# Post-Traumatic Growth for Military Personnel

## A Facilitator's Guide

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## Introduction

Post-Traumatic stress disorder (PTSD) has been an area of major concern for the military. With the wars in Afghanistan and Iraq, the problem concerning PTSD and Post Traumatic Stress continues. With this in mind, what can chaplains and military personnel do to help resolve these problems? These training materials (3 presentations) focus not so much on eliminating PTSD among service members, but in helping service members find meaning and psychological growth by wrestling with the damaging effects of trauma. If PTSD diminishes or is eliminated in the process, this would be optimal. Nevertheless, these presentations suggest that growth can take place even if one struggles with the effect of traumatic material. This is not to say that the negative effects of trauma will vanish, but that survivors can grow and gain strength from their experiences. In a sense, survivors become something different from what they once were, never to completely return again to what they were, but to experience and be something new through post-traumatic growth (PTG).

## Purpose

The purpose of this instructor's guide is to provide training materials (three presentations) for those who have been affected by traumatic material largely through combat and other stress- related events. The three presentations provided are: (1) Trauma and the Biology of Trauma, (2) Post Traumatic Stress Disorder and Post Traumatic Growth, and (3) and the Thrive Model (Taking Stock, Harvesting Hope, Re-authoring, Identifying Change, Valuing Change, and Expressing Change in Action). Helping service members grow from their traumatic experiences is the purpose for these training presentations.

## How to Use Materials

The presentations, taught by chaplains, cover a three hour block of instruction; three 50 minute sections will be presented to service members with three 10 minute breaks. Each section will cover the following: section one–trauma and biology of trauma; section two–PTSD and PTG; and section three–the THRIVE model).

Slides containing information, pictures, and videos are provided for each presentation. Information for each slide will be provided to facilitate the chaplain's knowledge base concerning the presented topic.

The first section highlights trauma and the biology of trauma. After taking part in this portion of instruction, service members should gain a strong sense that trauma is a natural, but painful part of life and reactions to trauma are necessary for survival. In a battle for territory, psychologist and psychiatrist continue to argue about whether PTSD is a physical or psychological issue. Of course the answer to this argument is that it is both. Defining trauma and taking service members through the biological journey of trauma within the body, service members should gain a greater understanding of what happened (or will happen) to them as they experienced trauma.

The second presentation covers PTSD and PTG. Post traumatic stress disorder can take a heavy toll on service member's lives, causing trouble with their family, work, and other aspects of life. Service members often feel alone or like no one understands them as they struggle with PTSD. Following this portion of the presentation, service members should recognize

that they are not alone if they are experiencing PTSD. As service member struggle with PTSD and try to make sense of what happened, they are more likely to experience PTG. In essence service members are not alone as go through the difficulties of PTSD, but they are also not alone as they begin their journey towards PTG.

The final presentation will emphasize the THRIVE model. This section of the presentation accentuates to service members that growth takes time and is different for every individual who experiences trauma. By taking stock, harvesting hope, re-authoring, identifying change, valuing change, and expressing change in action, service members will learn to achieve PTG by their own time table.

Power Point Slides and a handout containing examples of the THRIVE model will be provided for instructional purposes. Audio visual requirements for instruction will be projector, screen, and sound system.

**Resources and Informational Materials for Learning**

The instructor's guide also provides the following research and information that will be provided with each lesson plan.

Also slides are provided to enable the instructor to teach the materials without need for other resources.

*These materials were developed by Jeremy Brown, a chaplain candidate in the United States Army. If you would like to contact me for more information or have ideas for different lesson plans, feel free to email me at jeremy.brown6767@gmail.com.*

## Research and Information Used in Lesson Plans

### Trauma

In regards to definition, trauma has changed much over time. The word *trauma*, which comes from the Greek word "wound," was adopted into English and referred to the piercing or wounding of the physical body. As psychology adopted the word *trauma*, its definition came to imply a more emotional and spiritual meaning. Trauma now also includes the aspect of emotional wounding.[1]

Emphasis on trauma research has increased significantly in the last few decades. Recent events such as (but not limited to) the September 11th terrorist attacks, wars in Afghanistan and Iraq, Hurricane Katrina, the 2010 Haiti earthquake, 2011 Japanese tsunami, and a plethora of additional traumatic occurrences has drawn international attention to the impact of trauma on individuals' lives. Whether or not trauma is experienced physically, emotionally, psychologically, or all three, trauma most often brings damaging side effects.[2] Those who seem to suffer the most following a traumatic event are those who feel helpless during the incident, prepare themselves for the worst, think they are going to die, or feel paralyzed by fear.[3]

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1. Stephen Josephe, *What Doesn't Kill Us*: The New Psychology of Posttraumatic Growth (New York, New York: Basic Books, 2011), 22.

2. Jeffrey C. Schneider et al., "The Long-Term Impact of Physical and Emotional Trauma: The Station Nightclub Fire," *Academic Journal* 7, no. 10 (October 2012): 1–2.

3. Stephen Joseph et al., "Correlates of Post-Traumatic Stress at 30 Months: *The Herald of Free Enterprise Disaster" Behavior Research and Therapy* 32 (1994): 523.

Previously, the Diagnostic and Statistical Manual (DSM) IV of mental disorders described a traumatic event as an event "generally outside the range of usual human experience" and one that "would evoke significant symptoms of distress in most people."[4] The DSM IV highly emphasized feeling intense fear, helplessness, or horror as a requirement for identifying trauma responses and thus categorized disorders such as PTSD and acute stress disorder under *Anxiety Disorders*. Necessitating such reactions in order for proper trauma identification was not only invalidating to police officer, first responders, and military combat veterans it was also unnecessary.[5] Many who have been diagnosed with PTSD following trauma do not necessarily experience intense fear, helplessness, or horror.

The most recent version, DSM-V, no longer requires survivors to experience emotions such as fear, helplessness, or horror in correlation with trauma in order for mental health counselors to label an experience as traumatic or diagnose PTSD and draws a clearer line when describing what constitutes a traumatic event. Researchers discovered that "many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety or fear based symptoms, the most prominent clinical characteristics are anhedonic (Inability to experience pleasure from activities usually found enjoyable) and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms." Due to the distinct nature of trauma related experiences and reactions, the DSM-V now categorizes disorders of this nature separately under *Trauma and Stressor Related Disorders*. In order for an experience to be traumatic,

4. American Psychiatric Association, *Desk Reference to the: Diagnostic Criteria from DSM-IV-TR*, 4th ed. (Arlington: American Psychiatric Publishing, Inc., 2000), 218.

5. *DSM-IV-TR*, 218–219.

the survivor must have been exposed to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: directly experiencing the trauma, personally witnessing the event as it happened to others, learning that the trauma happened to a close family member or close friend, or experiencing repeated or severe exposure to aversive details of trauma.[6]

Traumatic experiences occur in a wide variety of ways. Examples include, but are not limited to: community violence (shooting, mugging, burglary, physical or sexual assault), sexual and physical abuse, natural disasters (hurricane, flood, fire, or earthquake), witnessing or being in a serious car accident, sudden unexpected or violent death of someone close (suicide, accident, murder), serious injury (burns, animal attack, work related), major surgery, life-threatening illness, domestic or family violence, dating violence, and war or political violence.[7] Due to the vastness of ways in which trauma can be experienced; this project will place greater emphasis on war related trauma, i.e., fundamentally explain what trauma is to include the biological process of trauma and how it relates to PTSD in war.

## Biology of Trauma

Trauma responses may seem to be mostly mental or emotional reactions to highly stressful and harmful events, but trauma is also very physical in nature. When soldiers engage in

6. *DSM-V*, 271.

7. Kelty Mental Health Resource Center, "What Are Some Examples of Traumatic Events that Can Lead to PTSD?," Kelty Mental Health, accessed January 19, 2014, http://keltymentalhealth.ca/faq/what-are-somme-examples- traumatic-events-can-lead-ptsd.

combat, become seriously injured, see someone else killed or injured, etc., they experience a variety of emotions revolving around the events. They also go through an assortment of physiological responses during and after the trauma.[8] What is the biological process of trauma, why is it so important, and how does this relate to PTSD?

For millennia, prehistoric humans predominantly survived by way of hunting and gathering. While hunting, humans frequently encountered life threatening events with dangerous animals and precarious situations. Over the centuries, humans in general have adapted in order survive dangerous encounters. A major reason for this survival is due to the fact that humans have a remarkable memory and high tolerance for emotion mixed with the recollection of a traumatic event. This causes the human to never forget what happened. The next time a human encounters a similar dangerous situation, they know there is reason to fear so they avoid the thing that will most likely harm or kill them.[9] It is important to note that the biological reaction to trauma is perfectly normal and a necessary reaction for survival. Problems arise when people who experience trauma cannot bring themselves down from a hyper state of arousal or when their lives revolve around response to the emotions that were created from the trauma. This largely determines who develops PTSD as compared to those who just experience post-traumatic stress. This involves experiencing PTS-like symptoms following trauma, but perhaps not as long or as intense as PTSD.[10]

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8. *What Doesn't Kill Us,* 49–51.

9. Robert Lemelson, and Mark Barad, *Understanding Trauma: Integrating Biological, Clinical, and Cultural Perspectives* (Cambridge: Cambridge University Press, 2008), 320–321.

10. *What Doesn't Kill Us,* 35–37.

Stress is a normal reaction to trauma. When experiencing a threatening situation, the human body goes into a fight-or-flight response. Initially the body and mind experience the alarm stage in which a person freezes in preparation for flight-or-fight. Next, the body moves into the resistance stage where biological, psychological, and social resources are activated in order to cope with the event. If the resistance stage fails, the individual goes into the exhaustion stage where he/she finally gives up and dies or continues to not move. This process takes place involuntarily and is central to the purpose of the autonomic nervous system (ANS).[11]

The ANS controls automatic biological responses and is comprised of two sections, the sympathetic nervous system (SNS) and parasympathetic nervous system (PNS). In laymen's terms, the SNS arouses the body through methods such as increasing heart rate, rate of breathing, and blood flow in order to assist the muscles for quick movement in reaction to stressors and trauma. The PNS serves to decrease biological arousal when the individual is either no longer under threat or in a situation where he/she cannot avoid the stressor. The human body is not designed to stay in hyper-alert mode for prolonged periods of time so the PNS helps the body calm down. The ANS is a natural and necessary part of organism survival and is a key element to the limbic system in the brain.[12]

The limbic system is the oldest part of the brain and operates the ANS. The limbic system is centrally located and directly in charge of how the brain manages trauma, fear-conditioning aimed at training the mind for proper responses

11. Hans Selye, *The Stress of Life* (New York: McGraw-Hill, 1976), 1-10.

12. *What Doesn't Kill Us,* 50.

in dangerous situations, and memory storage. Although the limbic system is composed of several components, the amygdala and hippocampus are the primary components that make up the limbic system. While the hippocampus manages the storing of memories for time and space, orders memory, and makes connections between memories, the amygdala plays a much larger role concerning trauma. The amygdala is responsible for processing incoming emotional information, particularly fear, anxiety, and emotional memory. When something traumatizing or extremely stress-inducing is experienced, the amygdala takes over brain operation and memory storage is stymied. The frontal cortex, which manages the storing of long-term and everyday occurrence-type memories, is disabled while the traumatic event is taking place. This in turn causes the experience to remain in "active memory."[13]

Memories remain in active memory until they are processed away into the hippocampus and frontal cortex. This explains why after a traumatic event, survivors continue to have intrusive thoughts and nightmares about the event as if the memory was still in the present. If the memory of the experience is not filed away through proper methods of coping, it will remain in active memory and continue to cause psychological and physical harm. This is when people who experience moderate to severe trauma worsen from PTS to PTSD. The way a human reacts following trauma in most cases will determine how PTS develops.

For example, an old German legend will help illustrate how perception of an event affects traumatic responses. Once upon a time on a cold winter night, a man arrived at an inn. He

13. *What Doesn't Kill Us,* 50.

was happy to reach shelter after a difficult and cold ride with his horse over a plain covered in snow. The keeper of the inn was surprised to see the man and asked him what direction he came from. The man pointed the direction he came from and the keeper of the inn looked at him in amazement. The landlord told the traveler that he had just ridden over the frozen, dangerous Lake of Constance. When the man heard this, he suddenly died through absolute fright. It was not so much the experience that traumatized this man as much as it was his realization of what really took place and what the danger was.[14]

Emotional trauma can be compared to a physical burn. When a person is burned, unless the area is cooled down quickly with water or by some other method, the skin will continue to burn internally. Depending on the severity of the burn, if not cooled or treated quickly, it will rapidly worsen until the burn fully sets in, becoming blistered and deadened. Quick reaction is especially important with burns. Much like physical burns, quick reaction following emotional trauma is also particularly important. Traumatic experiences "evoke strong biological responses that can persist and that can alter the normal course of neurobiological maturation," which in turn can cause an increase in things like mental illness and suicide. Expressing emotions tied to the traumatic event and utilizing positive coping techniques is important for long-term mental

14. Koffa (1936). A real-life example is cited by Kilpatrick et al., (1989) regarding a rape victim who developed PTSD only when it came to her attention, months after the event, that her attacker had killed another rape victim as paraphrased in What Doesn't Kill Us, 44.

and physical health.[15,16] When a traumatic experience is severe enough or the healing process not initiated in a timely manner (sometimes even when the healing process is initiated quickly), PTSD is likely to be the outcome.

## Post-Traumatic Stress Disorder

With the wars in Iraq and Afghanistan, US service members have experienced serious harmful side effects psychologically and physically due to direct exposure to combat-related events. Post- traumatic stress disorder (PTSD) has become a noticeable problem among the US military. Mental health professionals have struggled for years regarding ways to address this problem. According to the newest version of the Diagnostic and Statistical Manual for Mental Disorders, edition five, this section will explore the definition of PSTD and how it relates to service members?

At some point in life, most of us experience some type of trauma which can cause post-traumatic stress. Post Traumatic Stress is a natural occurrence that often takes place following trauma. The problem arises when post-trauma symptoms of severity and consistency increase by means of intrusive thoughts, emotional avoidance, negative cognitions and mood, and hyper-arousal. When these symptoms last for more than a month, they can cause clinically significant distress or

15. NCTSN Core Curriculum on Childhood Trauma Task Force, *The 12 Core Concepts: Concepts for Understanding Traumatic Stress Responses in Children and Families* (Los Angeles, CA, and Durham, NC: UCLA-Duke University National Center for Child Traumatic Stress, 2012), 22.

16. Jennifer J. Freyd, Bridget Klest, and Corlyn B. Allard, "Betrayal Trauma: Relationship to Physical Health, Psychological Distress, and Written Disclosure Intervention," *Journal of Trauma & Dissociation* 6, no. 3 (2005): 85.

impairment in social, occupational, or other areas of important functioning, and are not attributable to the psychological effects of substances or another medical condition. This is when trauma survivors transition into the potentially damaging arena of PTSD versus just PTS.[17] In order to understand a PTSD diagnosis, the following criterion is used.

The first criterion for diagnosing PTSD is intrusive thoughts which include unwanted recollection of traumatic events. Following trauma, service members will most likely experience recurrent, involuntary, and intrusive upsetting memories of the traumatic event. While some suffering from PTSD experience intrusive memories throughout the day, others struggle with content and/or affect relating to sequences of the traumatic event. Dissociative reactions such as flashbacks (the service member feels or acts as if they are re-experiencing the traumatic event) are also common as a PTSD reaction following trauma. In severe cases during flashback episodes service members can completely lose awareness of their present surroundings. Lastly, service members may experience intense or prolonged psychological distress or marked physiological reactions to "internal or external cues that symbolize or resemble an aspect of the traumatic event."[18]

The second criterion, avoidance, occurs when service members seek to escape overwhelming emotional pain through methods such as drugs, alcohol, or other forms of distraction. As a coping mechanism, avoidance allows the service member to escape or avoid upsetting memories, thoughts, or feelings about or related to the traumatic event. Avoidance also helps the service member to evade reminders such as people, places,

17. *DSM-V,* 271.
18. *DSM-V,* 271.

situations, or activities that stimulate upsetting memories, thoughts, or feelings tied to the event.[19] Avoidance can be somewhat healthy in the short-term aftermath of trauma (emotions may be too overwhelming to manage) but can become extremely detrimental in the long-term, particularly for those who struggle with drug and alcohol dependence.[20]

The third criterion is negative changes in cognitions and mood in relation to the traumatic event which was added to the DSM-V in order to address aspects of PTSD not previously covered in the DSM-IV. In order to qualify for PTSD, these alterations in cognitions (thoughts) and mood must begin or worsen after the traumatic event occurred. Following traumatic events, some service members lack the ability to remember important aspects of the trauma due to dissociative amnesia (memory breakdown) and not due to other explanations such as head injuries, alcohol, or drugs. Service members may also hold insistent and hyperbolic (exaggerated) negative beliefs about themselves, others, or the world. Some service members may experience inaccurate cognitions about the cause or consequences of traumatic events. Therefore, this may cause them to self-blame or blame others for what happened. Other common PTSD side effects that possible influence service members regarding this criterion include: persistent negative emotional states, extremely diminished interest or participation in significant activities, feelings of detachment or estrangement from others, or tenacious inability to experience positive emotions.[21]

Lastly, trauma triggers the body's survival response causing

19. *DSM-V,* 271.
20. *What Doesn't Kill Us,* 120–121.
21. *DSM-V,* 272.

service members to experience hyper-arousal, or always being on edge or alert status. When extreme alterations in arousal and reactivity related to traumatic events begin or worsen after the traumatic event happens, this becomes an area of concern. Extreme alterations include: cantankerous behavior and angry outbursts (with little or no provocation) usually communicated as physical or verbal aggression towards others or objects, reckless or self-destructive behavior, hyper vigilance (extremely aware), exaggerated startle response, difficulty with concentration, or sleep disturbance.[22]

Some service members who endured trauma during war did not experience significant post- trauma symptoms during or directly following deployment. The effects of trauma sometimes do not set in until months or even years after enduring traumatic experiences or returning home from war zones. Although these service members meet particular criteria for PTSD soon after trauma or arriving home from deployment, they may not meet the full diagnostic criterion until at least six months after the event. This is called PTSD with delayed expression. Just because the full effects of PTSD do not take root until seemingly much later than the trauma was experienced, this does not take away the legitimacy of the diagnosis or subjective experience of the service member. For some, effects of PTSD just take longer to become fully ingrained.[23]

Many combat veterans understand all too well the consequences of trauma. Veterans exposed to combat deal mostly with manmade sequences of terrifying occurrences which "shock the psychological system and violate core

22. *DSM-V,* 272.
23. *DSM-V,* 272.

assumptions that life is predictable, safe, and secure. Such events often reveal the ultimate fragility of existence, and can eventuate in both immediate distress and long-term interruptions to normal functioning."[24] When assumptions of life are challenged or fragile, service members have a greater likelihood of developing PTSD.

Several factors contribute to a combat veteran PTSD diagnosis. Examples include: participating in a long war, experiencing multiple deployments, witnessing human suffering and deprivation, suffering difficult living and work conditions, facing separation from home and family, experiencing conflict with military peers or supervisors,[25] coming under small arms fire, discharging a weapon during combat, being in a forward area in close contact with the enemy,[26] feeling in great danger of death, being shot or seriously injured, seeing someone wounded or killed, or wearing or riding with greater physical protection (body armor, up-armored vehicles, etc.) which increases survival during trauma. For some, combat related trauma is not a one-time occurrence. Nonetheless during deployment and with the necessity to continue the mission, managing emotional and physical consequences of the traumas can become difficult, if

24. Brian A. Sharpless and Jacques P. Barber, "A Clinician's Guide to PTSD Treatments for Returning Veterans," *American Psychological Association* 42, no. 1 (2011): 8.

25. Linda A. King et al., "Deployment Risk and Resilience Inventory: a Collection of Measures for Studying Deployment-Related Experiences of Military Personnel and Veterans," *Military Psychology* 18, no. 2 (2006): 90–91.

26. Roberto J. Rona et al., "The Contribution of Prior Psychological Symptoms and Combat Exposure to Post Iraq Deployment Mental Health in the UK Military," *Journal of Traumatic Stress* 22 (2009): 17.

not impossible.[27]

PTSD rates among returning combat veterans may seem low; however they are still prevalent. As previously mentioned, some scholars have estimated PTSD rates among combat veterans to be around 14%,[28] and others have estimated as high as 17%.[29] Sadly enough, an estimated 40% of combat veterans diagnosed with PTSD exhibit symptoms 10 years after onset. When PTS or PTSD is severe enough, survivors may have thoughts or desires of taking their own lives.[30] Due to the psychological toll trauma takes on individuals, feelings of depression, anxiety, and hopelessness usually follow trauma. Thoughts of suicide naturally occur under the emotional duress caused by trauma. Survivors search for means to stop emotional and physical pain through suicide.[31]

Taking the necessary steps towards recovery and growth may be extremely frightening for service members. Those who struggle with the aftermath of trauma and PTSD need to realize that they are not alone on their journey. This said, during their

27. Charles W. Hoge, *Once a Warrior Always a Warrior: Navigating the Transition from Combat to Home Including Combat Stress, PTSD, and mTBI* (Guilford, CT: Globe Pequot Press, 2010), xiii.

28. Terri Tanielian and Lisa H. Jaycox, *Invisible Wounds of War: Psychological and Cognitive Injuries, their Consequences, and Services to Assist Recovery* (Santa Monica, CA: The RAND Center for Military Health Policy Research, 2008), 48.

29. Karen H. Seal et al., "Bringing the War Back Home: Mental Health Disorders Among 103,788 US Veterans Returning from Iraq and Afghanistan seen at VA Facilities," *Archives of Internal Medicine* 167 (March 2007): 479–480.

30. "Violence Exposure, Psychological Trauma, and Suicide Risk in a Community Sample of Dangerously Violent Adolescents," 435.

31. Suicide.org Non-Profit Organization Website, accessed on December 19, 2013, "Suicide.org: Suicide Prevention, Awareness, and Support," Suicide.org, http://www.suicide.org/suicide-faqs.html.

recovery, as they learn that their natural responses to war were normal for survival; they will (hopefully) grow and as they progress on their journey, heal. Though road blocks to recovery can be eliminated, returning to that "normal state" before the traumatic material may not happen, but they can have hope that they can return to a stronger place of resiliency through positive growth.

## Post-Traumatic Growth

Positive growth following trauma has been categorized by the use of several different terms. Terms such as personal transformation,[32] post-traumatic growth,[33] thriving,[34] resilience,[35] benefit finding,[36] positive life change,[37] stress-related growth,[38] and meaning construction[39] are a few familiar expressions that emphasize growth following trauma. For the

32. John M. Schneider, *Finding My Way: Healing and Transformation through Loss and Grief* (Colfax: Seasons Press, 1994), 1–5.

33. "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence," 3.

34. Sean Massey et al., "Qualitative Approaches to the Study of Thriving: What can be Learned?" *Journal of Social Issues* 54 (1998): 338.

35. Susan Nolen-Hoeksema and Judith Larson, *Coping with Loss* (Mahwah, NJ: Erlbaum, 1999), 15.

36. Christopher G. Davis, Susan Nolen-Hoeksema, and Judith Larson, "Making Sense of Loss and Benefiting from the Experience: Two Constructs of Meaning," *Journal of Personality and Social Psychology* 75 (1998): 561.

37. Darrin R. Lehman et al., "Positive and Negative Life Changes Following Bereavement and their Relations to Adjustment," *Journal of Social and Clinical Psychology* 12 (1993): 92.

38. Stephen Armeli, Kathleen C. Gunthert, and Lawrence H. Cohen, "Stressor Appraisals, Coping, and Post- Event Outcomes: The Dimensionality and Antecedents of Stress-Related Growth," *Journal of Social and Clinical Psychology* 20 (2001): 367.

39. Robert A. Neimeyer, "Fostering Posttraumatic Growth: A Narrative Elaboration," *Psychological Inquiry* 15 (2004): 53.

use of this paper, the term "PTG" for post-traumatic growth will be utilized.

As mentioned in the introduction, the concept that suffering and trauma can potentially bring about positive change has been around for thousands of years. Early examples include ancient writings of Greeks, Hebrews, and Christians as well as deeply embedded teachings from Hinduism, Islam, and the Baha'i Faith.[40] Great emphasis was placed on the potentially transformative power of suffering. Progression by means of suffering did not gain great scholarly ground in the form of PTG until the 1990's with the rise of positive psychology.[41] Mental health professionals, through research, overwhelmingly found that people facing a wide variety of severely difficult circumstances went through momentous changes in their life, with the vast majority viewing these changes as highly positive.[42]

PTG is founded on principles of positive change that occur in reaction to adversity and trauma. PTG is "a positive psychology change experienced as a result of struggle with highly challenging life circumstances."[43] Although recognizing growth following trauma can be extremely difficult; with time, survivors generally agree that positive change would not have happened without trauma.[44]

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40. *Trauma and Transformation: Growing in the Aftermath of Suffering*, 45.

41. Martin E.P. Seligman and Mihaly Csikszentmihalyi, "Positive Psychology: An Introduction," *American Psychologist* 55, no. 1 (2000): 5.

42. "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence," 3.

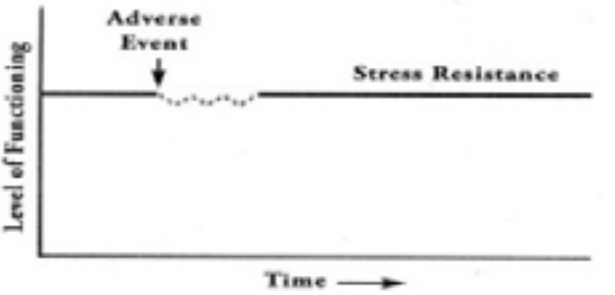
43. "Posttraumatic Growth Among OEF and OIF Amputees," 413.

44. "Posttraumatic Growth Among OEF and OIF Amputees," 413.

PTG cannot be achieved without first experiencing trauma. Asking people in advance if they would like to experience posttraumatic growth knowing they would have to go through severe trauma, most likely would end with a negative response. Although the actual event of trauma is never judged to be positive in nature, what is accomplished following trauma can be. Growth takes place due to struggling with the aftermath of trauma and not in spite of it. Emphasizing the potential for positive change following trauma allows individuals to be empowered and focus on growth. Recognizing aspects such as PTSD or other disorders is also good in the sense that it helps people receive proper psychiatric help, but also not helpful because it can cause individuals to focus too much on the negative aspects of trauma creating a bias that could stymie recovery in the long run. It is not about having PTSD over shadow PTG, but reversing it by having PTG over shadow PTSD.[45]

Post Traumatic Growth involves more than returning to a "normal" psychological state following trauma. Many survivors following trauma want to "get back to the way things were" but in most circumstances this is impossible. Trauma (which is perceived by everyone differently) changes individuals on a deep level. Taking into consideration the figure below, many mistakenly believe that the ultimate goal for trauma survivors should be returning to a regular level of functioning. Wrestling with the aftershock of trauma brings with it a greater potential for growth.

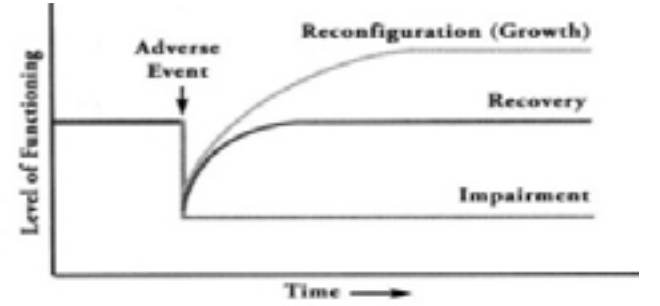
45. "Posttraumatic Growth Among OEF and OIF Amputees," 413.




*What Doesn't Kill Us*, 68. Personal Email Communication with L. Butler, May 20, 2010.graph for new.jpg

Struggling with the aftermath of trauma in most circumstances causes the survivor to change positively. Although negative aspects of the trauma (e.g., intrusion, avoidance, negative alterations in cognitions and mood, or marked alterations in arousal and reactivity) may continue long after the trauma is experienced, positive change also takes place. In fact, as mentioned previously, it is the struggling with stresses caused by trauma which actually brings about positive growth. Strengthening this ability to "resist or to bounce back from adversity is a key aim…however, rapidly returning to baseline functioning is not the only positive outcome following exposure to trauma. Some trauma survivors report posttraumatic growth: positive personal changes that result from their struggle to deal with trauma and its psychological consequences."[46] Ideally, survivors will not return to a "normal" psychological state following trauma, but a better psychological state as represented in the figure below.

46. Richard G. Tedeschi and Richard McNally, "Can We Facilitate Growth in Combat Veterans?" *American Psychologist* 66, no. 1 (January 2011): 19.




Virginia E. O'leary and Janet R. Ickovics, "Resilience and Thriving in Response to Challenge: An Opportunity for a Paradigm Shift in Women's Health," *Women's Health: Research on Gender, Behavior, and Policy* 1 (1995):121–142. In *What Doesn't Kill Us,* 69.adverse event.jpg

PTG seems to be best explained by the theory and analogy of the shattered vase. Imagine owning a beautiful vase which holds great sentimental value. One day the vase is knocked to the ground and shatters into seemingly innumerable pieces. What are the options available for dealing with the aftermath of the shattered vase? It seems the three main options are to try to put the vase back together using glue or sticky tape, take it as a total loss and throw the shards away, or pick up the "beautiful colored pieces and use them to make something new—such as a colorful mosaic."[47] PTG is like the last option. After experiencing horrendous traumatizing experiences, survivors become like the shattered vase. While they may not be able to return to their "normal" levels of emotional and psychological functioning, they have an opportunity to grow to something more.

Growth following trauma is different for every individual.

47. *What Doesn't Kill Us,* xiii.

Also, going through the phases of PTG is not an easy process. So how does one accomplish PTG, does it happen all at once? Does the trauma survivor experience growth and peace only after suffering a specific amount of pain and suffering? Some find greater meaning and growth only days or weeks after the trauma. Others may take months or years until they begin seeing positive changes that make sense of the trauma. Regardless of how long it takes, research suggests that PTG can be achieved at higher rates when survivors use the acronym THRIVE: taking stock, harvesting hope, re-authoring, identifying change, valuing change, and expressing change in action.

*Signpost #1: Taking Stock*

Taking stock emphasizes taking care of basic needs which are most often neglected due to shock following trauma. Before survivors can achieve a deeper foundation for growth following trauma, a quiet atmosphere of safety and protection must be established. During trauma, areas of the brain focused on survival take over brain operation and stymie cognitive processing. Taking stock involves assessing what is needed following the strong emotional imbalance that is created by trauma. The threat must be extinguished and body calmed physically before the brain can mentally engage in recovery.[48]48

Following trauma, an individual may feel overwhelmed with thoughts of not being able to manage their emotions. Likely emotional reactions include feeling numb, confused, empty, exhausted, tense, or disturbed with thoughts and recollections of what happened. Survivors are many times plagued with nightmares and suffer from sleep deprivation. As

48. *What Doesn't Kill Us,* 176.

the emotional reaction following trauma sets in, the survivor may isolate from family, friends, and reality. Some survivors cope by means of detrimental ephemerals (short-term) such as drugs, alcohol, domestic abuse, or other methods that only increase internal hopelessness. The survivor may lose interest in usual things and his/her career could suffer.[49]

Survivors find growth and understanding following trauma in their own way and on their own time. Some need a few weeks to process trauma and loss and others need years. During the taking stock phase of post-traumatic growth, looking at the positive side of things may seem nearly impossible. Telling someone to "look at the bright side" may even be disrespectful at this point in time. Survivors need to receive empathy, a sense of safety, and emotional equilibrium in order to begin their journey towards post-traumatic growth.[50]50

Ensuring that survivors prioritize taking care of basic needs following trauma is tantamount for emotional equilibrium and foundational for eventual growth. Too often trauma survivors go on "automatic pilot" following trauma and neglect necessary self-care. While it is true that life cannot be ignored, especially when one is supporting a family or making ends meet, survivors must take stock and prioritize themselves so they can transition to working through their personal trauma.[51]

*Signpost #2: Harvesting Hope*

Trauma survivors often carry with them a heavy burden of hopelessness. Regardless of the circumstances, trauma

49. *What Doesn't Kill Us,* 177.
50. *What Doesn't Kill Us,* 177.
51. *What Doesn't Kill Us,* 177.

can shake an individual to the very foundation of their being. Anyone who has experienced trauma can tell you that their life changed dramatically, never to fully return to the way it once was. Dealing with these changes in addition to the emotional impact caused by trauma can rob a survivor of the hope they once relied upon.

One method by which trauma survivors can harvest hope is by utilizing the miracle question and finding social support. The miracle question involves the survivors closing their eyes and imagining that they are going to sleep for the night and the miracle happens when the survivor wakes up. In the morning, things are different but in a good way. Essentially, the survivors think about how they feel now and compare it to how they felt when they woke up from the imaginative sleep. What changed and how can the survivor feel different from how they do in the present? As survivors begin to find meaning and visualize how they would like their lives to be different, they can recruit social support to help them with their goals. "Military personnel who perceive their missions as important and meaningful and who maintain regular contact with friends and family back home may experience less psychological distress during deployment"[52]52 and after returning home.

*Signpost #3: Re-authoring*

Re-authoring emphasizes how we see ourselves in relation to trauma. It is a "process of re- examining the beliefs that characterize one's assumptive world in light of an unexpected trauma, and these processes are related to posttraumatic

52. Matt J. Gray, Elisa E. Bolton, Brett T. Litz, "A Longitudinal Analysis of PTSD Symptom Course: Delayed Onset PTSD in Somalia Peacekeepers," *Journal of Consulting and Clinical Psychology* 72, no. 5 (2004): 912.

growth."[53] For example, following trauma, individuals view themselves based on their understanding of their experience. Some see themselves as victims, others as survivors, and others as thrivers. The term "victim implies passivity, defeat, helplessness whereas the term survivor implies recovery—a recognition that the person has gotten through adversity and taken back control of his or her life. But the term thriver goes even further. It implies activity, mastery, and hope."[54] Perception of self in relation to trauma carries a large impact in how growth is experienced.

Trauma causes survivors to view life differently as they dig deep to find meaning in life. One explanation "for the positive associations between PTSD symptoms and PTG is that PTG occurs when the trauma has been upsetting enough to promote engagement in positive meaning making."[55] Eventually survivors learn that helpful coping skills such as positive reinterpretation, problem solving, sense of coherence, and active coping are a result of struggling with trauma.[56]

The trauma itself is bad, but coping with the aftermath of trauma can have a positive effect. PTG does not "emerge as a direct result of a traumatic event in one's life; rather, the growth results from the individual's struggle with, and development

53. Richard G. Tedeschi, Lawrence G. Calhoon, and Arnie Cann, "Evaluating Resource Gain: Understanding and Misunderstanding Posttraumatic Growth," *Applied Psychology: An International Review* 56, no. 3 (2007): 399.

54. *What Doesn't Kill Us,* 194.

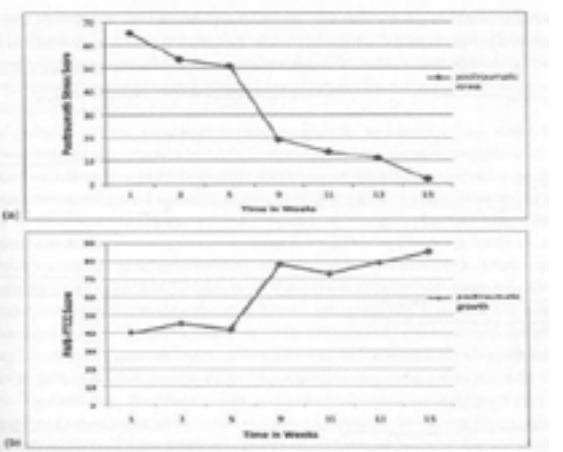
55. Richard G. Tedeschi and Lawrence G. Calhoon, "The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma," *Journal of Traumatic Stress* 9 (1996): 467.

56. Gulay Dirik and A. Nuray Karaci, "Variables Related to Posttraumatic Growth in Turkish Rheumatoid Arthritis Patients," *Journal of Clinical Psychology in Medical Settings* 15 (2008): 193.

of, a new reality or personal worldview following a traumatic event."[57] Re-authoring a traumatic experience can be extremely difficult and take a lot of time, but in the long run it is worth it.

*Signpost #4: Identifying Change*

Positive change occurs in small increments. In the beginning, negative effects from trauma frequently seem to heavily outweigh signs of positive changes. As time passes and survivors continue to persevere through adversity, signs of positive change will outgrow the negative effects from trauma. Identifying positive changes helps PTG increase and PTS decrease as indicated in the graph below. Over a long period of time, the Psychological Well-Being Post- Traumatic Changes Questionnaire (PWB-PTCQ) was administered to a small population of people who experienced trauma of varying kinds. Here are the results:



*What Doesn't Kill Us,* 153.what doesnt kill us.jpg

57. "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence," 1.

In addition to an increase of PTG and decrease in PTS are a wide variety of positive changes. Examples include: renewed appreciation of life, new possibilities, enhanced personal strength, improved relationships with others, spiritual change, etc.[58]58 Trauma should never be advertised a desired event, but when trauma sadly happens, growth which surpasses our original state is most likely to occur. Through methods such as keeping a journal, receiving feedback from loved ones, or possibly self-administering welfare questionnaires, service members are more likely to identify change and value aspects that could have only come because of their response to the trauma they experienced.

*Signpost #5: Valuing Change*

Valuing change is a critical step in correlation with PTG. Valuing change emphasizes releasing expectations of how life should be and transitioning to valuing life as shaped by life and our desires. Trauma wrecks the lives of those who experience it in many cases. Although positive changes that occur in a survivor's life may not be what the survivor expected or originally planned, it is still a part of the survivor's life. Learning to live life from a new perspective, valuing it is important if the survivor hopes to find peace. Valuing change emphasizes not necessarily "feeling better but about creating new meanings, finding new values, and changing how you think about yourself and your goals in life."[59]

*Signpost #6: Expressnig Change in Action*

58. Kanako Taku et al., "The Factor Structure of the Posttraumatic Growth Inventory: A Comparison of Five Models Using Confirmatory Factor Analysis," *Journal of Traumatic Stress* 21 (2008): 159.

59. *What Doesn't Kill Us,* 201.

Intellectually reframing traumatic experiences positively is not enough. Growth must be put into action by the way new behaviors are expressed. Examples of expressing change in action include: showing the acceptance of self, exhibiting purpose in life, improving relationships, achieving a sense of mastery, or branching out with others who have also experienced trauma. In other words, connecting behaviors with what has been learned about PTG is primarily what this phase emphasizes.[60]

Service members should track concrete examples as a way to recognize and measure change. Keeping track daily and weekly will enable the service member to maintain focus on the positive aspects of struggling with the after math of trauma. This does not mean that the service member does not still experience negative side effects from the trauma, but indicates that PTG is becoming a larger entity in the survivor's life than PTS or PTSD. If I were writing a script for a counselor/counselee scenario where PTSD is an issue, these phrases are good examples of expressing change in action:

> "This week when my sergeant yelled at me, I was initially upset, but soon after was able to collect my thoughts and manage my emotions more properly."
>
> "On Friday I came home and cooked dinner for my wife out of appreciation for her support during everything I have been experiencing after deployment."
>
> "I went to the PTSD recovery group on Wednesday to support others from my unit who I know have been struggling with PTSD symptoms themselves."

60. *What Doesn't Kill Us,* 203.

"I woke up this morning feeling more optimistic about life and rejuvenated for the day."

"Lately I feel a higher amount of gratitude towards my family, coworkers, and leaders. Today I sent a thank you letter to my commanding officer that was over me during deployment."

"This whole last week I smoked half the amount of cigarettes than I normally do."

"On Monday night I felt extremely anxious and depressed. Rather than drinking like I usually do in that state of mind, I went for a walk and then talked with my wife about what I was going through."

Keeping track of changes and how they are manifested is extremely important, even if the changes only seem inconsequential. Changes could be things like "becoming more self- accepting, autonomous, purposeful in your life, focused on deepening your relationships, masterful over your situation, and open to personal growth."[61]61 Any change toward growth is good change and should be tracked.

## Summary

PTSD is a major problem affecting at least as many as 15% of service members who return from war in Afghanistan and Iraq. Much research has been done with an effort to take care of this problem. In an attempt to address the problem of PTSD, the literature review focused of pertinent aspects revolving

61. *What Doesn't Kill Us,* 204.

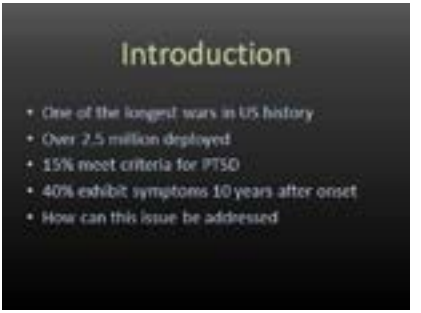
around combat-related experiences, namely: trauma, PTSD, biology of trauma, and PTG. In the process it emphasized that the trauma survivor is not alone during the aftermath of trauma, trauma is a normal and natural process, and growth takes time.

Service members experience trauma when they are exposed to actual or threatened death, serious injury, or sexual violence. Most, if not all, survivors go through a period of PTS following trauma. When symptoms of PTS continue for longer than a month, their situation most likely moves into the category of PTSD. In correlation with therapy from a certified mental health professional, service members can achieve PTG by implementing the principle-based THRIVE model into their lives. It is important to note that a small percentage of service members with PTSD experience unalterable brain changes and will most likely have PTSD for the rest of their lives. While this population may achieve PTG, they will most likely continue to struggle with PTSD.

## Section 1 Lesson Plan


**Slide #1 Note to Speaker: The Purpose of this sectin is to introduceyourself and the topic**

Coming back from war, service members have suffered a wide variety of physical and psychological problems. One of which has been PTSD. Some would naively argue that PTSD is not real or "made up." Research tells us that PTSD IS real. Struggling with this issue is a huge endeavor for mental health counselors and combat veterans. During this presentation, we will discuss issues revolving around PTSD, but this will not be the focus. The main focus of this presentation will be on PTG. PTG will be the main emphasis, but a few points on trauma and PTSD must be covered beforehand.




**Slide #2 (Introduction)**

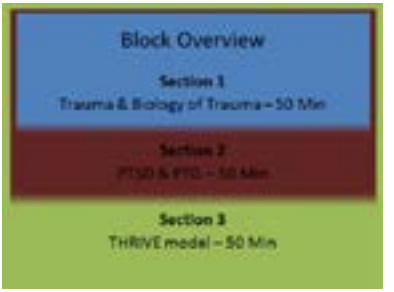
This is an important slide. Much of the audience in this brief most likely will be wondering why they are in attendance. Introducing the salient problem of PTSD and briefly discussing its impact on service members will prepare the audience for the information in this brief. Discuss the longevity of wars in Afghanistan and Iraq. The current war is shorter than the Vietnam conflict, but longer than any other US involved conflict.

Engaged in war against terrorism, US service members have experienced serious detrimental side effects psychologically and physically due to direct exposure to horrific combat-related atrocities. It is estimated that over two million service members have deployed to Afghanistan (Operation Enduring Freedom) and Iraq (Operation Iraqi Freedom) over the last decade for one of the longest wars of U.S. history. Of those who have deployed to these areas, many have deployed multiple times. In correlation with longevity, post-traumatic stress disorder (PTSD) has become a salient problem among the US military. In a review of 17 post-deployment epidemiological studies, which included more than 700,000 veterans, researchers concluded that 15% of all returning combat veterans meet criteria for PTSD. Sadly, but in reality, an estimated 40% of combat

veterans diagnosed with PTSD exhibit symptoms 10 years after onset.

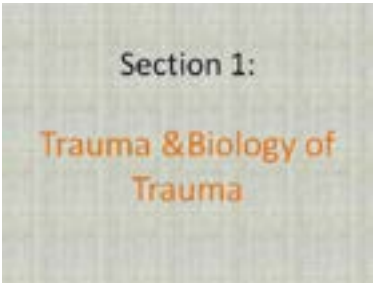

**Slide #3 (The Road Ahead...)**

As suggested, experiencing the atrocities of war can cause combat veterans to develop PTSD. In the process of addressing the issue of PTSD, the purpose of this project is three-fold: (1) provide service members and mental health care professionals information by means of a presentation regarding trauma, the biology of trauma, PTSD, PTG, and the THRIVE model; (2) teach service members how to personally implement the principle-based THRIVE model which they in turn can utilize in correlation with individual therapy with trained mental health counselors, preparing them to accomplish PTG; and (3) empower service members to achieve growth without invalidating their traumatic experiences or struggles with the aftermath of trauma. Following the presentation to service members they should gain a sense that they are not alone in their struggles, trauma is a natural process of life, and that growth is a journey that takes time and is different for every individual.




**Slide #4: (Block Overview)**

Within a three hour block of time, three 50 minute presentations with a ten minute breaks in between will be provided. The first 50 minutes will cover information regarding trauma and the biology of trauma, the second 50 minutes will go over PTSD and PTG, and the final 50 minutes will be spent covering the THRIVE model.




**Slide #5: (Section 1: Trauma & Biology of Trauma)**

Simply state: "Section one: Trauma and Biology of Trauma." Allowing the audience time to read the slide without saying anything should also be fine. This is just an outline of what will be covered during session one.


**Slide #6: (Trauma)**

Say something along the lines of: "first, we will begin by discussing trauma." If the presenter feels like he/she has a good handle on time and has practiced the presentation, feel free to open up here by asking the audience something like: "what is trauma?" Take in a few replies and then lead into the next slides regarding trauma definition.

Emphasis on trauma research has increased significantly in the last few decades. Recent events such as (but not limited to) the September 11th terrorist attacks, wars in Afghanistan and Iraq, Hurricane Katrina, the 2010 Haiti earthquake, 2011 Japanese tsunami, and a plethora of additional traumatic occurrences has drawn international attention to the impact of trauma on individuals' lives. Regardless if trauma is experienced physically, emotionally, psychologically, or all three, trauma most often brings with it damaging side effects. Those who seem to suffer the most following a traumatic event are those who feel helpless during the incident, prepare themselves for the worst, think they are going to die, or feel paralyzed by fear.

In regards to definition, trauma has changed much over time. The word trauma, which comes from the Greek word "wound," was adopted into English and referred to the piercing or wounding of the physical body. As psychology adopted the word trauma, its definition came to imply a more emotional and spiritual meaning. Trauma now also includes an aspect of emotional wounding.


**Slide #7: (DSM 4 Definition)**

Say something like: "Here is how the previous edition of the Diagnostic and Statistical Manual of Mental Disorders IV (a manual for mental health counselors for assessment and diagnosis for various disorders) defined trauma." Share the definition of trauma as described by the DSM IV in the points on the slide.

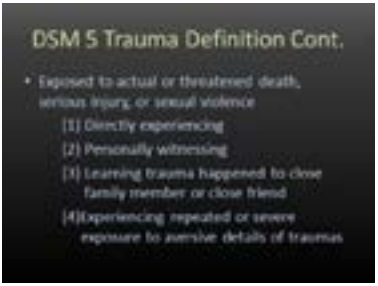
Previously, the Diagnostic and Statistical Manual (DSM) IV of mental disorders described a traumatic event as an event "generally outside the range of usual human experience" and one that "would evoke significant symptoms of distress in most people." The DSM IV highly emphasized feeling intense fear, helplessness, or horror as a requirement for identifying trauma responses and thus categorized disorders such as PTSD and acute stress disorder under *Anxiety Disorders*.


**Slide #8: (DSM 5 Definition)**

Say something like: "After further research, here are some of the changes to the definition of trauma included in the most up-to-date version of the DSM." Read the bullet points regarding changes. Ensure to define words such as "anhedonia" (not finding pleasure in things once found pleasure in; no feeling). Depending on how the presenter is managing time, this may be a good opportunity to ask the audience why these changes are important. After receiving audience questions and feedback, ensure to highlight empirically supported information.

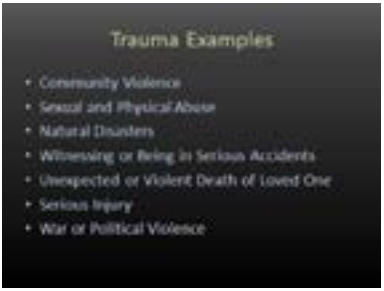
Emphasize to the audience that trauma and PTSD are no longer categorized under *Anxiety Disorders*. Researchers once believed that emotions such as fear, helplessness, or horror were the most salient factors describing trauma and leading to PTSD. Mental health professionals believed that police officers, first responders, and combat veterans were less likely to develop PTSD due to training that teaches them to deal with traumatic material and experiences. Research indicates that individuals from these populations many times do not necessarily experience fear, helplessness, or horror in correlation to trauma, but they still develop PTSD. PTSD more closely correlates with anhedonia than fear, helplessness, and horror. This played a major role in why trauma and PTSD are no longer categorized under *Anxiety Disorders*. They are now

categorized under their own criterion: *Trauma and Stressor Related Disorders*. Key note: the new DSM is more validating for combat veterans.




**Slide #9: (DSM 5 Definition Cont.)**

In order for an experience to be defined as traumatic, possibly leading to a PTSD diagnosis, it must meet certain criteria. The individual must be exposed to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: directly experiencing the trauma, personally witnessing the event as it happened to others, learning that the trauma happened to a close family member or close friend, or experiencing repeated or severe exposure to aversive details of traumas.




**Slide #10: (Trauma Emphasis)**

While there are many ways in which individuals experience trauma, here is a list of some of the most salient avenues. Read through the list. Here are some examples of a few of them: community violence (shooting, mugging, burglary, etc.); natural disasters (hurricane, flood, fire, earthquake, etc.); witnessing or being in a serious accident (vehicle, airplane, mechanical, etc.); sudden unexpected or violent death of someone close (suicide, accident, murder); serious injury (burns, animal attack, work related, etc.).

This gives a broad picture of trauma so the audience can realize (if they already have not) that trauma is experienced in diverse ways. Most, if not all people have gone through trauma at one point in their lives. Emphasize here that if the audience has experienced trauma in one form or another, they are not alone.


**Slide #11: (Emphasis on Combat Trauma)**

There simply is not enough time to go into detail regarding every type of trauma. Due to the vastness of ways in which trauma can be experienced; this presentation will focus mainly on combat related trauma. The presenter should take the opportunity here to briefly validate other major forms of

military trauma (military sexual trauma, domestic abuse, etc.). This will help the presenter address the equal importance of such issues, while at the same time emphasize to the audience that combat trauma is the main focus of this presentation.


**Slide #12: (Physiological or Psychological?)**

This slide should help the presenter with transitioning from trauma to the biology of trauma. Ask the audience whether they think the effects of trauma are physiological (physical) or psychological (emotonal/mental). Allow time for the audience to respond.

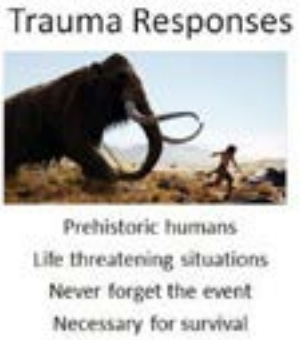

**Slide #13: (Physiological or Psychological? Response)**

Validate the responses of the audience. Emphasize that trauma responses are both physiological and psychological. Trauma physically impacts the brain and rest of the body. Trauma also changes the way we think and feel (in correlation with physical changes). Do not go too far into detail here. Physical changes due to trauma will be explained in greater detail in the following slides.

The presenter should say something simple like: "now that we have discussed trauma and its definition, let's talk about the biology of trauma."


**Slide #14: (Biology of Trauma)**

Trauma responses may seem to be mostly mental or emotional reactions to highly stressful and harmful events, but trauma is also very physical in nature. When soldiers engage in combat, become seriously injured, see someone else killed or injured, etc., they experience a variety of emotions revolving around the events. They also go through an assortment of physiological responses during and after the trauma. What is the biological process of trauma, why is it so important, and how does this relate to PTSD?




**Slide #15: (Trauma Responses)**

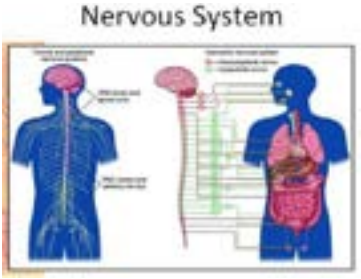
This slide allows for the presenter to talk about the history of trauma reactions and its necessity for human survival. Try to say something like: "For millennia, prehistoric humans predominantly survived by way of hunting and gathering. While hunting, humans frequently encountered life threatening events with dangerous animals and precarious situations. Over the centuries, humans in general have adapted in order survive dangerous encounters. A major reason for this survival is due to the fact that humans have a remarkable memory and high tolerance for emotion mixed with the recollection of a traumatic event. This causes the human to never forget what happened. The next time a human encounters a similar dangerous situation, they know there is reason to fear so they avoid the thing that will most likely harm or kill them.

It is important to note that the biological reaction to trauma is perfectly normal and a necessary reaction for survival. Problems arise when people who experience trauma cannot bring themselves down from a hyper state of arousal or when their lives revolve around response to the emotions that were created from the trauma. This largely determines who develops PTSD as compared to those who just experience post-traumatic

stress (involves experiencing PTSD-like symptoms following trauma, but perhaps not as long or as intense as PTSD)."


**Slide #16: (Hans Selye)**

Stress is a normal reaction to trauma. When experiencing a threatening situation (such as being chased by a predator or engaging in a combat situation), the human body goes into a fight-or- flight response. Initially the body and mind experience the alarm stage in which a person freezes (very short process) in preparation for flight-or-fight. Next, the body moves into the resistance stage where biological, psychological, and social resources are activated in order to cope with the event. In most cases, the individual experiencing the stressful event either fights the threat or runs away. In other situations, as an in-built survival technique the individual freezes, almost like they are paralyzed. In this scenario, the individual may not be recognized by the predator as food or a threat. This can have major complications for soldiers if they react this during combat. Stress responses are mainly controlled by the automatic nervous system.




**Slide #17: (Nervous System)**

**Central Nervous System (CNS):** Consists of the forebrain, midbrain, hindbrain, and spinal cord. The CNS is the processing center for all nervous systems.

**Peripheral Nervous System:** Relays information to the CNS after gathering information from the Motor and Sensory Nervous Systems. The Motor Nervous System contains the Automatic Nervous System which plays a critical role during trauma.

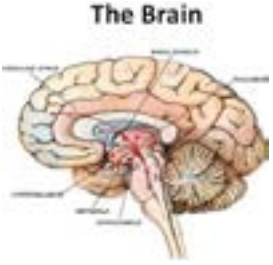
**Automatic Nervous System (ANS):** Also known as involuntary nervous system due to its management of involuntary muscles and reactions in response to outer stimuli. The ANS is primarily involved during times of stress and trauma and communicates vital emotional
information to the CNS. The ANS consists of the Sympathetic and Parasympathetic Nervous Systems

**Sympathetic Nervous System (SNS):** Accelerates the body and mind during times of stress and arousal.

**Parasympathetic Nervous System (PNS):** Slows down the body and mind during times of trauma when nothing can be

done.

The automatic nervous system (ANS) is just as it is described, automatic. The ANS takes over body operation during traumatic or threatening events and is comprised of two sections, the sympathetic nervous system (SNS) and parasympathetic nervous system (PNS). The SNS arouses the body through methods such as increasing heart rate, rate of breathing, and blood flow in order to assist the muscles for quick movement in reaction to stressors and trauma. The PNS serves to decrease biological arousal when the individual is either no longer under threat or in a situation where he/she cannot avoid the stressor. The human body is not designed to stay in hyper-alert mode for prolonged periods of time so the PNS helps the body calm down. The ANS is a natural and necessary part of organism survival and is a key element to the limbic system in the brain.




**Slide #18: (The Brain)**

Briefly describe the anatomy of the brain. The frontal lobe takes care of higher order thinking and is a main part of the outer brain. The Limbic system is centrally located and focuses on basic needs such as food, sex, and survival.

The **limbic system** is the oldest part of the brain and operates the ANS. The limbic system is centrally located and directly in charge of how the brain manages trauma, fear-conditioning aimed at training the mind for proper responses in dangerous situations, and memory storage. Although the limbic system is composed of several components, the **amygdala** and **hippocampus** are the primary components that make up the limbic system. While the hippocampus manages the storing of memories for time and space, orders memory, and makes connections between memories, the amygdala plays a much larger role concerning trauma. The amygdala is responsible for processing incoming emotional information, particularly fear, anxiety, and emotional memory.


**Slide #19: (Active Memory)**

When something traumatizing or extremely stress-inducing is experienced, the amygdala takes over brain operation and memory storage is stymied. The frontal cortex, which manages the storing of long-term and everyday occurrence-type memories, is disabled while the traumatic event is taking place. This in turn causes the experience to remain in "**active memory**."

Memories remain in active memory until they are

processed away into the hippocampus and frontal cortex. This explains why after a traumatic event, survivors continue to have intrusive thoughts and nightmares about the event as if the memory was still in the present. If the memory of the experience is not filed away through proper methods of coping, it will remain in active memory and continue to cause psychological and physical harm. This is when people who experience moderate to severe trauma worsen from PTS to PTSD. The way a human reacts following trauma in most cases will determine how PTS develops.


**Slide #20: (Analogy of the Burn)**

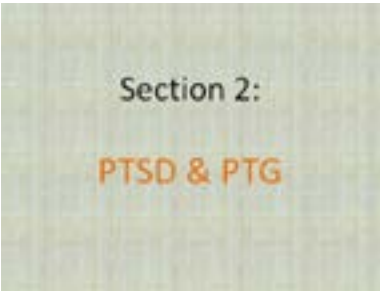
Share the analogy of the burn and talk about how this relates to trauma exposure and reaction. Emotional trauma can be compared to a physical burn. When a person is burned, unless the area is cooled down quickly with water or by some other method, the skin will continue to burninternally. Depending on the severity of the burn, if not cooled or treated quickly, it will rapidly worsen until the burn fully sets in, becoming blistered and deadened. Quick reaction is especially important with burns. Much like physical burns, quick reaction following emotional trauma is also particularly important. Expressing emotions tied to the traumatic event and utilizing positive coping techniques is important for long-term mental

and physical health. When a traumatic experience is severe enough or the healing process not initiated in a timely manner (sometimes even when the healing process is initiated quickly), PTSD is likely to be the outcome.


**Slide #21: (Questions)**

At this time, answer questions relating to session one. If the audience has questions about PTSD, thoughtfully, but briefly address the questions. Kindly inform the audience that PTSD will be covered in greater detail during session two. This might be a good time to do a check on learning or discuss in greater detail concerns that came up during session one (this depends on how the presenter is doing on time).

## Section 2 Lesson Plan




**Slide #1: (Questions)**

Simply state: "section two: Post-Traumatic Stress Disorder and Post-Traumatic Growth." Allowing the audience time to read the slide without saying anything should also be fine.


**Slide #2: (PTSD & PTG)**

Say something along the lines of: "Alright, let's begin by discussing PTSD." If the presenter feels like he/she has a good handle on time and has practiced the presentation, feel free to open up here by asking the audience something like: "What is PTSD and how does it affect service members?" Take in a few replies and then lead into the next slides regarding the history

of PTSD.

Many combat veterans understand all too well the consequences of trauma. Veterans exposed to combat deal mostly with manmade sequences of terrifying occurrences which "shock the psychological system and violate core assumptions that life is predictable, safe, and secure. Such events often reveal the ultimate fragility of existence, and can eventuate in both immediate distress and long-term interruptions to normal functioning." With such costs comes a greater likelihood of developing PTSD.


**Slide #3 (History of PTSD)**

Briefly describe historical events leading up to the modern definition of PTSD. PTSD has existed in one sense or another for millennia. For example, ancient Greek writings of Herodotus discussed the battle of Marathon in 490 BC. He mentioned an Athenian warrior who went blind (even though he was not physically wounded) when the soldier standing next to him was killed. In the 17th century, Swiss physician Johannes Hofer coined the term "nostalgia," describing what he saw in Swiss troops following war. During the civil war, troops heavily affected from detrimental experiences of war were termed "insane" or "nostalgic." The US did not become

more involved in clinical research regarding reactions to war until World War I.

During World War I, soldiers with adverse reactions to war were told they had "shell shock." Many physicians and mental health care workers viewed shell shock as due to a weakness within the soldier and not an outside event, thus the term shifted somewhat to "combat neurosis" following WWI. With World War II came recognition that even mentally sound soldiers were developing symptoms of combat neurosis so the name changed to "combat fatigue." Later, greater emphasis was placed on the stress aspect of trauma and the name was changed to "stress response syndrome" and defined in the first edition of the DSM. With the sway of the pendulum, reactions to battle trauma were categorized under "situational disorders" in the second edition of the DSM, reserving a "pre-existing" label only for those whose symptoms lasted longer than six months. It was not until 1980 after the Vietnam War that PTSD was first introduced as a diagnosis and categorized under *anxiety disorders* in the third edition of the DSM. Defining PTSD in various forms prior to the third edition was ambiguous and invalidating to those suffering from the aftermath of war. The DSM III PTSD diagnosis provided validation for combat veterans and provided a way for them to receive proper mental and physical help following war.


**Slide #4 (PTSD)**

The DSM IV more clearly defined trauma and standardized requirements for PTSD diagnosis. Highlight A thru F as requirements for DSM IV PTSD diagnosis. Now generally discuss the changes between DSM IV and DSM 5. For category A, trauma definition included experiences of those who were not afraid, but were exposed to trauma in correlation with job duties (even though they are trained to manage such scenarios. For category B, "re-experiencing" was changed to "intrusion symptoms." Category D was added to the DSM 5 (negative cognitions and mood). We will discuss in greater detail the most up-to-date PTSD definition and diagnosis criteria in the following slides.


**Slide #5 (A. Traumatic Exposure)**

This category is pretty much a recapitulation of what was discussed in session one of the presentation. Do not spend much time on this slide. Explain to the audience that this category was already discussed, but is presented here so that the audience can see where it fits in with PTSD diagnosis.

The most recent version, DSM-V, no longer requires survivors to experience emotions such as fear, helplessness, or horror in correlation with trauma in order for mental health counselors to label an experience as traumatic or diagnose PTSD and draws a clearer line when describing what constitutes a traumatic event. Researchers discovered that "many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety or fear based symptoms, the most prominent clinical characteristics are anhedonic and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms." Due to the distinct nature of trauma related experiences and reactions, the DSM-V now categorizes disorders of this nature separately under *Trauma and Stressor Related Disorders*. In order for an experience to be traumatic, the survivor must have been exposed to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: directly experiencing the trauma, personally witnessing the event as it happened to others, learning that the trauma happened to a close family member or close friend, or experiencing repeated or severe exposure to aversive details of traumas.


**Slide #6 (B. Instrusion Symptoms)**

The first criterion for diagnosing PTSD is intrusive thoughts which include unwanted recollection of traumatic events. Following trauma, service members will most likely experience recurrent, involuntary, and intrusive upsetting memories of the traumatic event. While some suffering from PTSD experience intrusive memories throughout the day, others struggle with content and/or affect relating to sequences of the traumatic event by way of recurrent upsetting dreams, or both. Dissociative reactions such as flashbacks (the service member feels or acts as if they are re-experiencing the traumatic event) are also common as a PTSD reaction following trauma. In severe cases during flashback episodes service members completely lose awareness of their present surroundings. Lastly, service members may experience intense or prolonged psychological distress or marked physiological reactions to "internal or external cues that symbolize or resemble an aspect of the traumatic event."

Intrusive symptoms are "distinguished from depressive rumination in that they apply only to involuntary and intrusive distressing memories." In B3 dissociative states could last anywhere from a couple of seconds to several hours and in severe circumstances, even days. In this case, the dissociative

event becomes as if the survivor is reliving the trauma in the present. This is sometimes referred to as "flashbacks." Some do not lose reality orientation and others go through a complete loss of present surrounding awareness. B4 and B5 may seem similar on the surface, but in reality they are quite different. B4 represents mental/emotional reactions (seeing someone who resembles an individual from combat-related trauma) to reminders of traumatic events, while B5 represents physical reactions (dizziness for survivors of head trauma; rapid heartbeat for traumatized veterans). Do not go too far into detail regarding this slide. Extra information was provided in the case that the audience has specific questions. Reading the slide and a simple explanation should suffice.


**Slide #7 (C. Avoidance)**

The second criterion, Avoidance, occurs when service members seek to escape overwhelming emotional pain through methods such as drugs, alcohol, or other forms of distraction. As a coping mechanism, avoidance allows the service member to escape or avoid upsetting memories, thoughts, or feelings about or related to the traumatic event. Avoidance also helps the service member evade reminders such as people, places, situations, or activities that stimulate upsetting memories, thoughts, or feelings tied to the event. Avoidance can be

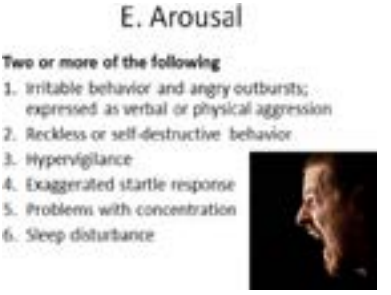
somewhat healthy in the short-term aftermath of trauma (emotions may be too overwhelming to manage) but can become extremely detrimental in the long-term, particularly for those who struggle with drug and alcohol dependence.


**Slide #8 (D. Negative Cognitions & Mood)**

The third criterion is Negative changes in cognitions and mood in relation to the traumatic event which was added to the DSM-V in order to address aspects of PTSD not previously covered in the DSM-IV. In order to qualify for PTSD, these alterations in cognitions and mood must begin or worsen after the traumatic event occurred. Following traumatic events, some service members lack the ability to remember important aspects of the trauma due to dissociative amnesia and not due to other explanations such as head injuries, alcohol, or drugs. Service members may also hold insistent and hyperbolic negative beliefs about themselves, others, or the world. Some service members even ascertain inaccurate cognitions about the cause or consequences of traumatic events which causes them to self-blame or blame others for what happened. Other common PTSD side effects that possible influence service members regarding this criterion include: persistent negative emotional states, extremely diminished interest or participation in significant activities, feelings of detachment or

estrangement from others, or tenacious inability to experience positive emotions.

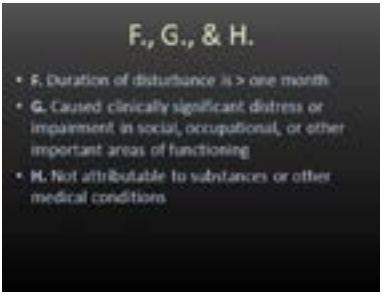
In D1, inability to remember important aspects of the trauma is due to "dissociative amnesia and is not due to head injury, alcohol, or drugs." In D2 persistent and exaggerated negative beliefs or expectations about oneself, others, or the world was caused by the traumatic event, and not something else. In D3, this also is a consequence of the trauma and not some other event. In blaming oneself, a survivor may believe such things as "it's all my fault that…happened," or "I lost my friend because I didn't…" In D4 negative emotions could include fear, horror, anger, guilt, and shame. In D6, positive emotions, as stated in the DSM, are (especially happiness, joy, satisfaction, or emotions associated with intimacy, tenderness, and sexuality). For the purpose of this presentation, simply reading through the slides should be sufficient. If questions arise, information was provided for further insight. Feel free to use any of the information above when presenting.




**Slide #9 (E. Arousal)**

Lastly, Trauma triggers the body's survival response causing service members to experience hyper-arousal, or always being on edge or alert status. When extreme alterations in arousal and reactivity related to traumatic events begin or worsen after the traumatic event happens, this becomes an area of concern. Extreme alterations include: cantankerous behavior and angry outbursts (with little or no provocation) usually communicated as physical or verbal aggression towards others or objects, reckless or self-destructive behavior, hyper vigilance, exaggerated startle response, difficulty with concentration, or sleep disturbance.

Trauma causes physical changes in the brain and body. Particularly for combat veterans, many times they have heightened sensitivity to threats or potential threats. Usually things that remind the survivor of the traumatic event are of particular concern for the survivor. For example, combat veterans may hear a care backfire and have a startled reaction. Physiological changes and heightened stress levels cause the survivor to react to situations detrimentally.




**Slide #10 (F., G., & H.)**

Previously, the DSM IV-TR separated the duration of disturbances into two separate length categories. Three months or less was considered "acute PTSD" and anything longer that three months was considered "chronic PTSD." The newest version (DSM 5) no longer has two separate length categories. Now when symptoms described in A thru E are experienced for more than one month the diagnosis is just "PTSD." Talk about this difference when describing F. The presenter should mainly read through or describe G and H without going into further detail unless the audience has questions.


**Slide #11 (Longevity of War)**

We have been at war in the Middle East for well over a decade now. Explain to the audience that certain factors cause service members to be more prone to PTSD development. Show the video and ask the audience why they think the longevity of war might increase PTSD development. Following a brief discussion, move onto the next slide. On slides 33 thru 40, the presenter should take this opportunity to make up time by going quicker or facilitating meaningful class discussion by going slower. This should depend on how the presenter is managing time. In other words, feel free to discuss in greater detail particular slides between 33 and 40 as long as other aspects of the presentation are not neglected and the presenter

does not go over time. The presenter may simply mention the title in each slide between 33 and 40, quickly moving on. It is important to note, however, that certain aspects of combat experiences makes one more prone to developing PTSD, worthy of at least mentioning.


**Slide #12 (Multiple Deployments)**

Validate the fact that 2.5 million service members have deployed to Iraq and Afghanistan. Of those who have deployed, many have deployed multiple times. If time permits, perhaps ask something along the lines of: "How do you feel multiple deployments have affected service members?" Answers may vary from divorce to suicide.


**Slide #13 (Witnessing Human Suffering)**

Without getting into too much detail (do not want to cause someone to have a severe trauma reaction), validate the fact that service members have seen or maybe even participated in human suffering. It is not recommended to ask too many questions about this topic unless the presenter feels that the situation is appropriate. Service members may share stories that trigger others service members who have had a severely traumatizing experience regarding this topic.


**Slide #14 (Coming Under Small Arms Fire)**
Briefly explain that coming under small arms fire and discharging a weapon can cause service members to be more prone to developing PTSD. Although the presenter may lead discussions about this topic, it is suggested that the presenter mention this as a factor and then move on.


**Slide #15 (Feeling in Great Danger of Death)**

The presenter may explain various aspects that cause service members to feel in great danger of death (i.e., IEDs, suicide bombers, etc.), or the presenter can ask the audience why they think service members would feel in great danger of death.


**Slide #16 (Being Shot at or Injured)**

Mention this as a PTSD developing factor. If appropriate, the presenter may lead a brief discussion about being shot at or injured. It is also okay to simply talk about this as a factor and then move on.


**Slide #17 (Seeing Someone Wounded or Killed)**

This is another potentially sensitive topic. The purpose of this presentation is not to trigger combat veterans in attendance, but to provide information. The presenter may mention this as a PTSD developing factor and then move on. If appropriate, the presenter may ask service members about how they think this would impact the lives those who witnessed something like this.


**Slide #18 (Progress=New Challenges)**

Highlight that service members are surviving at higher rates due to the advancement of defense armor and technology. Move to the next slide.


**Slide #19 (Progress=New Challenges)**

Greater survivability can become a burden for combat veterans. More service members are surviving, but more service members are also coming home with battle wounds that affect them adversely because of their survivability. It is a great honor to help more service members come home to their loved ones due to increased survivability, but it is also important to recognize that a certain percentage of combat veterans will come home with long-term physical and psychological issues.


**Slide #20 (The Diagnosis Trap)**

While PTSD diagnosis criteria has become more defined and standardized in the DSM 5, issues still arise regarding diagnosis. It seems like mental health professionals from various theoretical backgrounds interpret PTSD symptoms and severity differently. Some counselors utilize empirically supported PTSD assessment tools such as the PTSD checklist and others do not. Counselors also seem to utilize different assessment tools when assessing service members. It becomes important to note that PTSD is frequently under diagnosed, over diagnosed, and misdiagnosed. While PTSD diagnosis serves purposes such as validation and helping service members receive necessary help, it can also be detrimental.


**Slide #21 (The All-or Nothing Trap)**

Too often it seems like an imaginary line between those who have PTSD and those who do not have PTSD has been drawn. Those who have PTSD are labeled as "broken" and "need fixing." On the other hand, someone may be experiencing several PTSD symptoms, but not quite enough to be labeled as having PTSD. These individuals are told to suck it up and go back to duty. As a question, ask something like: "If a person has PTSD, does this mean that they are broken for life?" Answers may vary. It is okay if service members answer the question with "yes." If so, ask a follow-up question like: "So if someone is 'broken' for life, does it also mean that they cannot be stronger in some other area of their life due to struggling with PTSD and the aftermath of trauma?" The presenter may also ask a follow-up question like: "Can someone who is 'broken' for life find a way to manage their symptoms and maybe even grow stronger in some aspects of their life due to struggling with PTSD?" Following discussion, this should lead into the topic of PTG.


**Slide #22 (Desired Outcome: PTB)**

The presenter may say something like: "this leads us to our next topic of discussion, post-traumatic growth." PTG is founded on principles of positive change that occur in reaction to adversity and trauma. PTG is "a positive psychology change experienced as a result of struggle with highly challenging life circumstances." Although recognizing growth following trauma can be extremely difficult, over time survivors generally agree about realizing positive changes that would not have happened without the trauma.

PTG cannot be achieved without first experiencing trauma. Asking people in advance if they would like to experience posttraumatic growth knowing they would have to go through severe trauma, most likely would end with a negative response. Although the actual event of trauma is never judged to be positive in nature, what is accomplished following trauma can be. Growth takes place due to struggling with the aftermath of trauma and not in spite of it. Emphasizing the potential for positive change following trauma allows individuals to be empowered and focus on growth. Recognizing aspects such as PTSD or other disorders is also good in the sense that it helps people receive proper psychiatric help, but also not helpful

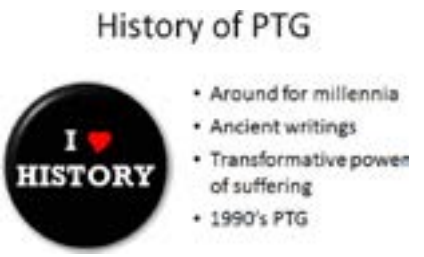
because it can cause individuals to focus too much on the negative aspects of trauma creating a bias that could stymie recovery in the long run. It is not about having PTSD over shadow PTG, but reversing it by having PTG over shadow PTSD.


**Slide #23 (What Doesn't Kill Us)**

The presenter should emphasize that they are showing a short clip for the purpose of short comical relief which also presents and educational point. Show the video and then move to the next slide.


**Slide #24 (Disclaimer)**

Following the video, ask the audience what they feel was realistic about the video and what was not. Highlight that the purpose of this section is to underscore the potential for growth following trauma, but not invalidate those who may be experiencing PTSD. PTSD is a real psychological and medical condition and should be treated as such. Because this presentation will focus on growth potential for those who experience trauma, it should be noted that this does not change the fact that PTSD diagnosed service members will most likely still feel "broken" in some ways as they struggle to make sense of their traumatic experiences and find growth.




**Slide #25 (History of PTG)**

Discuss the general history of PTG. Other terms for PTG: personal transformation, thriving, resilience, benefit finding, positive life change, stress-growth, and meaning construction. The concept that suffering and trauma can potentially bring about positive change has been around for thousands of years. Early examples include ancient writings of Greeks, Hebrews, and Christians as well as deeply embedded teachings from Hinduism, Islam, and the Baha'i Faith. Great emphasis was placed on the potentially transformative power of suffering. Progression by means of suffering did not gain great scholarly ground in the form of PTG until the 1990's with

the rise of positive psychology. Mental health professionals, through research, overwhelmingly found that people facing a wide variety of severely difficult circumstances went throughmomentous changes in their life, with the vast majority viewing these changes as highly positive.

**Slide #25 (Picture of Shattered Vase)**

PTG seems to be best explained by the theory and analogy of the shattered vase. Imagine owning a beautiful vase which holds great sentimental value. One day the vase is knocked to the ground and shatters into seemingly innumerable pieces. What are the options available for dealing with the aftermath of the shattered vase? It seems the three main options are to try to put the vase back together using glue or sticky tape, take it as a total loss and throw the shards away, or pick up the "beautiful colored pieces and use them to make something new—such as a colorful mosaic."

**Slide #27 (Picture of Shattered Vase)**

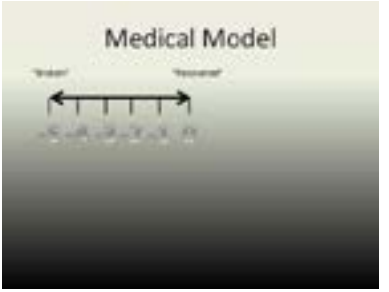
This is what it looks like when one tries to glue a vase back together. This is one of the better case scenarios. If the break is so bad that even the base shatters, getting a vase back to this point is extremely difficult, if not impossible. Be sure to note to the audience how weak this vase becomes when it is put back together. The presenter may also ask a question to the audience like: "how stable does this vase look?" The presenter should highlight the fact that the vase can never truly be like it once was after being shattered.

**Slide #28 (Picture of Colored Mosaic)**

The vase owner may not be able to put the vase back together in a way that it is stable or "returns to normal," but the vase owner can take the broken vase and make something else like a beautiful mosaic. In a sense it is still broken, but its brokenness is used to make it into something different and even more beautiful. After experiencing horrendous traumatizing experiences, survivors become like the shattered vase. While they may not be able to return to their "normal" levels of emotional and psychological functioning, they have an opportunity to grow to something different and even stronger.

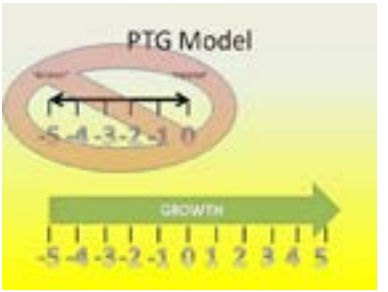

**Slide #29 (Returning to Normal)**

PTG involves more than returning to a "normal" psychological state following trauma. Many survivors following trauma want to "get back to the way things were" but in most circumstances this is impossible. Trauma (which is perceived by everyone differently) changes individuals on a deep level. Taking into consideration this figure, many mistakenly believe that the ultimate goal for trauma survivors should be returning to a regular level of functioning. Wrestling with the aftershock of trauma brings with it a greater potential for growth.



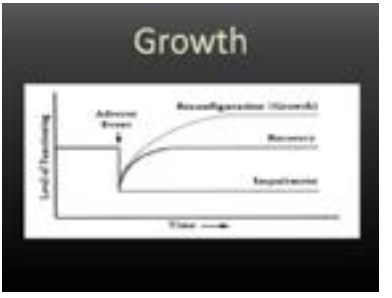

**Slide #30 (Medical Model)**

Psychology was originally founded with Sigmund Freud. He was originally a medical doctor but switched to working with people who had emotional/mental problems. Although he switched fields, he maintained the "doctor" to "patient" relationship with clients. Much like medical doctors want to help someone who is sick recover to normal or healthy physical states, Freud wanted to help those who struggled emotionally/mentally to return to "normal" capabilities of functioning. Many mental health professionals have adopted this "doctor" to "patient" model. Clients went to counselors and counselors would try to make the clients feel better. While many counselors did the best they could, they missed opportunities to empower clients by focusing too heavily on alleviating symptoms and not also assisting clients with achieving personal growth.




**Slide #31 (PTG Model)**

The PTG model emphasizes not returning back to "normal," but becoming something new and stronger. PTSD diagnosed service members should definitely seek help with professionally trained counselors, but also realize that growth necessitates personal empowerment. Its not about going to a counselor and depending on them to get "fixed," but receiving help from counselors and personally striving to make sense of trauma and find growth along the way. Struggling with the aftermath of trauma in most circumstance causes the survivor to change positively. Although negative aspects of the trauma (e.g., intrusion, avoidance, negative alterations in cognitions and mood, or marked alterations in arousal and reactivity) may continue long after the trauma is experienced, positive change also takes place. In fact, as mentioned previously, it is the struggling with stresses caused by trauma which actually brings about positive growth. Strengthening this ability to "resist or to bounce back from adversity is a key aim…however, rapidly returning to baseline functioning is not the only positive outcome following exposure to trauma. Some trauma survivors report posttraumatic growth: positive personal changes that result from their struggle to deal with trauma and its psychological consequences" Ideally, survivors will not return to a "normal" psychological state following trauma, but a better psychological state.




**Slide #32 (Growth)**

This is a chart to help drive home the idea of recovery vs. growth. Many trauma survivors set themselves up for failure by setting goals to become like they were prior to trauma. Trauma changes a person physiologically. While a survivor may find alleviation for PTSD symptoms to a certain extent, they will never be the same as they once were. Realizing that they are something different from what they once were, trauma survivors have the opportunity to grow to something more.


**Slide #33 (Dr. Craig Brown)**

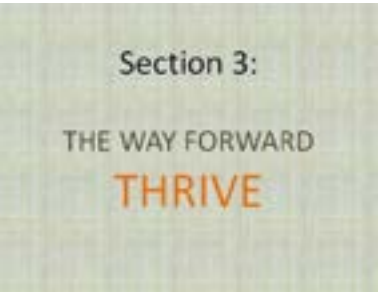
If time permits, share the radio interview with Dr. Craig Bryan regarding veteran resiliency and growth. If 15% of combat veterans return home with PTSD, this means that 85% are coming back resilient and mostly healthy. Sometimes we focus too much on the disorder and not enough on the inherent strength or our soldiers.


Take this time to review, do a check on learning, or simply allow the audience to ask questions.

**Slide #34 (Questions)**

## Section 3 Lesson Plan

### (Section 3: The Way Forward THRIVE)

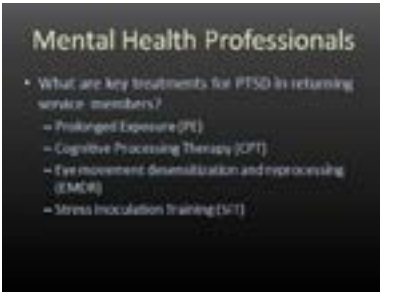



**Slide #1**

Simply state: "section three: The Way Forward: THRIVE." Allowing the audience time to read the slide without saying anything should also be fine. Before starting this session, ensure that each audience member has a copy of the THRIVE model worksheet.


**Slide #2 (PTSC Example)**
**Show Video: 8 min. 35 sec.**

Show the video. Allow time for the audience to process what they watched and then ask them what their reaction was to the video. Ask a question pertaining to the PTSD of the person in the video. Then ask if the audience could recognize ways in which the person found growth and understanding.




**Slide #3 (Mental Health Professionals)**

Mental health counselors have been working to address PTSD issues among combat veterans through various treatments. Some of the most prevalent treatments include: Prolonged Exposure, Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing, and Stress Inoculation Training. Providing this type of treatment requires mental health clinical certification as well as professional training regarding the specific type of treatment option. Many of these treatment options focus mainly on PTSD symptom alleviation and play a critical role for PTSD suffering veterans. This model emphasizes helping service member well-being increase from -5 to 0 (symptom alleviation). The emphasis of this presentation, however, is helping service member well-being increase from -5 to +5 (stronger than they were previously, also understanding that returning back to "normal" is impossible). Utilizing principle-based methods which will be explained in great detail later, in correlation with therapy,

PTSD-diagnosed service members can experience post-traumatic growth (PTG).

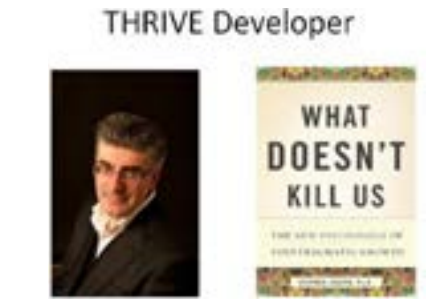
Do not let the audience leave with an understanding that PTSD diagnosed veterans do not need to receive professional mental help.


**Slide #4 (Barriers to Help)**

Combat veterans exposed to trauma who potentially meet criteria for PTSD diagnosis and treatment encounter several road blocks on their way to recovery. Of the many potential hindrances toward seeking help for PTSD associated problems, four factors are empirically salient. Lack of social support, preponderance of other life events, guilt and shame, and stigma towards mental health play key roles in keeping combat veterans from seeking help.

Briefly discuss barriers for service members regarding seeking help from mental health professionals. Ask such questions as: "what does it mean to lack social support?" or "how can preponderance of other life events cause a barrier to seeking help?" or "regarding guilt and shame, why does this cause service members to not seek help?" or "Why do you

think service members have negative feelings towards seeking professional help?" This is not a new topic for most service members and their responses will be what is legitimate for them. Validate and encourage discussion in this area.




**Slide #5 (THRIVE Developer)**

Briefly introduce the developer of the THRIVE model, Dr. Stephen Joseph, and his book *What Doesn't Kill Us: The New Psychology of Posttraumatic Growth*.


**Slide #6 (Messages)**

Taking necessary steps towards recovery and growth may be extremely frightening for service members struggling with the aftermath of trauma and PTSD but as they realize that they are not alone during their recovery, that their responses to war are natural and even necessary for survival, and that growth and healing is a journey, road blocks towards recovery will eventually be broken down. Service members will not return to a "normal" state of being, but to a stronger place of resiliency and growth.

Through learning about trauma, the biology of trauma, PTSD, PTG, and this model, service members should come to understand and adopt the three messages. Understanding the many people go through trauma, some developing PTSD, in various ways and that reactions to trauma are natural and normal, service members will hopefully come to realize that they are not alone in their journey. Many who go through trauma want to get back to "normal" soon after their experiences. Understanding that recovery and growth takes time, this will help the survivors practice greater patience and know more of what to expect in the process.


**Slide #7 (Victim-Survivor-THRIVE)**

The presenter should highlight that the goal of PTG is helping PTSD diagnosed veterans shift from being a victim to survivor and then finally to thriver. This is why Stephen Joseph's model/ acronym is called THRIVE.

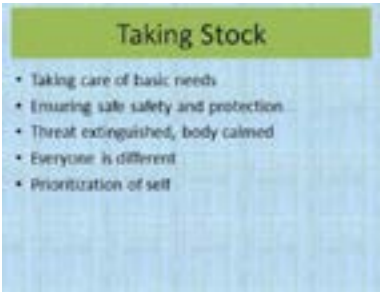

**Slide #8 (THRIVE)**

Go through each letter of the acronym THRIVE. Simply introduce the model and read the slide.


**Slide #9 (Taking Stock)**

According to Maslow's hierarchy of needs, basic needs such as sleep, food, and safety are absolutely necessary before anything else can be done. Emphasize that basic needs are

foundational for growth and progress in other areas. This slide is simply meant to lead the presenter into details regarding taking stock.




**Slide #10 (Taking Stock)**

Taking stock emphasizes taking care of basic needs which are most often neglected due to shock following trauma. Before survivors can achieve a deeper foundation for growth following trauma, a quiet atmosphere of safety and protection must be established. During trauma, areas of the brain focused on survival take over brain operation and stymie cognitive processing. Taking stock involves assessing what is needed following the strong emotional imbalance that is created by trauma. The threat must be extinguished and body calmed physically before the brain can mentally engage in recovery.

Following trauma, an individual may feel overwhelmed with thoughts of not being able to manage their emotions. Likely emotional reactions include feeling numb, confused, empty, exhausted, tense, or disturbed with thoughts and recollections of what happened. Survivors are many times plagued with nightmares and suffer from sleep deprivation. As the emotional reaction following trauma sets in, the survivor

may isolate from family, friends, and reality. Some survivors cope by means of detrimental ephemerals such as drugs, alcohol, domestic abuse, or other methods that only increase internal hopelessness. The survivor may lose interest in usual things and his/her career could suffer.

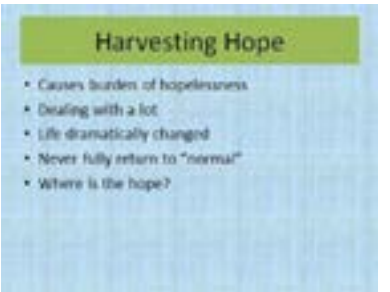
Survivors find growth and understanding following trauma in their own way and on their own time. Some need a few weeks to process trauma and loss and others need years. During the taking stock phase of post-traumatic growth, looking at the positive side of things may seem nearly impossible. Telling someone to "look at the bright side" may even be disrespectful at this point in time. Survivors need to receive empathy, a sense of safety, and emotional equilibrium in order to begin their journey towards post-traumatic growth.

Ensuring that survivors prioritize taking care of basic needs following trauma is tantamount for emotional equilibrium and foundational for eventual growth. Too often trauma survivors go on "automatic pilot" following trauma and neglect necessary self-care. While it is true that life cannot be ignored, especially when one is supporting a family or making ends meet, survivors must take stock and prioritize themselves so they can transition to working through their personal trauma.

After going through the slide, have the audience refer to their handout. Go through and discuss some of the methods that are helpful for properly taking stock.


**Slide #11 (Harvesting Hope)**

Simply state something like: "the next letter in the acronym is H for harvesting hope."




**Slide #12 (Harvesting Hope)**

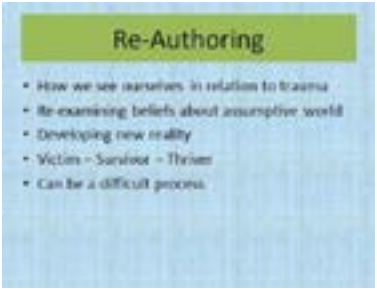
Trauma survivors often carry with them a heavy burden of hopelessness. Regardless of the circumstances, trauma can shake an individual to the very foundation of their being. Anyone who has experienced trauma can tell you that their life changed dramatically, never to fully return to the way it once was. Dealing with these changes in addition to the emotional impact caused by trauma can rob a survivor of the hope they once relied upon.

One method by which trauma survivors can harvest hope is by utilizing the miracle question and finding social support. The miracle question involves the survivors closing their eyes and imagining that they are going to sleep for the night and the miracle happens when the survivor wakes up. In the morning, things are different but in a good way. Essentially, the survivors think about how they feel now and compare it to how they felt when they woke up from the imaginative sleep. What changed and how can the survivor feel different from how they do in the present? As survivors begin to find meaning and visualize how they would like their lives to be different, they can recruit social support to help them with their goals. "Military personnel who perceive their missions as important and meaningful and who maintain regular contact with friends and family back home may experience less psychological distress during deployment" and after returning home.

After going through the slide, have the audience refer to their handout. Go through and discuss some of the methods that are helpful for properly harvesting hope.


**Slide #13 (Re-Authoring)**

Simply state something like: "next is re-authoring."




**Slide #14 (Re-Authoring)**

Re-authoring emphasizes how we see ourselves in relation to trauma. It is a "process of re- examining the beliefs that characterize one's assumptive world in light of an unexpected trauma, and these processes are related to posttraumatic growth." For example, following trauma,individuals view themselves based on their understanding of their experience. Some see themselves as victims, others as survivors, and others as *thrivers*. The term "*victim* implies passivity, defeat, helplessness whereas the term *survivor* implies recovery—a recognition that the person has gotten through adversity and taken back control of his or her life. But the term *thriver* goes even further. It implies activity, mastery, and hope." Perception of self in relation to trauma carries a large impact in how growth is experienced.

Trauma causes survivors to view life differently as they dig deep to find meaning in life. One explanation "for the positive associations between PTSD symptoms and PTG is that PTG occurs when the trauma has been upsetting enough to promote engagement in positive meaningmaking." Eventually survivors learn that helpful coping skills such as positive reinterpretation, problem solving, sense of coherence,

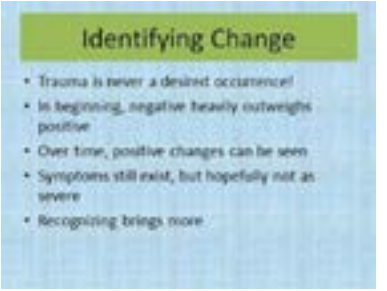
and active coping are a result of struggling with trauma. As survivors re-author their experience and what they gain as a positive, PTG usually follows.

The trauma itself is bad, but coping with the aftermath of trauma can have a positive effect. PTG does not "emerge as a direct result of a traumatic event in one's life; rather, the growth results from the individual's struggle with, and development of, a new reality or personal worldview following a traumatic event." Re-authoring a traumatic experience can be extremely difficult and take a lot of time, but in the long run it is worth it.

After going through the slide, have the audience refer to their handout. Go through and discuss some of the methods that are helpful for properly re-authoring.


**Slide #15 (Identifying Change)**

Simply state something like: "next is identifying change"



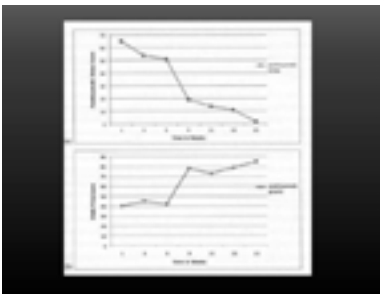

**Slide #16 (Identifying Change)**

Positive change commonly takes place following trial and adversity, even if it is only in small increments. In the beginning, negative effects from trauma most of the time seem to heavily outweigh signs of positive changes. As time passes and survivors continue to persevere through adversity, signs of positive change will outgrow the negative effects from trauma.

In addition to an increase of PTG and decrease in PTS are a wide variety of positive changes. Examples include: renewed appreciation of life, new possibilities, enhanced personal strength, improved relationships with others, spiritual change, etc. Trauma should never be advertised a desired event, but when trauma sadly happens, growth which surpasses our original state is most likely to occur. Through methods such as keeping a journal, receiving feedback from loved ones, or possibly self-administering welfare questionnaires, service members are more likely to identify change and value aspects that could have only come because of their response to the trauma they experienced.

After going through the slide, have the audience refer to their handout. Go through and discuss some of the methods

that are helpful for properly identifying change.



**Slide #17 (Blank Title, Line Graph)**

Identifying positive changes helps PTG increase and PTS decrease as indicated in the graph below. Over a long period of time, the Psychological Well-Being Post-Traumatic Changes Questionnaire (PWB-PTCQ) was administered to a population of people who experienced trauma of varying kinds. Here are the results: Struggling with the aftermath of trauma caused symptoms to eventually go down and PTG to increase.


**Slide #18 (Valuing Change)**

Simply state something like: “Next is valuing change.”


**Slide #19 (Valuing Change)**

Valuing change is a critical step in correlation with PTG. Valuing change emphasizes releasing expectations of how life should be and transitioning to valuing life as it is shaped by life and our desires. Trauma wrecks the lives of those who experience it in many cases. Although positive changes that occur in a survivor's life may not be what the survivor expected or originally planned, it is still a part of the survivor's life. Learning to live life from a new perspective, valuing it is important if the survivor hopes to find peace. Valuing change emphasizes not necessarily "feeling better but about creating new meanings, finding new values, and changing how you thing about yourself and your goals in life."

After going through the slide, have the audience refer to their handout. Go through and discuss some of the methods that are helpful for properly valuing change.


**Slide #20 (Call to Action)**

Simply state something like: "Lastly, we have expressing change in action."


**Slide #21 (Expressing Change in Action)**

Intellectually reframing traumatic experiences positively is not enough. Growth must be put into action by the way new behaviors are expressed. Examples of expressing change in action include: showing the acceptance of self, exhibiting purpose in life, improving relationships, achieving a sense of mastery, or branching out with others who have also experienced trauma. In other words, connecting behaviors with what has been learned about PTG is primarily what this phase emphasizes.

Service members should track concrete examples as a way to recognize and measure change. Keeping track daily and weekly will enable the service member to maintain focus on the positive aspects of struggling with the after math of trauma. This does not mean that the service member does not still experience negative side effects from the trauma, but indicates that PTG is becoming a larger entity in the survivor's life than PTS or PTSD. Examples of tracking the expression of change in action are as follows:

"This week when my sergeant yelled at me, I was initially upset, but soon after was able to collect my thoughts and manage my emotions more properly."

"On Friday I came home and cooked dinner for my wife out of appreciation for her support during everything I have been experiencing after deployment."

"I went to the PTSD recovery group on Wednesday to support others from my unit who I know have been struggling with PTSD symptoms themselves."

"I woke up this morning feeling more optimistic about life and rejuvenated for the day."

"Lately I feel a higher amount of gratitude towards my family, coworkers, and leaders. Today I sent a thank you letter to my commanding officer that was over me during deployment."

"This whole last week I smoked half the amount of cigarettes than I normally do."

"On Monday night I felt extremely anxious and depressed. Rather than drinking like I usually do in that state of mind, I went for a walk and then talked with my wife about what I was going through."

Keeping track of changes and how they are manifested is extremely important, even if the changes only seem inconsequential. Changes could be things like "becoming more self- accepting, autonomous, purposeful in your life, focused on deepening your relationships, masterful over your situation, and open to personal growth." Any change toward growth is good change and should be tracked.

After going through the slide, ask the audience what they think are some good examples of expressing change through action.


**Slide #22 (Word to the Wise)**

Once again caution the audience that the THRIVE model/ acronym is meant to be utilized when the trauma survivor feels like they are in a place to explore their traumatic experiences. For moderate to severe cases of PTSD, the THRIVE model should be utilized in correlation with therapy from a qualified

mental health professional.

This time to review, do a check on learning, or simply allow the audience to ask questions. This concludes the presentation.


**Slide #23 (Questions)**

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# THRIVE Handout

Developed by: Joseph, Stephen. *What Doesn't Kill Us: The New Psychology of Posttraumatic Growth*. New York, New York: Basic Books, 2011.

## Taking Stock

Taking stock emphasizes taking care of basic needs which are most often neglected due to shock following trauma. Before survivors can achieve a deeper foundation for growth following trauma, a quiet atmosphere of safety and protection must be established. During trauma, areas of the brain focused on survival take over brain operation and stymie cognitive processing. Taking stock involves assessing what is needed following the strong emotional imbalance that is created by trauma. The threat must be extinguished and body calmed physically before the brain can mentally engage in recovery. Each survivor finds recovery and growth on their own time and in their own way. Below are some methods to help you with taking stock:

1. *Check that you are physically safe*: Trauma aftermath can be chaotic. Find protection from what caused the trauma.
2. *Check that you are getting medical, psychological, and legal help you need*: Trauma potentially causes long-term issues. When needed, make sure you see doctors, mental health professionals, or legal attorneys for help.
3. *Check that you are eating well*: Trauma takes a physical toll on survivors. Ensure that you eat enough, but not too much. Eating plenty of vegetable and drinking enough water will help your body deal with physical aspects following trauma.
4. *Check that you are getting enough sleep*: This can be

particularly difficult following trauma. Try not drinking coffee in the afternoon or evening, eating too much before bedtime, or watching TV in bed. It may help to make a list of things you need to do before sleeping so you do not worry about it. Also try listening to music or doing something relaxing before bed. If this or other natural techniques do not work, you may need to meet with a psychiatrist about taking medication

5. *Stay physically active*: The body and mind work together. Not only does exercise and activity release feel good neurotransmitters like endorphins, they help trauma survivors become distracted for a time from dealing with traumatic memories. Exercise should leave you feeling refreshed and not exhausted.
6. *Keep pleasurable things in your life, and try to maintain your routines*: Following traumatic occurrences or when struggling with PTSD, survivors tend to fall into depression and out of routines. Taking time to do things that you enjoy will help you in the long run as you struggle to alleviate trauma aftermath symptoms.
7. *Practice learning to relax*: Learning to relax also helps alleviate trauma aftermath symptoms. Methods such as body scanning (laying down and focusing on one body part at a time, from the toes to the head, allowing you to relax little-by-little), mindfulness (focusing on personal breathing patters without judging or changing it), or other natural ways finding relaxation, helps you find greater physical and emotional equilibrium.
8. *Practice self-compassion*: In the aftermath of trauma, survivors frequently go through a wide variety of emotions. In the process they can be hard on themselves. This is a time when survivors must be compassionate with themselves. Imagine you have a friend who is having a

really had time, what would you say to them or how would you console them? Imagine you are consoling yourself as you would a friend, how would this change how you treat yourself?

9. *Be aware of triggers*: Many times trauma survivors feel like they have trauma reactions "out of the blue." Learning greater self-awareness regarding what causes trauma reaction can be beneficial for survivors. Anniversaries, vehicles backfiring, people that resemble individuals from a traumatic incident, or whatever else can cause a person to be "triggered." Becoming aware helps the survivor know what to expect and when they will need support.
10. *Avoid avoidance*: The aftermath of trauma can be extremely overwhelming for survivors. Some seek to avoid dealing with their issues by abusing drugs and alcohol, or utilizing some other form of distraction. This may seem to help them in the short run, but in the long run this only causes more problems. Although very difficult, the survivor must learn to deal with emotions and issues created by the trauma.
11. *Observe your reaction without judging*: Most people like to feel good. The problem with trauma is that it makes people feel bad in many ways, sometimes for a long time. When survivors try to push away or cover up "bad" emotions, they miss out on an opportunity to understand themselves. Observing reactions without judgment takes time and practice.
12. *Confronting traumatic memories and emotions*: Traumatic memories are understandably difficult and overwhelming, causing people to want to shut down. Eventually the survivor must come to confront traumatic memories. As they learn to do this in their own way and time, they can begin to make sense of what happened.
13. *Connecting with others*: Trauma has the tendency to make

people want to withdraw from social support. The survivor needs to wisely choose strong support and then fight the tendency to withdraw. You need support, for support is what will help you get through the most difficult times.

14. *Tuning into your emotions*: Trauma causes survivors to experience a wide variety of emotions. When survivors bottle up emotions and what they are experiencing, this cause major problems. The survivor must learn to put into words the emotions they are feeling and find an opportunity to express the emotions to trusted support people.
15. *Focus on what you can do to build on that*: Following trauma, you may not be able to do much due to overwhelming feelings of anxiety or some other issue related to experienced traumas. Learn what you can do and do that. Continue doing what you can do and then build on that.
16. *Laughter and smiling*: It may seem inappropriate and you may not feel like doing it, but laughter and smiling can be beneficial when not done superficially. First, it gives you a break from your worries. Second, laughter and smiling will bring to you greater social benefits. Lastly, positive emotions help with managing negative emotions. Whether you like watching movies, listening to comedians, or reading humorous books, participate when appropriate.
17. *Learning from the past*: While experiences in the past may not be as difficult as the trauma(s) most recently experienced, you utilized some form of coping techniques to help you get through them. Positive ways of helping you get through past adversities may help you with getting through present adversities.

**Notes:**

## Harvesting Hope

Trauma survivors often carry with them a heavy burden of hopelessness. Regardless of the circumstances, trauma can shake an individual to the very foundation of their being. Anyone who has experienced trauma can tell you that their life changed dramatically, never to fully return to the way it once was. Dealing with these changes in addition to the emotional impact caused by trauma can rob a survivor of the hope they once relied upon.

1. *Don't underestimate the power of hope*: Change and growth does not happen without growth. When survivors have something they can hope for, this causes a world of difference for them in their recovery.
2. *Remember*: To be hopeful does not mean that you don't care: This can be sensitive for those who lost someone close to them during a traumatic event. Some feel that being hopeful means that they do not care about the lost loved one. It is important to remember that being hopeful does not mean being forgetful.
3. *Be inspired*: Look for stories of personal growth: Find books and movies based on people who have had to overcome severe trauma and adversity. Allow pertinent stories to touch your life and provide you with hope and inspiration (even if it is only a little at first) in your life.
4. *Begin to practice hope*: Looking at things from the big picture can be helpful in one sense, but focusing on the small picture can be even more beneficial. Rather than taking on the burden of long term goals in a small amount of time, just focus on one day or even just one hour. Nothing is too

difficult when it is broken into smaller portions.

5. *Use the miracle question*: Imagine that you go to sleep with the problems and issues you are struggling with now. In the middle of the night, the miracle happens. When you wake up in the morning, things are different, but in a good way. What does that look like for you and how is it different? How can you achieve this, or maybe something similar?
6. *Use your social support*: As with taking stock, utilizing social support can help with harvesting hope. Associate with friends and family that can provide you support and help you with your goals of recovering and finding growth. Additional, genuine support helps with hope.
7. *Look to the future*: Imagine yourself being the person you want to be and in places where you want to go. See yourself accomplishing your goals and enjoy the emotions that come with that. It may be different from where you are now, but imagine it as if it were so.

**Notes:**

**Re-authoring**

Re-authoring emphasizes how we see ourselves in relation to trauma. It is a "process of re-examining the beliefs that characterize one's assumptive world in light of an unexpected trauma, and these processes are related to posttraumatic growth."[62] For example, following trauma, individuals view themselves based on their understanding of their experience. Some see themselves as victims, others as survivors, and others as thrivers. According to Stephen Joseph, the term

62. Richard G. Tedeschi, Lawrence G. Calhoon, and Arnie Cann, "Evaluating Resource Gain: Understanding and Misunderstanding Posttraumatic Growth," *Applied Psychology: An International Review* 56, no. 3 (July 2007): 396–406.

*victim* implies passivity, defeat, helplessness. The term *survivor* implies recovery—a recognition that the person has gotten through adversity and taken back control of his or her life. But the term *thriver* on the other hand goes even further. It implies activity, mastery, and hope. Perception of self in relation to trauma carries a large impact in how growth is experienced.

1. *Cultivate the growth mindset*: Those with growth mindsets look for opportunities to grow. They see change as possible, even when circumstances seem bleak. This is not naïve growth mind set (growing back an arm that was lost) but realistic growth mind set (learning to manage severe PTSD symptoms). In doing so, this allows survivors to tell new stories about who they are and the role of trauma in their lives.
2. *Use metaphors*: Metaphors help survivors see their situations from different perspectives. While metaphors can help survivors see things from different perspectives, ensure to use caution because metaphors can also limit a survivor's view about their ability to change.
3. *Expressive writing*: Utilize a blank piece of paper to write about what is bothering you. Write for ten minutes straight and then stop. Do the same thing every day for a week. Try writing in different ways and from different perspectives. This could help you with understanding situations from a different perspective.

**Notes:**

## Identifying Change

Positive change commonly takes place following trial and adversity, even if it is only in small increments. In the beginning, negative effects from trauma most of the time seem to heavily outweigh signs of positive changes. As time passes and survivors continue to persevere through adversity, signs of positive change will outgrow the negative effects from trauma. In addition to an increase of PTG and decrease in PTS are a wide variety of positive changes. Examples include: renewed appreciation of life, new possibilities, enhanced personal strength, improved relationships with others, spiritual change, etc.[63] Trauma should never be advertised a desired event, but when trauma sadly happens, growth which surpasses our original state is most likely to occur. Through methods such as keeping a journal, receiving feedback from loved ones, or possibly self-administering welfare questionnaires, service members are more likely to identify change and value aspects that could have only come because of their response to the

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trauma they experienced.

*Keep a journal of what goes well*: at the end of each day, spend 10 to 20 minutes writing about things that went well for you that day. Noticing positive changes will open your eyes to see greater positive changes. This does not mean that difficult circumstances relating to the aftermath

**Notes:**

## Valuing Change

Valuing change is a critical step in correlation with PTG. Valuing change emphasizes releasing expectations of how life should be and transitioning to valuing life as it is shaped by life and our desires. Trauma wrecks the lives of those who experience it in many cases. Although positive changes that occur in a survivor's life may not be what the survivor expected or originally planned, it is still a part of the survivor's life. Learning to live life from a new perspective, valuing it is important if the survivor hopes to find peace. Valuing change emphasizes not necessarily feeling better but about generating new meanings,

discovering new values, and changing how you think about yourself.

1. *Gratitude exercise*: Take five or ten minutes at the end of each day and write about three things you are grateful for from the day. Think about how these three things made you feel and what impact it played on your life. Continue doing this daily for a specified amount of time. This can help you value change.
2. *Imagining loss*: This involves imagining that you lose something or someone valuable to you (something or someone you have not already lost). By imagining what you have lost, you learn to value what you have. It may be uncomfortable, but this can be a powerful exercise to help you value not only change, but what you currently have in your life.

**Notes:**

## Expressing Change in Action

Intellectually reframing traumatic experiences positively is not enough. Growth must be put into action by the way new behaviors are expressed. Examples of expressing change in action include: showing the acceptance of self, exhibiting purpose in life, improving relationships, achieving a sense of mastery, or branching out with others who have also

experienced trauma. In other words, connecting behaviors with what has been learned about PTG is primarily what this phase emphasizes.

Service members should track concrete examples as a way to recognize and measure change. Keeping track daily and weekly will enable the service member to maintain focus on the positive aspects of struggling with the after math of trauma. This does not mean that the service member does not still experience negative side effects from the trauma, but indicates that PTG is becoming a larger entity in the survivor's life than PTS or PTSD. Examples of tracking the expression of change in action are as follows:

> "This week when my sergeant yelled at me, I was initially upset, but soon after was able to collect my thoughts and manage my emotions more properly."
>
> "On Friday I came home and cooked dinner for my wife out of appreciation for her support during everything I have been experiencing after deployment."
>
> "I went to the PTSD recovery group on Wednesday to support others from my unit who I know have been struggling with PTSD symptoms themselves."
>
> "I woke up this morning feeling more optimistic about life and rejuvenated for the day."
>
> "Lately I feel a higher amount of gratitude towards my family, coworkers, and leaders. Today I sent a thank you letter to my commanding officer that was over me during deployment."

> "This whole last week I smoked half the amount of cigarettes than I normally do."
>
> "On Monday night I felt extremely anxious and depressed. Rather than drinking like I usually do in that state of mind, I went for a walk and then talked with my wife about what I was going through."

Keeping track of changes and how they are manifested is extremely important, even if the changes only seem inconsequential. As Joseph put it, changes could be things like "becoming more self-accepting, autonomous, purposeful in your life, focused on deepening your relationships, masterful over your situation, and open to personal growth." Any change toward growth is good change and should be tracked.

**Notes:**