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Posttraumatic Growth in Combat Veterans

Richard G. Tedeschi

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Abstract Combat veterans and their families face significant challenges not only to their abilities to cope, but often to their fundamental belief systems. Traumatic events represent assaults on core beliefs, yet at times, produce cognitive processing that can ultimately result in personal transformations called posttraumatic growth (PTG). Clinicians can utilize a systematic therapeutic approach to facilitate PTG as they carry out a relationship of expert companionship. PTG in service members is described in this article, as well as the approach to facilitation of PTG.

Keywords Posttraumatic growth · Combat · Veterans · Military · Trauma

Attempts to strengthen our warriors may lead us to focus on ameliorating symptoms of posttraumatic stress disorder (PTSD), and helping them to recover from trauma and avoid secondary problems such as substance abuse and suicidal thinking. We may also attempt to strengthen them by enhancing their psychological fitness prior to anticipated traumatic experiences such as combat, a goal of the Comprehensive Soldier Fitness Program (www.army.mil/csf). A more resilient soldier would be less affected by trauma and recover more quickly from trauma experience. Whether we are considering prevention strategies or post trauma intervention, it is also useful to recognize that some soldiers enter the military with significant trauma histories while others may have little direct experience with trauma. Those with trauma histories may need to draw on those experiences in a way to provide inoculation against future trauma, while those with or without such histories may benefit from learning more about expected trauma responses, coping strategies, and outcomes. Although these outcomes have often been represented as inevitably or exclusively difficult, other outcomes of military service are frequent reports of positive experiences. Combat veterans and other trauma survivors report posttraumatic growth (PTG): positive personal changes that result from their struggle to deal with trauma and its psychological consequences (Tedeschi & Calhoun, 1995, 1996). Promoting understanding of these outcomes and how to achieve them is worthwhile for those entering military service and for those who have seen combat. Following is a brief overview of the concept of PTG, how this relates to the experiences of combat veterans, and a description of a strategy to facilitate PTG in those who see combat.

R. G. Tedeschi (✉)
Department of Psychology, University of North Carolina Charlotte, Charlotte, NC 28223, USA
e-mail: rtedesch@uncc.edu

A Model of Posttraumatic Growth

Janoff-Bulman proposed three kinds of posttraumatic growth processes: strength through suffering, existential reevaluation, and psychological preparedness (Janoff-Bulman, 2006), based on the reevaluation of the assumptive world—core beliefs about oneself and one's life—that are shattered or challenged by trauma. Psychological preparedness involves creating a rebuilt assumptive world to withstand future shocks to the system, just as communities rebuild in the aftermath of earthquakes (Calhoun & Tedeschi, 2006). Strengthening the self produces confidence in facing further difficulties. Existential reevaluation produces a sense of wisdom, life satisfaction, and purpose in life. Several variables increase the possibility of psychological growth in the aftermath of trauma (Calhoun, Cann, & Tedeschi, 2010).

The most essential element in the model of PTG is cognitive processing, engagement or rumination, first an intrusive, automatic type that later gives way to a more deliberate, reflective type that allows for a rebuilding of more resilient core beliefs. Other variables in the model can allow for the constructive process of reflective rumination, including the disclosure to supportive others of concerns surrounding traumatic events, the reactions of others to self-disclosures which have been described as "expert companionship" (Tedeschi & Calhoun, 2006), and the socio-cultural context in which traumas occur and attempts to process, disclose, and resolve trauma take place. At the outset, the personal dispositions of the survivor and the degree to which they are resilient can determine how much processing of the trauma is necessary, since relatively resilient people may not be affected as much as others, and certain coping strategies that allow for approaching the trauma and engaging with other people may be productive (Tedeschi & Calhoun, 1996). The resulting domains of PTG that may be reported include a greater sense of personal strength, a new appreciation of life, recognition of new possibilities or opportunities in the aftermath of trauma, improved interpersonal relationships marked by more compassion and emotional connection, and spiritual development (Tedeschi & Calhoun, 1996). These changes may help build strength of character (Peterson, Park, Pole, D'Andrea, & Seligman, 2008) that may in turn be reflected in the Global Assessment Tool used in the Comprehensive Soldier Fitness program (Peterson, Park, & Castro, 2011).

PTG in Military Service

PTG has been reported by survivors of a broad range of traumatic events (Tedeschi, 1999). Some of those that might more directly relate to military service include amputation (Phelps, Williams, Raichle, Turner, & Ehde, 2008), traumatic brain injury (McGrath & Linley, 2006), and bereavement (Engelkemeyer & Marwit, 2008). In studies of veterans that were often primarily focused on the development of PTSD, researchers occasionally reported some surprising findings where the veterans stated that combat experiences yielded positive outcomes for them. Several studies have found that reports of positive outcomes were common, and often associated with lower levels of PTSD, and higher levels of emotional maturity (Aldwin & Levenson, 2005; Aldwin, Levenson, & Spiro, 1994; Casella & Motta, 1990; Elder & Clipp, 1988). Using data from the National Vietnam Veterans Readjustment Study (Kulka et al., 1990), Dohrenwend et al. (2004) reported that 70.1% of male veterans regarded their experience in Vietnam as mainly positive, and asserted that there was no evidence that these reports represented a process of denial. Maguen, Vogt, King, King, and Litz (2006) also found numerous reports of PTG among veterans of the Persian Gulf War, with perceived threat while in the war zone the strongest predictor of change in appreciation for life.

A number of studies of veterans have focused on the experiences of POWs. The majority of American aviators captured by the North Vietnamese stated that they had benefited psychologically from their ordeal (Sledge, Boydstun, & Rabe, 1980). In this group, the more severe their mistreatment, the more likely they were to report posttraumatic growth. Similarly, a recent study by Feder and her colleagues assessed 30 aviators who had been POWs of the North Vietnamese (Feder et al., 2008). The vast majority reported PTG, especially enhanced sense of personal strength and appreciation for life. Israeli researchers compared levels of PTG among combat veterans of the 1973 Yom Kippur War who either had or had not been POWs (Solomon & Dekel, 2007). Former POWs had higher levels of PTSD symptoms and PTG than did combat veterans who were not POWs, and the levels of PTG were highest for those with moderately severe PTSD.

PTG: Some Clarifications

Despite the development of a substantial literature on PTG, some scholars have called into question the validity of reports of growth (e.g. Bonanno, 2004; Hobfoll et al., 2007; Tennen & Affleck, 2009). Responses to these criticisms can be found in Aspinwall and Tedeschi (2010) and in Tedeschi, Calhoun, and Cann (2007).One source of confusion is the assumption that those who report PTG are highly resilient people. In reality, persons who are resilient may experience less posttraumatic growth (Levine, Laufer, Stein, Hamama-Raz, & Solomon, 2009) at least soon after the trauma since they are less likely to struggle with the psychological consequences of trauma because they are capable of strong coping. Therefore, they are not confronted with challenges to their core beliefs, and do not need to engage in the processing of trauma that can usher in PTG. In contrast, an important outcome of PTG is often enhanced resilience. Therefore, resilience and PTG may appear to be negatively related early on in the aftermath of trauma, but positively related after a good deal of time has allowed for processing of the trauma into a growth experience.

Facilitation of Posttraumatic Growth Through Expert Companionship

Tedeschi and Calhoun (2006) described basic principles of clinical practice that facilitate PTG, calling this approach

"expert companionship." Some of the basic principles of expert companionship may be akin to basic principles of good clinical practice, but they are certainly crucial in helping trauma survivors move toward PTG. These practice principles include: respect for survivors that extends to being open to being changed by survivors; being the humble learner rather than the expert; highlighting how aspects of posttrauma experiences reported indicate developing areas of PTG; fashioning a narrative together with the trauma survivor that respects the horror of trauma while at the same time opening areas of change and development; and encouraging an appreciation for the paradoxical in the trauma experience, so that vulnerability can be strength, and loss is a change that can also be positive.

A PTG Program for Service Members

As part of the Comprehensive Soldier Fitness program, Tedeschi and McNally (2011) have described a pathway toward PTG, and ultimately resilience, for returning service members and their families. The components of this program are summarized here, and the application of this program is illustrated with the case of a Marine suffering from PTSD. The components of the program can form the basis for individual or family treatment interventions, or for psychoeducational and self-help programs.

Understanding Trauma Response is a Precursor to PTG

Before soldiers or service members' families can discern how PTG may occur, it is important for them to understand that the "seismic" nature of trauma experience, especially shattered beliefs about one's self, others, and the future, form the foundation for later posttraumatic growth (Tedeschi & Calhoun, 2004). There needs to be reassurance that *normal* physiological and psychological reactions to the experience of combat do not indicate a defect in one's character, or capabilities as a soldier. This aspect of the facilitation of PTG is based on the theoretical concept that core beliefs are challenged or shattered by trauma and that this begins the cognitive and emotional process that leads to PTG (Cann et al., 2010). The metaphor of the trauma as a seismic event mentioned above is a useful one for persons who are trauma survivors.

Emotional Regulation Enhancement

Anxiety reduction methods such as relaxation training, and control of intrusive thoughts and images are important so that soldiers can later focus on more constructive processes of understanding and evaluating traumatic events and their aftermath through reflective rumination in contrast to brooding. Management of emotional distress is an important aspect of the PTG theoretical model because it allows for more constructive cognitive processing of the complicated consequences of trauma experience (Calhoun & Tedeschi, 2006).

Constructive Self-Disclosure

Virtually all effective interventions rely on constructive self-disclosure and emotional support, and this is important as well for soldiers who will be working on the development of a coherent trauma narrative as part of the process of PTG. As soldiers begin to *tell the story* of the trauma or a series of traumatic events, the focus is usually on the aftermath of trauma, and how the incidents have affected their beliefs, relationships and identity. In attempting to describe such matters there may be some struggle, and use of metaphors and analogies is common in making connections between service members and clinicians. In cases where guilt is involved, clinicians may need to invoke principles of forgiveness interventions that emphasize the possibilities for PTG (Fischer, 2006). Reaching some common ground between service members and families may be an important part of this process, as well as honoring the memories of buddies who have died, as Klass, Silverman, and Nickman (1996) have described in their work on "continuing bonds" among the bereaved. Disclosure has been emphasized in the PTG theoretical model because it allows for social responses that can introduce trauma survivors to new schemas that can form the basis for a changed view of self, others, and how to live life. These disclosures can also allow for the development of emotionally significant relationships that can be the basis for changes in perception of self and others (Calhoun et al., 2010).

Creating a Trauma Narrative with PTG Domains

While being sensitive to the clearly negative aspects of traumatic experience, clinicians attempt to note the development of aspects of posttraumatic growth that service members or families may mention. The five domains of posttraumatic growth become part of the story of the aftermath of trauma that gives hope and a sense of purpose for a future for soldiers and families. To accomplish this, the development of dialectical thinking is crucial, and the clinician may need to model this at various points in treatment. The PTG model has emphasized dialectical thinking and an open, complex, cognitive approach to the trauma and its aftermath (Calhoun & Tedeschi, 1998), in order for trauma survivors to constructively process the confusing new reality they must confront. Creativity is encouraged in the thinking of the trauma survivors, especially

an appreciation for the fact that the basic principle of PTG is paradoxical—that loss can be a catalyst for gain. There are other paradoxes to be appreciated as well. Admission of vulnerability may be a strength, and acceptance rather than struggle can be a useful response to difficulty.

Developing Life Principles that Enhance Resilience

Transforming the doubt, guilt, and pain of posttrauma living into a clear sense of direction involves arriving at a set of principles that serve to guide decisions and actions to meet future challenges, thus promoting resilience. In the theoretical model of PTG, resilience and preparedness are predicted to be the fruits of this process (Calhoun & Tedeschi, 2006). Therefore, in this model, the relationship between PTG and resilience changes over time, with there being little relationship or perhaps even a negative one at the start, and a positive relationship between PTG and resilience as time goes on. This continuing process of developing resilience starts with navigating the aftermath of traumatic events and recognizing the personal strength it takes to succeed at this. Building on this sense of resilience often involves finding ways to be altruistic, accepting growth without guilt, and creating a changed social identity. Soldiers, and perhaps family members as well, may see themselves as trauma survivors, more compassionate and wise, and somewhat separate from others who have not gone through such traumatic experiences. The alienation that is sometimes felt by returning soldiers can be transformed into a deeper understanding of the human condition. These existential and sometimes spiritual changes reflect the ancient Greek/Roman concept of the hero. This concept is different from our contemporary conception of hero that most service members might have difficulty in achieving. However, they may be able to conceive of themselves as ordinary people who have experienced extraordinary events, and have returned to the everyday world to demonstrate how to live out hard-won wisdom.

An Example of Facilitating PTG in a Combat Veteran

Bill is a 28 year old former Marine who served in three deployments in Iraq and Afghanistan, and came to psychotherapy as he became alarmed about his escalating symptoms of PTSD. These symptoms included nightmares, intrusive images of battle, ruminations about his activities during combat, generalized anxiety, and avoidance of many social situations. When Bill came to the first psychotherapy session, he was reluctant to say much, made almost no eye contact, and talked very softly. He explained that he did not have much faith in this endeavor of therapy based on what he had experienced with other mental health professionals. He was receiving psychotropic medications from the VA, and was satisfied enough with that, but complained that the psychiatrist did not seem very interested in anything but his symptoms and did not ask about his other experiences beyond that. When he said to the psychiatrist that he felt he needed to talk more about what he had been through, he was referred to a psychologist whom he saw for three sessions, but who then left for another post. He was transferred to another therapist who seemed to know very little about the military. With that, he left, and has returned to the VA only for his medications.

When encouraged to tell his story, Bill reported the following. He went through a difficult childhood after his parents divorced when he was 5 years old. His mother was depressed, and paid little attention to him, staying in bed many days, and allowing his older sister to manage the household. His sister, in turn, concentrated on her schoolwork and became a brilliant scholar. He spent time with his father and stepmother, and his two younger stepsisters, but found his stepmother to be extremely punitive. He stated that she was critical and cold, and berated him no matter what he tried to do to get along. He finally came to the conclusion it was best to avoid her, and spent most of his time sitting in the back yard with little to do. He became resentful of his father for not protecting him from his stepmother. He was an average student who attracted little attention in school. His mother died of cancer during his senior year. He graduated from high school and spent two years in rather mundane jobs. He decided he wanted a challenge and to better himself, and enlisted in the Marine Corps. He stated that he found a camaraderie he had never had before, and distinguished himself during his training, especially with his marksmanship. He was especially proud that he was selected to train as a sniper.

The first few psychotherapy sessions focused on Bill's current struggles. He was enrolled in a community college and after two semesters had earned all As, despite the fact he found himself procrastinating often. He felt estranged from other students, who seemed to him to be lazy and concerned with trivial matters. He had no friends, but kept in touch with Marines with whom he had served. He tried to develop relationships with women, but could not feel any emotional connection with them. He spent his spare time working out, almost obsessively. He ran several miles each day, and tried to do this during the time when it was hottest. He avoided public places as much as possible, and would quickly go to the grocery store, get his things and leave. He carried a handgun at all times.

By the fourth session of psychotherapy, Bill began to recount his combat experiences as a sniper and team leader. He stated in an angry discussion how his best friend was killed when another team leader used bad judgment on a mission. He then described his work as a sniper in detail,

and various people he had killed. It became clear that it was sometimes hard for him to tell if those he had killed were insurgents. He discussed the satisfaction that came from performing well, and the rush of adrenaline he felt when he made a kill. He talked about how different this is from other kills in combat when soldiers shoot at the enemy who are shooting at them. But Bill said that for a sniper, who is hidden, and when the victim is unaware they are about to die, there is a sense of more control, and more responsibility for the death. Now, as he is back home, he has a great deal of ambivalence about his service. He made it clear that his time in the Marine Corps was the best time of his life. He enjoyed his work and was proud to serve. But he feels alienated as a civilian, and has been haunted by the killing he did, wondering about the morality of his actions on at least some occasions. He is also angry that some of his friends died due to some decisions he questions by superiors.

In subsequent sessions, Bill started to become tearful as he discussed his wartime experiences, and began to reflect on his childhood as well. He began to make more eye contact, and disclosed more. He had a meeting with his father where for the first time he denounced him for failing to show concern for him while growing up. To his surprise, his father accepted this without defending himself, and apologized.

Analysis of Treatment in Relation to the Program for Facilitation of PTG

The interventions with Bill followed the general principles of facilitating PTG described earlier. We can look at the progression of Bill's treatment in terms of the five elements in this program. Understanding trauma response as a precursor to growth; enhancing emotional regulation; constructive self-disclosure; creating a trauma narrative with PTG domains; and developing life principles that are robust to challenges.

In the second meeting with Bill, his clinician asked him if anyone had ever explained to him why he was experiencing the symptoms he had, he said that he hadn't received any explanation. Therefore, a review of the physiological and psychological mechanisms involved in trauma response was undertaken. The short, approximately 5 min psychoeducational intervention produced in Bill, as it does in many trauma survivors, a sense of relief that there was a way to understand his experiences, that they were commonplace, and that his mind and his body were responding in a rather expected and *normal* way to the extraordinary circumstances he had faced. His problem was framed as one that involved shutting off this emergency, self-protective reaction system that wasn't recognizing his new situation of relative safety. A more psychodynamic interpretation was also offered that incorporated his childhood experiences. It was pointed out that his sense of alienation had started early in his life when no one appeared to appreciate his emotional needs and respond to them. Some of these needs were met while in the Marine Corps, and his buddies became a surrogate family for him. Being discharged has produced a great sense of loss, and he found nothing in civilian life to make up for that. He even had trouble connecting with other veterans he met, since he felt that his job was unique and that they could not understand it. He also felt disdain for those who tried to play up the combat they saw, while he always tried to be modest about it. All of this alienation had early roots in being misunderstood, neglected, and unappreciated. In the Marine Corps, he found common experience, and perhaps most importantly for him, a place where people protected each other, to the death. Yet, even there, he found mistakes being made, and some who did not carry out this principle to the fullest. In his therapy, Bill took a while to come to understand that his anger and alienation arose out of an early and continuing lack of love, and that his avoidance of people produced a self-perpetuating pattern of loneliness. Not all this was addressed in the first explanations of the roots of trauma response, but evolved over the course of a number of sessions, and formed the basis for an emerging life narrative. This interpretation provided a basis for what his new, interpersonal mission was, in order to overcome this pattern of avoidance (see Wachtel, 1993). The therapist used the term "mission" frequently in treatment when encouraging experiments in change, as an obvious connection to military experience and his pride and determination in completing what he was asked to do. The therapy relationship also provided the corrective emotional experience to what had happened early in his life, allowing him the opportunity to try again to build a trusting relationship. The need to construct a robust set of core beliefs is apparent throughout these psychodynamic and interpersonal interventions. These beliefs had to accommodate his experiences of disappointment and betrayal, as well as allow him to continue to move into relationships with people in a constructive fashion that could allow for intimacy.

Emotional regulation was fostered in an essentially cognitive-behavioral approach using relaxation strategies. His military training and experience was incorporated into this aspect of the treatment. The clinician discussed with him how he used calming strategies in his marksmanship training. He was made aware of how his breathing and focusing strategies affected his physiological responses, including his heart rate, and therefore encouraged relaxation and good performance in the most stressful circumstances. Building on past success and experience is important throughout the process of facilitating PTG, because this allows people to recognize their strengths, and

attribute their success in managing trauma to their own capabilities. This can promote growth in the domain of *personal strength.*

Constructive self-disclosure is an aspect of all effective therapy. In an approach that facilitates PTG, the clinician responds fairly frequently to disclosures by considering ways to frame what is discussed in terms of strength and potential for PTG. For example, in the case of Bill, the clinician pointed out that as a child he tried multiple strategies in order to attempt to get adults to be responsive to his needs. He worked hard to try to obey the rules of his stepmother and to please her. He went to his father for advice on how to do this and made it clear he was struggling. He attempted to befriend his stepsisters. It appeared that it was not for lack of effort that his situation did not provide for his needs. Ultimately, he used avoidance in order to reduce the painful consequences of interacting within this blended family. The strategy appeared to be understandable under the circumstances. He showed flexibility and did not resort to substantial misbehavior. He always made attempts to do the right things throughout his years growing up, despite the painful circumstances of his life. Recognition of these strengths by the therapist helped Bill to perceive a theme that repeated itself throughout his life. He worked hard at things and tried to do things the right way. He applied this to his military service, and he applied this to his college courses and his psychotherapy as well. In fact, when he did not receive the type of reception he hoped for at the VA, he was willing to try again, just as he had done as a child in his family.

The disclosures are important in order to link together life events and attributions about these events into a coherent narrative. With such a narrative, there is a sense of logic to things, and less need to ruminate about what has happened. There is a story that makes everything easier to keep in mind, but the narrative also provides motives and explanations for behavior that allow a sense of resolution. An important part of the narrative that was created within therapy with Bill included this theme of perseverance, doing the right things, and completing the mission or doing his job. When the discussion turned to the moral questions of his killing as a soldier, the fact that he was committed to fulfilling the mission and doing his job helped Bill to understand some of his motives for his actions. When he talked about his obsessive exercising, this could be understood as an attempt to maintain his commitment to being a fit and ready Marine, an identity it was important to maintain while he was unsure of what a civilian identity would look like for him. Of course, other interpretations could be made of his running in the oppressive heat of summer—perhaps it was self-punitive. However, the clinician can choose to emphasize those motives that promote more positive self-concepts as a basis for PTG.

The narrative Bill and his therapist collaborated in creating needed to be honest. Bill would not tolerate easy rationalizations or skipping over the hard parts of his life. The clinician pointed out that this approach to therapy was consistent with the theme of wanting to do things the right way, and to complete the mission. They discussed how to make sure that this did not become exaggerated to the extent it became self-punitive, and how he needed to be careful about his running in the same way. Strengthening himself should not become an exercise in punishment. If he felt he had a need to confront failings, therapy was a better venue for that. It was pointed out that Bill's ability to confront himself and to push himself could yield significant gains for him during and after therapy, as his mission became more than overcoming symptoms of PTSD, but to eliminate his patterns of interpersonal avoidance, to forgive himself, and develop beyond what he was as a Marine. He came to recognize that his military service did not need to be the most significant point in his life, but that more could follow, if he could develop his capacities further and channel them in a constructive direction. This theme of developing PTG became gradually more evident, and the therapist frequently pointed out his development across time in therapy.

Certainly Bill's identity continues to transform. At this writing, he sees his alienation as an indication of the hard lessons of life he has learned, both in his family life and in combat. But his therapist has been encouraging him not to keep these to himself, but to look for avenues to share them. Some of his coursework provided opportunities, and he has written essays that used some of the themes he explored in therapy, and these essays have been further experiments in constructive disclosure.

Conclusion

Facilitating PTG among combat veterans, and perhaps their families, provides an opportunity to promote resilience and preparedness, and reduce PTSD symptoms as distress is ameliorated to an extent through the creation of meaning for the suffering that continues to be endured. This is not to say that PTG should be expected of all combat veterans, or that lack of reports of PTG by a veteran should be a cause for concern. However, it is apparent that these positive outcomes are commonplace and clinicians should continue to explore the possibilities for sensitively facilitating this process of growth. In doing so, a familiarity with the theoretical model of PTG that has been revised over the years (Calhoun & Tedeschi, 1998, 2006; Calhoun et al., 2010; Tedeschi & Calhoun, 1995, 2004) provides a firm basis for clinical interventions, as it suggests where in the process a trauma survivor is and the influences that might

facilitate the next steps in a difficult, but ultimately rewarding journey.

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