JOURNAL OF VETERANS STUDIES

The Politics of Treatment: A Qualitative Study of Canadian Military PTSD Clinicians

RESEARCH

JOHN WHELAN
MAYA EICHLER
DEBORAH NORRIS
DENISE LANDRY

*Author affiliations can be found in the back matter of this article

VIRGINIA TECH PUBLISHING

ABSTRACT

There has been an upsurge in post-traumatic stress disorder (PTSD) research, but these efforts have not included trauma clinicians. Using a constructivist grounded research methodology, we examined clinicians' views about military PTSD, their experiences in utilizing accepted interventions, and the personal impacts of this work. Our findings indicate that clinicians struggle with conceptualizations of PTSD, accepted treatments, and the requirements of navigating the Veterans Affairs Canada (VAC) bureaucracy. Demands to negotiate occupational realities while attempting care for clients underpinned experiences of emotional exhaustion. Contrasting the literature on secondary trauma, bureaucratic forces, implied expert status, and lack of supports for clinicians were at the root of exhaustion. Military trauma clinicians appear caught in the politics of treatment with detrimental effects on their health. This study is the first to explore clinician views on the benefits and costs of working with military trauma survivors.

CORRESPONDING AUTHOR:
John Whelan
Mount St. Vincent University, CA
j.whelanphd@gmail.com

KEYWORDS:
PTSD; clinicians; military; veterans; Canada

TO CITE THIS ARTICLE:
Whelan, J., Eichler, M., Norris, D., & Landry, D. (2021). The Politics of Treatment: A Qualitative Study of Canadian Military PTSD Clinicians. *Journal of Veterans Studies*, 7(1), pp. 217–231. DOI: *https://doi.org/10.21061/jvs.v7i1.227*

INTRODUCTION

Across Canada, thousands of mental health clinicians provide treatment to military members and veterans diagnosed with service-related mental health problems, including post-traumatic stress disorder (PTSD). They are employed on military bases, within government funded agencies, and in private settings. Following Canada's involvement in the Afghanistan War (2001–2014), concerns over veteran homelessness, suicides, and transitional difficulties have sparked numerous studies. However, this attention has not extended to the ranks of trauma clinicians. We set out to examine clinicians' views about military trauma, the ways in which they provide care, their views about effective interventions, and the personal effects of providing trauma therapy. The paper asks: How do clinicians working with veterans conceptualize military PTSD; how do they conceptualize treatment for military PTSD, what changes would they like to see; and, what are the personal consequences of providing therapy to traumatized veterans?

We begin with a brief overview of the literature on PTSD and on compassion satisfaction (CS), secondary traumatic stress (STS), vicarious traumatization (VT), compassion fatigue (CF), and burnout (BO). We describe the parameters of our study, including ethical considerations. We then present our four main findings regarding the views and experiences of military trauma clinicians: (a) understandings of PTSD as injury, (b) conceptualizations of treatment efforts, (c) effective approaches and recommendations for improved outcomes, and (d) effects on clinicians. We conclude with a discussion of our findings and a consideration of the limitations of this study.

LITERATURE REVIEW

CONCEPTUALIZATIONS AND TREATMENTS FOR MILITARY PTSD

Efforts to formalize the diagnosis of PTSD began in 1980 with the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) by the American Psychiatric Association (APA); a nosological classification system maintained in the DSM 5 (APA, 2013). Over the past two decades, neuroscientific imaging research (e.g., functional magnetic resonance imaging (fMRI), positron-emission tomography (PET), and magneto-encephalography (MEG) have bolstered a search for biological markers to support a disease view of PTSD (Bremner, 2007; Elinga & Bremner, 2002). Various cortical and subcortical structures (e.g., hypothalamic–pituitary–adrenal (HPA) axis, amygdala, hippocampus, prefrontal cortex, insula, limbic system), and neuroendocrine processes (e.g., cortisol, dopamine, serotonin) are advanced as potentially causative in PTSD symptom onset and maintenance but exact mechanisms remain elusive (Badura-Brack et al., 2017; Boone et al., 2001; Bremner, 2007; DiGangi et al., 2013; Eagle & Kaminer, 2015; Georgopoulos et al., 2010; Mišić et al., 2016). For Monson et al. (2006), the absence of reliable biological PTSD markers contributes to confusion over its status as a transitory, curable disorder, or an immutable biologically rooted disease process.

In practice, DSM conceptualizations of PTSD have been adopted by most Canadian clinicians. In keeping with the DSM, in 2016, the Department of National Defence (DND) and the Canadian Armed Forces (CAF) defined PTSD as a psychiatric condition that is caused by specific traumatic exposures and characterized by particular symptom clusters (e.g. re-experiences of trauma, avoidance of distressing memories, negative cognitions and moods, and hyperarousal). The evidence-supported approaches to treatment by DND and Veterans Affairs Canada (VAC) emphasize medication management and cognitive-behavioral therapies (CBT): Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) along with Eye Movement Desensitization Reprocessing (EMDR).

Yet the accepted concept of PTSD continues to have detractors. Prominent academic researchers (e.g., Davidson & Begley, 2012; Ledoux, 2015; Lieberman, 2013; Porges, 2011) have argued that neurobiological explanations of PTSD are based on incorrect assumptions about the role of structural damage to key brain regions. Other critics describe PTSD as "faddish" by pathologizing normal distress (Duckworth & Follette, 2012) and institutionalized masculine norms (e.g., toughness) in military contexts (Fox & Pease, 2012; Jakupcak et al., 2006). Mobbs and Bonanno (2018) contend that moral injuries (defined by Maguen and Litz (2012) as reactions to perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations) and transitional strain (e.g., loss of military identity) are the main sources of mental distress facing military veterans, not PTSD. In addition, the landmark study of adverse childhood experiences (Felitti et al., 1998) emphasized the importance of early development in understanding adult PTSD. These findings have not been incorporated into PTSD conceptualizations or evidence-based treatments (EBTs) for military trauma despite US studies (e.g., Cabrera et al., 2007; Van Voorhees et al., 2012) and Canadian studies finding a high incidence of ACE among PTSD diagnosed soldiers (Boulos & Zamorski, 2016; Whelan, 2013, 2015).

Evidence-Based PTSD Treatments

Two medication interventions (i.e., sertraline and paroxetine) are supported by the US Food and Drug Admimistration (FDA) for PTSD symptom management (Jeffreys, 2017). As noted by Jeffreys, PTSD treatment guidelines recommend trauma-focused, cognitive-behavioral therapies (CBT) as the first-line treatment for PTSD. These approaches were developed in the 1990s by behavioural psychologists emphasizing the importance of prior learning (i.e., classical and operant conditioning) and cognitive appraisal styles (e.g., catastrophic thinking, over-generalization) as compelling explanations for post-trauma symptoms (Brewin et al., 1996; Brewin et al., 2000). Two cognitive-behavioral therapies are designated EBTs for military PTSD: PE (Foa et al., 1991, 1999, 2005, 2009) and CPT (Monson et al., 2004, 2006), along with eye movement desensitization and reprocessing (EMDR; Shapiro, 1995, 2001).

Summarizing the Evidence for EBTs

Some research supports EMDR for military personnel (Graca et al., 2014; McLay et al., 2016) but other large scale studies raise concern over its use for military trauma (Haagen et al., 2015; Köhler et al., 2017). PE and CPT have an impressive research base spanning decades (Eagle & Kaminer, 2015), even though concerns over attrition (Tran et al., 2016) and non-response rates upwards of 50% have been reported for civilian and military clients (Monson, 2006; Nilamadhab, 2011). A comprehensive review and meta-analysis of randomized control trial (RCT) data by Tran et al. (2016) rated a low quality of evidence in support of CPT with military PTSD populations. In another review of the EBTs for military PTSD, Steenkamp et al. (2015) called for the development of better interventions.

Current attempts to improve PTSD treatment outcomes focus on expanding CPT dissemination, increasing therapist training, and modifying CPT treatment formats (see Laska et al., 2013; Resick et al., 2015; Thompson et al., 2018). Numerous other interventions have also been developed to treat PTSD, each with their respective research bases and proponents (e.g., somatosensory therapy, electroencephalography (EEG) Neurofeedback, Virtual Reality Therapy, Yoga), but have yet to meet RCT criteria. In sum, while many clinicians subscribe to EBTs to treat military trauma, others are employing various strategies to help these clients.

CONCEPTUALIZING EFFECTS ON PTSD CLINICIANS

The evidence suggests that clinicians can experience both positive and negative reactions through frequent and intense contact with traumatized clients (Bride et al., 2004; Elwood et al., 2011; Figley, 1995). Compassion satisfaction (CS) is meant to reflect life-affirming reactions among therapists, such as fulfilment and pleasure, based on work satisfaction, and competency and control over traumatic stories (Larsen & Stamm, 2008). Indeed, a number of quantitative and qualitative studies have reported a high potential for CS among mental health professionals (see Arnold et al., 2005; Birck, 2001; Collins & Long, 2003; Conrad & Kellar-Guenther, 2006; Steed & Downing, 1998).

Despite the salutogenic effect of CS, the preponderance of research has focused on deleterious effects resulting from work with trauma survivors such as STS, VT, CF, and burnout (BO). These terms are often used interchangeably to discuss the consequences of exposure to traumatic stories (Bride et al., 2004; Elwood et al., 2011; Figley, 1995). While related to concepts of STS, VT, and CF, BO refers to responses to occupational stressors and workplace factors, characterized by reactions of emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach et al., 2001; Maslach & Leiter, 2008). Numerous studies have reported significant relationships between job burnout and high job demands (e.g., workload, role conflict) and low job resources (e.g., lack of control, work autonomy) (Lee & Ashforth, 1996; Shoji et al., 2015; Sodeke-Gregson et al., 2013).

Adams et al. (2006) proposed that CF is a broad concept encompassing STS, VT, with BO as a latent clinical feature. In two large-scale prospective investigations, Shoji et al. (2015) found that only job BO increased the risk of developing STS. Despite conceptual differences, CF is believed to be the over-arching construct depicting negative effects on trauma clinicians. Those therapists experiencing CF often report PTSD symptoms ranging from low to severe (Brady et al., 1999; Chrestman, 1999; Follette et al., 1994; Kadambi & Truscott, 2004; Kassam-Adams, 1999), relational difficulties, physical, emotional, behavioural distress, and work ineffectiveness (Collins & Long, 2003).

A mixed picture has emerged for work-related variables like clinical experience, size of caseload, and availability of supervision and relationships with CF, STS, and BO (Chrestman, 1999; Craig & Sprang, 2010; Kassam-Adams, 1999; Meldrum et al., 2002). Several studies have reported a direct relationship between high clinician empathy and high CF (Cocker & Joss, 2016; Lynch & Lobo, 2012; Najjar et al., 2009) while others have not found these relationships (Baird & Jenkins, 2003; Devilly et al., 2009; Meyers & Cornille, 2002; Schauben & Frazier, 1995). In a 2014 study, Cieslak et al. reported a 33% STS rate among military trauma therapists with 20% of clinicians meeting full PTSD criteria. Across all indices of exposure, only number of trauma clients and associated paper work demands were associated with STS. Even so, several systematic reviews

of the CF, STS, and VT literature have concluded that the evidence for these concepts is meagre and inconclusive (Sabin-Farrell & Turpin, 2003; Sodeke-Gregson et al., 2013).

Garcia et al. (2014) investigated burnout among trauma clinicians working for the US Department of Veterans Administration (VA) finding that half of respondents reported high levels of exhaustion and cynicism. Organizational politics/bureaucracy, clinical workloads, and lack of control over workloads were associated with their results. In a United Kingdom (UK) study, Steel et al. (2015) examined the rapid expansion in mental health accessibility, reporting high levels of emotional exhaustion among clinicians but low rates of depersonalization (DP), supporting a developmental model of burnout as proposed by Maslach et al. (2001).

Treatment approaches have also been linked to CS and CF among clinicians. For Craig and Sprang (2010), the use of EBTs (i.e., PE, CPT) may protect clinicians from CF by reducing confusion among therapists and clients and possible manipulation by clients. This assertion is consistent with earlier arguments by Fonagy (1999) that the use of evidence-based strategies can improve therapist confidence and competence by creating necessary boundaries and therapeutic structure. However, Devilly et al. (2009) argued that clinician distress occurs primarily because of BO and that exposure to patients' trauma stories had no significant impact on clinicians.

In summary, the existing literature on the effects of trauma work on clinicians appears inconsistent and oftentimes contradictory. Furthermore, there is a lack of research devoted to the perspective of clinicians. As we show in this study, it is important to examine clinicians' views about military trauma, the ways in which they provide care to veterans, their experiences with interventions, and the personal effects of providing care to traumatized veterans. Finally, there is a lack of Canadian research on military trauma clinicians providing evidence-based care who are relatively inexperienced with the bureaucratic structures of DND and VAC. The current study aims to address gaps in the literature by focusing on the views and experiences of Canadian clinicians working with veterans diagnosed with PTSD.

DESCRIPTION OF THE STUDY

THEORETICAL AND METHODOLOGICAL FRAMEWORK

As part of a larger study on veteran transition, we explored the experiences of clinicians working with PTSD-diagnosed veterans using focus group data. We used a constructivist grounded approach (Boss, 2002; Charmaz, 2014) to identify key themes and concepts. Qualitative researchers rely on data reflecting meanings found in language, images, symbols, and social interactions collected through interviews, observations, text and discourse analyses, or ethnographies (Starks &Trinidad, 2007). A constructivist paradigm affords researchers the opportunity to extend knowledge by accounting for, and examing divergent constructions of social phenomenon (Bryman, 2013; Charmaz, 2014; Guba, 1990). To ensure rigour, qualitative researchers adopt a reflexive stance through a continual evaluation of subjective responses, intersubjective dynamics, and research processes (Finlay, 2002). Reflexivity requires investigators to recognise how their traditions, values, and personal qualities necessarily form part of the context for interactions with participants (Willig, 2001). For this reason, it is important for readers to understand who conducted the research. The first author is a CAF veteran and a practicing psychologist, the second and third authors are female academics in political studies and family studies with published research on veteran issues. The fourth author is a research assistant and trauma therapist.

DATA ANALYSIS

Constructivist grounded theory coding techniques were used to explore clinicians' understanding of military trauma. In keeping with Morse's (2015) suggestions, a thematic analysis of the interview transcipts and fieldnotes was carried out, noting key concepts. These concepts formed a list of initial codes which were grouped into themes and refined using constant comparison (Glaser & Strauss, 1967). Next, we used focused coding to sort, synthesize, and organize the data (Charmaz, 2014). We used theoretical coding to formulate a coherent and conceptual understanding of the data to paint a picture of clinician experiences. In keeping with Basit's (2003) recommendations, we used coding software to improve this process; in this study MAXQDA provided a memo and logbook system.

PROCEDURES AND DATA COLLECTION

Recruitment involved circulating a poster describing the study. Interested clinicians were contacted by the fourth author by telephone and email. Prior to participation, these clinicians were given additional information about the nature of the study and details for the proposed focus group interview.

The focus group was conducted in a university setting during February 2017 by the first and third authors. A topic guide was used, with questions and prompts to elicit information pertinent to the research questions. The interview was audio recorded, transcribed, and imported into MAXQDA software. Following the 90-minute interview,

group members were provided contact information for research team members. Notably, following the interview, participants volunteered to exchange personal contact information.

Participants

The focus group included four therapists (one male and three females) who work with veterans diagnosed with PTSD. Three participants identified as psychologists, one as a psychotherapist. One clinician had 6 years clinical experience; the other three had approximately 15 years experience. Pseudonyms were used to differentiate the four participants. Kate and Angela reported doctoral level training in CBT treatments for trauma, while Jeff and Mary were Master's level clinicians with training in feminist, EMDR, mindfulness, and interpersonal therapy approaches to trauma.

ETHICAL CONSIDERATIONS

The study was approved by Mount St.Vincent University's Research Ethics Board. All participants signed a consent form in which information regarding the purpose of the study and its potential implications was communicated. Before beginning the focus group, participants were reminded that participation was voluntary, that the interview could stop at any time, that they had the right to skip questions, and their consent to audio-record the focus group. Participants were reminded that the researchers would end the focus group if there were signs of distress.

STUDY FINDINGS

The analysis of clinician responses produced four inter-related themes coalescing around an over-arching theme of challenges to their expertise. These themes are summarized here and described in more detail in the subsequent sections.

1. Understandings of PTSD as injury: The first theme describes how clinicians understand PTSD either as a brain injury, as a relational injury resulting from a shattered assumptive world because of unresolved grief and loss, and/or as a vulnerability caused by prior childhood trauma.
2. Conceptualizations of treatment efforts: The second theme captures clinician treatment orientations, ranging from cognitive and behavioural interventions to approaches focussing on interpersonal (re) connection and care for clients.
3. Effective approaches and recommendations for improved outcomes: The third theme describes clinician experiences of effective interactions with clients, the limits and constraints of their work in effecting change, and the types of government and community resources needed for successful outcomes.
4. Effects on clinicians: The final theme describes the impacts of clinical work on the mental health and well-being of clinicians.

UNDERSTANDING PTSD AS AN INJURY

Consistent with the stated aim of this study, clinician narratives reflect their theoretical understandings of PTSD. For some clinicians, PTSD is seen as a normal reaction to grief and loss:

> [Originally] I don't know that I understood it [PTSD] any different than just this person's a victim of something, and these are the symptoms, and this is what their experience is (Angela).

> I see trauma, like, grief. I think they're probably interchangeable terms, but that grief never leaves you, it just changes, right, and trauma is much the same way (Kate).

There is a consensus that military PTSD is a layered phenomenon with a high prevalence of childhood trauma, a problematic military ethos, and loss of military identity. These clinicians appear to struggle to articulate a consistent and coherent model of military trauma that is reflective of ongoing controversies over the concept of PTSD (e.g., Wilson & Barglow, 2009; LeDoux, 2015). These explanations of PTSD range from (cognitive) false negative self-beliefs held by veterans and (emotional) reactions of shame and guilt, to (biological) dysfunction in particular brain regions, and stress hormone and neurotransmitter dysfunction (e.g., dopamine, cortisol).

Complicating clinician efforts to describe PTSD is their belief that a metaphor of "PTSD as legitimate injury" is often employed by veterans, VAC, and by the CAF to substantiate medical release and allow access to rehabilitative, treatment, and financial compensation. As such, the phenomenon of PTSD as injury appears to take on a life of its own independent of clinical understanding of trauma as a specific set of psychological and emotional reactions to distressing experiences.

There are notable differences between these clinicians based on their academic training. Clinicians (Kate and Angela) trained within the DSM diagnostic classification system describe PTSD as a structural brain injury requiring in-depth and repeated evaluations.

> I have a big poster on my wall that shows the hippocampus, the frontal lobe, the amygdala ...

> I show them how all that works, so in the sense of when you're having a big feeling .... it gets the amygdala going, right? That's the part of your essential nervous system .... it makes this part of your brain, the pre-frontal cortex, almost stop. That part of your brain helps you make decisions and think about what you want to do, and all of that stuff (Kate).

The other clinicians (Jeff and Mary) do not practice strictly within the DSM framework and understand military PTSD to be similar to other forms of interpersonal trauma characterized by shame, unresolved grief and loss, and disconnection from other people.

> I'm a registered counseling therapist ... I'm also an expressive arts therapist and I also do EMDR (eye movement desensitization and reprocessing) ... I think there is a lot of pre-existing trauma when you are dealing with [military] PTSD, and that there's sometimes a trigger in the military that isn't necessarily very traumatic that .... acted kind of like the final straw (Mary).

> I guess my training was much more ecologically influenced based on a lot of feminist psychology theory, which really sets diagnosis aside, to try to move from the medical model (Jeff).

Even so, all clinicians seem to wrestle with the idea of military PTSD. Clinicians describe how their understanding of trauma changed over time.

> I would say that I came from this very general clinical background looking at trauma... and that's where, you know, it started being divided up, the trauma, and that's when I went, Oh, I can't just treat it like sexual abuse, or whatever (Angela).

These descriptions reflect an interweaving of conflicting notions: As adherence to a biomedical understanding; as social-relational outcomes of military experiences and medical release; and, as an unrecognized vulnerability caused by childhood trauma.

> I would say ninety-something per cent of the people that I see, the guys that I see have some prior trauma. So, yeah, the concern is that, at times, that the trauma in the military that they've experienced won't be taken seriously (Angela).

> So I took it upon myself to go down to the military, this office and just have a chat with the director, and she started to tell me about the levels of divorce ... how their marriages were destroyed because they were away .... military veterans would come home and they would literally walk into an empty house ....and they were left with nothing. So that stuff really kind of knocked my socks off initially (Jeff).

In summary, clinician statements reflect discordant and often contradictory views about the nature of military trauma, ranging from biomedical explanations to ones focusing on social and interpersonal reactions among veterans. Their varied theoretical stances seem to impact their views about the nature and purpose of treatment interventions.

CONCEPTUALIZATIONS OF TREATMENT EFFORTS

When it comes to treatment, CBT clinicians see assessments and interventions as connected processes. There is agreement that military clients are used to being told what to do and expect clinicians to take control.

> So as much as I sometimes try to just let them lead it, a lot of [them] want you to lead because, they want to know that they're going to be getting better ... These folks are used to taking orders (Jeff).

Some clinicians report an expectation from their clients for them to take an expert stance, however, each practitioner arrived at their own interpretation whether this is the most helpful approach:

> I think the relationship is critical to any ... therapeutic approach you might use. But I know, for me, I often get asked to take the lead, so as much as I want to collaborate, people are looking for [me to take the lead]. "How are you going to help me?" .... I've tried many times just to sit back, let it be them, non-directive, and they'll ask very clearly, "Like, what am I going to do?" (Kate).

> [As clinicians] we need humility too, I think. Not being the expert. Not dictating how they're going to get better and, you know, I'm going to do this. But learning from them and listening to them (Mary).

> These guys just fall through the cracks. Over and over again. Yeah, they want me to be, "Dr. Angela, Please help me," because they're desperate by then (Angela).

Despite their clinical orientations, there is a tendency for all clinicians to explain the effects of their work in neurobiological terms.

> So [a client] had a really good two or three days. And I think that comes from whatever endorphins or whatever chemical change is going on from whatever experience they had in the session. Or if they connect with you, maybe have some hope, and that changes something chemically (Kate).

Interestingly, CBT and non-CBT clinicians hold differing views on their therapeutic roles. The former appear to be concerned with safety and de-escalating client distress whereas non-CBT clinicians are concerned with re-establishing connectedness.

> And re-training the brain, constantly to de-escalate, de-escalate, in these situations, making and forming those new associations (Angela).

Kate and Angela, whose practices are heavily oriented toward assessment of VAC clients, explain that treatment requires continual re-assessment and bureaucratic challenges, and having clients repeatedly recount their trauma stories.

> That can create a huge amount of anxiety as you continuously do these assessments and re-assessments. And, Oh my God, what will happen if I [the veteran] don't score in that trauma range? If I no longer have this diagnosis, but I still have these symptoms and I still have some of this, but I don't meet full criteria (Angela).

Clinician comments reflect a treatment paradox. While they are contracted to provide treatment for military PTSD symptoms, their actual focus is on managing veteran reactions from interactions with VAC, fears over their financial status and loss of support if they become well, secretly treating childhood trauma, and managing the isolation and disconnection arising from the loss of military identity. Clinicians report acrimonious exchanges with the VAC bureaucracy, which discourage discussions about possible systemic effects of bureaucracy on veteran mental health. Instead, they are confronted with expectations of speedy recoveries for chronic problems:

> You know, Veterans' Affairs .... taught us cognitive processing [therapy], and in 12 sessions they're supposed to be in and out. But one session on guilt and [problem] fixed. It's like, efficient.... Yeah, so anybody that's done any work in this area knows, yeah, it just doesn't work (Angela).

> It's the third-party involvement, which brings in the business side of it, which tries to convince us, and perhaps the clients, that this is what should be happening. You should be fixed after 10 or 12 sessions (Jeff).

> I do cognitive-behavioral, acceptance and commitment therapy, schema focus therapy. So, the people that I see, it's years [long], usually. There's nothing short-term about it (Angela).

It is surprising that none of the clinicians speak about therapeutic changes resulting from their efforts with veterans. Instead, their comments reflect expectations from veterans to take charge and to have their backs, to demonstrate expert status within prescribed VAC supported interventions while attempting to adhere to their professional obligations. There are tensions between their experience of daily clinical practice and the things they believe necessary to truly help their veteran clients.

WHAT WORKS/WHAT SHOULD HAPPEN

These clinicians talk about their training and expectations of client recovery in a relatively short timeframe. This acute care treatment model is prioritized and funded by VAC yet paradoxically creates powerful incentives for veterans to remain in treatment as chronic sufferers. Otherwise, veterans risk losing access to case management support, financial incentives, and access to other programs and services. Clinicians commented on how this treatment-benefits model often impedes progress:

> I've been seeing him [veteran] probably over five years. And he's chronic PTSD .... He's on disability... I could see him doing some volunteer work, but I think he's afraid to do it because it might be seen as work and .... he's afraid to lose his disability because he has so much anxiety.... So, we don't know a lot about what the rules are (Mary).

> I think the system creates a situation where they [veterans] feel that they don't have the ability to work, and they have a pension so it's like .... I'm financially set, and I don't want to mess with that, so don't ask me to go volunteer because that might mess up my pension (Jeff).

> We have to keep doing assessment and another assessment with somebody else, and so you know,

> they end up with all of these assessments … A lot of diagnoses. A lot of assessments. Lots of [fear] they won't believe me. You know, that's what I'm seeing (Angela).

Clinicians get caught in what we term the politics of treatment:

> Challenges to prove, so to speak, that what the military calls the mental injury, the OSI, the operational stress injury, is a direct result of their service because there will be arguments all to counter that. That they were pre-existing (Kate).

> It's really, really tough to have groups approved, to have any kind of alternative treatments …. and as soon as you use a term like, 'yoga' (laughter) it's, like, Oh my God, it's, you know…. Crunchy granola… so I try to explain, these are well-documented treatments, they've been used for decades now, and there's evidence, it's not my opinion, and it's just like, No… I don't find Veterans Affairs very supportive when it comes to approving things that are a little outside of the box (Angela).

Clinicians commented on the importance of consistent and long-term relationships with veteran clients and what is needed moving forward:

> It's not so much the type of therapy that we're doing. It's that consistency, that support, that they know you're going to be the one, that you're going to be there, and that you're not going to drop off the screen like everyone else has (Angela).

> There needs to be more education about how to de-escalate people who are in crisis and police are called …. the Mental Health Crisis Mobile Unit … they're supposed to be trained, and they're not supposed to call the police necessarily, because police tend … to exacerbate people. "Put that down, we're gonna taser you." (Mary).

These clinicians describe a prescriptive treatment-benefits model that focuses on ongoing management of identified symptoms for continued access to benefits support. This model does not appear to promote rehabilitation or entertain alternative forms of interventions, thereby contributing to a lack of treatment progress. They also point to an absence of government and community supports to assist them in their efforts to manage veteran distress.

EFFECTS ON CLINICIANS

The demands of feeling responsible to manage veteran distress and continually dealing with the VAC bureaucracy exert tremendous stress on clinicians. As one participant put it: "I'm speaking as a clinician when I say it puts an incredible amount of pressure on us, and I don't know how we negotiate that expectation." (Jeff). They describe instances where they are made to feel as if they are failing by third party insurers because problems are not resolved in short timeframes. They also describe self-protective strategies as these pressures begin to affect them personally. These include strategies to protect against emotional depletion by creating psychological distance from their clients. Following are examples of the types of self-protection employed by our participants:

> I work now 3 days [a week], and that is because of the PTSD clients. Because of hearing the trauma over and repeatedly. I must take better care of myself, more R & R. More exercise… it really struck me just recently when I went to see that movie, Hacksaw Ridge …. I think because of all the trauma that I've heard, many times in the movie I had to fight with myself to stay in my seat… after I left that movie, I mean, I was pretty upset the whole way home … so I don't want to see that stuff anymore (Angela).

> I don't watch the news. Just can't watch it. But I also survive because I do a lot of short-term therapy as well, and I get to see a lot of positive things, and I thank God that I'm a positive person. But I spend a lot of time baking at home and I'm starting another project. So, I'm, like, keeping it light and just having some fun. Got to have fun (Mary).

> Well, I hit a wall last summer and fall, I remember, and it wasn't so much about the stories I was hearing and the trauma that I was experiencing with clients. It was more things that were going on in my personal life. So, the lesson that I had to take … I try to look at the victories, the positive things that come out of therapy (Jeff).

> Really hard with kiddos to feel like you're doing enough. But I always feel like, 'It's the best that I can do.' *And I try not to be emotional*, because one of my very first supervisors said, "If you take on their emotions then you're not helpful." *So, it's not that I don't feel it, but I am very good at, have taught myself to create that distance* (Kate, emphasis added).

In our study, the toll of clinical work is an experience shared by all clinicians. Each of them are making work and personal life adjustments to manage these pressures. Surprisingly, they view these steps as proactive, self-protective strategies and not as a sign of impaired mental health. There was a general agreement with the following statement made by Angela:

> Well, people ask me, like, my husband will say—if there's something in the news about somebody suiciding or whatever—he'll immediately say, How are you? Like, people know that it's going to affect me, now. So, How are you? (Angela).

In one instance, it was only after a physical assault from a client that the clinician recognized her personal level of distress:

> I actually had .... my first ever physical assault at work ... I had a concussion that I didn't get diagnosed for three days. But during those three days, I was crying. Like, I'd cry every day I would go and just feel sad and depressed and totally out-of-character. But that was when I realized that I was exhausted.... So since then, since October, November, I've decided I need to make some changes, to not work [as much] (Kate).

DISCUSSION

In this study, we wanted to hear clinicians' views about military trauma, its treatment, and possible overlaps with the accepted DSM-PTSD model and evidence-based interventions. As shown, clinicians struggle to frame their understanding of PTSD and treatment within a biomedical model. The resulting unintegrated framework consisting of neurochemical, interpersonal, developmental, and institutional explanations of veteran distress is reflective of challenges facing the trauma field outlined above. While the accepted view of CBT-based EBTs are that exposure to distressing memories allows veterans to consolidate, reframe, and integrate these memories into an overall life narrative (Foa et al., 1991,1999; Monson et al., 2004), these clinicians speak repeatedly about needing to de-escalate and manage upset among their clients. Essentially, the demand on veterans to recount military trauma stories in therapy and during re-assessments appears to serve to substantiate ongoing impairment required to remain eligible for VAC support.

Our analysis revealed what we term "the politics of treatment." Clinicians find themselves caught between the expectations of their training, the bureaucracy, and their patients. The field they navigate is not neutral, objective, or apolitical, but rather shaped by conflicting interests and authorities. These interests construct PTSD as an injury for compensation purposes yet resolveable through accepted treatments which do not always match up with clinicians' experiences.

Consistent with the research (Boulos & Zamorski, 2016; Whelan 2013, 2015), these clinicians find a high incidence of developmental trauma among veteran clients. As they note, these histories cannot be relayed during assessments or addressed formally within military trauma-focussed interventions. As such, therapy seems to focus on symptom management and less about moving veterans forward in their lives. These clinicians work in a complicated arena consisting of veterans who, having lost their careers, are dependent upon, and in some cases desperate for support. These veterans are also fearful of losing VAC coverage-benefits; a bureaucratic system focused on expert evidence of continued dysfunction to substantiate treatment coverage. Clinicians are under considerable pressure to utilize authorized time-limited interventions and then left to defend the lack of progress from these same interventions.

These clinicians believe that progress for veterans require many things: rehabilitative incentives from VAC, acceptance of alternative interventions, inclusion of family members in treatments, long-term consistent therapy relationships, and community and other agency supports for distressed veterans. The requirements for veteran progress extend beyond currently approved treatment models focussed on symptom reduction.

The final theme reflects an undercurrent of distress among clinicians. Conceptually, the literature on compassion satisfaction/fatigue offered some insights here. However, CF is premised on a portrayal of clinician distress as shortcomings in training, personal attributes, or a feature of workplace environments. Indeed, burnout and CF have been conceptualized to revolve around emotional exhaustion, either from overwork or as a signal of clinician pathology (Maslach & Leiter, 2008; Kadambi & Truscott, 2004). These explanations for clinician exhaustion do not account for possible negative effects of training in standard interventions requiring emotional detachment and containment of therapeutic empathy as voiced by these clinicians and as outlined by Cocker and Joss (2016). These risks for CF may be particularly relevant for EBTs requiring clinicians to repeatedly revisit distressing memories.

In their efforts to provide care, clinicians report bureaucratic hurdles similar to those experienced by their clients, including isolation and suspicion over their efforts, and cumbersome interactions with VAC that focus on expert evidence and proof of injury. Even so, a key finding was that not all clinicians report emotional detachment efforts or the

same degree of BO and STS. The two clinicians identified as CBT practitioners discuss more signs of emotional exhaustion compared with the two non-CBT clinicians, possibly reflective of the requirement to repeatedly re-assess their clients. The other clinicians speak more optimistically about their relationships with veteran clients.

Interestingly, with the few exceptions of being affected by veteran stories involving harm to children, these clinicians make no references to the effects of hearing traumatic stories. Their distress seems to arise from an inability to help desperate people despite their clinical training and systemic expectations that tell them differently. Clinician perceptions of powerlessness to resolve veteran PTSD may reflect the confusion over PTSD as a disease or as a curable problem (Monson et al., 2006) that is re-enforced by bureaucractic rigidity. Both clinicians and veterans seem to be stuck in and share the dilemma surrounding PTSD as a brain injury.

The study's focus group highlights both positive and negative impacts on psychological health and well-being among the clinicians that appeared to divide around educational level. The two DSM-adherent practitioners are doctoral trained clinicians, whereas the other two practitioners are Master's degreed DSM-aware clinicians. For DSM-adherent clinicians, safety and symptom identification/management are priorities but for DSM-aware clinicians connection and quality of the therapy relationship matters most. Age, years of experience, and clinician gender do not differentiate reactions which is inconsistent with the literature. Conversely, clinical training, theoretical understandings of therapy goals, and degree of alignment with the medicalized view of PTSD are related to satisfaction or fatigue reactions. Many of the reported negative impacts such as anxiety, preoccupation with safety, emotional avoidance, and helplessness are sequelae of trauma; the same symptoms as their military clients.

The cycle of repeated assessment and denial of veteran PTSD claims also seems to play out a politics of treatment between VAC and clinicians. The Canadian Psychological Association (CPA, 2017) states that assessments by clinical psychologists involve detailed interviewing, standardizied testing of patients, and discussions with family members to answer specific questions concerning the nature, severity, and causal factors for presenting problems. The psychologists in our study point to the use of these assessments for other purposes (i.e., establishing the validity of military-related PTSD injuries). Despite their roles as experts, these assessments are often contested by VAC. This is particularly the case for participants Kate and Angela who routinely conduct standardized psychological evaluations. Veterans are also necessarily involved in this political exchange over fears of losing financial compensation and access to programs and services. These veterans do not want to appear to be benefiting too much from treatment during these re-assessments, a situation which creates yet another level of strain for clinicians in providing assessment-treatment activities.

Various explanations are offered on the benefits of treatment for veterans. These include: effecting alterations in neurotransmitter activity, teaching new skills, reducing anxiety, showing love, and reconnecting veterans socially. All these efforts, however, are situated in an arena occupied by veterans, clinicians, and VAC where short-term recovery is expected. This leads to routine requests to VAC for additional coverage, resulting in messages to clinicians that they are doing something wrong, undermining their sense of competence and confidence in the system. Clinicians offer divergent opinions as to whether PTSD is a recoverable injury or whether symptom reduction/containment is the best that can be expected, echoing Monson et al. (2006).

In sum, the relationships between clinicians as experts, veterans, and VAC are highly complex and contradictory. These relationships are characterized by 'save me' demands from veterans on the one hand, while continually proving competence to VAC on the other, producing a virtual emotional pressure cooker for clinicians.

Findings from this study highlight physical, psychological, and emotional impacts on clinicians who treat veterans. Many of our findings are inconsistent with the literature on BO and STS. Our results show no evidence that newer trauma therapists or those using alternatives to EBTs for PTSD are at heightened risk for the negative reactions suggested by Craig and Sprang (2010). In fact, the two therapists who do not adhere to EBTs seem psychologically healthier than the two CBT psychologists.

This study raises questions about the training of mental health clinicians working with military trauma. Adherence to EBTs requiring clinicians to repeatedly revisit distressing events while detaching from their own emotional reactions may be a contributing element to the phenomena of compassion fatigue and its sequela among trauma clinicians.

LIMITATIONS AND IMPLICATIONS FOR FUTURE RESEARCH

These clinicians' comments may reflect a broader set of problems facing Canadian clinicians working with military personnel and veterans. A number of concerns were raised about the limitations of standard EBTs. Even so, it was not possible to explore treatment fidelity in terms of clinician adherence to specific treatment protocols (e.g., PE, CPT) or actual veteran outcomes. While differences were found between clinicians based on their academic training, in

keeping with the tenets of qualitative research, the results are not generalizable to all clinicians. We do not assume that all non-DSM clinicians experience less deleterious effects compared to their DSM-adherent colleagues.

Finally, while veterans appeared to consistently blame VAC interactions for their lack of progress, it was not possible to explore factors such as treatment history, veteran motivation for change, or the social circumstances affecting their well-being. Our study represents an important, yet preliminary, investigation of Canadian military trauma clinicians based on their views. Future studies could include a broad canvass of clinicians across the country to explore issues reported in this study.

COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

All authors participated at various stages of this research, including literature review, data collection and analysis, conceptual development, and the development of this paper.

AUTHOR AFFILIATIONS

John Whelan *orcid.org/0000-0001-8612-0860*
Mount St. Vincent University, CA

Maya Eichler *orcid.org/0000-0002-5951-8707*
Mount St. Vincent University, CA

Deborah Norris *orcid.org/0000-0002-7653-8224*
Mount St. Vincent University, CA

Denise Landry
Mount St. Vincent University, CA

REFERENCES

Adams, R. E., Boscarino, J. A., & **Figley, C. R.** (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry, 76*(1), 103–108. DOI: *https://doi.org/10.1037/0002-9432.76.1.103*

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, Fifth edition,* Author. DOI: *https://doi.org/10.1176/appi.books.9780890425596*

Arnold, D., Calhoun, L. G., Tedeschi, R., & **Cann, A.** (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*, 239–263. DOI: *https://doi.org/10.1177/0022167805274729*

Badura-Brack, A. S., Heinrichs-Graham, E., McDermott, T. J., Becker, K. M., Ryan, T. J., Khanna, M. M., & **Wilson, T. W.** (2017). Resting-State Neurophysiological Abnormalities in Posttraumatic Stress Disorder: A Magnetoencephalography Study. *Frontiers in Human NeuroScience*, *11*, 1–8. DOI: *https://doi.org/10.3389/fnhum.2017.00205*

Baird, S., & **Jenkins, S. R.** (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, *18*(1), 71–86. *https://doi-org.ezproxy.msvu.ca/10.1891/vivi.2003.18.1.71*. DOI: *https://doi.org/10.1891/vivi.2003.18.1.71*

Basit, T. (2003). Manual or electronic? The role of coding in qualitative data analysis. *Educational Research*, *45*(2), 143–154. DOI: *https://doi.org/10.1080/0013188032000133548*

Birck, A. (2001). Secondary traumatization and burnout in professionals working with torture survivors. *Traumatology*, *7*, 85–90. *https://doi-org.ezproxy.msvu.ca/10.1177/153476560100700203*. DOI: *https://doi.org/10.1177/153476560100700203*

Boone, O., Brandes, D., Gilboa, A., Gomori, J. M., Shenton, M. E., Pittman, R. K., & **Shaylev, A. Y.** (2001). Longitudinal MRI study of hippocampal volume in trauma survivors with PTSD. *American Journal of Psychiatry*, *158*, 12481–251. DOI: *https://doi.org/10.1176/appi.ajp.158.8.1248*

Boss, P. (2002). *Family stress management: A contextual approach* (2nd ed.). SAGE. DOI: *https://doi.org/10.4135/9781452233895*

Boulos, D., & **Zamorski, M. A.** (2016). Contribution of the mission in Afghanistan to the burden of past-year mental disorders in Canadian Armed Forces personnel. *Canadian Journal of Psychiatry*, *61*(1), 64–76. DOI: *https://doi.org/10.1177/0706743716628857*

Brady, J. L., Guy, J. D., Poelstra, P. L., & **Brokaw, B. F.** (1999). Vicarious traumatisation, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, *30*(4), 3863–93. DOI: *https://doi.org/10.1037/0735-7028.30.4.386*

Bremner, J. D. (2007). Neuroimaging in posttraumatic stress disorder and other stress-related disorders. *Neuroimaging Clinics of North America*, *17*(4), 523–538. DOI: *https://doi.org/10.1016/j.nic.2007.07.003*

Brewin, C. R., Andrews, B., & **Valentine, J. D.** (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*, *68*(5), 748–766. *https://doi-org.ezproxy.msvu.ca/10.1037/0022-006X.68.5.748*. DOI: *https://doi.org/10.1037/0022-006X.68.5.748*

Brewin, C. R., Dalgleish, T., & **Joseph, S.** (1996). A dual representation theory of posttraumatic stress disorder. *Psychological Review*, *103*(4), 670–686. *https://doi-org.ezproxy.*

msvu.ca/10.1037/0033-295X.103.4.670. DOI: *https://doi.org/10.1037/0033-295X.103.4.670*

Bride, B. E., Robinson, M. M., Yegidis, B., & **Figley, C. R.** (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice*, *14*(1), 27–35. DOI: *https://doi.org/10.1177/1049731503254106*

Bryman, A. (2013). *Social research methods* (4th ed.). Oxford University.

Cabrera, O. A., Hoge, C. W., Bliese, P. D., Castro, C. A., & **Messer, S. C.** (2007). Childhood adversity and combat as predictors of depression and post-traumatic stress in deployed troops. *American Journal of Preventative Medicine*, *33*, 77–82. DOI: *https://doi.org/10.1016/j.amepre.2007.03.019*

Canadian Psychological Association. (2017). *https://cpa.ca/docs/File/Sections/Clinical%20section/What%20is%20Clinical%20Psychology.pdf*

Charmaz, K. (2014). *Constructing grounded theory (2nd ed.)*. SAGE.

Chrestman, K. R. (1999). Secondary exposure to trauma and self-reported distress among therapists. In B.H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, & educators* (2nd ed., pp. 29–36). Sidran Press.

Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., & **Benight, C. C.** (2014). A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services*, *11*(1), 75–86. *https://doi-org.ezproxy.msvu.ca/10.1037/a0033798*. DOI: *https://doi.org/10.1037/a0033798*

Cocker, F., & **Joss, N.** (2016). Compassion Fatigue among Healthcare, Emergency and Community Service Workers: A systematic review. *International Journal of Environmental Research and Public Health*, *13*, 618. DOI: *https://doi.org/10.3390/ijerph13060618*

Collins, S., & **Long, A.** (2003). Too tired to care? The psychological effects of working with trauma. *Journal of Psychiatric and Mental Health Nursing*, *10*, 17–27. *https://doi-org.ezproxy.msvu.ca/10.1046/j.1365-2850.2003.00526.x*. DOI: *https://doi.org/10.1046/j.1365-2850.2003.00526.x*

Conrad, D., & **Kellar-Guenther, Y.** (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect*, *30*, 1071–1080. *https://doi-org.ezproxy.msvu.ca/10.1016/j.chiabu.2006.03.009*. DOI: *https://doi.org/10.1016/j.chiabu.2006.03.009*

Craig, C. D., & **Sprang, G.** (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping*, *23*(3), 319–339. *https://doi-org.ezproxy.msvu.ca/10.1080/10615800903085818*. DOI: *https://doi.org/10.1080/10615800903085818*

Davidson, R. J., & **Begley, S.** (2012). *The emotional life of your brain: How its unique patterns affect the way you think, feel, and live and how you can change*. Penguin.

Devilly, G. J., Wright, R., & **Varker, T.** (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry*, *43*(4), 373–385. DOI: *https://doi.org/10.1080/00048670902721079*

DiGangi, J., Guffanti, G., McLaughlin, K. A., & **Koenen, K. C.** (2013). Considering trauma exposure in the context of genetics studies of posttraumatic stress disorder: A systematic review. *Biology of Mood & Anxiety Disorders*, 20133:2. DOI: *https://doi.org/10.1186/2045-5380-3-2*

Duckworth, M. P., & **Follette, V. M.** (2012). *Retraumatization: Assessment, treatment, and prevention*. Routledge. DOI: *https://doi.org/10.4324/9780203866320*

Eagle, G. T., & **Kaminer, D.** (2015). Traumatic stress: Established knowledge, current debates and new horizons. *South African Journal of Psychology*, *45*(1), 22–35. *https://doi-org.ezproxy.msvu.ca/10.1177/0081246314547124*. DOI: *https://doi.org/10.1177/0081246314547124*

Elinga, B. M., & **Bremner, J. D.** (2002). Are the neural substrates of memory the final common pathway in posttraumatic stress disorder (PTSD)? *Journal of Affective Disorders*, *70*(1), 1–17. DOI: *https://doi.org/10.1016/S0165-0327(01)00351-2*

Elwood, L. S., Mott, J., Lohr, J. M., & **Galovski, T. E.** (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review*, *31*, 25–36. *https://doi-org.ezproxy.msvu.ca/10.1016/j.cpr.2010.09.004*. DOI: *https://doi.org/10.1016/j.cpr.2010.09.004*

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & **Marks, J. S.** (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *14*(4), 245–258. DOI: *https://doi.org/10.1016/S0749-3797(98)00017-8*

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Brunner-Routledge.

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531–545. *http://dx.doi.org.ezproxy.msvu.ca/10.1177/104973202129120052*. DOI: *https://doi.org/10.1177/104973202129120052*

Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & **Street, G. P.** (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology*, *67*(2), 194–200. DOI: *https://doi.org/10.1037//0022-006X.67.2.194*

Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A., Riggs, D. S., Feeny, N. C., & **Yadin, E.** (2005). Randomized trial of prolonged exposure for posttraumatic stress disorder with and without

cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology*, *73*(5), 953–964. DOI: https://doi.org/10.1037/0022-006X.73.5.953

Foa, E. B., Keane, T. M., Friedman, M. J., & **Cohen, J. A.** (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. Guilford Press.

Foa, E. B., Rothbaum, B. O., Riggs, D. S., & **Murdock, T. B.** (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology*, *59*(5), 715–723. DOI: https://doi.org/10.1037//0022-006X.59.5.715

Follette, V. M., Polusny, M. M., & **Milbeck, K.** (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice*, *25*(3), 275–282. DOI: https://doi.org/10.1037/0735-7028.25.3.275

Fonagy, P. (1999). Achieving evidence-based psychotherapy practice: A psychodynamic perspective on the general acceptance of treatment manuals. *Clinical Psychology: Science and Practice*, *6*(4), 442–444. DOI: https://doi.org/10.1093/clipsy.6.4.442

Fox, J., & **Pease, B.** (2012). Military deployment, masculinity and trauma: Reviewing the connections, *Journal of Men's Studies*, *20*(1), 16–31. DOI: https://doi.org/10.3149/jms.2001.16

Garcia, H. A., McGeary, C. A., McGeary, D. D., Finley, E. P., & **Peterson, A. L.** (2014). Burnout in veterans health administration mental health providers in posttraumatic stress clinics, *Psychological Services*, *11*(1), 50–59. DOI: https://doi.org/10.1037/a0035643

Georgopoulos, A. P., Tan, H.-R. M., Lewis, S. M., Leuthold, A. C., Winskowski, A. M., Lynch J. K., & **Engdahl, B.** (2010). The synchronous neural interactions test as a functional neuromarker for post-traumatic stress disorder (PTSD): A robust classification method based on the bootstrap. *Journal of Neural Engineering*, *7*, 1–7. DOI: https://doi.org/10.1088/1741-2560/7/1/016011

Glaser, B., & **Strauss, A.** (1967). The constant comparative method of qualitative analysis. In B. Glaser & A. Strauss (Eds.), *The discovery of grounded theory: Strategies for qualitative research* (pp. 101–158). Aldine Publishing Company. DOI: https://doi.org/10.4324/9780203793206-6

Graca, J. J., Palmer, G. A., & **Occhietti, K. E.** (2014). Psychotherapeutic interventions for symptom reduction in veterans with PTSD: An observational study in a residential clinical setting. *Journal of Loss and Trauma*, *19*(6), 558–567. https://doi-org.ezproxy.msvu.ca/10.1080/15325024.2013.810441. DOI: https://doi.org/10.1080/15325024.2013.810441

Guba, E. G. (1990). *The paradigm dialog*. SAGE.

Haagen, J. F., Smid, G. E., Knipscheer, J. W., & **Kleber, R. J.** (2015). The efficacy of recommended treatments for veterans with PTSD: A metaregression analysis. *Clinical Psychology Review*, *40*, 184–194. DOI: https://doi.org/10.1016/j.cpr.2015.06.008

Jakupcak, M., Osborne, T. L., Michael, S., Cook, M., & **McFall, M.** (2006). Implications of masculine gender role stress in male veterans with posttraumatic stress disorder. *Psychology of Men & Masculinity*, *7*(4), 203–211. DOI: https://doi.org/10.1037/1524-9220.7.4.203

Jeffreys, M. (2017). *National Center for PTSD: Clinician's guide to medications for PTSD*. https://www.ptsd.va.gov/professional/treatment/overview/clinicians-guide-to-medications-for-ptsd.asp.

Kadambi, M. A., & **Truscott, D.** (2004). Vicarious trauma among therapists working with sexual violence, cancer, and general practice. *Canadian Journal of Counselling*, *38*, 260–276. http://ezproxy.msvu.ca/login?url=https://www-proquest-com.ezproxy.msvu.ca/scholarly-journals/vicarious-trauma-among-therapists-working-with/docview/195800208/se-2?accountid=12617

Kassam-Adams, N. (1999). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B.H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, & educators* (2nd ed., pp. 37–48). Sidran Press.

Köhler, K., Eggert, P., Lorenz, S., Herr, K., Willmund, G., Zimmermann, P., & **Alliger-Horn, C.** (2017). Effectiveness of eye movement desensitization and reprocessing in German armed forces soldiers with post-traumatic stress disorder under routine inpatient care conditions. *Military Medicine*, *182*(5), e1672–e1680. https://doi-org.ezproxy.msvu.ca/10.7205/MILMED-D-16-00307. DOI: https://doi.org/10.7205/MILMED-D-16-00307

Larsen, D., & **Stamm, B. H.** (2008). Professional quality of life and trauma therapists. In S. Joseph & P. A. Linley (Eds.), *Trauma, recovery and growth: Positive psychological perspectives on posttraumatic stress* (pp. 275–293). John Wiley & Sons. DOI: https://doi.org/10.1002/9781118269718.ch14

Laska, K. M., Smith, T. L., Wislocki, A. P., & **Minami, T.** (2013). Uniformity of evidence-based treatments in practice? Therapist effects in the delivery of cognitive processing therapy for PTSD. *Journal of Counseling Psychology*, *60*(1), 31–41. DOI: https://doi.org/10.1037/a0031294

LeDoux, J. (2015). *Anxious: Using the brain to understand and treat fear and anxiety*. Viking.

Lee, R. T., & **Ashforth, B. E.** (1996). A meta-analytic examination of the correlates of the three dimensions of job burnout. *Journal of Applied Psychology*, *81*(2), 123–133. DOI: https://doi.org/10.1037/0021-9010.81.2.123

Lieberman, M. D. (2013). *Social: Why our brains are wired to connect*. Crown Publishers.

Lynch, S. H., & **Lobo, M. L.** (2012). Compassion fatigue in family caregivers: A wilsonian concept analysis. *Journal of Advances in Nursing*, *68*, 2125–2134. DOI: https://doi.org/10.1111/j.1365-2648.2012.05985.x

Maguen, S., & **Litz, B.** (2012). *Moral injury in the context of war*. Department of Veterans Affairs. *www.ptsd.va.gov/professional/pages/moral injury at war.asp*.

Maslach, C., & **Leiter, M. P.** (2008). Early predictors of job burnout and engagement. *Journal of Applied Psychology*, *93*, 498–512. DOI: *https://doi.org/10.1037/0021-9010.93.3.498*

Maslach, C., Schaufeli, W. B., & **Leiter, M. P.** (2001). Job burnout. *Annual Review of Psychology*, *52*, 397–422. DOI: *https://doi.org/10.1146/annurev.psych.52.1.397*

McLay, R. N., Webb-Murphy, J. A., Fesperman, S. F., Delaney, E. M., Gerard, S. K., Roesch, S. C., Nebeker, B. J., Pandzic, I., Vishnyak, E. A., & **Johnston, S. L.** (2016). Outcomes from eye movement desensitization and reprocessing in active-duty service members with posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*, *8*(6), 702–708. DOI: *https://doi.org/10.1037/tra0000120*

Meldrum, L., King, R., & **Spooner, D.** (2002). Secondary traumatic stress in case managers working in community mental health teams. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 85–106). Routledge.

Meyers, T. W., & **Cornille, T. A.** (2002). The trauma of working with traumatised children. In C.R. Figley (Ed.), *Treating compassion fatigue* (pp. 39–55). Routledge.

Mišić, B., Dunkley, B. T., Sedge, P. A., Da Costa, L., Fatima, Z., Berman, M. G., Doesburg, S. M., McIntosh, A. R., Grodecki, R., Jetly, R., Pang, E. W., & **Taylor, M. J.** (2016). Post-traumatic stress constrains the dynamic repertoire of neural activity. *Journal of Neuroscience*, *36*(2), 419–431. DOI: *https://doi.org/10.1523/JNEUROSCI.1506-15.2016*

Mobbs, B. C., & **Bonanno, G. A.** (2018). Beyond war and PTSD: The crucial role of transition stress in the lives of military veterans. *Clinical Psychology Review*, *59*, 137–144. DOI: *https://doi.org/10.1016/j.cpr.2017.11.007*

Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & **Stevens, S. P.** (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *74*(5), 898–907. *https://doi-org.ezproxy.msvu.ca/10.1037/0022-006X.74.5.898*. DOI: *https://doi.org/10.1037/0022-006X.74.5.898*

Monson, C. M., Schnurr, P. P., Stevens, S. P., & **Guthrie, K. A.** (2004). Cognitive-behavioral couple's treatment for posttraumatic stress disorder: Initial findings. *Journal of Traumatic Stress*, *17*, 341–344. DOI: *https://doi.org/10.1023/B:JOTS.0000038483.69570.5b*

Morse, J. M. (2015). Analytic strategies and sample size. *Qualitative Health Research*. DOI: *https://doi.org/10.1177/1049732315602867*

Najjar, N., Davis, L. W., Beck-Coon, K., & **Doebbeling, C. C.** (2009). Compassion fatigue a review of the research to date and relevance to cancer-care providers. *Journal of Health Psychology*, *14*, 267–277. DOI: *https://doi.org/10.1177/1359105308100211*

National Defence and the Canadian Armed Forces. (2016). *Post-traumatic stress disorder: Backgrounder/ January, 13, 2016/ project number BG 16.00X*. *http://www.forces.gc.ca/en/news/article.page?doc=post-traumatic-stress-disorder/hjlbrhp4*.

Nilamadhab, K. (2011). Cognitive behavioral therapy for the treatment of posttraumatic stress disorder: A review. *Neuropsychiatric Disease and Treatment*, *7*, 67–81.

Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, self-regulation*. Norton.

Resick, P. A., Wachen, J. S., Mintz, J., Young-McCaughan, S., Roache, J. D., Borah, A. M., Borah, E. V., Dondanville, K. A., Hembree, E. A., Litz, B. T., & **Peterson, A. L.** (2015). A randomized clinical trial of group cognitive processing therapy compared with group present-centered therapy for PTSD among active duty military personnel. *Journal of Consulting and Clinical Psychology*, *83*(6), 1058–1068. DOI: *https://doi.org/10.1037/ccp0000016*

Sabin-Farrell, R., & **Turpin, G.** (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review*, *23*, 449–480. *https://doi-org.ezproxy.msvu.ca/10.1016/S0272-7358(03)00030-8*. DOI: *https://doi.org/10.1016/S0272-7358(03)00030-8*

Schauben, L. J., & **Frazier, P. A.** (1995). Vicarious trauma: The effects on female counsellors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19*, 49–64. DOI: *https://doi.org/10.1111/j.1471-6402.1995.tb00278.x*

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures (1st ed)*. Guilford Press.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed). Guilford Press.

Shoji, K., Lesnierowska, M., Smoktunowicz, E., Bock, J., Luszczynska, A., Benight, C. C., & **Cieslak, R.** (2015). What comes first, job burnout or secondary traumatic stress? Findings from two longitudinal studies from the US and Poland. *PLoS ONE*, *10*(8), Article e0136730. DOI: *https://doi.org/10.1371/journal.pone.0136730*

Sodeke-Gregson, E. A., Holttum, S., & **Billings, J.** (2013). Compassion satisfaction, burnout, and secondary traumatic stress in UK therapists who work with adult trauma clients. *European Journal of Psychotraumatology*, 4, 21869. DOI: *https://doi.org/10.3402/ejpt.v4i0.21869*

Starks, H., & **Trinidad, S. B.** (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*(10), 1372–1380. DOI: *https://doi.org/10.1177/1049732307307031*

Steed, L. G., & **Downing, R.** (1998). A phenomenological study of vicarious traumatisation amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *The Australian Journal of Disaster and Trauma Studies*. *http://www.massey.ac.nz/trauma/issues/1998-2/steed.htm*

Steel, C., Macdonald, J., Schroder, T., & **Mellor-Clark, J.** (2015). Exhausted but not cynical: burnout in therapists working within improving access to psychological therapy services. *Journal of Mental Health*, *24*(1), 33–37. DOI: *https://doi.org/10.3109/09638237.2014.971145*

Steenkamp, M. M., Litz, B. T., Hoge, C. W., & **Marmar, C. R.** (2015). Psychotherapy for Military-Related PTSD: A review of randomized clinical trials. *Journal of the American Medical Association*, *314*(5), 489–500. DOI: *https://doi.org/10.1001/jama.2015.8370*

Thompson, R., Simiola, V., Schnurr, P. P., Stirman, S. W., & **Cook, J. M.** (2018). VA residential treatment providers' use of two evidence-based psychotherapies for PTSD: Global endorsement versus specific components. *Psychological Trauma: Theory, Research, Practice, and Policy*, *10*(2), 131–139. *https://doi-org.ezproxy.msvu.ca/10.1037/tra0000220*. DOI: *https://doi.org/10.1037/tra0000220*

Tran, K., Moulton, K., Santesso, N., & **Rabb, D.** (2016). *Cognitive processing therapy for post-traumatic stress disorder: A systematic review and meta-analysis. CADTH Health Technology Assessment, No. 141*. Canadian Agency for Drugs and Technologies in Health.

Van Voorhees, E. E., Dedert, E. A., Calhoun, P. S., Brancu, M., Runnals, J., & **Beckham, J. C.** (2012). Childhood trauma exposure in Iraq and Afghanistan war era veterans: Implications for posttraumatic stress disorder symptoms and adult functional social support. *Child Abuse & Neglect*, *36*(5), 423–432. DOI: *https://doi.org/10.1016/j.chiabu.2012.03.004*

Whelan, J. J. (2013). Exploring the relationships between untreated adverse childhood events and substance abuse, and their impact on PTSD relapse rates among Canadian military veterans. In A. B. Aiken & A. H. Belanger (Eds.), *Beyond the line: Military and veteran health research* (pp. 180–195). McGill-Queen's University Press.

Whelan, J. J. (2015). Effects of developmental abuse and symptom suppression among traumatized veterans. *Psychology*, *6*, 540–548. DOI: *https://doi.org/10.4236/psych.2015.65052*

Willig, C. (2001). *Introducing qualitative research in psychology*. Open University Press.

Wilson, D., & **Barglow, P.** (2009). PTSD has unreliable diagnostic criteria. *Psychiatric Times*, *26*(7). *https://www.psychiatrictimes.com/view/ptsd-has-unreliable-diagnostic-criteria*

TO CITE THIS ARTICLE:
Whelan, J., Eichler, M., Norris, D., & Landry, D. (2021). The Politics of Treatment: A Qualitative Study of Canadian Military PTSD Clinicians. *Journal of Veterans Studies*, 7(1), pp. 217–231. DOI: *https://doi.org/10.21061/jvs.v7i1.227*

Submitted: 15 December 2020 **Accepted:** 05 February 2021 **Published:** 17 June 2021