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Facilitating Posttraumatic Growth Among Service Members and Veterans Through a Book Study Group Intervention

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Abstract

Posttraumatic growth (PTG) is defined as "positive psychological changes experienced as a result of the struggle with traumatic or highly challenging life experiences" (Tedeschi et al., 2018, p. 3). Trauma affects 60% to 80% of the population (Boals, 2018). This is especially true for service members and veterans (SM/V) due to the inherent danger that comes with the job. Posttraumatic stress disorder (PTSD) and its many comorbidities can plague the SM/V population. Treatment options are well-established but not always effective. Bibliotherapy can present a non-threatening way to introduce alternative perspectives, such as PTG, to navigating trauma. The aim of this study was to determine if implementing a book discussion group could prove to be an effective way to introduce and facilitate the concept of PTG to the target audience of service members and veterans. Though this pilot study was too small to offer definitive implications (n = 7), PTG was demonstrated by the results of the *Posttraumatic Growth Inventory - Expanded (PTGI-X)* that revealed a statistically significant difference in the growth achieved between the pre-test and post-test (t[6] = -4.06, p = 0.01, d = -1.53), as well as a large effect size of the intervention. Evidence of PTG was supported by the large effect size and statistically significant reduction of PTSD symptoms shown in the results between the pre-test and post-test of the *PTSD Checklist for DSM-5 (PCL-5)* (t[6] = 3.62, p = 0.01, d = 1.37). While the reduction of trauma-related guilt was not supported by this study, the desire to help others was partially supported by the moderate effect size noted in the analysis of the results of the *Situational Motivation Scale* (*SIMS*; Guay et al., 2000).

Dedication

The trauma did not stop with the impact; its ripples were felt far and wide and continue to be felt today. May the message of posttraumatic growth reach all who were affected by their loss. My work is done in honor of their memory. As long as we continue to say their names, their memory will never die.

Captain Bryan D. Willard, USMC

1st Lieutenant Brandon R. Dronet, USMC

Staff Sergeant Donnie L. F. Levens, USMC

Sergeant James F. Fordyce, USMC

Sergeant Jonathan E. McColley, USMC

Corporal Matthieu Marcellus, USMC

Lance Corporal Samuel W. Large Jr., USMC

Lance Corporal Nicholas J. Sovie, USMC

Staff Sergeant Luis M. Melendez Sanchez, USAF

Senior Airman Alecia S. Good, USAF

Acknowledgments

The impact we have on people is often unrealized. I had never heard of the term posttraumatic growth until I was in a meeting with one of my instructors during my master's program discussing a project that ended up being the beginning of this work. That discussion opened my eyes to a new perspective on my trauma that I had not previously considered. The ball that began rolling that day has changed my life immeasurably for the better. Professor Jason Kaufman, my then-instructor, became my doctoral advisor and has unwaveringly guided me through this process. Jason, thank you for your leadership, guidance, professionalism, and passion for what you do and how you do it. The impact you have made on my life has been significant.

To Jordan and Chelsey, you were among my thoughts in those fateful moments that I thought might be my last. I have watched you endure and persevere as you have faced trauma and loss much too early in your lives. My hope for you is to recognize your strength and continue your path toward growth. It is never too late to chase your dreams! I love you, and I am so proud of you both.

Isaiah, Zachary, Archer, and Miriam, you have been patient as I have worked through this process. I hope watching me do this work and follow my passion will stay with you as you continue to grow and follow your own paths in life. The world is yours; your potential is endless. I love you.

For over half of my life, I have been loved, supported, and encouraged by my husband, Steve. Your unyielding love and dedication to my mission is remarkable. Your level of support has made the study of posttraumatic growth not my mission but our mission. Thank you for taking this sometimes messy journey of growth with me. As with

the ancient art of Kintsugi, we are stronger and more beautiful than our original form because of our experiences. Thank you for always joining me in sharing our mission of remembrance and posttraumatic growth with all who can hear us. I love you, Steve.

Table of Contents

List of Figures

Chapter I

Introduction

Many service members and veterans (SM/V) who struggle with posttraumatic stress disorder (PTSD) feel stuck in their diagnosis, often do not find the help they need with traditional therapy, and struggle to move past the stigma of the trauma and into triumph. Many SM/V have not been introduced to the concept of posttraumatic growth (PTG). This study will investigate the potential for educating SM/V about the concept of PTG to help SM/V enrolled in college who struggle with PTSD achieve PTG.

Background of the Problem

Definition of Trauma

The word trauma is used regularly, often in a cavalier way, to describe an uncomfortable situation. However, trauma is defined as an experience that is perceived as potentially life-threatening that puts into question one's safety with the potential to leave lasting adverse effects (Figley, 2012). While the use of the word "trauma" is not always in keeping with the definition, the fact remains that many people authentically experience the symptoms described in the definition. Ultimately, as Tedeschi et al. (2018) point out, "whether or not an event is traumatic is in the eye of the beholder" (p. 4). Trauma can be associated with any aspect of life both acutely, as a single traumatic event, and chronically or repeatedly over an extended period. Trauma can be caused by an inexhaustible list of events that include but are not limited to physical violence, witnessed physical violence, interpersonal violence, natural disasters, motor vehicle accidents, life-threatening medical conditions, and war (Zeligman et al., 2019). Valent accurately states:

> Trauma is the nemesis of our lives. Sometimes it swamps us; at other times it haunts us. It is the fracture that stops us from running as we would wish. The word trauma comes from the Greek word meaning wound or penetration, as in stabbing. Technically, the penetration can range from minor to lethal, but it always leaves a scar and a vulnerability. (as cited in Figley, 2012, p. xxiv)

Kashdan and Kane (2011) reported that over half of the United States population has experienced at least one traumatic event over the course of their lives. Therefore, addressing the scars that trauma can leave behind is both necessary and relevant to the majority.

Posttraumatic Stress Disorder

When trauma is not effectively processed, its effects can manifest as intrusive memories, guilt, reliving the traumatic incident, poor sleep, numbness to both happy and sad situations, flashbacks, depression, and inability to be in the moment. The American Psychiatric Association (APA, 2022) identified these characteristics as symptoms of posttraumatic stress disorder (PTSD). The goal of treatment for PTSD is not necessarily to thrive but rather to survive. This results in a bleak outlook for survivors who are already in a reduced state of self-efficacy. Goldberg and Falk (2019) state that families of prisoners of war (POW) survivors were warned that they should expect their family members to come back as shells of themselves. Warnings of low expectations of the ability of former POWs to take care of themselves were provided. Psychologically, this prognosis can demoralize trauma survivors and their loved ones. People often fall short of expectations; when expectations are low to begin with, the outlook is dire.

The effects of PTSD can be compounded in trauma cases where death has resulted. Survivors can be left to feel their actions have caused harm to others or wonder why they survived when others did not; this concept is referred to as survivor guilt (Wang et al., 2018). Survivor guilt can leave survivors feeling undeserving of love, joy, or contentment. The survivor can feel increased guilt and shame when positive feelings are permitted to sneak in (Leys, 2006). In her study examining the relationship between survivor guilt and PTSD, Murray (2018) analyzed participants who had met the criteria for the diagnosis of PTSD. She determined that 90% of participants who were involved in fatal traumatic events experienced survivor guilt which was a predictor of PTSD. While the APA (1980) recognized survivor guilt as a symptom of PTSD, it has been downgraded to an associated feature in the current version of the publication (APA, 2020; Leys, 2006). Regardless, survivor guilt remains a predictor of PTSD (Wang et al., 2018).

Posttraumatic Growth

Many trauma survivors avoid seeking counseling (Angel, 2016). They might struggle with an inability to relate with a counselor, the inability to get consistent appointments, or inconsistency among providers resulting in a need for alternative methods of coping with PTSD symptoms. An alternative to traditional therapy is support groups or mentoring programs facilitated by either a mental health provider, a peer, or peers who are also trauma survivors (DeCoster, 2018). Many trauma survivors also find it difficult to relate to others depending on the trauma's circumstances or the associated stigma. When they finally realize that they are not alone, survivors can recognize their potential to live free from a “diminished version” (Falke & Goldberg, 2018, p. 34) of

themselves. On the occasion when a survivor is finally able to relate to the story of another survivor, there is greater potential to find a renewed sense of hope.

After recognizing that they are not alone, the survivor can acknowledge that growth and joy are not only possible but acceptable after enduring unimaginable suffering. Trauma survivors are often able to transform tragedy into meaning and purpose. In 1995, Tedeschi and Calhoon coined the term posttraumatic growth (PTG) to describe this phenomenon (Tedeschi et al., 2020). PTG can be achieved by a very wide variety of trauma survivors (Henson et al., 2021). Tedeschi et al. (2020) discussed five domains of growth in which PTG can occur: personal strength (discovery of greater internal strength than previously thought), relationship to others (feeling closer with others), new possibilities (recognizing that life can take a path not previously imagined), appreciation for life (a more positive outlook on each day), and spiritual and existential change (feeling a greater spiritual connection and understanding). Growth in all five domains is not required to achieve PTG.

Facilitating Posttraumatic Growth

Falke and Goldberg (2018) described a process that teaches a framework developed to facilitate PTG. This framework is divided into five phases: education, regulation, disclosure, positive new story, and service. This framework can be applied to each of the five domains of growth. While mental health providers can deliver it, the framework can be even more effective when delivered by fellow trauma survivors who are referred to as expert guides or expert companions. One of the most effective ways to facilitate PTG among trauma survivors is to provide a safe space for others who have also

experienced trauma (Zeligman et al., 2019). Relationships and disclosure are factors closely associated with achieving PTG.

In their study, Zeligman et al. (2019) pointed out that companionship, disclosure, and a sense of belonging among trauma survivors can be instrumental to healing and growth. They stated that listening and sharing with others, for many survivors, has been shown to be more effective in healing than seeking traditional therapy. Disclosure can help trauma survivors know that they are not alone in their struggles (Henson et al., 2021). Angel (2016) provided a clear definition of expert companionship:

> The role of the expert companion is to tolerate the most difficult of details of the trauma, recognize that growth is a result of the struggle to come to grips with the traumatic event and not the event itself, and demonstrate humility and respect (and not just offer comfort or solutions) while listening. (p. 58)

While PTSD is a widely known and understood diagnosis, PTG is not a regular part of the world's vocabulary. PTG often takes considerable time to realize after a traumatic event (Borowa et al., 2016). The more distress, the greater the potential for growth (Henson et al., 2021). It should be noted that experiencing PTG does not cure the symptoms of PTSD. Still, it can provide an opportunity for survivors of trauma to shift their narrative and recognize that they can grow because of the trauma they experienced, not in spite of it (Falke & Goldberg, 2018).

Survivor guilt can also be an indicator of an increased potential for achieving PTG. Deliberate rumination can lead to healthy coping (Armstrong et al., 2014). Disclosure often comes from rumination and can lead to social support. Recognizing that guilt can be a double-edged sword and can, in fact, be helpful in PTG is another step

toward acceptance of positive outcomes from trauma (Wang et al., 2018). When disclosure happens, trauma survivors recognize that they are not alone in their feelings. Education and disclosure can reduce the negative effects of survivor guilt and lead to the healing of the soul (Wang et al., 2018).

Military Service

The ethos of military service is unique. It is made up of what often seems to be a different language filled with acronyms and phrases that are very clear and engrained among service members but can be difficult for a civilian to decipher (DeCoster, 2018). The culture and inherent danger surrounding the military lifestyle require strict adherence to policies, principles, and unquestioning immediate response to orders. Members of military units often become very close through their unique shared experiences. This connection is often reinforced through combat, in which service members rely heavily on one another for survival (McCaslin et al., 2014).

PTSD in Service Members and Veterans

Because of the inherent risk involved in military service, traumatic experiences are commonplace for military personnel and can be both acute (a single traumatic event) and chronic (experienced repeatedly over an extended period) and can result in visible and invisible wounds (Angel, 2016). While many people come to the service with previously experienced trauma, serving, especially in a combat environment, is a breeding ground for acute trauma. Combat exposure is one of the most significant factors associated with PTSD diagnosis. Up to twenty-four percent of troops returning from a combat zone are diagnosed with PTSD (Borowa et al., 2016).

All of the factors mentioned earlier regarding the lack of success of traditional therapy in treating PTSD (inability to relate with a counselor, the inability to get consistent appointments, or inconsistency among providers) also ring true for service members and veterans (SM/V) (Bonar et al., 2015). Two reasons compound the failure of traditional therapy among military members. First, although less than it once was, there is a stigma surrounding mental health and admitting the need for help among military members. Mental and physical readiness is a necessity for troops to be considered combat-ready. Many troops avoid taking care of their mental health because they fear its appearance in their medical record (Bonar et al., 2015) could indicate a lack of combat readiness. This could prevent the service member from deploying or doing their job. Second, when the decision to seek mental health treatment is finally made, there is a very real potential that either the provider or service member will be required to move during the course of treatment, requiring the service member to start over with a new provider (Tedeschi, 2011). While Tedeschi reported this occurrence in a single case study, it is not uncommon due to the transient nature of those who serve in the military. Moore et al. (2021) noted that up to 40% of service members being treated for PTSD discontinue treatment early. The need to start the process over with a new therapist can be emotionally daunting and may contribute to the early discontinuation of treatment.

Facilitating PTG Among Service Members and Veterans

Many SM/V spend years ruminating over trauma that was experienced while serving. Additionally, because of war and inherently dangerous training environments, the trauma incurred by service members has a more significant potential to result in loss of life than trauma experienced among the average civilian population resulting in a

greater tendency toward survivor guilt. As a result, SM/V are often left feeling stuck in a diagnosis of PTSD and struggle with various comorbidities (Moore et al., 2021).

With the realization that PTG is both a common and accepted phenomenon, SM/V are presented with an alternative to being stuck solely in the PTSD diagnosis. Moore et al. (2021) presented a peer-to-peer training program titled *Progressive and Alternative Training for Healing Heroes* (Warrior PATHH) to introduce and facilitate PTG among SM/V. The program requires that SM/V actively seek alternatives to traditional therapy and happen upon this training. While effective, this training does not reach a high percentage of SM/V who may benefit from this intervention. Preemptively educating SM/V on the phenomenon of PTG on a large scale may help to facilitate the benefits of PTG among them (Tedeschi & McNally, 2011).

Student Service Members and Veterans

The transition from military service to civilian life can be difficult. Since the inception of the Post-9/11 Veterans Educational Assistance Act of 2008 (Post-9/11 GI Bill), the tendency for SM/V to enroll in continuing education has increased dramatically. By 2020, there were an estimated five million SM/V enrolled in college classes utilizing the Post-9/11 GI Bill (Currier et al., 2018). They bring unique circumstances, strengths, challenges, and aftereffects of trauma. Due to their non-traditional student status (marriages, divorces, children, household responsibilities, and advanced age) and loss of military unit camaraderie, many of these student service members and veterans (SSM/V) are left feeling isolated, unable to relate to their non-SSM/V peers, and unable to adapt to the transition to a college environment with ease (Borsari et al., 2017).

Many of these SSM/V are enrolling in college courses and feeling the effects of the invisible and visible injuries sustained while serving (Rattray et al., 2019). While the statistics regarding SSM/V experiencing mental health concerns are similar to those of traditional college students, the tendency to seek mental health services for veterans is lower (DeCoster, 2018). Based on the number of veterans who utilize the Post-9/11 GI Bill and the percentage of veterans diagnosed with PTSD or traumatic brain injury (TBI), it is estimated that 1 in 27 first-time college students will fit into this category (Lopéz et al., 2016). The sustained trauma effects are compounded by the stigmas and challenges associated with seeking mental health services for invisible injuries. While resources are available to help SSM/V, they are underutilized. SSM/V can find themselves in a position where the effects of their diagnosis can feel compounded by a loss of personal connection with other service members and an inability to relate to traditional college students (McCaslin et al., 2014).

The number of military veterans taking advantage of education benefits is at the highest rate since the post-WWII era (Rattray et al., 2019). This phenomenon will increase the ratio of students who fit the category of SSM/V who struggle with invisible trauma-related injuries. Thus, it is essential to pay close attention to this demographic of college students. Experiencing PTG can have a lasting effect on veterans who experience future trauma, making them more resilient to the effects of PTSD (Tsai et al., 2015). Educating SSM/V on the existence of PTG and facilitating PTG can promote understanding of these outcomes. Learning how to achieve PTG is worthwhile for those entering military service and for those who have seen combat (Tedeschi, 2011), in addition to those SSM/V engaging in a college experience (DeCoster, 2018). It is

hypothesized that making the knowledge of PTG as commonplace as PTSD will promote more PTG among SSM/V trauma survivors.

Purpose Statement

This study aims to determine whether educating student service members and veterans (SSM/V) about posttraumatic growth (PTG) can positively impact their functioning. By educating SSM/V on the concept of PTG, SSM/V may realize PTG in themselves. Furthermore, SSM/V may recognize that they have already experienced PTG as a result of their trauma. The knowledge of the phenomenon may help SSM/V recognize that they are not alone in their struggle and help SSM/V accept that experiencing PTG is both acceptable and desirable. This knowledge can empower those who have struggled through the aftermath of trauma.

Hypotheses

The current study will seek to test three hypotheses to determine if gaining knowledge of the phenomenon of posttraumatic growth (PTG) through an intervention will promote PTG among student service members and veterans (SSM/V) who have experienced trauma and struggled with posttraumatic stress disorder (PTSD). PTSD and PTG can and do coexist (Zieba et al., 2019). While PTG does not eliminate the symptoms of PTSD (Hensen et al., 2020), recognizing existing growth or the potential for growth in oneself can help trauma survivors recognize that there is an alternative to the stigma surrounding PTSD. Joseph et al. (2012) pointed out that “trauma need not be a wholly destructive force in a person’s life” (p. 317). Therefore, gaining knowledge of the phenomenon of PTG is an important step in acknowledging and accepting the growth that can result from trauma.

The posttraumatic growth intervention will consist of a book study and periodic discussions of the book's content among SSM/V. This experience will lend itself to discussion and disclosure among SSM/V, who may be able to relate to one another through shared military experience. The book *Transformed by Trauma: Stories of Posttraumatic Growth* (Tedeschi et al., 2020) will be provided to participants who will have the opportunity to read the book and participate in regular discussions with other SSM/V who have also experienced trauma.

First, it is hypothesized that a posttraumatic growth intervention will facilitate posttraumatic growth among SSM/V who experienced trauma.

Tedeschi et al. (2020) is broken into three sections: understanding PTG, the domains of PTG, and moving through the growth process. In section one, an introduction to PTG is provided. Throughout the text, stories are included; these stories can provide a link to SSM/V that can help the participants relate to their own trauma. Tedeschi et al. present a narrative that can provide a springboard to PTG facilitation. While reading is an effective means of gaining knowledge, solidifying that knowledge can occur through discussions and disclosure among SSM/V who have experienced trauma. Wyant and Bowen (2018) suggested that book club discussions can both reinforce ideas and highlight concepts that may have been overlooked by a reader in a college environment, thus improving retention and knowledge gained. Participating in a book club discussion can also help to build community among its members. Henson et al. (2021) noted that disclosure among people who share something in common could promote PTG. While personal relationships (spouses, close friends, children) are more organic relationships, having the ability to relate to trauma experienced while serving in the armed forces could

also be a catalyst for a close connection among its members. Establishing an engaging community of SSM/V where a culture of trust has been created could facilitate PTG among the community members.

Second, it is hypothesized that a posttraumatic growth intervention will decrease trauma-related guilt among SSM/V who experienced trauma.

In the Kip et al. (2022) study of PTSD symptoms among adult trauma survivors, participants in war were found to have the highest occurrence of trauma-related guilt. While this study did not specify military members, in the United States, those who experience the atrocities of war are almost exclusively military members. SSM/V can find it difficult to relate with traditional students on campus. For those who struggle with trauma-related guilt, this struggle may be amplified. Participation in the posttraumatic growth intervention with others with shared backgrounds may help SSM/V who struggle with guilt recognize that they are not alone in their struggle and help SSM/V let go of self-judgment surrounding the guilt they feel as a result of the trauma experienced. Held et al. (2017) found that accepting one's actions that contribute to feelings of guilt without judgment is an effective way to cope and reduce the level of guilt felt by trauma survivors.

Third, it is hypothesized that a posttraumatic growth intervention will promote a desire in SSM/V to help others achieve PTG.

After an individual recognizes PTG in themselves, it is a natural progression to desire to share that knowledge with others. Tedeschi et al. (2020) is an engaging and inspiring text that can provide SSM/V a connection to others who have achieved PTG and hope for those who struggle with recovery from trauma. A significant part of

discovering PTG in oneself comes from disclosure. Tedeschi (2011) provided a powerful example of how disclosure is one of the most effective ways to realize PTG. In achieving and realizing PTG through disclosure, SSM/V will also understand the need to share this newfound knowledge with others who struggle to cope with trauma. Moore et al. (2021) and Zeligman et al. (2019) both stressed the need for and importance of fellow survivors of trauma, as opposed to clinical therapists, to guide one another toward realizing PTG. The posttraumatic growth intervention will be led by a fellow SSM/V trauma survivor whose example will also prove to inspire SSM/V who participate in the intervention to help others who struggle with trauma recovery.

Significance of the Research

The implications of this research could have a significant positive effect on those who struggle to get past the guilt and stigma of their trauma. If more people who struggle with symptoms of posttraumatic stress disorder (PTSD) are educated on the topic of posttraumatic growth (PTG) and are introduced to the stories of others who have experienced trauma and have become stronger because of it, they could also recognize PTG in themselves. The term PTG was coined in 1995 (Tedeschi et al., 2020), and its validity has been tested through many studies, but the fact remains that many people have not been introduced to this phenomenon. Introducing the term and concept of PTG could help those who struggle with PTSD recognize that: (a) they are not alone, (b) there is an alternative to the stigma of PTSD that can be empowering, and (c) there is a name that goes along with some of the things that they may have been experiencing while helping them to recognize and accept that it is ok to have experienced growth as a result of trauma (Tedeschi, 2011).

Limitations

This study is limited to student service members and veterans (SSM/V) in the Upper Midwest and may not represent SSM/V nationwide. While many colleges and universities are in areas with robust military presence, strong military presence is not found in the Upper Midwest region of the country, resulting in a greater level of separation for SSM/V from the military culture. Additionally, the Midwest presents a significantly different lifestyle and culture that is very different from either coast or the South.

Definition of Key Terms

Trauma: Exposure to actual or threatened death, serious injury, or sexual violence. The incident must have been directly experienced, witnessed in person while it occurred to others, or have occurred to a close family member or friend (APA, 2013).

Posttraumatic Stress Disorder (PTSD): A mental health condition resulting from experiencing or witnessing one or more traumatic events. Resulting symptoms can include intrusive memories, guilt, reliving the traumatic incident, poor sleep, numbness to both happy and sad situations, flashbacks, depression, and inability to be in the moment (APA, 2022).

Posttraumatic Growth (PTG): Positive psychological change experienced due to struggling with trauma.

Service Members and Veterans (SM/V): A comprehensive reference to encompass active duty service members, those who serve in the active reserves, those who serve in the National Guard, and those who have previously served in any of the aforementioned capacities but have returned to civilian status.

Student Service Members and Veterans (SSM/V): Service members and veterans who are enrolled in any form of a post-secondary education institution, including public or private two or four-year colleges and universities, graduate school, junior/community college, career/technical schools, vocational/trade schools, and religious-affiliated schools.

Chapter II

Review of the Literature

Definition of Trauma

According to Figley (2012), trauma is defined as an experience that is perceived as potentially life-threatening that puts into question one's safety with the potential to leave lasting adverse effects. However, Boals (2018) pointed out that an event such as bullying, divorce, or having one's sexual orientation revealed does not have to be life-threatening to be considered traumatizing. While the word "trauma" can have a varied elusive meaning and is sometimes misused as a simple catchphrase, the fact remains that many people authentically experience the symptoms previously described. In fact, Boals (2018) stated that 60% to 80% of the population has experienced trauma. Tedeschi et al. (2018) compared the effects of trauma to that of an earthquake. Trauma is an experience that could be considered seismic and can shake us to our core.

Trauma can be defined both objectively and subjectively. Similar events can have a dramatically different effect on each individual who shares the experience. More important than what the traumatic experience is, is how the trauma is perceived by the individual. Tedeschi et al. (2018) pointed out that an event is only traumatic if it is experienced as such. Boals (2018) used the construct of event centrality, "the extent to which a person perceives an event as a central part of their identity" (p. 78), to be helpful in distinguishing how trauma affects people differently. Moreover, Boals (2018) found subjective trauma (i.e., perceived trauma) is more indicative of trauma-related issues than objective trauma. When an individual sees a traumatic event as a turning point in their life story (Boals, 2018), the individual will likely have a difficult time overcoming its

effects. An event that one person can let go of can cause another to reevaluate their core beliefs. Tedeschi et al. (2018) say, “The definition of what constitutes a traumatic event may change over time and may be different across cultures…whether or not an event is traumatic is in the eye of the beholder” (p. 4).

Trauma can be associated with any aspect of life both acutely, as a single traumatic event, and chronically or repeatedly over an extended period. Trauma can be caused by an inexhaustible list of events that include but are not limited to physical violence, witnessed physical violence, interpersonal violence, natural disasters, motor vehicle accidents, life-threatening medical conditions, and war (Zeligman et al., 2019). The effects of trauma can be debilitating. Figley (2012) pointed out that trauma can be all-consuming and likens its effects to that of a penetrating wound that leaves behind vulnerability with its scars. Kashdan and Kane (2011) reported that over half of the United States population has experienced at least one traumatic event over the course of their lives. Therefore, addressing the scars that trauma can leave behind is both necessary and relevant to the majority.

Posttraumatic Stress Disorder

When trauma is not effectively processed, its effects can manifest as intrusive memories, guilt, reliving the traumatic incident, poor sleep, numbness to both happy and sad situations, flashbacks, depression, and inability to be in the moment. The American Psychiatric Association (APA, 2022) identified these characteristics as symptoms of posttraumatic stress disorder (PTSD). Boals (2018) stated that while 60% to 80% of a population will experience trauma, 8% to 11% will struggle with PTSD. Priebe et al. (2018) pointed out that PTSD first appeared as a recognized disorder in 1980 in the third

edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* (APA, 1980).

Throughout the updated versions of the *DSM*, clarifying the criteria for diagnosing PTSD has proven to be challenging. Each version of the *DSM* has identified a requirement of exposure to a traumatic event called an index trauma to be identified to receive a diagnosis of PTSD. Through the updates, PTSD has been moved from the chapter generalizing anxiety disorders to a chapter titled "Trauma - and Stress-Related Disorders." The APA (2013) lists an additional criterion to the original requirements of establishing a PTSD diagnosis. The additional symptoms include persistent negative beliefs and blame placed on oneself or others regarding the trauma, feelings of detachment, and dissociative symptoms. Additionally, Sareen (2014) noted the added requirement for exposure to trauma as opposed to the negative response to that exposure. As has been found in previous literature, the definition of index trauma has changed with regard to whether a single traumatic event is required to be identified as the index trauma or compounding events should be considered (Priebe et al., 2018; Sareen, 2014). More important than the event is how the event affects the trauma survivor's sense of self. Boals (2018) suggested that the most critical aspect of PTSD symptoms is the level of the centrality the event or events have in one's life. Symptoms of PTSD are more severe for those who have experienced interpersonal trauma than non-interpersonal trauma (Priebe et al., 2018).

The effects of PTSD can be compounded when interpersonal trauma has resulted in death. Survivors can be left to feel their actions have caused harm to others or wonder why they survived when others did not; this concept is referred to as survivor guilt (Wang

et al., 2018). Browne et al. (2015) found that the guilt associated with trauma has been positively related to the phenomenon of PTSD. Further, Priebe et al. (2018) pointed out that when guilt associated with trauma is not resolved, PTSD can be exacerbated (Held et al., 2017). Survivor guilt can leave survivors feeling undeserving of love, joy, or contentment. The survivor can feel increased guilt and shame when positive feelings are permitted to sneak in (Leys, 2006). In her study examining the relationship between survivor guilt and PTSD, Murray (2018) analyzed participants who had met the criteria for the diagnosis of PTSD. She determined that 90% of participants who were involved in fatal traumatic events experienced survivor guilt which was found to be a predictor of PTSD. While The DSM (APA, 1980) has historically recognized survivor guilt as a symptom of PTSD, it has been downgraded to an associated feature in the current version of the publication (APA, 2020; Leys, 2006). Regardless, survivor guilt remains a predictor of PTSD (Wang et al., 2018).

Sareen (2014) reported about multiple comorbidities for people with PTSD and stated that over 90% of those diagnosed with PTSD will experience at least one comorbidity: (a) major depressive disorder, (b) alcohol use/dependence, (c) anxiety disorder, and (d) borderline personality disorder. People who have a PTSD diagnosis can also struggle with parenting difficulties, a reduction in household income, sleeping disorders, and physical health issues. Traumatic brain injury is also reported as a contributor to symptoms of PTSD. Poor sleep and physical injury can lead to a decreased pain threshold; cardiovascular, neurological, metabolic, and respiratory problems; obesity; and joint pain. These problems have the potential to deepen existing depression and can lead to suicidal ideation.

There are many treatment options available to those who struggle with PTSD. Depending on what type of trauma is experienced, different modes of treatment may be more appropriate. Treatments for PTSD include cognitive behavioral therapy (CBT), prolonged exposure, eye movement desensitization, reprocessing therapy, and various pharmacotherapy options. Sareen (2014) pointed out that there is a severe shortage of sufficiently trained professionals to handle the number of patients presenting with PTSD. She noted that it may be necessary to use alternative solutions to meet the needs of those struggling with PTSD.

Another option for treatment is bibliotherapy. Bibliotherapy is "the guided reading of written materials in gaining understanding or solving problems relevant to a person's therapeutic needs" (Riordan & Wilson, 1989, p. 506). This type of therapy can be an effective method of treatment for various mental health conditions, including PTSD, and can be deemed as a viable alternative for those people who are less likely to seek traditional therapy treatment (Glavin & Montgomery, 2017). Through reading, a person who struggles with PTSD can often see themselves in the text and thereby process and potentially reframe their narrative to more effectively cope. Glavin and Montgomery (2017) note that engagement in cognitive reading can be an avenue to achieve traditional therapies such as CBT and prolonged exposure in a non-traditional way.

The goal of treatment for PTSD is not necessarily to thrive but rather to survive. This results in a bleak outlook for survivors who are already in a reduced state of self-efficacy. Dekel et al. (2012) stated that individuals who were prisoners of war (POW) included in their study were 7 times more likely to experience extreme PTSD than those who experienced combat without the additional trauma of capture. However, Goldberg

and Falk (2019) reported that while 30% of Vietnam veterans came home with PTSD, only 4% of POWs suffered the same fate. Goldberg and Falk (2019) reported that families of POW survivors were warned that they should expect their family members to come back as shells of themselves. Warnings of low expectations of the ability of former POWs to take care of themselves were provided. Psychologically, this prognosis can demoralize trauma survivors and their loved ones. However, from the research, different results emerged. Kiland and Fretwell (2013) reported on research conducted by Dr. William Sledge regarding outcomes for POWs across multiple wars. They found that 61% of POWs reported perceived benefits as a result of their POW experience.

Posttraumatic Growth

As Goldberg and Falk (2019) pointed out, dire outcomes are not a foregone conclusion for trauma survivors. Trauma survivors are often able to transform tragedy into meaning and purpose. As Frankl (1992) so aptly stated, "Even the helpless victim of a hopeless situation, facing a fate he cannot change, may rise above himself, may grow beyond himself, and by so doing, change himself. He may turn a personal tragedy into a triumph" (p. 147). Tedeschi and Calhoun (1995) noted that the meaning resulting from the struggle with trauma dates back to biblical times, in which a certain amount of credibility is given to those who can overcome the worst of times. In 1995, Tedeschi and Calhoun coined the term posttraumatic growth (PTG) to describe this phenomenon (Tedeschi et al., 2020).

Post-trauma covers a wide period of time that can range from days to years following a trauma (Tedeschi et al., 2018). Additionally, the word "growth" was intentionally chosen because PTG embraces the possibility of exceeding previously held

beliefs of the level of life satisfaction, whereas resilience reflects the ability of a person to return to the baseline achieved before the traumatic experience. Tedeschi et al. (2018) state that "The struggle that leads to PTG is not usually at first a struggle to grow or change, but rather to survive or cope. The growth tends to be unplanned and unexpected" (p. 5).

Dekel et al. (2012) found that growth is a response to distress. With higher levels of PTSD comes the potential for higher levels of PTG. It is notable that those who were initially more resilient and did not experience PTSD symptoms also did not show a high level of PTG. In their seminal work around PTG, Tedeschi and Calhoun (1995) likened the ability to the ability to achieve PTG to physical fitness. Those who are very fit to begin with do not show significant gains when taking on additional challenges. Those who are severely unfit become easily frustrated and quickly give up, but those who are of average ability have the greatest potential to show significant gains with confidence and effort. Dekel et al. (2012) pointed out that it is not the experience of trauma that causes growth but rather the emotional struggle in the aftermath of trauma that promotes PTG.

PTG can be achieved by a very wide variety of trauma survivors (Henson et al., 2021). For each individual who experiences growth as a result of enduring trauma, the journey will be varied. Tedeschi et al. (2018) defined five domains of growth in which PTG can occur: personal strength, relationship to others, new possibilities, appreciation for life, and spiritual and existential change. Growth in all five domains is not required to achieve PTG.

Personal strength, the first domain of PTG, is often realized sometime after surviving a traumatic event. When individuals look back to see the challenges they have

endured as a result of their trauma, they can be struck with a feeling of amazement. Calhoun and Tedeschi (2006) succinctly described the feeling of an individual who has experienced personal strength, “I am more vulnerable than I thought but much stronger than I ever imagined” (p. 5). While this strength is often not recognized at the moment, hindsight allows the individual to reflect with awe on their journey through the aftermath of trauma. Tedeschi et al. (2020) shared an account of a person who recognized their personal strength in their ability to show kindness, grace, and forgiveness to themself. They continued to point out that strength can mean someone has the ability and fortitude to push through, but it can also mean that someone has the strength to step back and ask for help. As is true for all domains, personal strength can present very differently for each individual who experiences PTG.

Relationships to others may change dramatically as a result of enduring trauma. Often, after experiencing trauma, people will retreat into themselves for fear of rejection, lack of understanding and support from others, or because it is difficult to relate to others. Experiencing growth in this domain can result in stronger, more authentic relationships in spite of the challenges. Some important relationships often develop around trauma. Tedeschi and Calhoun (1995) pointed out that “the recognition of one’s vulnerability can lead, especially in men, to more emotional expressiveness, willingness to accept help, and therefore an employment of social supports that had previously been ignored” (p. 35). When trauma survivors can find a person whom they can feel safe sharing their experience with, there is an increased potential for growth. Growth in this domain may also lead to a decision to leave relationships that are unhealthy.

New possibilities are often realized and acted upon in the third domain of PTG. People who have experienced what feels like a seismic shift in their lives may have a greater tendency to seize new experiences and opportunities instead of waiting because they often have a clearer understanding that life is short. As with all domains of PTG, new possibilities can present differently for different people. It can be shown when a person decides to quit their job and go for their dream job, or it can mean trying something new, whether it be a new hobby or traveling to a new place. Or, as Tedeschi et al. (2020) pointed out, a person's life may not change drastically, but they may become more fulfilled by the opportunities they already have. The desire to seize a new possibility may have been present in an individual for a long time; PTG is demonstrated when a person decides that it is necessary to do something about it. Tedeschi et al. (2020) share an account of a person's experience with this domain of PTG that is all too familiar to many survivors who have had a brush with death, "Instead of the past flashing before his eyes, he was grieving the future that never existed, but could have" (pp. 86-87).

Appreciation for life can also represent a domain for growth. The small things that can easily be taken for granted can take on an elevated meaning for someone who has experienced significant trauma. Joseph et al. (2012) recounted a story of a woman who survived a very traumatic experience. She survived the experience only to later have her husband die suddenly. Even after the death of her husband, she recognized that the first traumatic experience helped to build her resilience. She has become a person who is deeply appreciative of her life, despite the trials that she has survived. This is not always a domain that is easily recognized at that moment, but hindsight can provide space and perspective that allows the person to eventually recognize the growth.

Of all of the domains of PTG, *spiritual and existential change* has undergone the greatest modification in its definition. At its inception, the scope of spiritual and existential change was limited to religion, thereby excluding those who do not practice a particular religion. Since PTG was coined in 1995, the domain of spiritual and existential change has been expanded to be more inclusive of individuals who are not constrained by formal religious beliefs. The instrument by which PTG is measured, the *Posttraumatic Growth Inventory (PTGI)*, has been increased from two items to now include six items that represent a more comprehensive representation of the existential change that is not limited to religion.

As with all areas of research, PGT is not immune from skepticism. There is mention in the literature that PTG is merely a practice of self-deception, meaning it is illusory in nature (Dekel et al., 2012). Particularly when growth is self-reported, skeptics are hesitant to accept the validity of PTG. Dekel et al. (2012) would consider prolonged PTG to be a failure to cope sufficiently with trauma and propose that high levels of PTG over a long period of time may indicate that individuals have not successfully recovered from PTSD. The authors stated that continued distress is needed to experience continued growth and therefore consider the self-reported continued growth to be an embellishment of reality. In their in-depth discussion of validity reports, both positive and negative, Tedeschi et al. (2018) responded to the skeptics and reminded readers that PTG is both a process and an outcome that embraces the paradox "at the core of PTG: that loss can produce gain" (p. 40). Tedeschi et al. (2018) continued by pointing out that while there are limited longitudinal studies evaluating PTG over the long term, the construct of PTG was developed through and can be validated by longitudinal clinical relationships with

patients who have experienced the phenomenon of PTG. Additionally, validation has also occurred through observations of individuals who have witnessed PTG in trauma survivors, thus not only relying on self-report as validation for the phenomena. In their longitudinal study, Dekel et al. (2012) found that with the passing of time came a decrease in PTG even though the level of PTSD remained the same. This may result from other life events, aging, declining health, and loss tempering the growth that had been experienced in previous years. This evaluation only considers the PTG as an outcome; it fails to consider that PTG is also a process. While the symptoms of PTSD can be reduced or even eliminated, the growth achieved should not be expected to reverse after seismic trauma has been experienced.

Facilitating Posttraumatic Growth

Many trauma survivors avoid seeking counseling (Angel, 2016). They might struggle with an inability to relate with a counselor, the inability to get consistent appointments, or inconsistency among providers resulting in a need for alternative methods of coping with PTSD symptoms. Glavin and Montgomery (2017) noted that a shortage of mental health providers nationwide is also cited as a reason for the lack of follow-through with the treatment of PTSD by all who struggle with this diagnosis. Through their review of the literature, Glavin and Montgomery (2017) reported that community-based therapy could be a more accessible and less stigmatized method for receiving needed treatment for PTSD. An alternative to traditional therapy is support groups or mentoring programs facilitated by either a mental health provider, a peer, or peers who are also trauma survivors (DeCoster, 2018). Many trauma survivors also find it difficult to relate to others depending on the trauma's circumstances or the associated

stigma. When they finally realize that they are not alone, survivors can recognize their potential to live free from a "diminished version" (Falke & Goldberg, 2018, p. 34) of themselves. On the occasion when a survivor is finally able to relate to the story of another survivor, there is greater potential to find a renewed sense of hope and, thus, PTG.

Survivor guilt can further complicate the struggle in the aftermath of trauma. Self-judgment is a keystone to survivor guilt. While well-meaning bystanders may be quick to exonerate survivors of culpability, the survivor will often be the last to let themselves off the hook. Self-acceptance is one of the most challenging aspects of healing from trauma. Browne et al. (2015) suggested that conveying thoughts of guilt may be one of the most important aspects to address when considering the overall coping of PTSD. It may be difficult for a survivor to see a perspective different from the one they have constructed in their own mind that lays the guilt squarely on their shoulders. Held et al. (2017) described this as hindsight bias and stated that the only way for a survivor to cope adequately is to reframe and find acceptance of oneself without judgment. This seems an impossible feat for many survivors of guilt and can be the most significant hurdle to navigate.

Survivor guilt can also be an indicator of an increased potential for achieving PTG. Deliberate rumination can lead to healthy coping (Dekel et al., 2012; Armstrong et al., 2014). The internal struggle that results from trauma-related guilt often leads to a survivor turning inward. Taking the leap from rumination to opening up to others can be daunting. Browne et al. (2015) pointed out that those who struggle with trauma-related guilt may be less responsive to therapy that may be considered effective for someone who

struggles with PTSD without the associated guilt. A less threatening way to process the internal struggle may be to connect with others' stories of struggle through reading. When a survivor is able to relate to the experience of others and finally realize that they are not alone in their struggle, they may find it easier to accept themself with less judgment. Held et al. (2017) argued that accepting oneself is more important than simply being aware when they are having thoughts of guilt. Reading can be the bridge that closes this gap.

Learning about others' stories can also lead to disclosure and result in a previously unrecognized or unaccepted network of social support. As survivors begin to share their experiences with others, they can begin to reframe and, most importantly, find self-acceptance. Recognizing that guilt can be a double-edged sword and can, in fact, be helpful in PTG is another step toward acceptance of positive outcomes from trauma (Wang et al., 2018). When disclosure happens, trauma survivors recognize that they are not alone in their feelings. Education and disclosure can reduce the adverse effects of survivor guilt and lead to the healing of the soul (Wang et al., 2018).

After recognizing that they are not alone, the survivor can acknowledge that growth and joy are not only possible but acceptable after unimaginable suffering. Falke and Goldberg (2018) were the first to create a curriculum around a framework that was initially developed by Tedeschi and Calhoun to facilitate PTG. The framework is divided into five phases: (a) education, (b) regulation, (c) disclosure, (d) positive new story, and (e) service.

The *education* phase involves understanding the impact of our struggle on all aspects of our lives, accepting the struggle, and recognizing that from the struggle, we can grow. Tedeschi et al. (2018) summarized the education phase in the phrase, “It is not

what's wrong; it's what happened" (p. 147). Understanding this concept can be freeing for a trauma survivor.

Regulation involves the implementation of positive practices in our lives that can help us manage symptoms of stress, such as insomnia, anxiety, and intrusive rumination (Tedeschi et al., 2018), to establish a healthy balance. Falke and Goldberg (2018) provided an extensive list of practices that include but are not limited to meditation, exercise, spending time with horses, archery, purposeful breathing, art, music, and time in nature. The intention is to fully implement these practices in our lives as opposed to adopting them for a limited time. These practices become part of the individual with the intent of also removing unhealthy coping methods and practices (i.e., excessive drinking, eating, or drug use).

Tedeschi et al. (2018) stated that *disclosure* addresses intrusive rumination and allows trauma survivors to more fully process and gain control over intrusive thoughts. The idea is that intrusive rumination will give way to more constructive rumination. Faulke and Goldberg (2018) stated that disclosure is "about not being afraid to share what has happened to you during your life, the things you did and didn't do, and not carrying the guilt and shame with you anymore" (p. 53). Disclosure can happen in various ways, including verbally, through journaling or a diary, with poetry, or through songwriting.

From disclosure, a trauma survivor is able to create a *positive new story* that can only be shaped by the individual living and telling their story in their own way and on their own terms. Tedeschi and Calhoun (1995) noted that "For many survivors, the struggle with trauma represents the first time they have considered their life as a 'story'"

(p. 85). The story they tell effectively ties together all phases of their life: pre-trauma, the traumatic experience, and the aftermath (Tedeschi et al., 2018).

Finally, *service* is about paying it forward in limitless ways. Often, survivors of trauma are able to find a new and meaningful mission in their lives. This often involves the concept of becoming an expert companion to others. Angel (2016) provided a clear definition of expert companionship:

> The role of the expert companion is to tolerate the most difficult of details of the trauma, recognize that growth is a result of the struggle to come to grips with the traumatic event and not the event itself, and demonstrate humility and respect (and not just offer comfort or solutions) while listening. (p. 58)

One of the most effective ways to facilitate PTG among trauma survivors is to provide a safe space for others who have also experienced trauma (Zeligman et al., 2019). Relationships and disclosure can help establish these safe spaces. In their study, Zeligman et al. (2019) pointed out that companionship, disclosure, and a sense of belonging among trauma survivors can be instrumental to healing and growth.

Listening and sharing with others, for many survivors, is much more effective in healing than seeking traditional therapy. Disclosure can help trauma survivors know they are not alone in their struggles (Henson et al., 2021). While mental health providers can deliver the framework laid out by Falke and Goldberg (2018), it can be even more effective when delivered by fellow trauma survivors who are referred to as expert guides or expert companions. In fact, Tedeschi et al. (2018) pointed out that PTG most often occurs without professional intervention. Rather, PTG is more naturally facilitated by other trauma survivors who are exercising the phase of service as an expert companion.

The framework established to facilitate PTG can be applied to each of the five domains of growth: personal strength, relationship to others, new possibilities, appreciation for life, and spiritual and existential change. Falke and Goldberg also point out that these phases are not linear, with one falling after the other, but are often negotiated together. The process is iterative and continuous. This is not to say that we constantly start over; more importantly, each phase energizes another phase resulting in PTG.

While PTSD is a widely known and understood diagnosis, PTG is not a regular part of the treatment vocabulary. PTG often takes considerable time to realize after a traumatic event (Borowa et al., 2016). The more distress, the greater the potential for growth (Henson et al., 2021). It should be noted that experiencing PTG does not cure the symptoms of PTSD. Still, it can provide an opportunity for survivors of trauma to shift their narrative and recognize that they can grow because of the trauma they experienced, not in spite of it (Falke & Goldberg, 2018).

Military Service

According to the Council on Foreign Relations (2020), the United States military comprises one-half of one percent of the United States population, approximately 1.3 million active-duty personnel. Active duty military comprises six services: Army, Navy, Marine Corps, Air Force, Space Force, and Coast Guard. Each has a unique and varied role within the Department of Defense. The reserve component of the military adds just under one million additional service members to the ranks. These individuals are composed of reserve forces from each of the active components in addition to National Guard components. According to Congressional Research Services (2021), “Between

September 11, 2001, and August 24, 2021, a total of 1,031,500 reservists (which includes the National Guard) have served under voluntary or involuntary federal orders" (p. 8). While this number may be inflated because those individuals who have been activated more than once are reported each time separately, the impact of reserve forces in active service is notable. Given the statistic that up to 24% of troops returning from a combat zone are diagnosed with PTSD (Borowa et al., 2016), this equates to a staggering 559,000 service members who are potentially struggling with the symptoms of PTSD. This number does not consider the number of service members who have left active or reserve service and are still dealing with the aftereffects of trauma.

When an individual leaves the military, they often take with them the lessons, culture, and ethos that were ingrained during their active service. Anyone who has served in the military and then returns to civilian status under conditions other than dishonorable is considered a military veteran. The title veteran includes a wide range of people in the United States. A person who served in the active or reserve forces for a single enlistment or tour of duty (usually a minimum of two years) is considered a veteran. On the other end of the spectrum, a service member who has actively served for twenty or more years and has retired from the military is also considered a veteran.

The ethos of military service is unique; it is made up of what often seems to be a different language filled with acronyms and phrases that are very clear and engrained among service members but can be difficult for a civilian to decipher (DeCoster, 2018). The culture and inherent danger surrounding the military lifestyle require strict adherence to policies, principles, and unquestioning immediate response to orders. Members of military units commonly become very close through their unique shared experiences.

This connection is often reinforced through combat, in which service members rely heavily on one another for survival (McCaslin et al., 2014).

PTSD in Service Members and Veterans

Because of the inherent risk involved in military service, traumatic experiences are commonplace for military personnel and can be both acute (a single traumatic event) and chronic (experienced repeatedly over an extended period) and can result in visible and invisible wounds (Angel, 2016). While many people come to the service with previously experienced trauma, serving, especially in a combat environment, is a breeding ground for acute trauma. Combat exposure is one of the most significant factors associated with PTSD diagnosis. Up to twenty-four percent of troops returning from a combat zone are diagnosed with PTSD (Borowa et al., 2016).

The prevalence of guilt associated with PTSD is high among service members and veterans (SM/V), especially those who served in combat, because they tend to believe they are responsible for fellow service members' safety (Browne et al., 2015). Many SM/V spend years ruminating over trauma that was experienced while serving. Additionally, because of war and inherently dangerous training environments, the trauma incurred by service members has a greater potential to result in loss of life than trauma experienced among the average civilian population resulting in a greater tendency toward survivor guilt. As a result, SM/V are often left feeling stuck in a diagnosis of PTSD and struggle with various comorbidities (Moore et al., 2021), such as depression, anxiety, and substance abuse disorders.

Mindfulness may reduce feelings of trauma-related guilt. In their study of 128 veterans who were trained in cognitive processing therapy (CPT) and mindfulness skills

and were participating in a PTSD treatment program, Held et al. (2017) found that guilt intensity can be reduced when people learn how to accept their actions without judgment. Veterans do not generally have a problem recounting experiences from which that guilt stems. They do, however, struggle with the emotions related to the event. The authors found that the participant's ability to "act with awareness and accept oneself without judgment is a more crucial step in recovery than simply being aware when guilt arises and describing the guilt sensations" (Held et al., 2017, p. 430). Mindfulness and self-awareness are crucial in self-acceptance. Veterans are often good storytellers and can commonly recount events with a level of detachment. While the authors discounted the theory that discussion of an event is part of this process, it could be hypothesized that discussion combined with mindfulness may help in processing guilt and finding self-acceptance (Held et al., 2017).

The factors mentioned earlier regarding the lack of success of traditional therapy in treating PTSD (inability to relate with a counselor, the inability to get consistent appointments, or inconsistency among providers) also ring true and can even be amplified for SM/V (Bonar et al., 2015). Although potentially less than it once was, there is both public and self-stigma surrounding mental health and admitting the need for help among military members. Mittal et al. (2013) found that according to the veteran participants in their study, the public perceives veterans with PTSD as dangerous and unpredictable. Furthermore, participants of the study reported that the public blames the veteran for being responsible for developing PTSD because they knowingly put themselves at risk for such a disorder by volunteering to serve. These public stigmas,

while not held beliefs of all members of the public, are often perceived as true by SM/V and thereby have an effect on how they internalize and navigate their symptoms of PTSD.

Mittal et al. (2013) also reported that some self-stigmas that emerged from the research included a perception that the individual was weak because they struggled with symptoms of PTSD. Service members can also be concerned about the leadership in their chain of command, perceiving them as weak for being labeled with and seeking treatment for PTSD and thus losing confidence in the service member's ability to perform their duties. Mental and physical readiness is a necessity for troops to be considered combat-ready; many troops avoid taking care of their mental health because they fear its appearance in their medical record (Bonar et al., 2015) could indicate a lack of combat readiness. This could prevent the service member from deploying or doing their job. Additionally, Mittal et al. (2013) pointed out that as a result of avoidance of treatment, there is a tendency to turn to unhealthy methods of coping, such as substance abuse and other comorbidities.

When the decision to seek mental health treatment is finally made, there is a very real potential that either the provider or service member will be required to relocate during the course of treatment, requiring the service member to start over with a new provider (Tedeschi, 2011). While Tedeschi reported this occurrence in a single case study, it is not uncommon due to the transient nature of those who serve in the military. Moore et al. (2021) noted that up to 40% of service members being treated for PTSD discontinue treatment early. The need to start the process over with a new therapist can be emotionally daunting and may contribute to the early discontinuation of treatment. This

tendency, while high in the civilian population, is amplified in the military population affected by PTSD.

Glavin and Montgomery (2017) reported that of the post-9/11 veterans who had been diagnosed with PTSD, 10% received recommended treatment. Often, veterans are referred to other sites for treatment. When this happened, only 23-40% of those referred followed through with treatment. The stigma surrounding mental health is often reported as a reason for the lack of follow-through among veterans (Glavin & Montgomery, 2017). A shortage of mental health providers nationwide is also cited as a reason for the lack of follow-through with the treatment of PTSD by all who struggle with PTSD. Glavin and Montgomery (2017) reported that community-based therapy could be a more accessible and less stigmatized method for receiving needed treatment for PTSD. Mittal et al. (2013) reported that the participants in their study noted that they were empowered when they could interact with other service members who experienced PTSD as a result of combat. The collective strength of a support group helped participants to resist the stereotypes, whether they were felt by the public or themselves. The authors suggested that peer-based intervention may be particularly effective in facilitating the treatment of PTSD and reducing stigmas associated with the diagnosis.

Glavin and Montgomery (2017) also cited bibliotherapy as an effective means of dealing with mental health issues for those who cannot or will not seek professional support. Khokhlova and Bhatia (2023) reported that participation in book study groups promotes increased self-awareness, empathy, appreciation for differing perspectives, emotional maturity, interpersonal skills, and a shared sense of belonging among

participants. A combination of these concepts could reduce a gap that needs to be filled for SM/V.

Facilitating PTG Among Service Members and Veterans

With the unique struggles associated with PTSD among SM/V, there is a distinct need to find effective treatments and coping strategies for this population. The phenomenon of PTG is universal among those who struggle with trauma. Angel (2016) reported that 75% of all veterans who are diagnosed with PTSD also experienced PTG. However, for military populations, as with civilian populations, PTG is not a commonly recognized or understood construct. Tedeschi and McNally (2011) noted that training surrounding PTG prior to deployments and potential interaction with potentially traumatic experiences could help to normalize the seismic shift that can occur as a result of trauma. Introducing the concept of PTG among SM/V can be helpful in unlocking the stigma surrounding PTSD both before and after the occurrence of trauma.

With the realization that PTG is both a common and accepted phenomenon, SM/V are presented with an alternative to being stuck solely in the PTSD diagnosis. The five phases of the framework shared by Falk and Goldberg (2018) to facilitate PTG: education, regulation, disclosure, positive new story, and service, can also be applied to SM/V. Moore et al. (2021) described a peer-to-peer training program titled *Progressive and Alternative Training for Healing Heroes* (Warrior PATHH) to introduce and facilitate the phases of PTG among SM/V by introducing the framework and applying it to the five domains of growth: personal strength, relationship to others, new possibilities, appreciation for life, and spiritual and existential change. The program begins with a week-long in-person introduction to PTG and is followed by a virtual element to provide

continued support among participants as they implement their newly learned strategies for self-regulation and growth. Warrior PATHH is not actively advertised; instead, it requires that SM/V actively seek alternatives to traditional therapy and happen upon the application and registration for this training. While effective, this training does not reach a high percentage of SM/V who may benefit from this intervention. Preemptively educating SM/V on the phenomenon of PTG on a large scale may help to facilitate the benefits of PTG among them (Tedeschi & McNally, 2011). Falke and Goldberg (2018) described the process of facilitating growth that is taught at Warrior PATHH and is accessible to all audiences. However, the nuances of Warrior PATHH training may be difficult to conceptualize when reading the text independently.

While reading is an effective means of gaining knowledge, solidifying that knowledge can occur through discussions and disclosure among SM/V who have experienced trauma. Khokhlova and Bhatia (2023) found in their qualitative research that participation in a book study group helped participants develop an openness to seeing others' perspectives on topics covered in the texts that were studied. Khokhlova and Bhatia (2023) also noted that a common theme that emerged from their research was that participation in the book club helped promote self-acceptance, self-knowledge, and self-awareness, along with a greater appreciation of those aspects in others. Having the opportunity to see and be open to others' stories and observations lends to much deeper discussions of the topics allowing participants to make connections between interrelated topics and resulting in a greater depth of thinking around the designated subject of study.

Occasionally, a text will provide insight and engagement into a topic that proves to be a conduit to transformation in a person’s life; Tedeschi et al. (2020) combined the

concepts of PTG along with engaging stories of PTG to present such a text. While the text is universal among all who struggle with trauma, the examples provided are centered around SM/V and their families and, therefore, incredibly relatable to an SM/V population. Tedeschi et al. (2020) is divided into three sections: understanding PTG, the domains of PTG, and moving through the growth process. Tedeschi et al. presented a narrative that provides a springboard to PTG facilitation.

Student Service Members and Veterans

The transition from military service to civilian life can be difficult. Since the inception of the Post-9/11 Veterans Educational Assistance Act of 2008 (Post-9/11 GI Bill), the tendency for SM/V to enroll in continuing education has increased dramatically. By 2020, there were an estimated five million SM/V enrolled in college classes utilizing the Post-9/11 GI Bill (Currier et al., 2018). These student service members and veterans (SSM/V) bring unique circumstances, strengths, challenges, and aftereffects of trauma. Due to their non-traditional student status (marriages, divorces, children, household responsibilities, and advanced age) and loss of military unit camaraderie, many of these SSM/V are left feeling isolated, unable to relate to their non-SSM/V peers, and unable to adapt to the transition to a college environment with ease (Borsari et al., 2017). SSM/V may also feel the perceived public stigmas discussed earlier among their non-military classmates resulting in further alienation.

Many of these SSM/V enroll in college courses and feel the effects of the invisible and visible injuries sustained while serving (Rattray et al., 2019). While the statistics regarding SSM/V experiencing mental health concerns are similar to those of traditional college students, the tendency to seek mental health services for veterans is

lower (DeCoster, 2018). Based on the number of veterans who utilize the Post-9/11 GI Bill and the percentage of veterans diagnosed with PTSD or traumatic brain injury (TBI), it is estimated that 1 in 27 first-time college students will fit into this category (Lopéz et al., 2016). The sustained trauma effects are compounded by the stigmas and challenges associated with seeking mental health services for invisible injuries. While resources are available to help SSM/V, they are underutilized. SSM/V can find themselves in a position where the effects of their diagnosis can feel compounded by a loss of personal connection with other service members and an inability to relate to traditional college students (McCaslin et al., 2014).

The number of military veterans taking advantage of education benefits is at the highest rate since the post-WWII era (Rattray et al., 2019). This phenomenon will increase the ratio of students who fit the category of SSM/V who struggle with invisible trauma-related injuries. Thus, it is essential to pay close attention to this demographic of college students. Experiencing PTG can have a lasting effect on veterans who experience future trauma, making them more resilient to the effects of PTSD (Tsai et al., 2015). Educating SSM/V on the existence of PTG and facilitating PTG can promote understanding of these outcomes. Learning how to achieve PTG is worthwhile for those entering military service and for those who have seen combat (Tedeschi, 2011), in addition to those SSM/V engaging in a college experience (DeCoster, 2018).

Bibliotherapy combined with a discussion group among SSM/V is a fitting intervention for those in an academic environment. Wyant and Bowen (2018) suggested that book club discussions can both reinforce ideas and highlight concepts that may have been overlooked by a reader in a college environment, thus improving retention and

knowledge gained. Henson et al. (2021) noted that disclosure among people who share something in common could promote PTG. While personal relationships (spouses, close friends, children) are more organic relationships, having the ability to relate to trauma experienced while serving in the armed forces through a book study group could also be a catalyst for a close connection among its members. Establishing an engaging community of SSM/V where a culture of trust has been created could facilitate PTG among the community members.

Khokhlova and Bhatia (2023) noted that book clubs can easily be conducted online, allowing for a diverse combination of participants geographically and demographically. This allows for a potentially small population of SSM/V at one higher education institution to connect with a larger population of SSM/V, thereby increasing the opportunity for connection and expert companionship among the collective SSM/V population.

Summary

One of the invisible scars of trauma is PTSD. While 8% to 11% of the population is diagnosed with PTSD (Boals, 2018), up to 24% of troops returning from a combat zone are labeled with a PTSD diagnosis (Borowa et al., 2016). Combat exposure is one of the most significant factors associated with a PTSD diagnosis for SM/V. While there are many treatment options available to professionals to help those who struggle with PTSD, even getting an SM/V to agree to seek treatment can prove challenging. The prevalence of guilt associated with PTSD is high among SM/V (Browne et al., 2015) and can make treatment even more challenging. Whether it is a shortage of providers, a lack of treatment-seeking, or a lack of follow-through by the SM/V who struggles with the

aftereffects of trauma that prevent treatment success, it is necessary to consider alternatives to traditional treatment options for PTSD and its comorbidities.

An alternative treatment option presented in the research is bibliotherapy. Books, whether prescribed by a professional or suggested by a fellow SM/V, can provide valuable perspective to an SM/V who struggles with the aftermath of trauma and may help them recognize that they are not limited by the stigma that can accompany the diagnosis of PTSD.

PTG is one such topic that a trauma survivor may not have been introduced to if not through reading about it. PTG has been around for centuries but has been conceptualized as a construct since 1995. Tedeschi et al. (2020) eloquently describe PTG by comparing it to the ancient art of Kintsugi, in which broken pottery is restored. "The metaphorical lesson from this craft is that cracks are not meant to be hidden, but rather held up for all to see the beauty and glory in their strength and resurrection" (p. 13). From the struggle, a new and stronger version of the survivor can emerge. Having access to powerful literature can provide an opportunity to internalize a concept (such as PTG) and can help a survivor find meaning (Schaff, 2018).

When reading is combined with a discussion among a group of individuals with similar backgrounds, a sense of belonging and connection can emerge, promoting a greater depth of understanding of the material (Kokhlova & Bhatia, 2023). A group of individuals who share even more in common than SM/V is SSM/V, who all share a common goal of achieving some level of success in post-secondary education. Introducing SSM/V who have struggled with trauma to a book study group designed to facilitate PTG has the potential to make a significant impact on their life journey.

Chapter III

Method

Subjects

Participants were initially intended to be student service members and veterans (SSM/V) from public colleges and universities throughout the Upper Midwest who self-reported having experienced trauma. Trauma is defined as an experience that is perceived as potentially life-threatening. Trauma affecting SSM/V could have occurred before service, during service, or both. The goal was to recruit 40 participants across community colleges, technical colleges, and universities. Participants would be divided into small groups of eight to eleven members per group. SSM/V from public institutions were invited to participate from Minnesota and Wisconsin.

Recruitment proved to be a significant challenge. After two attempts at recruitment of SSM/V from colleges and universities across Minnesota and Wisconsin came up empty, recruitment efforts were refocused to all service members and veterans (SM/V). Even with extensive recruitment efforts, only a total of nine participants completed the pre-intervention survey. While the number of participants fell significantly short of the originally stated goal, the actual number met the original small group goal of eight to eleven members per group. This number had the potential to establish a functional positive group dynamic.

Measures

Participants were asked to respond to a variety of items regarding five areas of interest: (a) traumatic life events, (b) posttraumatic stress, (c) posttraumatic growth (PTG), (d) trauma-related guilt, and (e) desire to help others. In addition, participants

were asked to respond to a series of demographic items. During the posttest, participants were also asked an open-ended question: "Prior to the book discussion group, what did you already know about posttraumatic growth? How does that compare with what you know about it now?"

Traumatic life events were captured using the *Life Events Checklist for DSM-5 Extended Version (LEC-5*; Weathers et al., 2013). The *LEC-5* (see Appendix A) is a 17-question survey that was developed in conjunction with the Clinician-Administered PTSD scale. The *LEC-5* is widely used to help contextualize subject experiences of potentially traumatic events. Gray et al. (2004) evaluated the psychometric properties against other validated surveys and found the mean Kappa coefficient to be .61 with a retest correlation of $r = .82$.

Posttraumatic stress was measured using the *PTSD Checklist for DSM-5 (PCL-5;* Blevins et al., 2015). The *PCL-5* (see Appendix B) consists of 20 self-report items that seek to measure PTSD on a 5-point scale ranging from 0 = not at all to 4 = extremely. Blevins et al. (2015) conducted two studies that successfully demonstrated the validity of the *PCL-5*. Study 1 ($N = 278$) indicated internal consistency of .94 and test-retest reliability of .82 while demonstrating convergent validity of .74 to .85 and discriminant validity of .31 to .60. Study 2 ($N = 558$) demonstrated similar results that served to strengthen the results of study 1.

Posttraumatic growth was measured using the *Posttraumatic Growth Inventory - Expanded (PTGI-X*; Tedeschi et al., 2017*)*. The *PTGI-X* (see Appendix C) consists of 25 self-report questions relating to five areas of growth: relating to others, new possibilities, personal strength, spiritual and existential change, and appreciation for life. The items are

measured on a 5-point scale ranging from 0 = I did not experience this change as a result of my crisis to 5 = I experienced this change to a very great degree as a result of my crisis. The *PTGI-X* added four items to the original *PTGI* instrument to better measure existential and spiritual change among all individuals. The original instrument *PTGI* (Tedeschi & Calhoun, 1996), has been widely utilized to measure PTG among individuals who have experienced trauma but was less inclusive of those who do not practice traditional religious beliefs. Tedeschi et al. (2017) used samples from the United States (N = 250), Turkey (N = 502), and Japan (N = 314) and found internal reliability of .97 for the United States, .96 for Turkey, and .95 for Japan.

Trauma-related guilt was measured using the *Trauma-Related Guilt Inventory (TRGI*; Kubany et al., 1996*)*. The *TRGI* (see Appendix D) consists of 32 self-reported items in which participants are asked to circle one of five responses ranging from extremely true/always true to not at all true/never true, which are given values from 4 to 0, respectively. Seven items were reverse scored, ranging from never/none to always/extreme, and are given values from 0 to 4, respectively. Kubany et al. (1996) conducted seven studies. Studies 1 through 4 were used to design and refine the *TRGI*. Studies 5 through 7 were used to assess the stability and validity of the *TRGI* with three different participant samples. Study 5 assessed the test-retest correlations for six factors: global guilt, guilt cognitions, distress scales, hindsight bias/responsibility, wrongdoing, and lack of justification. The coefficient alpha results were: .86, .84, .73, .79, .74, and .83 respectively. The results remained consistent for the final two studies demonstrating the internal consistency of the *TRGI*. To aid scoring for *TRGI,* scaling was changed to a unified measure.

The desire to help others was measured using the *Situational Motivation Scale (SIMS*; Guay et al., 2000*)*. The *SIMS* (see Appendix E) consists of 16 items across six subscales measured on a 7-point scale ranging from 1 = corresponds not at all to 7 = corresponds exactly. Guay et al. (2000) conducted five studies to develop and validate the internal consistency and construct validity of the *SIMS*. The alpha values found across the six subscales were: intrinsic motivation = .86, identified regulation = .65, external regulation = .73, and motivation = .62.

Demographics items were also collected regarding (a) age, (b) gender, (c) race, (d) branch of service, (e) highest rank achieved, (f) military occupation specialty, (g) diagnosis of PTSD and (h) type of post-secondary institution in which they are enrolled. Additionally, participants were asked when their trauma occurred: before service, during service, or both. Because the participants of the study changed from SSM/V to SM/V, question (h) was eliminated from Qualtrics.

Design

Participants were originally recruited through an email that the director of military, veteran, and adult learner services for the state of Minnesota distributed to veteran assistant contacts at each of the Minnesota State colleges and universities as well as at the University of Minnesota campuses (see Appendix F). They requested the email be forwarded to all student service members and veterans (SSM/V) on each campus. Veteran assistant contacts for Wisconsin colleges and universities were contacted directly with the request to forward the email to SSM/V on specific campuses. A flier was embedded in the email and appealed to SSM/V who struggle with trauma and who may be looking for relief from their symptoms (see Appendix G). Both the email and flier

included a URL and QR code that would send potential participants directly to Qualtrics to sign the informed consent form. Additionally, the request was made of VA assistance offices to print and display the flier at their location. Initial recruitment was conducted during the third and fourth week of April 2023 to reach students as they completed their spring semester and prepared for summer.

Recruitment proved to be a significant challenge. After two attempts at recruitment of SSM/V from colleges and universities across Minnesota and Wisconsin came up empty, recruitment efforts were refocused to include all service members and veterans (SM/V). Even with the increased pool of potential participants, recruitment efforts required four iterations to the Institutional Review Board. Participants were finally gained through an organization that honors the service and sacrifice of the American military called wear blue: run to remember. Additional recruitment was achieved through advertising efforts on social media: Facebook, Instagram, and Linkedin.

The first phase of the research began by gathering data in Qualtrics. Both the email and flier included a URL and QR code that sent potential participants directly to Qualtrics to sign the informed consent form (see Appendix H). Immediately after the consent form, participants were asked to provide their contact information: name, mailing address, and email address. Next, participants were asked to respond to each of the following measures as part of the pretest: *Life Events Checklist for DSM-5 Extended Version (LEC-5*; Weathers et al., 2013), *PTSD Checklist for DSM-5 (PCL-5;* Blevins et al., 2015), *Posttraumatic Growth Inventory - Expanded (PTGI-X*; Tedeschi et al., 2017*)*, the *Trauma-Related Guilt Inventory (TRGI*; Kubany et al., 1996*)*, and the *Situational Motivation Scale (SIMS*; Guay et al., 2000*)*. After the completion of the measures,

participants were then asked demographic questions regarding (a) age, (b) gender, (c) race, (d) branch of service, (e) highest rank achieved, (f) military occupation specialty, (g) and diagnosis of PTSD. Additionally, participants were asked when their trauma occurred: before service, during service, or both. The information gathered in the final question block in Qualtrics was used to schedule the intervention. Participants were asked to rank their top four options from 1-4 from a list of potential meeting times. Participants also had an opportunity to check days of the week that would not work for them to meet during the intervention. Upon completion of the items in Qualtrics, SM/V were sent a package through the United States Postal Service that included a cover letter (see Appendix I), a mental health resource document (see Appendix J), a copy of the book *Transformed by Trauma: Stories of Posttraumatic Growth* (Tedeschi et al., 2020), and the *Book Study Group Reading and Discussion Guide* (see Appendix K).

Due to the nature of the topic of trauma, there was potential for significant emotions to arise for participants while they processed the text during reading or during book discussion group sessions. The facilitator is not a mental health professional and was not equipped to handle such incidents. Participants were provided a resource document that directed them to mental health professionals and resources that could be helpful if needed (see Appendix J). This document was provided in the package sent to each participant. Additionally, the facilitator verbally addressed the potential for a need for professional intervention at the beginning of each book discussion group session. The document was also shared in the Zoom chat at the beginning of each book discussion group session to ensure access was available to these resources at all times.

The intervention was supposed to occur during the summer term of 2023 (May - July 2023). Due to the difficulties in recruitment, the intervention began on August 22, 2023, and concluded on September 26, 2023. The intervention was supposed to be conducted every other week for a total of six meeting times, which would take 45 to 60 minutes per meeting. The determination was made with input from the participants to meet weekly instead of every other week. All book discussion group meetings were held online on the Zoom platform. Participants were supposed to be divided into groups of 8 to 11, and a designated meeting time would have been scheduled for each group. Due to the low numbers, one meeting time was coordinated among the group. Group meetings were held on Zoom at 8:00 p.m. Central Standard Time each Tuesday from August 22, 2023 - September 26, 2023. Tedeschi et al. (2020) is divided into three sections and is sixteen chapters long. Session 0 was the initial meeting. Participants were asked to read the preface and introduction prior to the meeting. Session 0 was shorter than the meetings that followed. The group facilitator provided an overview of the book and why it was chosen, discussed expectations and norms for the book discussion group, and provided a reading schedule. Section 1 (chapters 1-6; p. 13-66) was the assigned reading for session 1. Section 2 was read over the course of session 2 (chapters 7-9; p. 79-126) and session 3 (chapters 10-11; p. 127-160). Section 3 was read over the course of the final two sessions, session 4 (chapters 12-14; p. 161-222) and session 5 (chapters 15-16; p. 223-271).

Transformed by Trauma: Stories of Posttraumatic Growth (Tedeschi et al., 2020) and the *Book Study Group Reading and Discussion Guide* were used both in preparation for book discussion group meetings and during book discussion group meetings. The prompts provided in the reading and discussion guide were used by participants to guide

their reading. Each participant was encouraged to process the text in a way that worked for them. This could have included taking notes in the margins, highlighting or underlining the text, and/or the reading and discussion guide. Participants could also have considered journaling as a method of processing. During sessions 1-5 of the book study group intervention, the reading and discussion guide were used to start the conversation surrounding the assigned reading for the session. An opportunity was provided for participants to contribute to the discussion by asking questions, sharing stories, or listening. The structure was intentionally loose as comments, stories, and discussions from participants and the facilitator guided each session.

While reading the text was very much preferred, very low pressure was placed on participants' completion of the assigned reading. This approach was taken to prevent participants from being discouraged from attending discussions if they had not completed the suggested reading. Wyant and Bowen (2018) stated that book clubs are an effective way to provide shared context among individuals, can lead to a higher level of intimacy among group members, and may increase perspective through listening to others' responses, questions, and experiences. I focused on these aspects. If participants had not completed the assigned reading for the day, I suspect their attendance at the discussion group may have prompted reading after the Zoom session and thus the benefit of reading the text, albeit delayed.

During the final session, the final chapters were discussed, and time was provided to complete the measures through a Qualtrics link that was shared in the Zoom chat and via email. Participants were asked to respond to four of the five original measures during the posttest: *PTSD Checklist for DSM-5 (PCL-5;* Blevins et al., 2015), *Posttraumatic*

Growth Inventory - Expanded (PTGI-X; Tedeschi et al., 2017*)*, the *Trauma-Related Guilt Inventory (TRGI*; Kubany et al., 1996*)*, and the *Situational Motivation Scale (SIMS*; Guay et al., 2000*)*. Additionally, SM/V were asked about their level of participation in the book study group: amount read and the number of sessions attended. SM/V had an opportunity to answer the open-ended question: "Prior to the book discussion group, what did you already know about posttraumatic growth? How does that compare with what you know about it now?" Additionally, SM/V were able to provide an open response regarding their feelings surrounding the intervention.

Procedure for Data Analysis

Pretest and posttest data for each measure were collected and analyzed using JASP (https://jasp-stats.org) statistical analysis software. Each instrument was used to evaluate a specific hypothesis. The *PTGI-X* was used to test hypothesis one: *it is hypothesized that a posttraumatic growth intervention will facilitate posttraumatic growth among SSM/V who experienced trauma*. The *TRGI* was used to test hypothesis two: *it is hypothesized that a posttraumatic growth intervention will decrease trauma-related guilt among SSM/V who experienced trauma*. The *SIMS* was used to test hypothesis three: *it is hypothesized that a posttraumatic growth intervention will promote a desire in SSM/V to help others achieve PTG*. While *PCL-5* did not directly test any of the hypotheses, it provided valuable feedback in the analysis of the data and support for the analysis of hypothesis one.

Pre-test data were collected for each measure to establish a baseline before the intervention was conducted. After the intervention, post-test data was collected and compared with pre-test data using a t-test. The purpose of the t-test comparison was to

determine if there was a statistically significant difference in the level of posttraumatic stress and growth experienced as a result of the intervention. Additionally, the t-test comparison was used to determine if SM/V's willingness to help others who struggle with the effects of trauma changed as a result of the intervention. The same data were then analyzed using Cohen’s d to determine the effect size of the intervention across each variable: posttraumatic stress and growth, trauma-related guilt, and willingness to help others.

Chapter IV

Results

Demographic Characteristics

Nine service members and veterans (SM/V) from across the United States responded to requests to participate in the current study. The data from seven SM/V was used in the data analysis. The ages reported within the sample ranged from 37-52, with one participant who declined to answer. The genders within the sample were typical of a military organization, with the number of male participants outnumbering females (5 males, 2 females). The entire sample (n = 7) reported being white. The sample was made up of SM/V from the Army (n = 4), Marine Corps (n = 2), and Air Force (n = 1). The highest rank achieved by the sample ranged from enlisted (E6) to officer (O6) (3 enlisted, 4 officers). The military occupational specialty of the sample was varied and included professionals in the fields of infantry (n = 2), aviation (n = 2), medical (n = 1), intelligence (n = 1), and administrative (n = 1). Four participants reported a formal diagnosis of posttraumatic stress disorder (PTSD), while three participants reported no formal diagnosis of PTSD. Every respondent (n = 7) reported their trauma occurred while they were in the military. Of the six intervention meetings held, one participant attended four meetings, four participants attended five meetings, and two participants attended all of the meetings. Three participants read over half the book but did not finish, and four participants read the whole book.

The *Life Events Checklist for DSM-5 Extended Version (LEC-5*; Weathers et al., 2013) was used to report potentially traumatic events in an individual's life. The results revealed significant traumatic events for each participant. Each participant described the

"worst" traumatic event that had occurred. The responses included (a) an improvised explosive device (IED) attack in Afghanistan, (b) cleaning up human remains from an IED attack and then proceeding to be hit by an IED, (c) being stranded on a military base while it was under attack, (d) helping to provide aid to a fellow service member who had been doused by fuel and had caught fire and then the service member later died from his injuries, (e) sexual assault, (f) aviation mishap, and (g) being ambushed while on a mission. Each respondent reported that the stated traumatic incident had occurred 10-19 years prior. Each respondent reported that the traumatic event either happened directly to them or was directly witnessed by them. When asked how many times participants had experienced similar events to the "most stressful event," one respondent answered once, with the others listing "a few times," 3 times, 4-5 times, three participants indicated 10 or greater times, and one respondent lost track of how many times they had experienced similar stressful events.

Posttraumatic stress was measured both pre-intervention and post-intervention using the *PTSD Checklist for DSM-5 (PCL-5;* Blevins et al., 2015). While the *PCL-5* did not directly test any of the hypotheses, it did provide valuable feedback in the analysis of the data. Per the National Center for PTSD (2022) scoring protocol, each scoring a minimum of 31-33 with a score of two in each of the following clusters: 1-5, 6-7, 8-14, and 15-20 is indicative of PTSD. Each of the participants met the minimum requirement for a provisional diagnosis of PTSD.

One participant who responded to the pre-intervention survey and attended the first of six interventions removed themself from the study. Their demographics and pre-intervention data have been omitted from the current study.

Data from another participant were removed from all data analyses because of inconsistencies in their response set. This participant completed both the pre-intervention and post-intervention surveys and attended four of the six book study group meetings. Disparities existed in this participant's responses on the *LEC-5* from the pre-intervention survey. While this participant reported witnessing and learning about a number of traumatic events, they declined to report the worst significant event, nor did they respond to the question regarding how long ago the traumatic event happened. Additionally, the pre-intervention *PCL-5* indicated no evidence of PTSD. The total for the pre-intervention *PCL-5* score for the excluded participant was 14. PTSD is indicated with a minimum score of 31-33. In an email sent by the eliminated participant prior to the intervention, they indicated that the things they considered traumatic were viewed in videos during their military training. Neither the participant's responses on the pre-test survey nor his email communication were sufficient to satisfy the current study's aims to determine if gaining knowledge of the phenomenon of PTG through an intervention will promote PTG among service members and veterans *who have experienced trauma and struggled with PTSD*. For these reasons, this participant is considered an outlier relative to the other participants, and their scores have been eliminated from the data analysis.

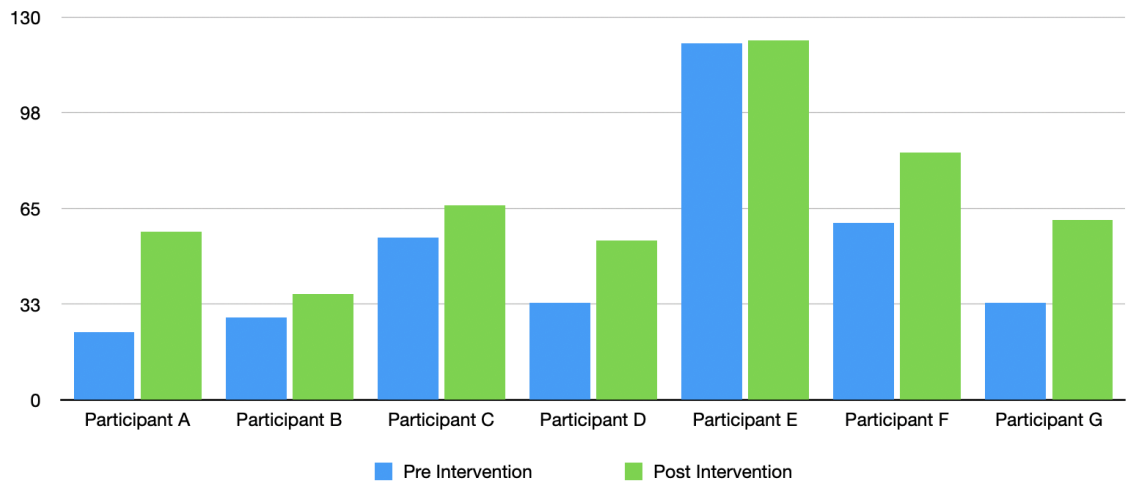
Posttraumatic Growth

It was hypothesized that a posttraumatic growth intervention would facilitate posttraumatic growth among SM/V who experienced trauma. Posttraumatic growth was measured both pre-intervention and post-intervention using the *Posttraumatic Growth Inventory - Expanded (PTGI-X*; Tedeschi et al., 2017). Results from the *PTGI-X* revealed a statistically significant difference in the growth achieved between the pre-test and

post-test ($t[6] = -4.06$, $p = 0.01$, $d = -1.53$), as well as a large effect size of the intervention. The mean score in the pre-test group was 50.43 ($SD = 34.05$), and the post-test mean was 68.57 ($SD = 27.58$). As shown in Figure 1, each participant experienced growth between the pre-test and post-test; however, participant E only gained one point on the *PTGI-X* between the pre-test and post-test. Notably, this participant began and remained significantly higher than the other participants in the study. While the small sample size is insufficient to make specific claims about the data, if this pilot sample is representative of the population, the results of this test would be suggestive, thereby supporting the first hypothesis.

Figure 1

PTGI-X Pre-Test and Post-Test Mean for Each Participant

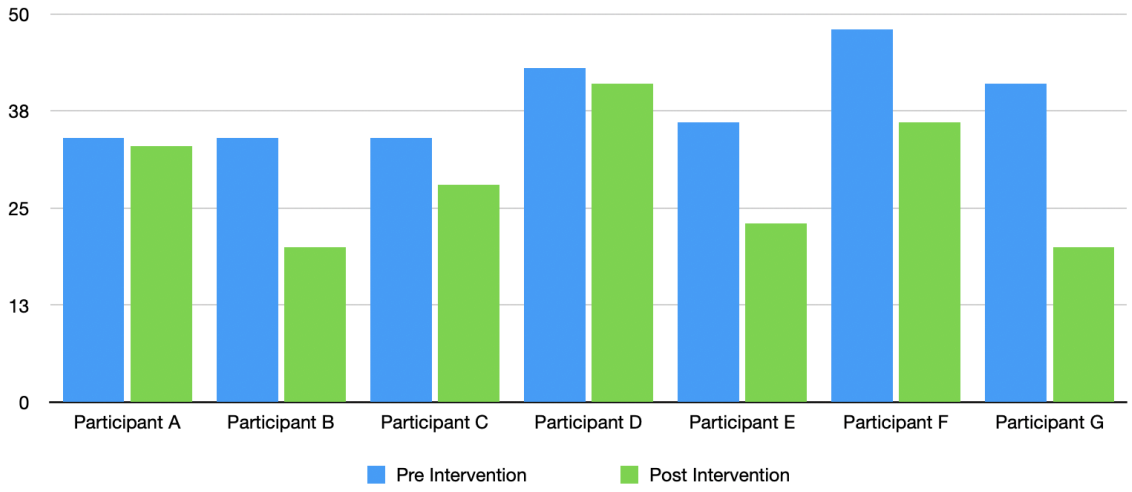


Additionally, post-intervention results for each of the respondents reveal a reduction in PTSD symptoms (see Figure 2). Per the scoring protocol of the National Center for PTSD (2022), "evidence for the *PCL* for *DSM-IV* suggests that a 5-10 point change represents reliable change (i.e., change not due to chance) and a 10-20 point change represents clinically significant change" (p. 3). Given the limited sample size, this

study can not make specific claims regarding implications to a population. However, if this pilot sample is representative of the target population, the results provided are suggestive. Results from the *PCL-5* revealed a statistically significant difference in the reduction of PTSD between the pre-test and post-test ($t[6] = 3.62$, $p = 0.01$, $d = 1.37$), as well as a large effect size of the intervention. The mean score in the pre-test group was 38.57 ($SD = 5.53$), and the post-test mean was 28.71 ($SD = 8.24$) (see Figure 1).

Figure 2

PCL-5 Pre-Test and Post-Test Means for Each Participant



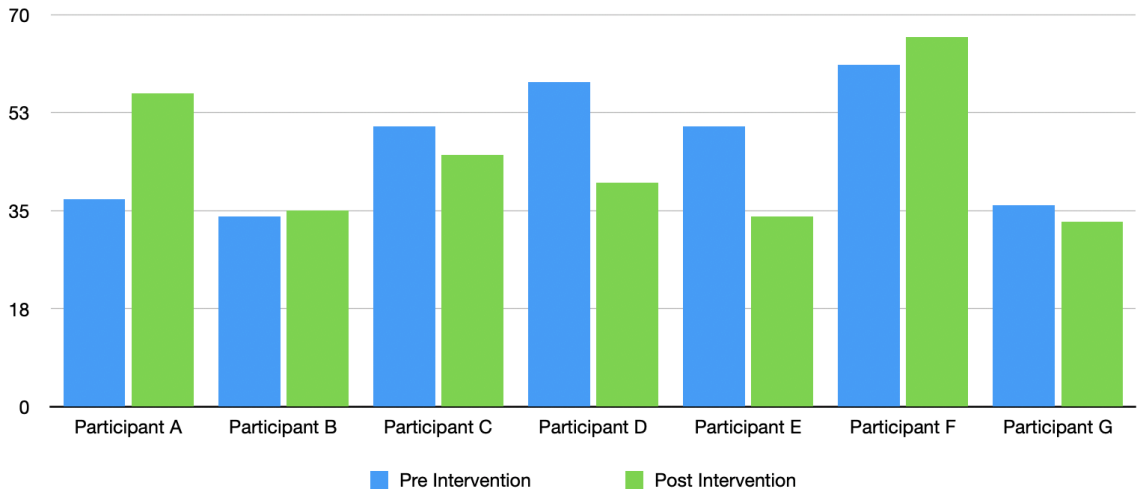
Trauma-Related Guilt

It was hypothesized that a posttraumatic growth intervention would decrease trauma-related guilt among SM/V who experienced trauma. Trauma-related guilt was measured both pre-intervention and post-intervention using the *Trauma-Related Guilt Inventory (TRGI*; Kubany et al., 1996*)*. Results from the *TRGI* did not reveal a statistically significant difference between the pre-test and post-test regarding a reduction in trauma-related guilt ($t[6] = 0.51$, $p = 0.63$, $d = 0.19$) or a notable effect size of the intervention. The mean score in the pre-test group was 46.57 ($SD = 10.98$), and the

post-test mean was 44.14 (*SD* = 12.56) (see Figure 3). Due to the lack of any notable significance in this test, the second hypothesis of the present study was therefore not supported.

Figure 3

TRGI Pre-Test and Post-Test Mean for Each Participant



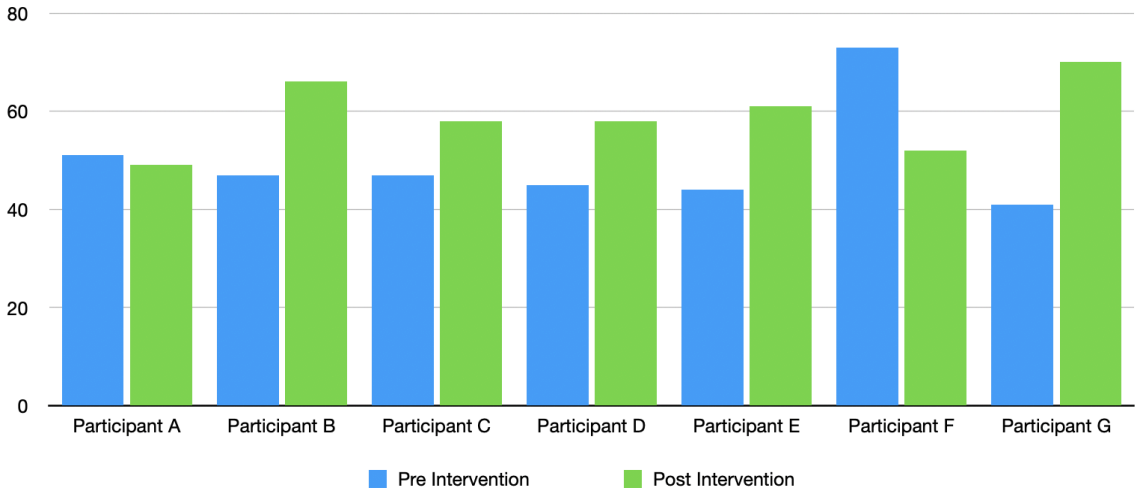
Desire to Help Others

It was hypothesized that a posttraumatic growth intervention would promote a desire in SM/V to help others achieve PTG. Desire to help others was measured both pre-intervention and post-intervention using the *Situational Motivation Scale (SIMS*; Guay et al., 2000*)*. Results from the *SIMS* did not reveal a statistically significant difference in the desire to help others between the pre-test and post-test ($t[6] = -1.53$, $p = 0.18$, $d = -0.58$). However, a moderate effect size of the intervention is noted. The mean score in the pre-test group was 49.71 (*SD* = 10.72), and the post-test mean was 59.14 (*SD* = 7.36), demonstrating relevant data to the study. While the sample set is too small to adequately make claims, the results of this test are at least partially suggestive. The desire

to help others, as seen in Figure 4, indicates that the third hypothesis could be partially supported.

Figure 4

SIMS Pre-Test and Post-Test Mean for Each Participant

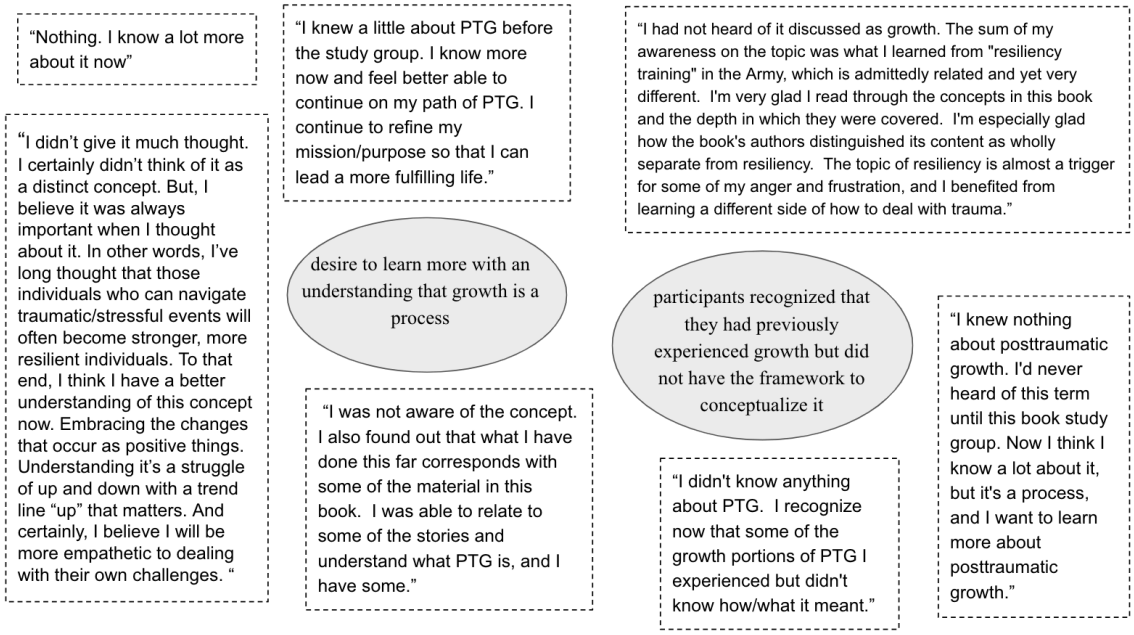


Open-Ended Questions

At the conclusion of the intervention, each of the participants had an opportunity to answer an open-ended two-part question, "Prior to the book discussion group, what did you already know about posttraumatic growth? How does that compare with what you know about it now?" Four participants stated that they knew nothing about posttraumatic growth (PTG) prior to the intervention, two did not understand PTG as a specific concept, and one knew "a little" about PTG. The general consensus regarding the second part of the question was that they now knew a great deal more about PTG. Two themes emerged from the data (see Figure 5). First, the participants revealed a desire to learn more with an understanding that growth is a process. Second, participants recognized that they had previously experienced growth but did not have the framework to conceptualize it.

Figure 5

Themes and Responses from Participants - Open-Ended Question

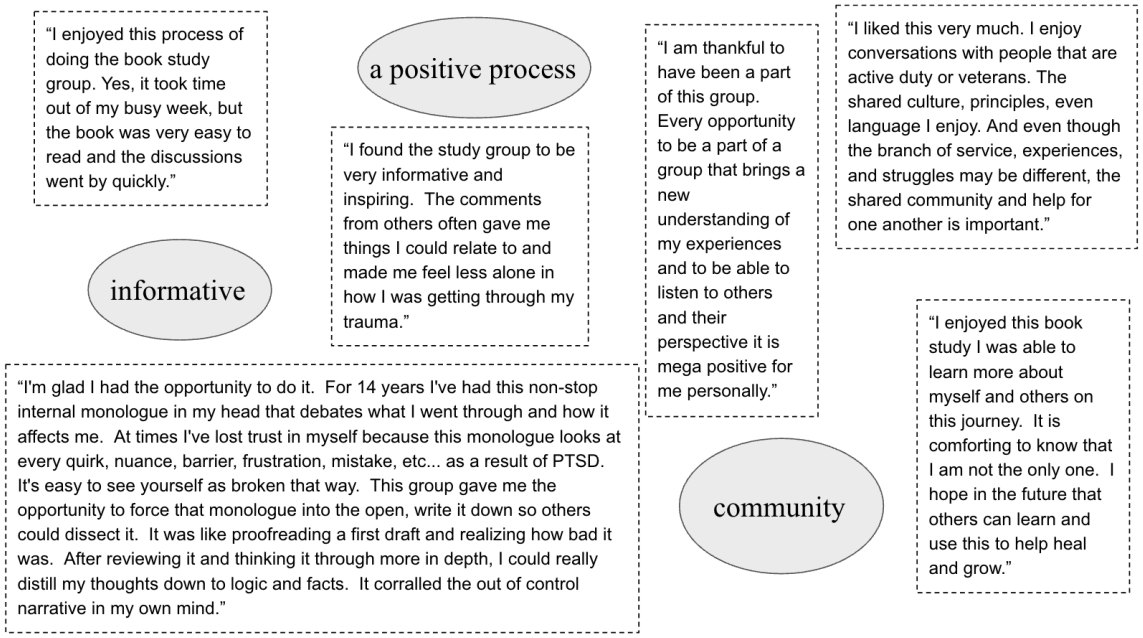


Note. The gray ovals indicate themes. The white rectangles indicated verbatim responses from participants.

At the conclusion of the intervention, participants were also able to provide an open response regarding their feelings surrounding the intervention. Three themes emerged from the data analysis (see Figure 6). First, participants enjoyed the process of the intervention and viewed it as a positive process. Second, participants viewed the intervention as informative. They learned not only about themselves but also about others and were able to better understand themselves because of the perspectives shared by other group members. The final theme to emerge was the power of community. The intervention helped participants to recognize and acknowledge that they were not alone in their struggle, which was both comforting and empowering.

Figure 6

Themes and Responses from Participants - Feelings Surrounding the Intervention



Note. The gray ovals indicate themes. The white rectangles indicated verbatim responses from participants.

Chapter V

Discussion

Summary of Findings

Trauma is defined as an experience with the potential to leave lasting adverse effects that are perceived as potentially life-threatening and put into question one's safety (Figley, 2012). Kashdan and Kane (2011) reported that over half of the United States population has experienced at least one traumatic event over the course of their lives. Therefore, addressing the emotional scars that trauma can leave behind is both necessary and relevant to the majority. When trauma is not effectively processed, its effects can manifest as posttraumatic stress disorder (PTSD). The goal of treatment for PTSD is not necessarily to thrive but rather to survive. This might result in a bleak outlook for survivors who are already in a reduced state of self-efficacy. Furthermore, the effects of PTSD can be compounded in trauma cases where death has resulted. Survivors can be left to feel their actions have caused harm to others or wonder why they survived when others did not; this concept is referred to as survivor guilt (Wang et al., 2018).

Nonetheless, trauma survivors are often able to transform tragedy into meaning and purpose. In 1995, Tedeschi and Calhoon coined the term posttraumatic growth (PTG) to describe this phenomenon (Tedeschi et al., 2020). Often, trauma survivors find help not through traditional therapy but through peers or others who have shared or similar experiences. When they realize that they are not alone in their experiences, survivors can recognize their potential to live free from a "diminished version" (Falke & Goldberg, 2018, p. 34) of themselves and acknowledge that growth and joy are not only possible but can be internalized after enduring unimaginable suffering.

One of the most effective ways to facilitate PTG among trauma survivors is to provide a safe space for others who have also experienced trauma (Zeligman et al., 2019). Learning about others' stories can lead to disclosure and result in a previously unrecognized or unaccepted network of social support. As survivors begin to share their experiences with others, they can begin to reframe their narrative and, most importantly, find self-acceptance. Zeligman et al. (2019) pointed out that companionship, disclosure, and a sense of belonging among trauma survivors can be instrumental to healing and growth. They stated that listening and sharing with others, for many survivors, has been shown to be more effective in healing than seeking traditional therapy. Furthermore, education and disclosure can reduce the adverse effects of survivor guilt and lead to the healing of the soul (Wang et al., 2018) and, ultimately, PTG. Establishing an engaging community of survivors through a book study group where a culture of trust has been established could facilitate PTG among the members or could provide the catalyst for establishing such a community.

It should be noted that experiencing PTG does not cure the symptoms of PTSD. Still, it can provide an opportunity for survivors of trauma to shift their narrative and recognize that they can grow because of the trauma they experienced, not in spite of it (Falke & Goldberg, 2018). While PTSD is a widely known and understood diagnosis, PTG is not a regular part of the world’s vocabulary.

Because of the inherent risk involved in military service, traumatic experiences are commonplace for military personnel and can result in visible and invisible wounds (Angel, 2016). Combat exposure is one of the most significant factors associated with a PTSD diagnosis. Up to twenty-four percent of troops returning from a combat zone are

diagnosed with PTSD (Borowa et al., 2016). Many service members and veterans (SM/V) spend years ruminating over trauma that was experienced while serving. Additionally, because of war and inherently dangerous training environments, the trauma incurred by service members has a more significant potential to result in loss of life than trauma experienced among the average civilian population resulting in a greater tendency toward survivor guilt. As a result, SM/V are often left feeling trapped in a diagnosis of PTSD and struggle with various comorbidities (Moore et al., 2021).

With the realization that PTG is both a common and accepted phenomenon, SM/V can be presented with an alternative to being stuck solely in the PTSD diagnosis. Moore et al. (2021) presented a peer-to-peer training program titled *Progressive and Alternative Training for Healing Heroes* (Warrior PATHH) to introduce and facilitate PTG among SM/V. The program requires that SM/V actively seek alternatives to traditional therapy and happen upon this training. While effective, this training does not necessarily reach a high percentage of SM/V who may benefit from this intervention. Preemptively educating SM/V on the phenomenon of PTG on a large scale may help to facilitate the benefits of PTG among them (Tedeschi & McNally, 2011).

The aim of the current study was to provide PTG education to SM/V through a book study group to determine if knowledge of the phenomenon could help SM/V recognize that they are not alone in their struggle and also recognize that experiencing PTG is both acceptable and desirable. Participants of the study were provided with a study guide and the book *Transformed by Trauma: Stories of Posttraumatic Growth* (Tedeschi et al., 2020). The contents of the book were discussed over the course of six weekly meetings on Zoom. The goal was to share experiences and perspectives among

group members to empower participants who have struggled through the aftermath of trauma with knowledge of PTG.

Nine participants initially joined the study, with usable data collected from seven of them. The participants reported ages ranged from 37-52, with one participant declining to answer. Five white males and two white females participated. The services represented were Army (n = 4), Marine Corps (n = 2), and Air Force (n = 1) and ranged from enlisted (E6) to officer (O6) (3 enlisted, 4 officers). While the sample was small, it was an ideal number of participants to potentially establish a strong group dynamic.

Posttraumatic Growth

Given the limited sample size, this study can not make specific claims regarding implications to a population. Still, the results of the analysis are intriguing. It was hypothesized that a posttraumatic growth intervention would facilitate posttraumatic growth (PTG) among SM/V who experienced trauma. While the *Life Events Checklist for DSM-5 Extended Version (LEC-5*; Weathers et al., 2013) was not used to measure growth among participants, it did provide valuable details of participants' lives that support the findings of this pilot study. The *LEC-5* gave participants an opportunity to describe the "worst" traumatic event that had occurred. The responses included: (a) an improvised explosive device (IED) attack in Afghanistan, (b) cleaning up human remains from an IED attack and then proceeding to be hit by an IED, (c) being stranded on a military base while it was under attack, (d) helping to provide aid to a fellow service member who had been doused by fuel and had caught fire and then the service member later died from his injuries, (e) sexual assault, (f) aviation mishap, and (g) being ambushed while on a mission. While potentially "typical" for SM/V, these experiences are each shocking in

their own right and strengthen the sentiment that combat zones are a breeding ground for trauma. The participants of this study were certainly among the up to twenty-four percent of troops returning from a combat zone who are diagnosed with PTSD (Borowa et al., 2016). It could be argued that this number significantly underrepresents the actual number of SM/V who struggle with PTSD because while four participants of this study reported a formal diagnosis of posttraumatic stress disorder (PTSD), three participants reported no formal diagnosis of PTSD. However, per the *PTSD Checklist for DSM-5 (PCL-5;* Blevins et al., 2015), each participant (n = 7) met the minimum requirement for a provisional diagnosis of PTSD.

Also of note are the SM/V who do not recognize or acknowledge the trauma that affects their daily life but suffer from various comorbidities without understanding why they experience them. This issue was demonstrated through the course of the intervention with the participant whose data was eliminated from the analysis. While this participant reported witnessing and learning about a number of traumatic events, they declined to report the worst significant event on the *LEC-5*. Additionally, the pre-intervention *PCL-5* indicated no evidence of PTSD for the excluded participant, with a score of 14. PTSD is indicated with a minimum score of 31-33. Where each of the other participants' scores on the *PCL-5* decreased between the pre-test and post-test, the scores of the eliminated participant's *PCL-5* increased from 14 to 32 from the pre-test to the post-test, a net increase of 18 points. During the intervention, the eliminated participant discovered that the comorbidities they were experiencing, particularly "explosive rage," were perhaps due to underlying unresolved trauma. This participant also came to the realization that they needed to seek mental health treatment. Involvement in the intervention helped them

recognize that they can seek help for their symptoms and that they do not have to brave them alone. In their response to the post-intervention question regarding what they knew before and what they now know about PTG, the eliminated participant responded that they previously knew nothing about PTG and, "It brought [a] realization to my world that I might actually need help." This observation follows what Khokhlova and Bhatia (2023) found in their qualitative research that participation in a book study group helped promote self-acceptance, self-knowledge, and self-awareness, resulting in a greater depth of thinking around the designated subject of study.

It also follows that recognizing growth can take considerable time to realize after a traumatic event (Borowa et al., 2016), and the more distress, the greater the potential for growth (Henson et al., 2021). Per the *LEC-5* results, the trauma experienced by the participants of the study was not only significant for each participant, but it also occurred ten or more years before the intervention. Though the sample size is too small to make any definitive claims, the time elapses between the traumatic experience and even being ready to acknowledge that something positive could come from the trauma is telling. Each participant showed growth prior to and after the intervention (see Figure 1). However, the eliminated participant's data showed no perceptible growth before or after; this is indicative of not having perceived a significant traumatic event in their life. While they recognized unresolved issues during the intervention, PTG is not typically experienced during the phase where trauma has just been realized and acknowledged.

While the small sample size is not sufficient to make definitive claims, if this pilot study is representative of the population, the results of this test are suggestive. PTG was demonstrated by the results of the *Posttraumatic Growth Inventory - Expanded (PTGI-X*;

Tedeschi et al., 2017) that revealed a statistically significant difference in the growth achieved between the pre-test and post-test, as well as a large effect size of the intervention. Evidence of PTG was supported by the large effect size and statistically significant reduction of PTSD symptoms shown in the results between the pre-test and post-test of the *PCL-5*. While the literature does not consistently support an inverse relationship between an increase in PTG and a decrease in PTSD, the results of this pilot study do support an inverse relationship.

Trauma-Related Guilt

It was hypothesized that a posttraumatic growth intervention would decrease trauma-related guilt among SM/V who experienced trauma. Trauma-related guilt was measured both pre-intervention and post-intervention using the *Trauma-Related Guilt Inventory (TRGI*; Kubany et al., 1996*)*. Trauma-related guilt can be a significant aspect of the aftereffects of trauma and can be a barrier to moving forward. It was anticipated that exposure to the stories in Tedeschi et al. (2020) and organic conversations among group members would lead to a decrease in trauma-related guilt. However, the data does not support this hypothesis. Due to the lack of any notable significance in this test, the second hypothesis of the present study was therefore not supported.

Desire to Help Others

It was hypothesized that a posttraumatic growth intervention would promote a desire in SM/V to help others achieve PTG. Desire to help others was measured both pre-intervention and post-intervention using the *Situational Motivation Scale (SIMS*; Guay et al., 2000*)*. While results from the *SIMS* did not reveal a statistically significant difference in the desire to help others between the pre-test and post-test, they did show a

moderate effect size. While the sample set is too small to make claims adequately, the results of this test are at least partially suggestive.

Two participants joined the study, presumably and primarily to help the facilitator complete the intervention and this research. Their motives for joining the study affected the results of the *SIMS*. Their pre-test to post-test data seemingly dropped because their mission of "helping others" had been accomplished by participating in the study and thereby helping the facilitator. Every other participant showed a significant increase in their *SIMS* results. Had initial attempts at recruitment been more successful and there not been the need to use social media and recruitment outlets where people know the facilitator of the intervention, this hypothesis could have been better supported by the data. Additionally, had there been a larger sample, the results of this question may have been more telling. This hypothesis should be revisited in future research on this topic.

Open-Ended Questions

The post-test posed a two-part open-ended question that offered participants an opportunity to provide feedback on the intervention. While the sample size of this pilot study was small, the responses to the two-part question "Prior to the book discussion group, what did you already know about posttraumatic growth? How does that compare with what you know about it now?" were telling. The participants knew very little to nothing about PTG prior to the intervention. Through reading and discussions, participants gained significant knowledge and perspective on PTG and expressed a desire to continue learning about the concept of PTG.

The open-ended question also revealed that the intervention helped some of the participants recognize that they had already experienced PTG but had not focused on or

acknowledged it. Simply having the nuanced vocabulary to address feelings, concepts, and frustrations associated with trauma might have helped participants add practical tools to coping and provide an avenue for growth. The participants appreciated having other SM/V who could relate to specific frustrations. Resilience was a theme that was addressed both on the post-test survey and during group discussions. For example, one subject succinctly shared their feelings on resiliency versus PTG in their response to the open-ended questions.

> I had not heard of it [PTG] discussed as growth. The sum of my awareness on the topic was what I learned from "resiliency training" in the Army, which is admittedly related and yet very different. I'm very glad I read through the concepts in this book and the depth in which they were covered. I'm especially glad how the book's authors distinguished its content as wholly separate from resiliency. The topic of resiliency is almost a trigger for some of my anger and frustration, and I benefited from learning a different side of how to deal with trauma (see Figure 5).

The participants experienced many “aha” moments similar to this during the intervention that helped them to recognize that they were not alone in their struggles.

Throughout the course of the intervention and at the conclusion, when participants were able to provide an open response regarding their feelings surrounding the intervention, they repeatedly returned to the theme of community. They appreciated the opportunity to share in a community with others who had shared similar experiences. They could relate to one another’s experiences regarding reintegration into a civilian population; their eyes were opened to shared symptoms or experiences that they

previously thought were unique to them. This brought a sense of belonging and, at times, relief. While this was a small pilot study, the group size was an ideal number of participants for a positive group dynamic that was made apparent as the intervention evolved.

Implications

Though this pilot study was too small to offer definitive implications, the results support the argument that educating SM/V who have experienced trauma on the concept of PTG can help SM/V achieve PTG. Participants realized the potential for PTG in themselves and recognized that they had already achieved PTG in many ways. Through the course of the intervention and in their responses on the post-test survey, participants consistently recognized that because of the group dynamic developed and the sense of community created among them, they were not alone in their struggle. It is presumed that participants were empowered to continue their pursuit of PTG and to help educate others on this concept. While this was all achieved on a small scale through this pilot study, the results imply that it could effectively be applied on a much larger scale to compound the impact.

Strengths and Limitations

The primary strength of this research was the innovative design of this intervention that was developed and run by an individual with no training in the therapy field. The aim was to make a difference in the lives of others through an intervention rather than simply collecting preexisting data through the creation of a survey or analysis of preexisting data. The model created provides a concrete intervention that has the

potential to be improved upon and replicated to conduct further research in the study of posttraumatic growth.

Limitations were apparent in the sample size, the limited racial diversity, and the inability to test the original target audience of student service members and veterans (SSM/V). Another limitation of this research was the region of the country that the participants would be pulled from. Due to the challenges in the original recruitment, this expected limitation became a strength as the restriction of recruitment only in the upper Midwest was removed. The participants represented regions of the country from the Northeast, the West Coast, the Midwest, and the South.

Finally, the researcher and facilitator of the intervention is a veteran who has experienced significant trauma. This can be considered both a strength and a limitation of the research. One of the most effective ways to facilitate PTG among trauma survivors is to provide a safe space for others who have also experienced trauma (Zeligman et al., 2019). Having a member of the target audience act as the facilitator to a book study group intervention seemingly brought credibility and relatability to the group affording an opportunity for increased authenticity in discussions as there were no "outsiders" among the participants in the discussion. However, when the researcher is closely connected and personally affected by trauma and PTG while also meeting each of the requirements for group members, there is a vested interest in the results, and the potential for bias exists. The facilitator ensured objectivity by establishing and relaying clear ground rules prior to the first discussion, creating a safe space for sharing, actively listening, and encouraging all participants to contribute to the conversations. This objectivity was demonstrated with the response of one participant in the open-ended responses on the post-test survey. They

stated that they were thankful for the facilitator's organization, leadership, and efficiency in doing the group study.

Recommendations for Further Research

While this pilot study was valuable, it produced limited results because of the small sample size. Conducting additional research with the same target audience and a significantly larger, more diverse sample would be beneficial in strengthening and validating the findings of this study. A more robust recruitment effort would need to be made to recruit effectively. Perhaps coordinating with pre-deployment and post-deployment training of active and reserve service military units would prove more effective. Additionally, developing partnerships with veterans affairs groups and medical facilities could produce a bigger sample size to conduct this or a similar intervention model. Changing the intervention model to a one-time presentation and open discussion of the concept of PTG, along with an invitation to read the text, could be more accessible, require less time commitment, and prove more effective in collecting pertinent data and reaching a broader, more diverse audience.

It also would be beneficial to revisit the original target audience, SSM/V. SSM/V bring unique circumstances, strengths, challenges, and aftereffects of trauma. Due to their non-traditional student status (marriages, divorces, children, household responsibilities, and advanced age) and loss of military unit camaraderie, many of these SSM/V are left feeling isolated, unable to relate to their non-SSM/V peers, and unable to adapt to the transition to a college environment with ease (Borsari et al., 2017). While resources are available to help SSM/V, they tend to be underutilized. SSM/V can find themselves in a position where the effects of their diagnosis can feel compounded by a loss of personal

connection with other service members and an inability to relate to traditional college students (McCaslin et al., 2014). Based on the number of veterans who utilize the Post-9/11 GI Bill and the percentage of veterans diagnosed with PTSD or traumatic brain injury (TBI), it is estimated that 1 in 27 first-time college students will fit into this category (Lopéz et al., 2016). To effectively recruit SSM/V, a more robust recruitment effort that provides incentives such as elective credits for participation in a book study intervention could incentivize SSM/V to participate.

Trauma is universal, and the concept of PTG is valuable for all audiences. During the recruitment phase of this study, considerable time was spent communicating with the leadership of the non-profit, wear blue: run to remember. This organization was born from trauma and exemplifies the domains of PTG. Military spouses are among the strongest people I have come in contact with. It would be valuable to conduct this intervention with military spouses and families who have experienced significant trauma.

It is imperative that further study and education surrounding the phenomenon of PTG be continued in a way that will not risk warping it into another military buzzword. A thoughtful and properly placed education on the concept of PTG could have significant implications for military and civilian populations alike.

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Appendix A

Life Events Checklist for DSM-5 Extended Version Instrument

(LEC-5; Weathers et al., 2013)

Part 1:

For each event, participants are asked to check one or more of the boxes that: (a) happened to them personally; (b) they witnessed it happening to someone else; (c) they learned about it happening to a close family member or close friend; (d) they were exposed to it as part of their job (for example, paramedic, police, military, or other first responders); (e) they are not sure if it fits, or (f) it does not apply to them.

1. Natural disaster (for example, flood, hurricane, tornado, earthquake)
2. Fire or explosion
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)
4. Serious accident at work, home, or during recreational activity
5. Exposure to toxic substances (for example, dangerous chemicals, radiation)
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)
9. Other unwanted or uncomfortable sexual experience
10. Combat or exposure to a war-zone (in the military or as a civilian) prisoner of war)
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)
12. Life-threatening illness or injury
13. Severe human suffering
14. Sudden violent death (for example, homicide, suicide)
15. Sudden accidental death
16. Serious injury, harm, or death you caused to someone else
17. Any other very stressful event or experience

Appendix A (continued)

Part 2:

A. If you checked anything for #17 in PART 1, briefly identify the event you were thinking of.

B. If you have experienced more than one of the events in PART 1, think about the event you consider the worst event, which for this questionnaire, means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event.

1. Briefly describe the worst event (for example, what happened, who was involved, etc.).

2. How long ago did it happen?

3. How did you experience it?

4. Was someone's life in danger?

5. Was someone seriously injured or killed?

6. Did it involve sexual violence?

7. If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

8. How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?

Appendix B

PTSD Checklist for DSM-5 Instrument

(PCL-5; Blevins et al., 2015)

1. Repeated, disturbing, and unwanted memories of the stressful experience?
2. Repeated, disturbing dreams of the stressful experience?
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?
4. Feeling very upset when something reminded you of the stressful experience?
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?
6. Avoiding memories, thoughts, or feelings related to the stressful experience?
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?
8. Trouble remembering important parts of the stressful experience?
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?
10. Blaming yourself or someone else for the stressful experience or what happened after it?
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?
12. Loss of interest in activities that you used to enjoy?
13. Feeling distant or cut off from other people?
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?
15. Irritable behavior, angry outbursts, or acting aggressively?
16. Taking too many risks or doing things that could cause you harm?
17. Being “superalert” or watchful or on guard?
18. Feeling jumpy or easily startled?
19. Having difficulty concentrating?
20. Trouble falling or staying asleep?

Appendix C

Posttraumatic Growth Inventory - Expanded Instrument

(PTGI-X; Tedeschi et al., 2017)

1. I changed my priorities about what is important in life.

2. I have a greater appreciation for the value of my own life.

3. I developed new interests.

4. I have a greater feeling of self-reliance.

5. I have a better understanding of spiritual matters.

6. I more clearly see that I can count on people in times of trouble.

7. I established a new path for my life.

8. I have a greater sense of closeness with others.

9. I am more willing to express my emotions.

10. I know better that I can handle difficulties.

11. I am able to do better things with my life.

12. I am better able to accept the way things work out.

13. I can better appreciate each day.

14. New opportunities are available which wouldn't have been otherwise.

15. I have more compassion for others.

16. I put more effort into my relationships.

17. I am more likely to try to change things which need changing.

18. I have a stronger religious faith.

19. I discovered that I'm stronger than I thought I was.

20. I learned a great deal about how wonderful people are.

21. I better accept needing others.

22. I have a greater sense of harmony with the world.

23. I feel more connected with all of existence.

24. I feel better able to face questions about life and death.

25. I have greater clarity about life’s meaning.

Appendix D

Trauma-Related Guilt Inventory Instrument

(TRGI; Kubany et al., 1996)

1. I could have prevented what happened.

2. I am still distressed about what happened.

3. I had some feelings that I should not have had.

4. What I did was completely justified.

5. I was responsible for causing what happened.

6. What happened causes me emotional pain.

7. I did something that went against my values.

8. What I did made sense.

9. I knew better than to do what I did.

10. I feel sorrow or grief about the outcome.

11. What] did was inconsistent with my beliefs.

12. If I knew today—only what I knew when the event(s) occurred—I would do exactly the same thing.

13. I experience intense guilt that relates to what happened.

14. I should have known better.

15. I experience severe emotional distress when I think about what happened.

16. I had some thoughts or beliefs that I should not have had.

17. I had good reasons for doing what I did.

18. Indicate how frequently you experience guilt that relates to what happened.

19. I blame myself for what happened.

Appendix D (continued)

20. What happened causes a lot of pain and suffering.

21. I should have had certain feelings that I did not have.

22. Indicate the intensity or severity of guilt that you typically experience about the event(s).

23. I blame myself for something I did, thought, or felt.

24. When I am reminded of the event(s), I have strong physical reactions such as sweating, tense muscles, dry mouth, etc.

25. Overall, how guilty do you feel about the event(s)?

26. I hold myself responsible for what happened.

27. What I did was not justified in any way.

28. I violated personal standards of right and wrong.

29. I did something that I should not have done.

30. I should have done something that I did not do.

31. What I did was unforgivable.

32. I didn't do anything wrong.

Appendix E

Situational Motivation Scale Instrument

(SIMS; Guay et al., 2000)

Why are you currently engaged in this activity?

1. Because I think that this activity is interesting.

2. Because I am doing it for my own good.

3. Because I am supposed to do it.

4. There may be good reasons to do this activity, but personally, I don't see any.

5. Because I think that this activity is pleasant.

6. Because I think that this activity is good for me.

7. Because it is something that I have to do.

8. I do this activity but I am not sure if it is worth it.

9. Because this activity is fun.

10. By personal decision.

11. Because I don't have any choice.

12. I don't know; I don't see what this activity brings me.

13. Because I feel good when doing this activity.

14. Because I believe that this activity is important for me.

15. Because I feel that I have to do it.

16. I do this activity, but I am not sure it is a good thing to pursue it.

Appendix F

Recruitment Email

Greetings fellow service members and veterans,

My name is Susan Craig, and I am a doctoral student in the Department of Educational Leadership at Minnesota State University, Mankato. I am also a veteran. I served as an officer in the United States Marine Corps on active duty from 1999-2009. During that time, I was involved in a fatal helicopter crash and have struggled with PTSD and survivor guilt for many years as a result.

My research is focused on posttraumatic growth among service members and veterans who have experienced trauma and are enrolled in post-secondary education in the upper Midwest. I am passionate about helping others find alternatives to the stigma that surrounds trauma and PTSD for many of us.

I invite you to join me as a participant in my research project. If you choose to participate, you will be part of a book study group. I will provide you with a copy of a book that changed my life, as well as a study guide that breaks the reading into manageable sections and includes prompts to help guide your reading and our group discussions. The time requirement will include 6 book discussion meetings over the summer (every other week between May and July) for 45-60 minutes per meeting. All meetings will be conducted on Zoom.

I am happy to provide more information. Please let me know if you have questions. If you would like to participate, I invite you to click on this link which will bring you to a survey to begin the process. Please plan for 15-30 minutes to complete the survey. https://mnsu.co1.qualtrics.com/jfe/form/SV_eJ9HfPvCgd4xRbM

Thank you for considering participating in this important work. I hope to make a difference in your life and in the lives of others through my research.

With gratitude,
Susan Craig
susan.craig@mnsu.edu
Primary Investigator: Jason Kaufman, Ph.D., Ed.D.
IRB Net #: 2035189

Appendix G

Recruitment Flier

Military Service Members and Veterans Needed

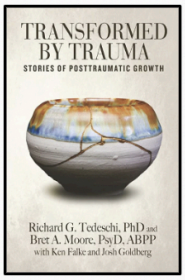
We have all heard of PTSD, but have you heard of PTG?

Posttraumatic Growth

To join the study: https://mnsu.co1.qualtrics.com/jfe/form/SV_eJ9HfPvCgd4xRbM

Research Participants Needed for a Book Study Group

From PTSD → To PTG
(Posttraumatic Growth)



Each participant will receive:

- A free book and study guide
- A new perspective on your trauma
- An opportunity to connect with other service members and veterans

My name is Susan Craig, I am a doctoral student and I am a veteran. I served as an officer in the United States Marine Corps for 10 years. During that time, I was involved in a fatal helicopter crash and have struggled with PTSD and survivor guilt for many years as a result. **Learning about PTG changed my life.** Can it change your life? Please consider helping me answer this question by participating in this research.

Department of Educational Leadership, Minnesota State University, Mankato
Principal Investigator: Jason Kaufman, Ph.D., Ed.D.
IRB Net #: 2035189
For questions contact Susan Craig: susan.craig@mnsu.edu

Appendix H

Informed Consent Form

FACILITATING POSTTRAUMATIC GROWTH

(Minnesota State University, Mankato IRBNet ID #2035189)

INFORMED CONSENT

INTRODUCTION

You are invited to participate in a research study in which you will participate in a book study group with other student service members and veterans enrolled in public colleges and universities in Minnesota and Wisconsin. The goal of the study will be to determine if learning about posttraumatic growth through reading and discussion can help those who struggle with the aftereffects of trauma and posttraumatic stress disorder recognize and accept posttraumatic growth in themselves. This research is being conducted by Susan E. Craig (doctoral candidate at Minnesota State University, Mankato) under the direction of Jason A. Kaufman, Ph.D., Ed.D. (Minnesota State University, Mankato).

PROCEDURE

If you agree to participate in this study, you will be sent a copy to read of "Transformed by Trauma: Stories of Posttraumatic Growth" and agree to participate in six Zoom discussions about the book with a small group (45-60 minutes each). Groups will meet every other week between May and July 2023. After agreeing to participate, you will be asked to respond electronically to a survey at the beginning and then at the end of the study regarding your experiences with trauma, posttraumatic stress disorder, guilt, growth, and willingness to help others. During discussions, you will have an opportunity to share your experiences, ask questions, or simply listen in.

POTENTIAL RISKS OF PARTICIPATION

The risks involved with participation are no greater than those in daily life. You will not be required to share during discussion groups. However, reading, talking, and hearing about others' experiences may bring up feelings that may make you uncomfortable. Resources will be provided if you determine at any point in the process that you need professional help. If you decide to leave a discussion early, please share your concerns with Susan via email.

POTENTIAL BENEFITS OF PARTICIPATION

Participation has the potential to help you move toward posttraumatic growth. The potential benefit for society is that this research may demonstrate that educating individuals on the concept of posttraumatic growth can facilitate posttraumatic growth among trauma survivors.

Appendix H (continued)

STATEMENT OF CONFIDENTIALITY

All information obtained in this research project will be kept confidential by Susan Craig and Professor Kaufman. All information will be stored in a locked file cabinet at the Edina site of Minnesota State University, Mankato. Your name will be changed in the research report to protect your identity. However, it is important to understand that you will be discussing your personal experiences weekly online with a small group of fellow veterans. If you would like more information about the specific privacy and anonymity risk posed by online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager.

VOLUNTARY NATURE OF THE STUDY

Your decision to participate in this study will not affect your current or future relationship with Minnesota State University, Mankato. If you decide to participate, you are completely free to withdraw at any time without the risk of penalty.

CONTACTS AND QUESTIONS

This research project is being conducted by Susan Craig at Minnesota State University, Mankato, with her advisor, Professor Jason Kaufman. If you have any questions about this research study, contact Susan Craig at susan.craig@mnsu.edu or Professor Kaufman at jason.kaufman@mnsu.edu. If you you have any questions about participants' rights and/or research-related injuries, please contact the Director of the Institutional Review Board at 507-389-1242or irb@mnsu.edu.

STATEMENT OF CONSENT

"I have read this consent form and voluntarily consent to participate. My signature below assures the researchers that I am 18 years of age or older. All of my questions concerning this research have been answered by the researchers Susan Craig and/or Jason Kaufman. A copy of this form has been offered to me.

"I understand that my information collected as part of the research, even if identifiers are removed, will not be used for future research studies."

Name _____ Date _____

Signature _____

Appendix I

Cover Letter

Greetings Book Study Group Participants,

First, let me say Thank You!! I am so grateful that you have agreed to participate in this book study group! I hope that through this process, you will learn about posttraumatic growth and how it might influence your life. My mission is to help those who struggle with the aftereffects of trauma to gain a new perspective. This book had a profound effect on my life; I would like to see if can have a similar effect on yours.

In this package, you will find the book, *Transformed by Trauma: Sories of Posttraumatic Growth* by Richard Tedeschi and Bret Moore. You will also find a study/discussion guide. The guide is broken up by session and will hopefully help to prompt your thinking as you read. The book and guide are yours to keep; please feel free to take notes in the margins, highlight, and write in the book and on the guide as much as you would like.

For the first meeting, please read the preface and introduction of the book. Our first meeting will be on May XX, 2023 at xx:xx p.m. I will introduce myself, go over the plan, and discuss the ground rules for the book study group.

While completing the suggested reading for each session is preferred, it is OK if you don't. Please, if you did not finish the week's reading, still join each scheduled session. There are benefits to participating in the group even if you have not completed the reading. Your attendance is important, and your voice (if you choose to share it) is important.

My Zoom meeting room information is: xxxxx. I will also send the Zoom link in an email for each meeting. You can expect a weekly email to provide prompts for reading and a reminder about scheduled meeting times.

I look forward to meeting you over Zoom on May XX, 2023 at xx:xx. Please feel free to reach out to me with any questions or concerns. I can be reached at susan.craig@mnsu.edu

Thank you again! I look forward to getting started!

With gratitude,
Susan Craig

Appendix J

Mental Health Resource Guide

If at any point during this book study group (either while reading or during sessions), you feel like things are becoming too heavy and you feel the need for additional support, please reach out to your mental health provider (if you have one), or refer to this document for resources available to you.

- Suicide Crisis Line for veterans (available 24 hours a day)
    - Dial 988, then Press 1
    - chat online https://www.veteranscrisisline.net/
    - text 838255
- Visit National Alliance for Mental Illness (NAMI)
  https://www.nami.org/Your-Journey/Veterans-Active-Duty
  scroll down and find your local NAMI by state (on the left in the blue section)
- Call the NAMI Helpline at: 800-950-6264
- Or text "HelpLine" to 62640

Appendix K

Book Discussion Group, Reading and Discussion Guide

Session 0: Preface and Introduction. (p. 1-12)

- Facilitator introduction and background
- Expectations for participation
    - Please read the designated section prior to the discussion, but if you do not finish, it is ok; we will discuss the content of the section during the session, and you may decide to return to it later.
    - Please attend every session (even if you did not complete the reading)
    - The book is yours, write in it, mark it, highlight it, and USE it!
    - Please turn on your camera during sessions.
    - Please be respectful of one another with your comments and responses.
    - Talking in the sessions is wonderful but not required. Everyone needs to be comfortable and should not expect to be singled out.
- Overview of reading schedule and dates
- Our purpose is to learn, understand, and grow. We are all at different places in our journey; growth looks different to each of us. I hope this experience contributes to your growth journey in a positive way.

Session 1: Section 1 - Understanding Posttraumatic Growth (ch. 1-6, p. 13-78)

<u>Discussion prompts - Chapter 1</u>:

- Kinstugi is discussed on the first few pages. What are your thoughts about this concept?

Appendix K (continued)

- Definition of posttraumatic growth (PTG) - have you ever heard of it? What is it? What is trauma?

Discussion Prompts - Chapter 2:

- How does PTG relate to PTSD?
- How is PTG different from resilience?

Discussion Prompts - Chapter 3:

- What are your thoughts about the origin of PTG?
- How is PTG reflected among the world religions?

Discussion Prompts - Chapter 4:

- PTG looks different across different cultures. PTG may look different to each of us in this group, but we can also see similarities. How does the culture you are part of affect your potential for growth?
- Does seeing other points of view and how others experience PTG help you to see your potential for growth differently?

Discussion Prompts - Chapter 5:

- What is the definition of PTSD?
- What are some misconceptions of PTSD or things you did not know or realize about it?

Discussion Prompts - Chapter 6:

- The struggle we have experienced is unique, but we also share the common bond of service. It can be hard to be one of the few military people on campus or in classes.

Appendix K (continued)

- What are your thoughts or feelings, or opinions about the connection to civilians at your school?
- What other thoughts do you have about anything that came from section 1 of the book?

Session 2: Section 2 - Domains of Posttraumatic Growth (ch. 7-9, p. 79-126)

Discussion Prompts - Chapter 7: New Possibilities

As you read the stories, is there any part of the person's struggle, trauma, or growth that you can relate to? Do you see anything reflected in your own life? Does anything stand out to you in this story?

- Eric - the story of a Marine who finally followed his heart and passion after trauma and left the Marine Corps to follow his dream and passion for art.
- Leslie - a mother who lost her Marine son to an overdose. Divorced twice, depressed. Found passion and purpose through her nonprofit in honor of her son: Permission to Start Dreaming Foundation

Discussion Prompts - Chapter 8: Personal Strength

As you read the stories, is there any part of the person's struggle, trauma, or growth that you can relate to? Do you see anything reflected in your own life? Does anything stand out to you in this story?

- Karen - Awaking the sleeping giant. Story of a woman who witnessed and experienced a lot of abuse growing up. She joined the Air Force and once again experienced trauma through rape. She was closed off, and therapy was not helpful

Appendix K (continued)

for her, but made a connection with another woman who she opened up to and who opened up to her.

- Paul - He was always unaccepting of himself and expected more; he was never quite satisfied with himself. His father was a quadriplegic and instilled a "Never give up" mentality in Paul. He learned that personal strength is not only about power and will; it is about flexibility, kindness, and gentleness toward self and others.

Discussion Prompts - Chapter 9: Changes in Relationships with Others

As you read the stories, is there any part of the person's struggle, trauma, or growth that you can relate to? Do you see anything reflected in your own life? Does anything stand out to you in this story?

- Joe - His story is about how his estranged relationship with his father changed after he lost his friend while serving. Joe was able to reconcile with his father before he died of cancer.
- DJ - He had a great upbringing. After a significant injury, he used his resources to help others. The passion had been there since he was young, but the trauma helped remind him of his passion to help others.

Session 3: Section 2 - Domains of Posttraumatic Growth (ch. 10-11, p. 127-160)

Discussion Prompts - Chapter 10: Appreciation for Life

As you read the stories, is there any part of the person's struggle, trauma, or growth that you can relate to? Do you see anything reflected in your own life? Does anything stand out to you in this story?

Appendix K (continued)

- David - He was a medic who prioritized work over family, even after promises were made. He finally shifted his focus to his family after witnessing a horrific scene in Iraq.
- Bryan - After 26 years of service, he struggled with impatience, rage, and frustration with civilians. He attributes his turnaround to his experience with other vets while learning about PTG at Boulder Crest in VA.

Discussion Prompts - Chapter 11: Spiritual and Existential Change

As you read the stories, is there any part of the person's struggle, trauma, or growth that you can relate to? Do you see anything reflected in your own life? Does anything stand out to you in this story?

- Aaron - His friend talked about recently becoming closer to God and being unafraid to die. Soon after, he was killed. Aaron turned to the chaplain that his friend had a relationship. The experience made Aaron look for answers and helped him to gain a stronger faith.
- Mickey - He was raised the “right” way and took the “right” steps. He married the girl from church, enlisted, and deployed. His wife met someone else and left him. Mickey was distracted while deployed and hit and killed a child while he was driving distracted. These events rocked his world and forced a new perspective.

Section 2 wrap-up - What story or domain did you see yourself reflected most in? Do you find that you can relate to any of these characters? Does anything you read about the domains of PTG help you to shift your perspective or at least see a new perspective?

Appendix K (continued)

Session 4: Section 3 - Moving Through the Process of Growth (ch. 12-14, p. 161-222)

Discussion Prompts - Chapter 12: PTG Process 1: Learning From Trauma

Ian returned from deployment fine, but then started to slowly fall apart. He began to withdraw when he felt like things were going wrong and he could not control what was happening. His wife put her foot down and demanded he figures it out or leave. Ian found a therapist who helped him understand what was happening to him and assured him there was a way through and better days were possible.

- Three lessons
    1. It does not take an event that most would consider obviously traumatic to create a stress reaction.
    2. Symptoms do not always show up immediately after a traumatic experience.
    3. The symptoms are not necessarily dramatic.
- Does Ian's story resonate with you? If so, what part(s)?
- Does Ian's story give you hope? If so, what part(s)?

Discussion Prompts - Chapter 13: PTG Process 2: Managing Distress

It is important to find ways to cope with trauma. For some, therapy is helpful, but often, the most helpful way of dealing with trauma comes through finding effective practices. These will not look the same for all people. The chapter suggests a few; the authors refer to them as preventative maintenance. Which, if any, have you tried? Have you had success in using the practices consistently? What is your experience in using these practices?

Appendix K (continued)

- Sleep - adequate, restful sleep.
- Alcohol - limiting use, not using it for medicine.
- Nutrition - you are what you eat.
- Exercise - does not have to be a formal program or done at a gym.
- Learn to Relax - meditation and breathing techniques.
- Think Differently - letting go of self-defeating thoughts.

Discussion Prompts - Chapter 14: PTG Process 3: Disclosure

Disclosure can come in many forms of expression: talking, artwork, music, etc. Also, disclosure does not always mean the person disclosing shared everything. Disclosure looks different for everyone, but the most important part about disclosure is sharing at some level. This can lead to more sharing, and with sharing, trauma survivors can begin to let go of the stigma that may surround the traumatic experience.

- Have you disclosed any details of your trauma?
- Who have you disclosed to?
- How has it helped?
- Have you found relief after disclosing your trauma?
- How do you see disclosure helping you to relieve symptoms of PTSD?

Session 5: Section 3 - Moving Through the Process of Growth (ch. 15-16, p. 223-271)

Discussion Prompts - Chapter 15: PTG Process 4: Putting the Story Together

DJ points out that in the beginning, the trauma defines you. PTG is not so much about what happened but rather what happens in the aftermath that ultimately defines you and

Appendix K (continued)

your growth. Connections with others are key. You must find a community to help you so you can later help others.

- When does the story of your trauma start?
- After considering your traumatic event, do you think the story begins earlier than you originally thought?
- What was lost as a result of your trauma?
- Does Ian's analogy of "every day is a free day" because he should have died on the battlefield resonate with you?
- Resilience is about getting back to where you were pre-trauma. Do you feel like this is an attainable goal?
- PTG is not about getting back to where you were, you are changed so that is impossible. You can, however, experience growth because of your trauma that propels you farther than you thought possible. Does this notion give you hope? Have you experienced this? Do you think this is possible?
- Community made a big difference for DJ; how has your community affected you since your trauma?
- Expert companion - have you had one? Have you been one?

<u>Discussion Prompts - Chapter 16: PTG Process 5: The Mission</u>

An everyday hero is "an ordinary person who experiences an extraordinary event, survives it, and returns to the everyday world to express an important truth about life" (p. 257). In this chapter, we learn about how individuals use their trauma to propel them forward into a new mission. Each of them found a way to connect with others; they

Appendix K (continued)

became expert guides. Consider the following individuals' stories and how they persevered. Does their story touch you? Can you relate? What do you see in each story that resonates with you?

- Saudi - Chief Master Sergeant in the Air Force whose son committed suicide. How she connected with another mom and eventually started her own organization to honor her son.
- Eric - The Marine who left active duty to follow his dream and become an artist. He created art that others related with, then later taught others to help them express their feelings and provide them an outlet for their trauma also.
- Joe - He had a rocky relationship with his father but reconciled before his father died of cancer. He had the gift of connecting with others and helped many with his kindness and compassion.

<u>Conclusion - Transformed By Trauma Wrap-Up</u>

“It is best to think of posttraumatic growth as a process, a way of living, rather than an achievement” (p. 226). Remember that “from struggle comes strength…and like the ancient art of Kintsugi, the beauty, grandeur, and strength comes when we put our lives back together and reveal our new selves to the world” (p. 280)

- Recap of the book
- Lessons learned, big takeaways (will look different for everyone)
- Completion of post-book study group survey