forwarded by peers to approximately 100 individuals. Due to the difficulty in finding willing participants, some of the population parameters were adjusted. For example, during the recruitment period, it was discovered that prior to 2006, Air Force and National Guard components deployed for 4 to 5 months; therefore, a change request was sent to the IRB for approval to adjust the defined duration of deployment from 6 to 4 months. Additionally, the sampling size was adjusted from 10 to 7 participants due to difficulties in finding participants. The use of seven participants continued to allow for metathemes to emerge from this exploration; however, this sample size is further discussed in the limitations of this study, and areas for future research are suggested.

Table 1

Participants' Demographics

	Time in service in years	Number of deployments	Mental health discipline	Military affiliation
P1	6	1	Psychiatric nurse practitioner	Army
P2	24	1	Clinical social worker	Army
P3	16	2	Clinical social worker	Army
P4	21	3	Psychologist	Air Force
P5	15	1	Psychiatrist	Air Force
P6	9	1	Clinical social worker	National Guard
P7	13	2	Psychologist	Army

Data Collection

The data collection process began with identifying potential participants through colleagues as described in Chapter 3. The potential contact was sent an invitation letter via email that contained explanations of the proposed participant group, purpose of the study, and participation parameters, as well as a consent form. When the singed consent forms were returned, the participant was emailed to arrange a date, time, and location (via

video conferencing or telephone) for the interview to occur. The participants were contacted the day prior to confirm meeting arrangements. The format of the interviews was semistructured, with participants answering five central questions related to their deployment experiences. Interviews were conducted by telephone or via video-conferencing, with three occurring telephonically and four being conducted over Skype. An interview guide was used for in-depth interviews to ensure consistency in the interview process (see Appendix A). Probing questions, described in Chapter 3, were also used to explore topics further. All participants were allowed to answer the questions in any manner and style they saw fit, with an ample time of 60 minutes. The longest interview lasted for 37 minutes, while the shortest interview lasted for 11 minutes. The average duration for the in-depth interviews was 24 minutes. The audio recordings of the interviews were then transcribed and sent to the participants for validation.

Data Analysis

Moustakas's (1990) five steps of heuristic analysis were used to conduct the examination of the data. Data collected included descriptions of MMHP deployments during OIF/OEF. In addition, descriptions of dilemmas faced, the psychological impact, and meanings assigned to this experience were collected during the interview process.

Moustakas's (1990) five principles within the heuristic analysis process were used: immersion, incubation, illumination, explication, and creative synthesis (Patton, 2002). The first step of immersion was conducted through transcription of interviews and the initial review and coding of data. I transcribed each interview through the use of the InqScribe program. All transcripts were then sent to participants for member checking.

After validation was received from participants authenticating the document, the data were read and reread in an attempt to gain a holistic understanding of the participants' words and experiences. I reviewed the data, keeping in mind the defined research questions to focus the analysis. During this immersion process, transcripts were reviewed, producing an initial list of codes. The first reading of a participant's transcript allowed for precoding by underlining significant quotes and passages. Participant transcripts were examined and coded in sequential order; allowing for the first participant's data to be coded, progressing then to the second, and so forth. As additional codes began to emerge, earlier transcripts were reviewed to ensure inclusion of all applicable themes. In vivo coding was used during this first cycle coding process to enable labeling directly from the participants' words. A code book was used to record emergent themes, producing a complication of the codes, their content descriptions, and brief data example. Note cards were also used to record codes and content in relation to the defined research questions. In addition, a Microsoft Word table was created to track codes and overlapping themes between the participant transcripts. Analytic memo writing was used to document and reflect on the coding process, choices, and how the process of inquiry was taking place. A personal file was also kept to allow for documentation of a chronological account of interviews, locations, reflection notes, and methodology issues.

Table 2

Overarching Codes Emerging in First Cycle Coding: RQ1

	Indirect fire	Never really off-duty	Barracks = mixed
P1	X		X
P2	X	X	
P3	X	X	X
P4	X	X	
P5	X		
P6			
P7	X	X	

Note. Codes will be further described in relation to themes later in this chapter.

Table 3

Overarching Codes Emerging in First Stage Coding: RQ2

	Assignment expectation change	Threat of suicide	Plucked from one = deployed with another	Travel = difficult
P1	X		X	
P2	X	X	X	
P3	X	X	X	
P4	X	X	X	X
P5			X	X
P6			X	X
P7		X		X

Note. Codes will be further described in relation to themes later in this chapter.

The second step of incubation encompassed quiet contemplation, allowing for clear and profound awareness of meanings to emerge. During incubation, transcripts were reviewed along with the code book, note cards, Microsoft Word table, analytic memos, and personal file. Further reflection was added to the personal file, along with additional analytic memos being created during the incubation phase. The third step of illumination involved an attempt to link the reviewed literature and interpretations, reconstructing the data using pattern coding for categorization. The illumination phase encompassed second cycle coding with the goal of developing a sense of thematic results from first cycle codes. The use of second cycle coding allowed for organization and synthesis of interpretive perceptions that were drawn from previously examined theoretical concepts. The use of pattern coding allowed for the development of metacode categories labeling similarly coded data. Specifically, pattern coding was used to produce explanatory codes that identified an emergent theme by pulling together the coded material and reviewed literature into a more meaningful analysis in Chapter 5.

Table 4

Overarching Themes Emerging in Second Stage Coding: RQ1-4

	Environmental hazards	Mission purpose	Posttraumatic growth	Shared trauma
P1	X	X	X	X
P2	X	X	X	X
P3	X	X	X	X
P4	X	X	X	X
P5	X	X	X	X
P6	X		X	X
P7	X		X	X

Note. Themes will be further described in correspondence with codes later in this chapter.

In the explication phase, full comprehension of the experience began to emerge through self-dialogue and reflection. During the explication phase, reflection notes and analytic memos, kept throughout the data collection and analysis process, were examined thoroughly. This process allowed for internal reflection and exploration regarding my deployment experience in relation to those of the participants. Self-reflexivity allowed for careful consideration of the ways my past experiences, beliefs, and roles influenced my interactions and interpretations of the research environment. The heuristic discipline was utilized in an attempt to gain understanding beneath the subjective experience by revealing the objective nature realized by the individual. Results from the explication phase are offered in the reflections of the researcher section in Chapter 5. Finally, creative synthesis was utilized to bring the pieces of emerging patterns together allowing for new perspective and meanings to be rendered in Chapter 5.

Results

Results for Research Question 1

The following list was created from analysis of the code book, second cycle coding, reflection notes, original transcriptions and audio files of the interview sessions to answer the first research question: How do military mental health providers describe dilemmas faced as they attempt to navigate the personal aspects of shared trauma?

The first theme and subsequent codes which emerged in examination of the aforementioned research question was:

1. Environmental Hazards:
    a. In Direct Fire

P1: So during the summer months, I would be roughly estimating here but, there was at least one event per week. So it could be more or less. That would usually involve indirect fire where we had rocket attacks coming in and we would have to seek cover. One point I could actually feel my barracks shake because there were six that hit in my sector one morning. So that was probably the most intense…You know just the constant threat of knowing that could happen at any time.

P2: We took, you now of course everybody took the occasional mortar round. Fortunately for us, often times they would try to hit the airfield and they would usually end up in the middle of nowhere…For some reason Haji eventually got smart and started putting the rockets and the mortar where the troops were and

there were a couple that actually, it landed about 20 meters, 20 yards from where I was early one morning…and then we took a particularly nasty rocket attack one day and I don't know if you all had these facilities or not but they hit our damn Burger King.

P3: Two weeks prior to us arriving, a mortar had hit a chu while the two guys who were in the chu were on skype with their family back home which really kind of freaked some people out. When we got there, there were some soldiers who refused to go back in their chus who were sleeping in bunkers and stuff like that…We took a lot of IDF, several times a week.

P4: We did get rocketed about 20 times during the deployment, so we were in danger even though you try not to think about that.

P5: I would say two to three times a week we got mortared. So we were spending time in the bunkers about one to two hours, each time.

P7: As far as my own experience of being in a combat zone, it did impinge maybe a little bit on the mission. It was...indirect fire, rockets, and mortars.

b. Increased Threat=Special Precautions

P1: There were a lot of elevated threat levels when there were intelligence reports that were filtering down the chain of command saying that we were at increased

risk for some sort of insider threat and then we would have to take special precautions like being confined to our barracks or only leaving wearing full body armor.

c. No Preconceptions

P6: I don't know that I know any different. They were, I don't know it is a deployment. I guess I didn't have any preconceived notions. It's the environment I went into and that is what I dealt with and managed okay.

The second theme and corresponding codes emerging through the examination were:

2. Living Conditions:

a. Barracks=Mixed Rank

P1: Most of my deployment I was in barracks which interestingly was mixed enlisted and officer. The rooms could hold up to six or eight. Yeah fit like six people and we varied anywhere from four to six during the time I was there. So, of course we had a shared bathroom and shower facility. So, pretty similar to standard enlisted barracks.

P3: I didn't have my own chu. So, I actually roomed with my tech. because it was a dark FOB my female tech. would have had to have been, they had a chu for my male tech. and he had a roommate…but then my tech. they did not have a chu to put her in unless it was all the way across the FOB. We didn't want to break up the team so she just roomed with me.

b. Lived with Troops=Important to Me

P2: I was down there with the troops which was important to me. The only downside to where I was at is we did not have hard cover and some of the chus had hard cover that they had built over them.

c. Some Places=Didn't have Anything

P4: Some places where we went we didn't have anything, we just had a room in the aid station and hung out for a few days…We did go out to a Combat Outpost in Afghanistan once for a few days and that was much more austere. We slept on the ground in a covered tent. The entire place was about the size of a football field, walled structure, guard towers, excreta. We were there for three to four days. That was the roughest place.

The third and final theme and subsequent codes emerged in relation to RQ1:

3. Mission Expectations:

a. Never really off-duty

P2: That was the other thing, as you know; you're never really off duty. You're on duty 24/7. Our clinic was open 7 days a week. I worked 7 days a week…Just completely relaxing and shutting down, as you know, never occurred.

P3: We worked a lot. I probably saw 15 or 16 patients a day.

P4: You're on call 24 hours a day.

P7: I was quite busy almost every day for the entire deployment.

b. Boredom=how to manage

P4: Additionally to be honest with you, it was just kind of boredom and kind of how to manage that. You're there kind of in case something happens.

c. This is My Only Life

P7: When I was in Kuwait, so I had no military experience prior to coming into the Army, nobody in my family, nobody in my extended family. I joined because they said we will pay for part of your school and we will give you a scholarship and I am like oh suddenly I love the Army. So, I just never really considered myself much of a military minded individual. So, when I was in Kuwait I remember thinking what the hell am I doing here. This is unreal, this is there is there no way that I am actually in a combat zone now and I found myself basically just telling myself okay for these 15 months this is my life, my only life. I am not going to have a life outside this deployment because I don't want to be constantly reminded of home and have my mind split like that…My first deployment I phoned home maybe three times in the last month or two of the deployment but the first 13 months didn't phone, didn't skype, I would maybe email and that was it. I didn't want to hear voices from home, I didn't want to see images from home and I found that that actually made things quite a bit easier.

Results for Research Question 2

The following list was created from analysis of the code book, second cycle coding, reflection notes, original transcriptions and audio files of the interview sessions to

answer the second research question: How do military mental health providers describe dilemmas faced as they attempt to navigate the professional aspects of shared trauma.

The first theme and subsequent codes which emerged in examination of the aforementioned research question were:

1. Mission Purpose:
    a. Assignment Expectation Change

P1: I originally deployed with the expectation that I was going to be the prescriber with the Army Combat Stress control unit. When I got there I found out that because I could prescribe and they needed my skill set in the Air Force hospital. Yeah so they, just like my Army predecessor who I was replacing, they also put me in the Combat Stress Clinic inside the Air Force hospital.

P2: After we had been there for about six months was when we got the official notification that our deployment was going to be extended to 15 months. So, we were one of those units that were extended which I think is important to understanding some of the additional stress of the soldiers that we saw.

P3: Then we closed down Iraq and so we were responsible for getting rid of all our equipment and doing all of that stuff. Then I transitioned to Kuwait for a follow on mission and that was way worse than being in Iraq. Oh my gosh that was miserable.

P4: The war kicked off and they delayed everybody's redeployment. So that was kind of a drag too but still it ended up being only six months. Were as at that time, the Air Force was doing four month rotations so we got extended a little longer than we normally would have.

b. Being Strong Even When you Don't Feel It

P2: You've got to be strong even when you don't feel it. It's important that the soldiers you are working with sense confidence in what you are doing even if you're insecure. The soldiers that you are working with can't; they have got to believe you're somebody that they can lean on and that is why you are there.

c. Mission=Present and Available

P2: You know looking back on it, you know there's the generic mission of supporting the mental health of the force certainly but if I look back on how did I actually do that. I think it can be summarized in two very simple concepts. One was being present and available and number two was doing trauma work.

P4: So the Afghanistan one, the most difficult was we were actually out with folks doing stuff with them and I am not sure that, that was such a good idea or that we made much of a difference to be honest with you. We went to FOB's we went to Combat Outpost we did all that kind of stuff. Partly just to show presence and they might come talk to us. I suppose it helped for a few people but overall I don't know that it really did.

P5: We went out to a far forward base and you know we then served, I belive it was dinner or lunch, the female mental health tech. and I, we went out there and we flew out to that site and we just kind of hung out them for a couple of days so that they kind of knew who we were because we were their mental health support…We kind of did whatever we could to get people to know us outside of strictly mental health.

d. Make Own Way

P5: I think it was also really challenging being an Air Force provider administratively belonging to the Air Force but con ops wise belonging to the Army when they were transitioning leadership to Canada…You just had to figure out how to make your own way and get what you needed.

e. Deployment Length

P2: I think what I know is, that it probably takes three or four months before people start feeling like they know what they are doing down range.

P5: I think I was the last group that left at four months and I think by the time it was time for me to leave, one part of me was ready to go because of course I had missed my family and yet at the same time I wasn't ready to go because I felt like I had just started getting to work. Several months is only enough time to really kind of just get settled, know everybody, get corporate buy into who you are and the services that you can provide and then have them begin to trust you enough for you to start some of your programs and then it was just time to go.

The second theme and corresponding codes emerging through the examination were:

2. Death:

    a. Death=Response from Me

P2: As I would get closer in the morning I would always look if they had posted the Como Black sign because if I saw that sign posted outside the phone center then I knew somebody had died. I knew that it was going to require a response from me.

    b. Threat of suicide

P2: The threat of suicide just hung over everything we ever did…and we had two suicides in my brigade, there were certainly a couple of other suicides, one in the sustainment brigade, one with the 82nd there and we always had to respond to those as well.

P3: Most of the issues we had, we had a lot of suicidal and homicidal ideation.

P4: I think with all of them one of the challenges is what do you do with someone who maybe is a suicide risk. How do you manage that?

P7: Saw every branch of the military, as well as, DoD civilians. Did a ton of therapy, very little group, almost all individual and lots and lots and lots as you

can imagine evaluations, a lot of command directed evaluations. Dealt with a lot of suicidality and a lot of homicidally.

c. Trauma Work

P1: I was tasks to go provide Traumatic Event Management to a FOB after they were devastated by a vehicle born improvised explosive device. I was working just basically in the role of a therapist doing group therapy and traveling around the base also for people who weren't already coming to the debriefing groups just to check in with commanders and make sure everyone know about the services that we could offer.

P2: Most of what I did was dealing with the psychological trauma of the incidents that occurred and we had a lot of them, as well as, and once again even though this is dated today in the DSM V if you look into the chapter where it talks about trauma and stress related disorders that was the bulk of the work.

d. Causalities

P2: Yeah and you know we took a lot of causalities. My brigade alone lost over 50 soldiers and some of those were, you know, on the FOB itself.

P4: We did see causalities and killed soldiers. At the FOB I was at, there was a Forward Surgical Team (FST) …So, whenever anyone in the AO was injured they were medevac'd to the FOB so the FST could treat and stabilize them before

sending them forward. So since we were there, we saw the war wounded causalities…that was a rough reminder of what was going on.

The third theme and corresponding codes emerging through the examination were:

3. Professional Isolation:

    a. Only Behavioral Health Provider

P2: First of all, it was me and a tech. for the brigade, an E-4 who was probably at about one year outside of graduating the 68x course. So, although he had previous deployment experience he had not deployed as an X-ray and he was kind of limited in his X-ray experience.

P3: I was the only behavioral health provider. It was myself and I had two techs. and we were up in North Western Iraq up near Syria and Turkey. So we were responsible for FOB Sykes which had about 3,500 civilian and military personnel and then we were responsible for four outlying COP's that we did weekly visits out to.

P4: So this Afghanistan one, it was just me and a technician. We were assigned to an Area of Responsibility (AO) where we did a combat stress mission. Within that AO we had five other FOB's we went to when we could.

    b. Plucked from Group=Deployed with Another

P1: So I got pulled away from them and attached to a Combat Stress Control unit.

P2: I was technically PROFIS from the medical center…You know you get back, they give you a three day and then you report back to duty for all the reverse SRP and all of that and I showed up for that formation and my Battalion Sergeant Major was there and after they did accountability, I just walked up to the Sergeant Major and said, hey look I am out of here, I am going back to the hospital. So I didn't do any of the post deployment debriefings, you know where they run you through, at the time it was Battle Mind and all of that and the SRP.

P3: I deployed PROFIS, so I went with people I didn't know that I got to know but then when I came back.

P4: One of the challenges that happened was the Air Force when they send out assets they don't sent them out like the Army does as a unit, as a group. So, we were plucked from one medical group there and deployed with another one which is really crappy because then you don't really connect and you don't do the whole process with them.

P5: I was basically deployed by myself, well not by myself but I came from my own organization. The only one from my organization to deploy to join a group of about, maybe 10 other Air Force members who were going to support the Army component in Afghanistan. I was the only U.S. psychiatrist for Kandahar Air

Field. There was a Canadian mental health component, and together we serviced KAF and its forward bases.

P6: I was actually a critical fil attaching to a…National Guard unit based on their provider having to return from the deployment…I was by myself, an individual deplorer.

The fourth and final theme and subsequent codes emerged in relation to RQ2:

4. Environmental Challenges:
    a. Experience in Field=Challenges

P3: I was a First Lieutenant when I deployed the first time. You know not a lot of Lieutenant Colonels want to take advice from a First Lieutenant… So previously all my experience was with family and children and then they say, oh hey you are going to go deploy and you're going to work with soldiers. I am like, I don't work with just adults and I am by myself what are you talking about? So, I had to kind of reframe it a little bit and just look at the soldiers as if they were big kids which essentially is what they were.

P7: It was my first time overseas, I had been licensed, I got licensed as we were doing the train up for the deployment. So, the first time I saw a soldier as a licensed professional was during deployment.

b. Environment=Lack of Confidentiality

P3: We were co-located within the aid station and they were in one of those big hangers so it was a pretty decent environment. We had two rooms, so clinic size we were small because literally we had two rooms and not a lot of confidentiality because everyone who came into see us had to walk straight through the hanger to come back to us. Everybody knew who was there for behavioral health.

c. Travel=Difficult

P4: One challenge with the Afghanistan one was there were rotating flights, the chinooks and the helicopters it was just hard to schedule and get on because we were very low on the priority of shipping or however the Army determined priority of who goes and who doesn't. Air Force mental health team was not high on the list…We avoided driving in convoys to FOB's because convoys got blown up; although we did do one of them, which went fine.

P5: For the most part we flew to our primary destination point and then at times we would caravan from there and one time our caravan was one Humvee. We were supposed to always caravan in at least three but one time it was just us and so at times is was a little bit intimidating.

P6: The most difficult was probably just connecting with other command and staff upon being requested to come out and provide the service or response and then

the logistical work to get there. Dealing with the realities of the location and being in a combat setting and getting to where you needed to be.

P7: When we were flying we were lazed once which was quite scary. I was actually in the cock pit, I got invited to be in the cock pit and I had the headsets on so that I could listen to the flight crew and they started freaking out. I mean they started losing their minds, I am like oh this is fun what happened guys and apparently someone painted the bird with a laser which is usually followed by a rocket attack but none came and I was fine.

Results for Research Question 3

The following list was created from analysis of the code book, second cycle coding, reflection notes, original transcriptions and audio files of the interview sessions to answer the third research question: What meanings do military mental health providers choose to assign to their shared trauma experiences?

The first theme and subsequent codes which emerged in examination of the aforementioned research question were:

1. Posttraumatic Growth
    a. Proud of Deployment:

P1: I can certainly say I am very proud of what I did there. You know, even though I probably wasn't as busy in terms of number of patients I saw per day. I saw people in some of the most desperate and stressful situations in their entire lives so I am just proud that I was able to be there and do what I did.

P2: Yes, if asked I would go again.

P4: As far as making a difference for people I think I did. Even though I think it was a small number. I am proud of what happened and what I did and what my family went through and what we did.

P5: There was also this sense of pride that I was contributing to something much bigger than me and that the ideal of it was a good ideal and you know at that point it wasn't about should we be there or shouldn't we be there. We are there and what do we do and how can we take care of everybody the best way that we can so that they can, so when everybody goes home everybody is as functional as they can be.

b. Made me Better Professionally

P2: Well, I guess from a tangible standpoint, it certainly made me better at what I am doing now…When I start talking about these disorders I can speak to some real life examples of how these disorders manifest, what do they look like, what do they sound like, what do they feel like when your deployed. And that's really what being an Army Social Worker is about, is being ready to deploy and so I think that it impacted me in that it's made me better at what I do now.

P7: Occupationally it has helped me, my entire career I have either worked Active Duty Army or VA…Even though I still, I don't know someone else's experience,

so I can't put myself in their shoes as you know obviously no one can put themselves in someone else's shoes who has deployed but we can share the same language. So there is an immediate buy in, in that therapy relationship that I would not have had, had I not had many of the same experiences.

c. Perspective

P1: It really puts everything in perspective, right. So, I mean, you are there in a life or death situation and you know you hear about this…I guess if ever I feel like I am having a hard day, all I have to do is remember what some of those situations were like in Afghanistan and it does help me put things in perspective…Even in the most horrible situations imaginable, you can always find something good. You can find people who care, people who are helping each other and trying to make the world a better place.

P3: Most of the things that people tend to get upset about don't really matter because they're really so insignificant compared to you know some of the things, sitting and listening to the soldiers talk about some of their experiences and you know if the worst thing that happens to me is they don't have Dr. Pepper in the DFAC when I go through okay whatever, you know. Because I have listened to guys talk about, you know, watching their friends get blown up and, you know, dying in their arms and all that good stuff and really and truly I have never experienced that so I count myself pretty lucky.

P4: I think things in life that maybe were taken for granted before are viewed a little bit differently… I think I probably appreciate things more now than I did before I went to Afghanistan... I would say I have tremendous appreciation for those who are on the frontlines fighting.

P5: Maybe that was my biggest conflict in terms of coming back was that I had a totally different perspective as to what was important. Not a completely different perspective. Just an appreciation for some of the things I might have thought were important before I deployed were not as important as after I deployed… It really did change my perspective in many ways about what was important but it also I think reinforced for me the importance of enjoying the moment because you don't always know what comes next.

d. Honored

P5: I think for me it was just so very humbling to treat these people whose primary job was to go outside the wire and to create a safer environment for you know whether it be the country itself or the United States and what our goal and visions are.

P6: I am very honored to serve, to have deployed and I am very thankful I had that opportunity and I am thankful for those that you know I had the opportunity to serve with and to be a support for. It's something I certainly will always take with me.

e. Significant Impact

P4: As far as making a difference for people I think I did. Even though I think it was a small number.

P6: It has had a pretty significant impact. It certainly has afforded me the opportunity I guess to serve in a role that is extremely important to me and provided service to a population that again is extremely important. I think it had an impact on my overall just kind of, I don't know, confidence in myself, confidence in my abilities as a provider…I mean very positive overall.

P7: It was the most impactful single experience I have ever had. Not just in the military but my entire life and I have traveled extensively in my life and this is still far and away the most productive I have ever felt, the most useful I ever felt, and the most I guess more of a healer than I have ever felt before or sense. The job was just sometimes an act between life or death and to be in that situation and know that you helped somebody. To have somebody come back and say, thanks so much sir I wouldn't be alive if it wasn't for you. I wanted to kill myself and now I don't and that's all to do with our work. It has had more of an impact on me than anything else has before or since.

I remember before I left for deployment I heard an interview, I cannot remember the generals name but he was asked you know at the time…the first three years I was in the Army we had a huge surge of soldiers especially NCO's, seasoned

senior NCO's getting out of the Army in droves because it was 12 months deployed, 12 months home, 12 months deployed, 12 months home and so this general was asked, how do we keep our soldiers in the service and he said, deploy them and I remember thinking oh that's maybe the stupidest thing I have ever heard in my life. That is a good way to get people out of the Army and then I deployed and I came back and I re-upped, I signed up for another four years because I thought, I am actually doing good here, I am making a difference and I am doing something for the service members who are actually pulling the trigger. So, it made me want to stay in uniform

The second theme and corresponding codes emerging through the examination were:

2. Lessons Learned:

    a. Need to Be Prepared vs. Don't Know if You Can Be

P2: I think number one is you got to be prepared and to be honest with you I don't know if there is any way you can truly be prepared because until you are actually in the middle of dealing with all that death. I had spent 22 years preparing for that but, until you're actually in the middle of it, its indescribable.

    b. Cannot Do it Alone

P1: Just the coordination between the different members of the staff. It was a multidisciplinary team…I was always surrounded by my peers and as I mentioned the pace was not very fast of patients. So, we would definitely have down time

when none of us were seeing patients at least some of us were available. We had a common area where we would get together and talk.

P2: And it is important to have somebody that you can reach back to because you know one of the great things about technology today is email you can reach just about anybody. And you can't do it alone you have got to have somebody.

c. No Regret=Not Eager to Do Again

P3: They were good experiences, I don't regret having them, I am not eager to do them again just because I think the toll on relationships is significant.

P4: I think it was valuable. I think it was probably one of the most, I don't know, important experiences that I had. Although, I would not want to go back; I just wouldn't. It wasn't that fun.

The third and final theme and subsequent codes emerged in relation to RQ3:

3. Change in belief systems:

a. Always different

P3: And when you come back it takes you a little while to re-acclimate. It's always a little different; it never goes back to the way it was so you know. You don't necessarily feel as close to everybody as you did but since I, I have been back now for two years and so I think that transition is finally starting to fully happen.

P7: In other ways I am harder than I was prior to my experience. It has been a long time since I have been back and my language still has not come back to baseline. I have...I don't know how to put this. There is a bit less softness in my therapy relationships than there were and so I think and kind of unconsciously I am comparing some experiences where I have less, I have found I have less patience in my mind stupid things, I don't know how else to put it. So somebody comes in, I had someone actually while I was deployed, the second time so this was after my whole clinical deployment; that was all pissed off because he was reserve and he said I require 10 hours of sleep a night and they are only letting me have 8 and so we had a come to Jesus about what the Army owes you, what the Army doesn't owe you and I told him don't come into my office and waste my time again unless you have something real to talk about. When he left I thought well I wonder how really therapeutic that was but that was probably the only downside that there is an edge to me that was not there prior to deployment for sure and other people have noticed that as well.

b. Anger/Contempt

P2: I came back in January and I came back tired, angry, and bitter…You know there's still this sense of bitterness that just won't go away and I guess it won't.

P4: I also get angry easier when I hear people who are clueless to the military and what military men and women have sacrificed. Most civilians who are not part of the military have no idea what goes on or what kind of sacrifices are made…I also

feel a bit of contempt for the Afghan people as I think they don't really appreciate what we're doing to try to help them.

c. Spiritual/faith beliefs changed

P4: I think spiritual wise and faith wise I don't believe a lot of the stuff that I may have believed before. So I think it affects that.

P7: Spiritually it has defiantly given me in some ways a broader religious experience than I had, had before. I mean I came into the Army as a Protestant Christian recruited out of a small Christian graduate school. In some ways it's, the experience has curbed some of the how I express myself religiously but as far as how I feel about things with respect to religion or just spirituality I do feel it has broadened quite a bit.

Results for Research Question 4

The following list was created from analysis of the code book, second cycle coding, reflection notes, original transcriptions and audio files of the interview sessions to answer the fourth research question: What were the most difficult psychological aspects of deployment for military mental health clinicians? It is important to note, several codes identified for RQ2 also emerged in examination of RQ4.

The first theme and subsequent codes which emerged in examination of the aforementioned research question were:

1. Shared Trauma:
    a. Death=Response from me

P2: As I would get closer in the morning I would always look if they had posted the Como Black sign because if I saw that sign posted outside the phone center then I knew somebody had died. I knew that it was going to require a response from me. My first thought was, I hope it wasn't a suicide and then, number two, I hope it wasn't a lot of guys because if it was my brigade then it would certainly trigger me getting involved in doing the debriefings. I ended up doing about, I think, 19 of those things and they were always difficult and then it was always followed up with, because I sort of had a protocol that I followed, that I attended every memorial service that we had. I felt it was important that the guys and usually the platoon that had just had a battle buddy killed and I had done the debriefing with them I felt it was important for me to be at the memorial service to show support and to show support to the chain of command but those were always very difficult.

P6: I also worked mortuary affairs a couple of times and that certainly was a new and different experience to me, one I had not anticipated. That was I guess difficult in a sense of not knowing or being prepared ahead of time.

b. Trauma work

P1: Just like two weeks after I got into country, I was tasked to provide Traumatic Event Management to FOB Salerno after they were devastated by a vehicle born improvised explosive device… I heard the first flight that was cleared to land there after the attack and that was just hours after that happened. They had very

primitive barricades set up where the VBIED had penetrated the barrier and they were even, they were giving us intelligence reports that another attack was likely. So yeah, I was definitely on edge, this was my first deployment and I had only been in theater for a few days. So that was, it definitely rattled me quite a bit. I did not sleep very well while I was there.

P2: Most of what I did was dealing with the psychological trauma of the incidents that occurred and we had a lot of them…I think it had, it always had to do with I guess what would be referred to simply as a traumatic event.

P7: It was probably the first 6 months of the deployment were probably the most difficult and it was based primarily in the clinical sense because I had never dealt with so many suicidal people through the course of my career…So, all of a sudden I am thrown in this situation where a lot of people walking through the door where there primarily because I either I want to kill myself or I put a gun to my head last night. The number of weapons that apparently misfired was staggering over the 15 months. I think wow, I kind of lost faith in the ability for America to make weapons because so many times apparently, allegedly, pulled the trigger and click but I think a lot of that was just kind of this is a cry for help. I need help and zero suicides for anybody who had actually been seen by my mental health team. We had zero completed suicides. So that was the most difficult situation the first half of the deployment. Second half that was probably

the best part of the experience was having the confidence of knowing I can handle, we can handle suicidal soldiers. Give me a few weeks and we can get out of this, we can pull out of this together. So I had a number of folks that; I can't be here anymore, you have to get me MEDEVACed or I am going to kill myself. We would just make a deal with them, give me one month, you come to see me twice a week for one month and if you still want to go I guarantee you I will MEDEVAC you out of here and we never ever once had to follow through on that.

c. Command buy into Behavioral Health

P3: Trying to convey to commanders when a soldier truly needed to be evaced from theater and getting them to buy off on it. Instead of them thinking the soldier was just doing it for the attention or wanted to go home or whatever. On my first deployment, I had a soldier that we had, had on unit watch for about two weeks and we made the recommendation that he needed to be evaced and the Lieutenant Colonel who was his Squadron Commander said no, no, no, no, no. While he was on unit watch his escort left his rifle in the Humvee with him and he got it and he pulled the trigger, it miss fired, he pulled it again and it miss fired again at which point he decided that he was a little freaked out that he actually tried to kill himself. He came in, so we found the bullet that had the firing pin marking on it because he had tried once and then he ejected that one and then had tried it again. So we had both of them that had the firing pin markings on it…So we knew he had actually had tried and so I ended up having to go around that Squadron

Commander….So that's probably the biggest challenge was trying to get those combat arms guys to buy into behavioral health and it actually is kind of a real issue.

d. In Direct Fire

P1: Responding to the indirect fire. You know just the constant threat of knowing that could happen at any time…To a very small extent I did experience some nightmares. You know they even still come from time to time. I think I am back in Bagram sometimes having an IED attack. Do you know the apple alarm that sounds just like the air raid serein? So, you know that does get me sometimes…So yeah, I mean it obviously had an extremely powerful emotional impact on me.

P2: We took, you now of course everybody took the occasional mortar round. Fortunately for us, often times they would try to hit the airfield and they would usually end up in the middle of nowhere… For some reason Haji eventually got smart and started putting the rockets and the mortars where the troops were and there were a couple that actually, it landed about 20 meters, 20 yards from where I was early one morning…And then we took a particularly nasty rocket attack one day and I don't know if you all had these facilities or not but they hit our damn Burger King.

P4: We did get rocketed about 20 times during the deployment, so we were in danger even though you try not to think about that.

P5: When I went to Kandahar was when, Summer 2006, when rocket attacks, mortar attacks were just starting to take off in Kandahar so it was just different times. Somehow I managed to live in such a state of denial that even after I had been there for several months, almost inevitably when I would hear a mortar land I would say who is slamming the door again and then the sirens would go off.

e. Being Outside the Wire=Being a Potential Target

P4: So, I think the most difficult part of the Afghanistan deployment was actually being outside the wire and being a potential target.

P5: The traveling was not my favorite piece just because you knew that you were deliberately going into potentially harm's way but we knew we had a task to do and it did give me a much better appreciation for what it was like for all the troops who had to go outside the wire much more frequently to do a job which does include firefighting.

The third and final theme and corresponding codes emerging through the examination were:

2. Relationships:

a. Toll on Relationships

P3: I would say that impact wise, it has definitely interfered with some relationships that I had whether it be friendship or dating. One of the friends that I was really good friends with prior to my first deployment we are no longer friends. Mostly just because of things that kind of transpired through the whole deployment process and then coming back. Then relationship wise I was seeing someone during my first, well about mid-way through my first deployment, then through my second deployment but we just never got to spend a lot of time together and you know you don't necessarily get to talk a lot when you're deployed as well…I think the tool on relationships is significant. Like I said I have a really good group of friends who my relationship with them hasn't changed at all but family and friends are definitely very important to me and going to hang out in the dessert for another year not so important.

b. Being Away from Family

P3: I think that I have a really good support system but just the being away from family and friends during holidays and birthdays and big milestones. That's always challenging.

P4: My third deployment, the Qatar one, the most difficult part was just being away from home again.

c. Harder on spouse

P4: I mean it was harder on my spouse to be honest with you for all of them than me. I think that is something that often is forgotten, their sacrifice also.

Results for Research Question 5

The following list was created from analysis of the code book, second cycle coding, reflection notes, original transcriptions and audio files of the interview sessions to answer the fifth research question: How did the clinician attempt to care for themselves while simultaneously caring for others during deployment and the six months following return from deployment?

The two themes and subsequent codes which emerged in examination of the aforementioned research question in relation to deployment were:

1. Connecting with Others:
    a. Hang Out

P1: I was always surrounded by my peers and as I mentioned the pace was not very fast of patients. We had a common area where we would get together and talk and plan recreational things.

P2: I think for me it was very important to have a group of guys to hang out with and we ended up, let me see, it was the typical medical folks; myself, the physical therapist, the dentist, the physical therapy NCO, a couple of the doc's who were with us and then there would just be some guys who would kind of come through as part of the surge that would hang out with us and we would always go to chow together, for supper every night and then we would, after chow we would go to the dental clinic. Of course the dental clinic was closed, and we would go to the waiting room and we would watch Haji versions of DVD's.

P3: On my first deployment what we did for self-care was there were two other female providers in the CSC and so we had convinced our commander that about once a month we needed to fly to one of the other locations even if it was just for a day just to kind of decompress...Because we were all individually located so it was kind of our way to process stuff and do all that good stuff. My second deployment what we did was every night after close of clinic we watched, I think at that time we were watching Castle, and then we watched Bear Grill. So every night after we closed the clinic we would all go to dinner together, come back, hang out, and watch one or two episodes of something before we went to bed.

P4: I was always paired with another man, another male so we were gender equals so we shared experiences and we kind of talked about ourselves. So there was some support there with our team.

P5: We had a small group of people we would spend time with and they were pretty much the people I worked with.

P6: The connection with fellow colleagues primarily PA's and other providers.

P7: The Occupational Therapist and I would talk nightly…So the two of us every single night there was a, I think what they were going to build a pool so it was just the dirt was dug out but they never did anything with it. It was a huge pit and the dog would go out just after dusk and do her business and then the OT and I would

just talk about the day's events and sometimes with a lot of expletives, sometimes with some tears, and sometimes sharing laughs and stuff like that and that definitely helped keep me sane and motivated and wanting to get up the next day and do the same thing.

b. Paired up with Chaplin Staff

P4: We had a Chaplin group there, we short of paired up with Chaplin staff which is also helpful.

P5: We would go over to the Chaplin's place which was always…I mean the Chaplin's place on Kandahar was awesome, we really liaised a lot with the Chaplin's office so we got to know them pretty well.

P6: I did utilize the Chapin Corps services, going to church etcetera.

c. Keeping in Touch with Family

P5: Keeping in touch with family…At the time video capabilities weren't great so I would, you know, talk, voice skype with my husband and family over the phone. Use, you know, the phones down in the MWR facilities.

P6: The contact with family back home.

2. Exercise:

    a. Gym/Running

P2: Now, toward the end of the deployment I did get toward right before supper I would go for a short run, by myself because I just needed sometime away and then sometimes particularly there is a six month period during the summer that after we would watch our DVD me and the PT NOC, we would go for a run at ten ‘clock at night because then it was only 105 degrees and you could do it. That was probably some stress management for me as well because then we could just kind of bullshit with one another and get a little exercise.

P4: So what I did and what I encourage my tech. to do is to, you know, go to the gym a lot. So it was a regular two hour thing for me probably.

P5: I worked out for two hours every day…I was running a lot, inside, on treadmills and so yeah I exercised every day.

P6: Increased exercise.

P7: I tried to work out one or two times a day, six days a week, and that definitely helped a ton because I don't think I slept a whole night in 15 months.

The three themes and subsequent codes which emerged in examination of the aforementioned research question regarding post-deployment were:

1. Took time away:
    a. Took leave

P1: So, my wife met me in, you know, North Carolina after I out processed through Ft. Benning in Georgia...When it was all said and done we were in Europe, we got free airfare, we had three weeks to kick around Germany, France, and Luxemburg. So, I think that was definitely a great way to unwind after the deployment.

P2: So, I took 30 days of leave.

P5: As soon as I came home, I think my husband and I went out to California for a week. We took some time off.

P7: I took leave right when I got home, almost a month that helped.

    b. Drank alcohol

P2: Because I was sort of living by myself…I sat in my budget motel, I watched, TV, and I drank a lot of beer.

    c. Family and friends

P3: I had my family…they were about five hours away; I have friends who lived…so it was a pretty easy transition.

P6: Just kind of tried to re-engage with family…Really just kind of take some time to reconnect with family.

2. Transitioned:

    a. Transitioned Jobs

P1: So, like as soon as I got back from my deployment, let's see here, I was also out processing from active duty and I know I raised a lot of eyebrows when I got back. I was getting questioned like, are you sure about this you just got back from deployment and you're getting off active duty. As soon as I did that I was rushing with my checklist doing everything I had to do because I already had my civilian job set up.

P2: So, I took 30 days of leave. Came back and I basically out processed for the next three weeks and went back on retirement status.

P5: I switched from being OIC of mental health element to being OIC another one so I kind of just transitioned into a new job too. So kind of everything was coming back starting a little bit new but everything else was already in place.

3. Nothing Formal:

    a. Never Got Help

P4: I never got any help…I think the second one was a lot harder than any of the others and I didn't realize that until about four months back and I was, things didn't feel right but eventually it kind of settled down. I never really thought about it. I never really, you know formally did anything.

P5: When I came back from my deployment I remember them asking all of these questions you know; are you still exercising, no…are you sleeping better, no. The general practitioner who is asking all of these questions she said are you depressed. I said no but this is just real life, I mean in Kandahar I had a very limited life style…She was like do you need to see mental health and I am like no, I am just being very honest with you. I am not depressed, I am happy and glad I am back but it's just real life living in the sates verse living in Kandahar…For the most part, I feel like I transitioned overall fine. I mean I don't feel like I had any problems redeploying.

b. Talking to others who Deployed

P6: I think, I just kind of settling back in with life. Talking with others who have deployed…and as needed talk with others about different experiences.

P7: Stayed in very close contact with the people I deployed with which helped a lot being able to, we tell our soldiers to talk about our experiences and so I followed that advice myself and it helped me a lot.

c. Reframing

P7: Then just, I think compartmentalizing some of the experiences. As a psychologist, reframing did a lot of good. I would go to the grocery store and someone would be losing their minds over a bruised piece of fruit and damn it give me the manager this is outrageous and my first thought was oh wow this is what I deployed for, for this pettiness and then I thought this exactly why I

deployed. So that somebody can have so little fear for their life that something this stupid and petty can be important to them and so I was actually quite glad to see something like that because I thought okay this is…we may be the only nation in the world that somebody can have that as an actual worry that they go home with and have to process that with their spouse. So that helped a lot.

Discrepant and Nonconforming Data

In the course of the interviews it was normal to touch on topics from several angles and in some cases obtain comments which did not emerge as patterns throughout the qualitative process. These are recorded here in context and organized by the theme.

1. Reflection on Current Events:

P4: I see what's going on now in Iraq and think of the wasted effort of a lot of soldiers and others put forth with the whole Middle East stuff just to be sort of pissed down our leg, so to speak. So I think I look back on what's going on now and just view it as kind of a waste and maybe see things like that differently than what I had before.

2. Retrospective Records Review:

P2: Well we actually did a study…We went back and did a retrospective records review of all our records and we looked at the principle diagnosis and certainly we tried to use the V codes when we could but the most common diagnosis was adjustment disorders and then certainly PTSD. We saw our fair share of partner relational problems but certainly it was soldiers in crisis because they found out things that were going on back home…They let the spouses if you deployed with

your spouse you were able to live together and of course when you are living together under those tight living conditions, under that stress, inevitably marital problems arose which I had not anticipated.

3. Talking to Others about Deployment Experience:

P1: You are one of the first people I talked to from deployment in a long time. So that reminded me I really was there, it wasn't just a dream. The interview was sort of therapeutic for me because I haven't talked to too many people about deployment.

4. Living Life Simply:

P5: I slept better when I was in Kandahar than I do in the states. You know I actually talked to people about this when I came back because it is really striking how, at least for me and my experience when I deployed, I don't think my experience for me in that respect was too different from the people who at least stay inside the wire and do more of the supportive work. Once you're done with you job for the day there is not a lot of choice in what you do the rest of the day. You know, it's not like, oh am I going to go to the mall or try out this new restaurant…I lived simply and because of that I exercised more and I slept more because there wasn't much else to do.

5. More Time for Prevention Deployed:

P5: I did miss sleeping like I did in Kandahar and did miss working out as much as I did in Kandahar but I didn't know how to get that time back because that time was in traffic and then doing administrative work. I mean, it is so interesting how

all of our models preach preventative medicine but we don't have time in our clinic day to do that right, our clinic day is just patient, after patient, after patient.

6. Philosophy of War:

P5: In terms of the philosophy of war and I have been thinking about it more now…It is so interesting to me the idea of war and the sense that do you ever feel like we are all saying the same thing but no one understands? So we get into these gigantic fights but we're probably on some level fighting for some of the same ideas they just manifest themselves completely differently. Some of them manifest horrifically. So, it's just so interesting to me that we ask our youngest to do the hardest work and I know that the leadership knows that, yet at the same time, do they know that? Does that make sense? What else can we do right, you know that is more idealistic and philosophical than it is pragmatic but I think that was probably one of the hardest things for me is just that our youngest are doing the most work. And they don't know any different because they are so young and they don't know that life can be different and life can be better.

7. Less Fear in Life:

P7: For me I have a lot less fear in my life in general. I just, it's not that I don't care about death but it doesn't concern me like it did before. I do feel like I am in some ways healthier through that experience because I made it through and I didn't lose it while I was there. So I think that built up some natural resiliency for me.

8. Rarely Felt Directly in Harm's Way:

P7: I would say, as however we had IED's, rockets, mortars, and stuff like that; I rarely and it is important because other providers I know were really directly in harm's way. I rarely felt that I was directly in harm's way. The second deployment when I was in Bagdad we had a lot more mortar attacks but the aiming, I just never felt like oh my God I am going to die. So that does, that is a different experience than some of the providers have had so that is meaningful. So I didn't have to come home and deal with a lot of the potential PTSD symptoms that a lot of my cohorts had to deal with because they were a lot more in harm's way.

Evidence of Trustworthiness

Credibility was achieved within this qualitative research through the use of tools utilized to check for accuracy of findings. Credibility procedures included checking transcripts to ensure no obvious mistakes and no drift in the definition of codes. To increase credibility, this qualitative study used member checking through taking final reports back to participants, along with using detailed and contextual descriptions throughout the exploration (Laverty, 2003). Member checking was employed through a process in which participants confirmed data and interpretations. Through this process, emerging themes, interpretations, and conclusions were verified by having the participants examine and approve ideas or explanations generated (Laverty, 2003). In an attempt to further ensure credibility, my reflective commentary is provided in Chapter 5 (Shenton, 2004).

When examining transferability, one can expect the more abstract pattern expressed by the theoretical construct and the patterns they describe to be found in different subcultures. The specific content of those patterns, in contrast, will depend on the specific subculture being studied. If a construct is truly transferable it will serve as a guide for investigating a new sample. In an attempt to ensure transferability, one goal of this study was to generate scholarly literature that has the ability to facilitate future research. To ensure transferability, I documented the steps and procedures followed as detailed as possible; with Chapter's 3 and 4 presenting a demographic description of participants, number of participants, data collection methods, length of data collection session, and time period of which data was collected (Shenton, 2004). Additionally, to increase the odds of transference into future works, detailed descriptions of data collection and analysis, as well as, a rich narrative of the experiences of the participants are provided in this chapter, as well as, Chapter 5.

Dependability was established in relation to the ability of the research to be repeated, with the same content, with the same methods, and the same participants, to produce similar results (Shenton, 2004). To assist with dependability, Chapters 3 and 4 offer an explanation of the research design and implementation by describing what was planned and extracted throughout this qualitative process (Shenton, 2004). Chapter 4 provides a description of steps taken in the field; while Chapter 5 offers a reflective appraisal of the study proposing an evaluation of the effectiveness of the study as a whole (Shenton, 2004).

Conformability has been described as the qualitative researcher's comparable

concern regarding objectivity (Shenton, 2004). To ensure conformability, I attempted to safeguard, as much as possible that the presented research findings were results produced by the participants, rather than the preferences of the researcher (Shenton, 2004). To address conformability, the role of the researcher, presented in Chapter 3, outlines my experiences within the phenomenon being explored, as well as, strengths and weaknesses surrounding these predispositions. Furthermore, Chapter 4 offers an in depth methodological description to allow for integrity of the results to be examined (Shenton, 2004). Finally, recognition of this studies short comings and effects on findings are offered in Chapter 5.

Summary

This phenomenological study of military mental health deployments, specifically the experiences of individuals who previously served on Active Duty, National Guard, or Reserve components and deployed for 4 months or more, to Forward Operating Bases (FOB), in active combat zones, during OIF/OEF, revealed patterns and themes of meaning across the participants. When examining how MMHP describe dilemmas faced as they attempted to navigate the personal aspects of shared trauma; the themes of environmental hazards, living conditions, and mission expectations emerged. When examining the second question of how MMHP describe professional dilemmas faced while attempting to navigate shared trauma, participant's stories merged along the themes of mission purpose, death, professional isolation, and environmental challenges. In an examination of meaning MMHP chose to assign to their deployment experience, participants identified overarching themes of posttraumatic growth, lessons learned, and

changes in belief systems. The most difficult psychological aspects of deployments for MMHP's were grouped into the categories of shared trauma and relationships. Finally, MMHP described self-care while deployed under the themes of connecting with others and exercise. Upon return from deployment up to 6 months following, MMHP reported utilizing techniques under the categories of, took time away, transitioned, and nothing formal. Included in Chapter 5 are discussions of the implications of the findings, limitations of the study, social change implications, self-reflections, and future recommendations.

Chapter 5: Summary

Introduction

The purpose of this phenomenological study was to find meanings from MMHP experiences of deployment for 4 months or more to Forward Operating Bases (FOB) in active combat zones during OIF/OEF and the impact these experiences had on their personal and professional lives. The following research questions were posed for this exploration:

RQ1—Central research question/qualitative: How do military mental health providers describe dilemmas faced as they attempt to navigate the personal aspects of shared trauma?

RQ2—Central research question/qualitative: How do military mental health providers describe dilemmas faced as they attempt to navigate the professional aspects of shared trauma?

These questions contained multiple overlapping phenomena, which required explicit attention in order to understand the main phenomenon as a whole. Therefore, the following subquestions were explored:

RQ3—Qualitative: What meanings do military mental health providers choose to assign to their shared trauma experiences?

RQ4—Qualitative: What were the most difficult psychological aspects of deployment for military mental health clinicians?

RQ5—Qualitative: How did the clinicians attempt to care for themselves while simultaneously caring for others during deployment and the 6 months following return from deployment?

The population was defined as individuals who previously served on Active Duty, National Guard, or Reserve components and who deployed for 4 months or more to Forward Operating Bases (FOB) in active combat zones as mental health professionals during OIF/OEF. A total of (N =7) participants were interviewed for this study. This was a limitation of the study, as the original intent was to find (N =10) participants. After nearly 2 months and contacting approximately 100 individuals to find willing participants, the results were rendered using the seven participants who could be contacted.

Moustakas's (1990) five principles within the heuristic analysis process were used to conduct the analysis of the data. Data collected included descriptions of deployment experiences, the most difficult aspects of deployments, how the clinicians attempted to care for themselves, and the impact this experience had on their lives. Descriptions of environmental aspects and meanings placed on the experience were also collected during the interview process.

This phenomenological study of MMHP deployments revealed patterns and generalizations of meaning across the seven participants. In examining how MMHP described dilemmas faced as they attempted to navigate the personal aspects of shared trauma, the themes of environmental hazards, living conditions, and mission expectations emerged. MMHP described professional dilemmas faced while attempting to navigate

shared trauma along the themes of mission purpose, death, professional isolation, and environmental challenges. In an exploration of meanings MMHP chose to assign to their deployment experience, participants identified overarching themes of posttraumatic growth, lessons learned, and changes in belief systems. The most difficult psychological aspects of deployments for MMHP were grouped into the categories of shared trauma and relationships. Finally, MMHP described self-care techniques while deployed under the themes of connecting with others and exercise. In relation to redeployment up to 6 months following, MMHP reported using techniques under the categories of took time away, transitioned, and nothing formal.

Interpretation of the Findings

Overall, this study validated various findings reviewed in the previous literature in relation to shared trauma and resilience, offering a glimpse into these concepts with regard to MMHP deployments. Results of this examination further expand the knowledge base of research conducted on MMHP who deploy in shared traumatic realities and meanings these individuals place on this lived experience. The following offers an examination of themes that emerged throughout this exploration in relation to previously established literature within the fields of shared trauma, resiliency, and military mental health.

Professional Isolation/Environmental Challenges

Prior research has indicated that an increased presence of MMHP in combat, through frequent deployments, has forced this set of professionals to perform roles outside typical clinical services, to address uncommon ethical dilemmas, to work in

unfavorable conditions with some level of risk to personal safety, and to function in some degree of professional isolation (Miller & Warner, 2013). Additionally, while most Army brigades have several physicians assigned to the element, there is usually only one mental health provider (Linnerooth et al., 2011).

This phenomenological exploration provided additional confirmation regarding MMHP deployments involving risk to personal safety, working in some degree of professional isolation, and unfavorable conditions. All participants confirmed instances of experiencing indirect fire while deployed. P1 mentioned occurrences of elevated threat levels and the directions to take special precautions such as wearing full body armor while on the FOB. Participants 2, 3, and 4 experienced deployments where they were the only mental health provider, executing their mission in professional isolation, while Participants 4 and 5 described their missions outside the wire in terms of being a potential target. P3 discussed being co-located within the aid station and the lack of confidentiality this provided behavioral health clients. Finally, P6 reported that she had no preconceived notions regarding deployment; it was a deployed environment, and she dealt with it.

Mission Purpose

Prior literature suggests that while MMHP experience various stressors, their overall concern during deployment is the success of the mission through achieving clinic goals (McCauley et al., 2012). This study found Participants 2 and 5 summarizing their deployment mission as being present and available for soldiers, while P2 discussed the need for MMHP to be strong even when they do not feel strong. Furthermore, P2 asserted that soldiers have to believe that MMHP are people they can lean on, as this is the

primary reason MMHP are present in this combat environment.

Posttraumatic Growth

In the currently evolving literature, shared trauma has been found to produce both acute/chronic stress reactions as well as positive awareness allowing for posttraumatic growth and resilience. Throughout this exploration, all participants discussed some type of posttraumatic growth associated with their deployments. These expressions were coded in the following categories: proud of deployment, made me better professionally, perspective, honored, and significant impact. P7 offered that his deployment as a MMHP was the single most impactful experience of his life before and since. In relation to acute/chronic stress reactions, P1 offered to a small extent experiencing some nightmares and sometimes thinking back to deployment, specifically to instances of indirect fire when experiencing certain stimuli. P1 explained these occurrences by stating that deployment obviously had an extremely powerful emotional impact. P2 described sitting in a motel room over leave, watching TV and drinking a lot of beer. Additionally, P2 offered that he came back tired, angry, and bitter, with this sense of bitterness never subsiding.

Lessons Learned

Research within the field has indicated that working with the military population can be a rewarding professional experience; however, risk factors of secondary traumatic stress and shared trauma must be addressed to maximize the positive benefits of these shared experiences (Voss-Horrell et al., 2011). In this study, Participants 1, 2, 3, and 4 all discussed lessons learned from their deployment experience. P3 and P4 asserted that they

had no regrets regarding their deployment; however, they did not want to deploy again. P1 and P2 expressed that they had learned that MMHP cannot do it alone and must reach out to others for support. P2 discussed the need to be prepared for deployment and questioned whether one can ever really be equipped for the combat environment.

Change in Belief Systems

Prior literature has revealed that practitioners who experience catastrophic environmental events can find themselves impacted on a variety of levels, including intra-psychic, interpersonal, and communal, leading to alterations of self and world views (Tosone et al., 2012). The framework of resilience offers a lens of examination concerning how stressful situations are interpreted or made sense of in the context of one's overall life experience (Bartone, 2006). Through this exploration, Participants 2, 3, 4, and 7 all identified changes in their belief systems due to their deployment experience. P2 and P4 reported manifestations of anger and contempt in relation to their shared trauma experience. P2 expressed that he returned from deployment tired and angry, with a bitterness that has not gone away. P4 explained that since deployment, he had more easily become angry at individuals who did not understand military sacrifice. P3 expressed that upon return from deployment, it takes a period of time to reacclimate and that it is always a little different regarding feeling as close to everyone. P4 offered that in relation to faith, he did not believe a lot of the things he might have believed before. Furthermore, P7 explained his compartmentalizing as the ability to reframe experiences to rationalize and justify reasons for going to war. Finally, Participants 1, 3, 4, and 5 all offered that their deployment experience had changed their perspective in some way.

Participants described changes in perspective with words such as *a newly found appreciation*, *those things taken for granted are now viewed differently*, *most things people get upset about not really mattering*, and *even in horrible situations you can find something good*.

Shared Trauma

Shared trauma has been defined in the literature as a concept capturing the experience of clinicians striving to provide services to individuals dealing with trauma while simultaneously addressing the same issues within their own lives (Tosone et al., 2011). In the conducted research, all participants described some sort of shared trauma experience while deployed. These shared trauma experiences were coded under the following terms: *death = response from me*, *trauma work*, *command buy into behavioral health*, *in direct fire*, *being outside the wire = being a potential target*. Specifically, P2 discussed how death within his unit required a response from him and how difficult memorial services were for him. P4 and P5 expressed that during their travel time outside the wire, the environment reinforced that they were potential targets. Finally, all participants confirmed experiences of indirect fire while deployed, with variances in frequency, proximity, and psychological impact. P6 confirmed experiencing indirect fire with no further description. On the other end of the spectrum, P2's description of deployment offered what locations had hard cover versus which did not, the enemy's tactics regarding indirect fire, as well as specific instances when indirect fire hit and the witnessed aftermath.

Connecting With Others

Previously reviewed literature indicated that identifying with one's unit or group was related to increased motivation and improvement of performance during deployment (McCauley et al., 2012). Furthermore, to cope with potentially traumatic events, some providers compartmentalized, while others described working through thoughts and feelings in social groups or solitary self-reflection periods (Gibbons et al., 2013). This study indicated that all participants endorsed hanging out with others in an attempt to care for themselves while deployed. Furthermore, Participants 4, 5, and 6 all described pairing up with chaplain staff for self-care. In contrast, P2 described instances in which he worked out alone due to needing time away. In relation to identifying with one's group, Participants 1, 2, 3, 4, 5, and 6 confirmed being the only individuals to deploy from their assigned unit. P4 offered that he was plucked from one medical group and then deployed with another one. P4 expressed that this practice is "crappy" due to not being able to connect with and complete the entire deployment process with one cohesive group.

Coping Strategies

In prior explorations, MMHP described the use of a homogeneous set of behaviors to care for their own personal well-being during deployment (Miller & Warner, 2013). The choices of reported coping strategies were consistent and involved exercise, maintaining faith, and staying in contact with friends and family (Miller & Warner, 2013). This examination confirmed prior findings by revealing that Participants 2, 4, 5, 6, and 7 all used exercise while deployed in an attempt to care for themselves. P5 and P6 mentioned keeping in contact with family while deployed. Participants 4, 5, and 6 all

described using chaplain staff to assist with self-care.

Transition

Prior research indicated in examination of postdeployment effects that prior knowledge of deployment's psychological impact did not prevent these professionals from experiencing adjustment challenges (Miller & Warner, 2013). Confirming these findings, this exploration found P2 discussing the need to be prepared for deployment in contrast to never really being able to be truly ready until one had experienced combat trauma. P2 offered that he had spent 22 years preparing but that until he was in the middle of deployment it was indescribable. Furthermore, P2 and P4 both reported feelings of anger and contempt post deployment. P4 further offered that he had difficulties with things just not being right after his Afghanistan deployment. P1 stated that his deployment experience had an extremely powerful emotional impact while also asserting that he was very proud of what he did. P3 asserted that it takes a period of time to reacclimate post deployment. P6 offered that her deployment experience was something she would always take with her. Finally, P7 asserted that his deployment was the single most impactful experience of his life.

Limitations of the Study

Important limitations are acknowledged in this study. Due to the number of participants and the research methodology employed, questions arise over the extent to which findings can be generalized. This phenomenological inquiry explored the lived experiences of deployed MMHP; however, the results are not generalizable to a larger population. The sample size of (N =7), while allowing for metathemes to emerge, posed a

challenge for produced results to be generalized to a larger population. The original intent was to find (N =10) participants; however, after nearly 2 months and contacting approximately 100 individuals to find willing participants, the results were rendered using the seven participants who could be contacted. The results of this research can only be used to describe military mental health deployments as they apply to the participants. While this investigation is intended as a meaningful and an important part of a puzzle, it only represents one piece offering a glimpse into the selected phenomenon. Furthermore, the stories of MMHP deployments were obtained by conducting semistructured interviews, allowing participants to self-report deployment events. No objective measures or additional verification were used to corroborate participants' reports. Therefore, it was presumed that participants provided truthful information in conveying their experiences as deployed MMHP during OIF/OEF

The use of heuristic inquiry necessitated awareness to be used as protection from imposing my assumptions or biases (Laverty, 2003). The use of this methodology required the ability to be reflective, insightful, and constantly open to the experience (Laverty, 2003). While biases and assumptions are embedded in the research and are essential to the interpretive process; I provided considerable thought to my own experience and offers claims concerning how my position relates to the issue being explored later in this chapter (Laverty, 2003).

In an attempt to respond to these concerns, a number of significant issues are considered. First, limited research has been conducted on the population of MMHP who deployed during OIF/OEF. As a result, the application of the phenomenological

methodology allowed for efficacious exploration, as well as production of metathemes and in-depth descriptions related to the phenomenon. Second, phenomenological research does not focus on knowing how many or how often an exposure has occurred; rather, it focuses on meanings individuals discern from particular lived experiences (Englander, 2012). In phenomenological research, representativeness cannot be evaluated on the basis of sampling method, as the goal is general knowledge about the phenomenon (Englander, 2012). Historically, foundational research within the field of psychology was conducted with a small number of subjects (Englander, 2012). Small sample sizes can provide sufficient and accurate information as long as members possess a certain degree of expertise about the phenomenon of interest (Guest, Bunce, & Johnson, 2006). To ensure variation and expertise regarding the phenomenon, this study involved a rich diversity of participants, including a psychiatric nurse practitioner, clinical social workers, a psychiatrist, and a psychologist. Additionally, participants served in the following military branches—Army, Air Force, and National Guard—with deployments spanning the range of stages within the OIF/OEF conflict, namely 2006-2013.

Recommendations

This study raised several issues and questions for further study. Although qualitative studies are not intended to be generalizable to other target populations, they have the ability to ascertain indications of prominent areas to explore in future qualitative and quantitative research with MMHP populations. The results of this research may facilitate further investigations to include exploring the experiences of enlisted behavioral health technicians often deployed alongside MMHP. Additional research could evaluate

the relationship between quality of mental healthcare and formalized military mental health deployment training for MMHP's focusing on the concepts of shared trauma and resiliency. It would also be useful to better understand where and when MMHP's develop adaptive coping mechanisms, so that training can be strategically taught and placed prior to deployment. Future investigation could examine what informal strategies MMHP utilize post-deployment. Finally, the difficulty in recruiting participants may dictate a variation of strategies be utilized to examine this population with the possibility that quantitative strategies might be less invasive and more conducive for the MMHP populace. Additional research continues to be necessary to address the lack of current investigation within the deployed MMHP population in relation to shared trauma and resilience.

Personal Reflections of the Researcher

Qualitative research, heuristic phenomenology in particular, allows for the researcher to examine a chosen phenomenon in relation to their personal experience (Kafle, 2011). From my experience as an Active Duty, Army, Licensed Clinical Social Worker, who deployed during OEF for 9 months to a Forward Operating Base (FOB), I have witnessed and encountered the effects of shared trauma and resilience in relation to the chosen phenomenon.

In a very personal sense, this study stands as a cumulative growth and reflection period, underscoring my own journey and ability to continue to serve our nation's heroes. Further allowing for the personal and academic exploration of the concept of resilience and how stressful situations get interpreted or made sense of in the context of one's

overall life experience (Bartone, 2006). During interviews with the participants, I was impressed by their dignity, sense of responsibility, and patriotism. Listening to their stories reaffirmed my personal belief in the unwavering human determination to survive and the, sometimes daily, struggle to find meaning in an experience. Overall, human beings appear to be meaning-making creatures attempting to make sense of chaotic, arduous, and traumatic experiences (Bartone, 2006).

While listening to the participants' stories and analyzing the data, I began to reflect on emerging themes and experiences in relation to present-day global events with the realization that, in the current world climate, clinicians will continue to experience the same traumatic events as their clients. This reflection led to the production of the following analytic memo written during the data collection and analysis phase. At that point within the data collection phase, the following meanings had been placed on deployment experiences:

> P1: I can certainly say I am very proud of what I did there. You know, even though I probably wasn't as busy in terms of number of patients I saw per day. I saw people in some of the most desperate and stressful situations in their entire lives so I am just proud that I was able to be there and do what I did.
>
> P2: Yes, if asked I would go again.
>
> P3: They were good experiences, I don't regret having them, I am not eager to do them again just because I think the toll on relationships is significant.

I began to question; while all these answers seem a little different are they all tied together in some way; a calling to something larger than us? Why do we, in this profession, subject ourselves to this line of work? Do we in some way place meaning behind our suffering to rationalize this professional role which has such a tremendous impact on us personally?

> P5: There was also this sense of pride that I was contributing to something much bigger than me and that the ideal of it was a good ideal and you know at that point it wasn't about should we be there or shouldn't we be there. We are there and what do we do and how can we take care of everybody the best way that we can so that they can, so when everybody goes home everybody is as functional as they can be.

The following personal stream of thought was recorded in an attempt to further analyze and understand the data being collected. I think, I do, and in some way we all have to place meaning behind suffering in order to progress with our lives. Throughout the data collection and analysis phases of this study, this task emerged as fundamental in order to continue on within the MMHP role. Prior research has asserted the ability to designate meaning in life experiences maybe the most crucial factor in developing resiliency (Osran et al., 2010). Which led me to the following question; at what point in time does personal sacrifice outweigh the calling to something larger than us? Participant 3 offered, "The tool on relationships is significant. Family and friends are definitely very important to me and going to hand out in the dessert for another year not so important."

Furthermore, what is my own personal tipping point? I do not know if I can answer that question. Furthermore, I do not know if I want to answer that question. I have said, "I will not volunteer to go again," but if called it remains my duty and in light of recent global events, along with my current duty assignment, more days than not, another deployment presents itself as imminent. As I admit this to myself, I begin to tear up thinking of that gut wrenching feeling a mother is overcome with when she is forced to walk away from her child as she marches off to war; the word sorry which will never feel like enough when leaving a husband/father behind to secure the home front. The first deployment, I rationalized that my child was young enough he would not have memory of my absence but what now, what if? Participant 4 offered, "My kids for the first one were young so they, young enough where it wasn't that big of an issue."

Then I transitioned my thought to words a drill sergeant spoke to me approximately six years ago, "if not you, then who?" If not me, then who would be down range for these soldiers to lean on in their time of need?

> P2: You've got to be strong even when you don't feel it. It's important that the soldiers you are working with sense confidence in what you are doing even if you're insecure. The soldiers that you are working with can't; they have got to believe you're somebody that they can lean on and that is why you are there.

Why should I be immune to the sacrifice paid to ensure our country is free? If it were my son down range, I would hope he had access to the best medical and mental health care available. For all the mothers and fathers out there who have felt the pain of seeing their daughters and sons march off to war for the past decade, I continue to put my uniform on

every day. This self-reflection reinforced one theme which emerged throughout this exploration, that despite the hardships faced as part of the deployment experience, a few participants indicated they would do it again, and all found positive elements within this shared traumatic experience.

Additional reflection led to the following realization. In line with many of my participants, return form deployment was filled with transition and a call to march on completing the mission. I and I believe MMHP, as a profession; often do not speak of our deployment experiences. Furthermore, I question if this cultural norm influenced willingness to participate and the need to reduce this studies sample size. As professionals, MMHP do not talk, we listen to others. Participant 1 offered, "You are one of the first people I talked to from deployment in a long time." While Participant 6 stated, "I am not a big talker as you can probably tell."

Prior to embarking on this dissertation journey, I rarely thought about, let alone spoke about my deployment experience or meaning placed on this segment of time in my life. While completing the data collection and analysis portion of this study, an acquaintance asked me, "How do you do what you do?" I initially stood there frozen in time attempting to gather the words to explain something which cannot be fully described. Finally, thinking to myself, I do what I do because it is my mission. I do not often dwell on the how, for there is no simple answer.

As I continued to speak to other MMHP, this question of how, the bigger impact and meaning behind the experience emerged as a profound concept with multiple interpretations. Simply deduced, Viktor Frankl's theory on resiliency offers; if one can

place meaning behinds one suffering therein lies the resiliency factor within each human being (Bartone, 2006). In my exploration of Frankl's literature, the interpretation of meaning is never clearly defined. That is to say, Frankl does not appear to make the argument that individuals must place some sort of positive spin in defining their suffering. Rather, they must simply find meaning. Who are we to judge if one man's meaning is better than another's? Three different participants offered varying meanings. Participant 2 exclaimed, "I came back tired, angry, and bitter. You know there is still a sense of bitterness that just won't go away and I guess it won't." Participant 4 summarized his experience as, "I think it was valuable. I think it was probably one of the most, I don't know, important experiences that I had. Although, I would not want to go back; I just wouldn't. I wasn't that fun." While Participant 6 offered, "I think it has had a pretty significant impact. It's something I certainly will always take with me." Instead of attempting to judge or tell others what meaning should be assigned to an experience, should we focus on assisting others in finding their own true meaning? Through this examination, I am inclined to offer; maybe the question of how will never have a simple answer but we as a profession must continue to research this challenging and less explored subject to enable us to take care of our own.

Implications

The implications of positive social change include a better understanding of MMHP deployments, this experiences impact on individual's personal and professional lives, and the potential to minimize negative influences and maximize potential positives. A substantial body of research suggests that clinicians may be affected by shared trauma

within the realms of psychological, social, and interpersonal with this study affirming the impact of deployment experiences depending on such factors as professional isolation, personal safety, environmental challenges, as well as, mission purpose and expectations.

Results from this exploration can be utilized to inform interventions which promote positive, shared trauma, coping behaviors specifically related to; increasing collegial bonds, ability to define the meaning behind the mission, and posttraumatic growth. To minimize the negative influences of MMHP deployments, the military must embrace the understanding of both personal and professional dilemmas encountered during these experiences and develop focused training for this population. Assisting MMHP in identifying trigger areas of shared trauma in conjunction with resiliency techniques may help minimize the negative aspects of deployment and promote posttraumatic growth. If the military mental health community chooses to focus on retaining quality MMHP, then there needs to be a focus on the resiliency of this population. In consideration of developing appropriate interventions for MMHP, the organization should consider the findings of this study along with prior research indicating MMHP do not seek formal treatment. Rather, they appear to utilize familial, social, and informal communal support systems. Lending the focus of further exploration to examine how support systems are established and utilized within this population.

The importance of these findings to social change can be found in generating a broader understanding of the construct and components of shared trauma and resilience, their pathways, and reinforcement of existing knowledge on these subjects. Social change benefits include decreasing negative personal and professional psychological impact,

increasing resiliency skills for future shared trauma experiences, and increasing readjustment to aid clinicians both personally and professionally. This study attempted to produce a foundation for current MMHP who have deployed and begin the groundwork of exploration for those to come. It is hoped that this study will be utilized for positive change in the profession of military mental health and the population of service members treated by these clinicians.

Conclusion

This phenomenological study traced the journey of seven MMHP who experienced deployments during OIF/OEF, within the frameworks of shared trauma and resilience. These providers openly shared their individual stories and perspectives for research purposes, revealing personal and professional insights into the shared traumatic reality of combat. In the aftermath of shared trauma, providers experienced resiliency and posttraumatic growth taking lessons learned into their next phase of life. Findings from this study demonstrated that MMHP experienced personal challenges during deployment; however appeared to focus the most dialogue regarding the description of these experiences on professional aspects of the phenomenon. Meanings assigned by participants revolved around posttraumatic growth, lessons learned, and change in belief systems. The most difficult psychological aspects of deployment were categorized under shared trauma and relationships. While participants described a homogeneous set of techniques of self-care while deployed to include exercise and connecting with others. Overall, the participants in this study emerged from their deployment related experiences with a great sense of meaning, perspective, and purpose for their lives.

With the current world climate dictating the need for MMHP to continue to be placed in shared traumatic environments; the military as an organization must take the lead in ensuring MMHP are adequately equipped for the personal and professional strains of war and cared for upon their return. As agents of social change, leaders within the profession of military mental health must find ways to develop cultural norms which foster the inherent need for caretakers to take care of themselves. It is my hope, the findings cultivated from this study will add to the body of knowledge that informs the military mental health profession in facilitating the development and implementation of programs to further assist those who have dedicated their lives to helping others.

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Appendix A: Interview Protocol

Background Information:

The purpose of this study is to understand and describe military mental health deployments from the practitioner's perspective.

Procedures:

If you agree to be in this study, you will be asked to:

- Participate in a 60 minute interview.
- Participate in a potential follow up interview to last no longer than 30 minutes.
- Provide feedback to the researcher regarding transcripts and themes produced.

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Participating in this study involves some risk of the minor discomforts that can be encountered in daily life, such as stress or becoming upset. Being in this study would not pose risk to your safety or wellbeing. The potential benefits of this study will allow the profession to better understand the positive and negative aspects of deployments for military mental health clinicians; allowing for development of programs to better support this population

Privacy:

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by locked file cabinet. Data will be kept for a period of at least 5 years, as required by the university.

Demographics:

1. Time in service (TIS):
2. Date of exiting the service (ETS) or retirement:
3. Number of deployments, location, and duration:
4. Mental health discipline:
5. Gender/Race:

Open-ended questions:

1. Please describe your deployment experience and be as specific and detailed as possible.

Possible Probes:

a. What were the environment conditions of your deployment?

b. What was your mission throughout the deployment experience?

c. What was your professional role throughout the deployment experience?

d. What was your typical case load throughout your deployment?

e. What were the most difficult situations you experienced during deployment?

2. How did you attempt to care for yourself during deployment?

3. How did you attempt to care for yourself for the 6 months following deployment?

4. What kind of impact has this experience had on your life?

   Possible Probes:

   a. What lessons, if any, have you drawn from this experience?

   b. How, if at all, have you been changed by your deployment experience?

   c. What meaning (s) have you placed on your deployment experience?

5. Is there anything else you would like this researcher to know?

Appendix B: Participant Consent Form

You are invited to take part in a research study of military mental health practitioners who have deployed during OIF/OEF. The researcher is inviting mental health clinicians who practiced in a deployed setting during OIF/OEF to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Tashina Miller, who is a doctoral student at Walden University.

Background Information:
The purpose of this study is to understand and describe military mental health deployments from the practitioner's perspective.

Procedures:
If you agree to be in this study, you will be asked to:

- Participate in a 60 minute interview.
- Participate in a potential follow up interview to last no longer than 30 minutes.
- Provide feedback to the researcher regarding transcripts and themes produced.

Here are some sample questions:

- Tell me about your deployment experience.
- What were the most difficult situations you faced during deployment?
- How did you attempt to care for yourself during deployment?

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as stress or becoming upset. Being in this study should not pose risk to your safety or wellbeing. The potential benefits of this study will allow for the field to better understand the positive and negative aspects of deployments for military mental health clinicians; allowing for development of programs to better support this population.

Payment:
Thank you gifts will be provided to participants and will consist of a gift card covering a meal at the restaurant of the participants choosing.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by locked file cabinet. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email or phone. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is **09-09-14-0196054** and it expires on **September 8, 2015.**

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix C: Pilot Test Participant Consent Form

You are invited to take part in a research study of military mental health practitioners who have deployed during OIF/OEF. The researcher is inviting mental health clinicians who practiced in a deployed setting during OIF/OEF to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Tashina Miller, who is a doctoral student at Walden University.

Background Information:
The purpose of this pilot study is, to test a developed interview protocol regarding military mental health deployments from a practitioner's perspective. The data collected during this pilot test will not be analyzed for the purposes of this study. The intent of this pilot test is solely to assist in further refinement of an interview protocol.

Procedures:
If you agree to be in this study, you will be asked to:

- Participate in a 60 minute interview.

Here are some sample questions:

- Tell me about your deployment experience.
- What were the most difficult situations you faced during deployment?
- How did you attempt to care for yourself during deployment?

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as stress or becoming upset. Being in this study should not pose risk to your safety or wellbeing. The potential benefits of this study will allow for the field to better understand the positive and negative aspects of deployments for military mental health clinicians; allowing for development of programs to better support this population.

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Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email or phone. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is **09-09-14-0196054** and it expires on **September 8, 2015.**

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of consent _____

Participant's Signature _____

Researcher's Signature _____