PSYCHOLOGICAL INOCULATION
AND RESILIENCY TRAINING PROGRAM

THESIS

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the Degree Master of Social Work in the Graduate
School of The Ohio State University

By

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American military members returning from deployment to Iraq and Afghanistan demonstrate mental health issues requiring urgent intervention. Intense combat stress compounded by extended and multiple deployments, stop/loss policies (compulsory continuation of military service), uncertain recall timelines, and expanded ground warfare for military members untrained for combat situations, contributes to the increasing need for mental health services. More than 1.4 million veterans have returned from Operation Enduring Freedom and Operation Iraqi Freedom. Military members present an initial Post Traumatic Stress Disorder (PTSD) prevalence of ten percent and twenty-six percent present with a mental disorder diagnosis when first returning from combat. According to researchers, the incidence of PTSD may double within two years post deployment. As many as sixty percent of military members who screen positive for PTSD, generalized anxiety, or depression do not seek mental health services. The most common reason cited is stigma. Those diagnosed with PTSD endure:

- Protracted human pain and suffering
- Significant occupational effects
Increased interpersonal dysfunction, divorce rates, substance abuse, incidence and severity of medical and legal issues, and suicide risk

Researchers postulate that veterans with PTSD rarely fully recover.

A pre-deployment training program focused on increasing resiliency to mental health disorders inoculates military members prior to deployment with specific coping skills and provides an effective cognitive processing framework. Researchers and policy makers support a preventative approach as optimum, have proven structured training produces effective change, and report psychological resilience can be learned and implemented through a training program. A pre-deployment inoculation approach stems issues related to stigma, lessens the burden on the mental and medical health systems, and society, and most importantly, significantly decreases human pain and suffering of military members and their families following in-theater military service. A literature review reveals program foundational theoretical approaches including social support, internal locus of control, self-efficacy, optimism, coping skills, and cognitive behavioral training fosters mental resilience and recovery. A preventive psychological program enabling military members to flourish following their deployment, both mentally and physically, would increase post-traumatic adjustment and growth.
Short-term and long-term objectives of the Psychological Inoculation and Resiliency Training Program include a decrease in incidence rates of: divorce, substance abuse, legal involvement, unemployment and homelessness, PTSD, depression, and anxiety. Additionally, this program will decrease provision of both acute and non-acute mental health services in theater and in local communities, and decrease military psychological evacuation rates from the theater of operations.

The Psychological Inoculation and Resiliency Training Program impacts societal, military, and individual stability by decreasing:

- Human anguish and suffering
- Suicide rate of military members and veterans
- Burden on civilian and military Mental Health systems
- Encumbrance on the civilian and military Legal Systems
- Reliance on Social Services and Compensation and Pension.

Societal and individual social/economic stability would be increased along with an increase in the United States Armed Forces stability, reliability, and voluntary retention rates. Finally, this program will foster, through post-traumatic growth, a new generation of national leaders with military combat experience.
DEDICATION

To my husband, Colonel Steven Douglas Wert, for his unending patience, support, encouragement, and unwavering love, you are the person I most respect, admire, and love.

To Dr. Claire Walsh, who taught and demonstrated psychological resiliency. My work is based on your example—I am still discovering the gifts you taught me.

For my children, Clinton, Joshua, Kathleen, Jacob, Benjamin, Rebecca, and Caroline, may you never lose your way—your love and laughter is my joy.

For my sister, Jill Kuchinos, without whom this thesis would not exist—for so many reasons. Thank you for always being there!

To all those who have served their country as American military members, may we always remember your sacrifice—and honor your service. This program is dedicated to all who have ‘fallen’ after they returned from combat.
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CHAPTER 1.

LITERATURE REVIEW

1.1. Introduction

The United States has been at war for over five years, since September 11, 2001. During that time, over 1.4 million military members have been deployed to Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom (Iraq) (DOD 101, 2006). These United States Air Force, Army, Coast Guard, Marine, Navy, Reservists, and National Guard members operate under intense combat situations in which their lives are in danger at all times. According to Hoge, Castro, Messer, et al, 2004, at least 94% of deployed soldiers in Iraq have been fired upon by enemy with small arms weapons. They found almost 70% of those soldiers in Iraq have personally known another soldier who was killed or seriously injured, and 51% indicated they had come into contact or uncovered a dead body (Hoge et al., 2004). Additionally, over 75% of deployed military members in Iraq have directed fire toward enemy soldiers, and 48% killed an enemy soldier during their deployment to Iraq (Hoge et al., 2004). Enemy
guerilla tactics, the unending threat of attack, and the similarity to urban environments at home, add to military members stress when they return from deployment (Hoge et al., 2004). In addition, the young age of current service members (45.6 % of active duty Air Force enlisted members are younger than 26 years old) indicates the impact from combat service will be long lasting- and comes at a time when coping skills, insight, and maturity are not fully developed (United States Air Force Personnel Service, 2006).

As a result, over 30% of returning deployed military members demonstrate mental health issues requiring intervention within the first year following their return from combat service (Hoge et al., 2004). The most common psychological problems among this population are Post Traumatic Stress Disorder (PTSD), depression, and anxiety (Hoge et al., 2004). Many military members avoid initiating mental health care due to the cultural stigma attached to these issues within active duty, Reserve, and National Guard units (Hoge et al., 2004). The military culture has traditionally upheld not reporting psychological issues at least early as WWI, where those soldiers with problems were removed from their units, and sent far from enemy lines for treatment and stabilization (Hyams, Wignall, & Roswell, 1996). This negatively impacted the soldier and his unit, and though treatment has been moved to far forward locations, in order to decrease the psychological issues associated with removing the soldier from his unit, the stigma of mental health problems remains (Cameron Ritchie, 2005; Hyams et al., 1996).
Individuals and their families dealing with PTSD endure protracted human pain and suffering, family instability, significant occupational effects, and increased interpersonal dysfunction, divorce rates, substance abuse, incidence and severity of medical issues, and suicide risk (Brown, 1984; Grieger et al., 2006). Society is impacted by increased interpersonal violence, legal costs, mental health and medical expenditures, and community services to these military members and their families (Grieger et al., 2006). Currently the Department of Defense (DOD) addresses these concerns through post deployment assessment which provides a self-report of issues, however, military members concerned for their careers decline full disclosure of their symptoms and do not seek treatment until their symptoms are acute or they separate from the military.

A pre-deployment psychological inoculation approach fosters soldiers’ abilities, in-theater and post deployment, to adjust to the stress they experience as a result of their military service. Psychological resiliency training before deployment circumvents the need for significant revision of existing post-deployment medical and mental health services, and offsets human pain and suffering as a result of combat. Individuals volunteering to serve their country possess inherent strengths, which may strengthen them as they adjust to post-deployment or civilian life. Combat situations likewise develop resilient characteristics, which may significantly serve these military members and their families. A post-deployment treatment approach has been supported by
Congress (through funding), DOD, and the Veterans Affairs Health Care system and is currently operational.

The goal of this program is to increase military members’ inherent strengths prior to deployment to increase psychological resiliency following deployment by fostering internal locus of control, self-efficacy, optimism, social support, and coping skills. This powerful approach offers every soldier the opportunity to add to their personal mental “toolbox”, increasing their effectiveness as a soldier, leader, manager, spouse, and parent, both within the military and beyond. Increased psychological resiliency provides each soldier life-long abilities which enhance functioning regardless of initial abilities.

Issues explored by this inquiry are:

- Psychological resiliency
- Psychological factors providing resiliency
- Benefits of resiliency
- Pre-deployment program attributes and requirements provide resiliency.
1.2. Clinical Diagnosis

Post Traumatic Stress Disorder (PTSD) is a serious psychological condition that occurs as a result of experiencing a traumatic event (Foa, Keane, & Friedman, 2000). This psychologically significant trauma considered “outside of the range of usual human experience” elicits symptoms that identify PTSD (DSM III, 1980, p. 236). These symptoms are: re-experiencing the traumatic event or frightening elements of that event; emotional numbing, or less involvement with the external world; avoidance of thoughts, people, memories, and places associated with the traumatic event; and hyper-arousal, often indicated by overreaction to environmental triggers (DSM III, 1980, p. 236; Foa et al., 2000).

PTSD is a complex condition and often presents with other psychological disorders (Foa et al., 2000). Once diagnosed, combat related PTSD symptoms appear to consistently disable veterans and PTSD develops chronicity and resistance to treatment. (Hoge et al., 2004). According to the National Center for PTSD, approximately 30% of those with PTSD develop this chronic, treatment-resistant form of PTSD (NCPTSD, n.d.). The National Comorbidity Study project found post traumatic treatment interventions have little effect on the intensity of symptoms or provide improvement after six years of treatment (Kessler et al., 1995). Current data shows chronicity 25 years after the initial trauma in veteran populations is directly proportional to the severity and intensity of combat exposure (Roy-Byrne, Arguelles, Vitek, et al., 2004). Additionally, veterans with insignificant symptoms for most of their lives may experience intense, immediate on-set of PTSD symptoms following retirement, anniversary dates of service, or
reunions with other veterans—altering their ability to function, regardless of how long past their combat service may be or how long they have been without symptoms (NCPTSD, n.d.).

For military members and their families, PTSD intrudes on multiple aspects of their lives. Harmless events, such as cars backfiring and helicopters flying nearby can stimulate wartime memories and reactions (Brown, 1984). Sleep disturbances commonly include vivid nightmares in which the veteran revisits traumatic events, sometimes physically responding as if these images are real and present (Brown). Numbing of emotional responses, a wartime survival necessity, becomes socially isolating and restricts the veteran from forming or maintaining significant and meaningful close interpersonal relationships. In addition, the veteran deals with survival guilt associated with having survived combat and the loss of fellow combatants (Brown).

1.3. Historical Background

Soldiers returning from battle have struggled with adjustment and PTSD like symptoms throughout history. During the Civil War, veterans with symptoms which included psychological and physical components of PTSD were diagnosed with “irritable heart syndrome” or “nostalgia” (Hyams, Wignall, and Roswell, 1996). Similar symptoms during WWI were identified as soldier’s heart, shell shock, effort syndrome or DeCosta’s syndrome and were effectively “cured” by an exercise program and staff support (Cameron Ritchie, 2005; Hyams et al.,
During WWII, soldiers having physical or mental problems were removed from combat, and over evacuation led to chronic psychiatric conditions (Cameron Ritchie, 2005). In WWII, acute stress disorder, battle fatigue, combat exhaustion, operational fatigue, or war neurosis identified these same symptoms and medical staff preferred to give a diagnosis of “normal response to extreme stress” rather than “war neurosis” (Hyams et al.). Acute stress disorder was used commonly, until the Vietnam War, when symptoms which were chronic and pervasive were labeled Post Traumatic Stress Disorder (Hyams et al.).

In 1963, United States Armed Forces altered policy for treating psychological stress and implemented PIES--Proximity, Immediacy, Expectancy, Simplicity, which provided mental health provision as close to the soldier as possible (Cameron Ritchie, 2005). In spite of this change in treatment approach, the lifetime incidence rates of PTSD for those serving in the Vietnam theater is 30.9% for men and 26.9% for women (Kessler et al., 1995). Substantial numbers of Vietnam veterans report PTSD symptoms at least once in their life—22.5% for men and 21.2% for women (Kessler et al., 1995). In all, over half of male Vietnam veterans and slight less than half of all women Vietnam veterans have experienced PTSD symptoms (Kessler et al., 1995).
1.4. Prevalence

American military members returning from deployment to Iraq and Afghanistan demonstrate an initial Post Traumatic Stress Disorder (PTSD) prevalence of 10% and 26% present with a mental disorder diagnosis within the first year (Kang & Hyams, 2005). According to the National Comorbidity Survey Report completed in 2005, civilian lifetime incidence rates for PTSD are 3.6% for men and 9.7% for women (Wang & Kessler, 2005). According to Wolfe, Erickson, Sharkansky, and King (1999), the incidence of PTSD may double within two years post deployment due to a period of readjustment and denial of symptoms. Research indicates that a third of veterans with PTSD are undiagnosed (Rosen, Chow, Finney, et al., 2004). As many as 60% of military members screening positive for PTSD, generalized anxiety, or depression do not seek mental health services (Grieger, Cozza, Ursano, et al., 2006). The most common reason cited is stigma (Hoge et al., 2004). More than 1.4 million veterans have returned from Operation Enduring Freedom and Operation Iraqi Freedom and another 1.1 million are Reserves or National Guard, slated for deployment within the next two years (DOD 101, 2006). PTSD incidence rates are slightly higher for soldiers serving in the National Guard and Reserves (20-21%), as compared to 18% of active duty personnel (Hoge et al., 2004). Those diagnosed with PTSD endure protracted
human pain and suffering, significant occupational effects, increased interpersonal dysfunction, divorce rates, substance abuse, incidence and severity of medical issues, and suicide risk (Grieger et al., 2006). Research by Foa, King, and Friedman (2000) indicates that veterans with PTSD do not recover and experience significant vocational, social, and marital impairment.

1.5. Impact on Society

Grieger et al. (2006) identified a primary challenge for mental health systems will be maintaining sufficient staffing levels to address the needs of returning military veterans. Currently, the Veterans Affairs Health System, the largest provider of health care for military veterans, spends $250 million per year on PTSD programs for 87,000 veterans (Rosenheck, n.d.). This averages approximately $2874 per patient per year. Veterans also are eligible to receive Compensation and Pension payments from the U.S. government, based on their disabilities related to military service. In 2005, these annual disability payments totaled $23.4 billion dollars and were paid to 11% of all military veterans (Bilmes, 2007). According to VA statistics, there were 244,846 veterans receiving disability for PTSD that same year (VA, 2006). These benefits, for both physical and mental disabilities, will increase as military members separate or retire from military service.
Societal impacts resulting from Post Traumatic Stress Disorder include significant economic impacts. Hourani (2006) reported a significant relationship between high levels of stress and decreased occupational functioning, including absenteeism, decreased production, and interpersonal problems. Those with a diagnosis of PTSD are 50% more likely to be currently unemployed, have three times longer periods of unemployment, and work harder and longer for lower wages (Savoca & Rosenheck, 2000). Veterans with chronic PTSD are unable to maintain employment due to the intrusion of their symptoms on daily activities, as a result, the 30% of those with PTSD identified as chronic find stable employment impossibility, strongly affecting their family’s income (NCPTSD, n.d.). Sleeplessness, nightmares, flashbacks, and anxiety affect the veteran’s well being, along with their spouses and children. Additionally, irritability, anger, avoidance, and hyper-vigilance contribute to workplace conflict jeopardizing the veteran’s employment. After cycling through many jobs, veterans eventually become dependent on family financial support and those who lack additional support become homeless. Decreased economic stability for those with PTSD affects society at large, however, for the veteran and his family, this additional hardship increases the stress experienced by veterans and their families already struggling with PTSD symptoms.

Additionally, those with PTSD demonstrate a higher incidence of involvement with the legal system and threaten the safety of themselves, family members, and society. Veterans with PTSD have increased rates of suicide (Hartl, Rosen, Drescher, Lee, & Gusman, 2005). Suicide attempt rates for
inpatients with PTSD is 54% and those with comorbid depression demonstrate a 75% suicide attempt rate (Nemeroff, Bremner, Foa, et al., 2006; Oquendo, Friend, Halberstam et al., 2003). The comorbid rate of PTSD and substance abuse ranges between 60-80% (Brown, Recupero, & Stout, 1995; Keane, Geraldi, Lyons, & Wolfe, 1988; Kofoed, Freidman, & Peck, 1993; Lombardo & Gray, 2005). Those with a PTSD diagnosis are five times more likely to be diagnosed with either drug abuse or dependence (Regier, Farmer, Rae, et al., 1990).

Compared to non-veteran populations, veterans with substance abuse diagnoses are ten times more likely to have comorbid PTSD (Brady, Beck, & Coffey, 2004). Those seeking treatment demonstrate more severe addiction and are consistently more resistant to treatment (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Brown, et al., 1995; Brown, Stout, & Mueller, 1999; Coffey, Schumacher, Brimo, & Brady, 2005; Navajits, Weiss, & Shaw, 1999). Homelessness is also an issue for veterans with PTSD. Although statistics specific to veterans with PTSD are not available, in 2004 there were 500,000 homeless veterans. (Marks, 2005). Due PTSD symptoms affect on economic stability, PTSD increases a veteran’s likelihood of becoming homeless.

Families of veterans with PTSD suffer along with the veteran. PTSD significantly impacts veterans and their families by promoting role reversal, dysfunctional interactions, lack of communication and family instability (Brown, 1984). Role reversals strongly affect familial relationships and interactions, and impact the military veteran’s self esteem. Veterans dealing with PSTD symptoms such as sleeplessness, anxiety, and hyper-vigilance are less able to be employed,
to participate in stressful family decisions, and often, spouses become head of the household. Interpersonal violence was found to be significantly more common for veterans with PTSD (Beckham et al., 1997; Hartl, Rosen, Drescher, et al., 2005; Kulka, Schlenger, Fairbank, et al., 1990). In the National Vietnam Veterans Readjustment Study, one third of male veterans with PTSD were involved in partner violence- an incidence rate two to three times greater than veterans without a PTSD diagnosis and civilian male populations (Jordan et al., 1992; NVVRS; Kulka et al., 1990; Straus & Gelles, 1990). Military veterans with PTSD are twice as likely to be divorced once and three times more likely to have multiple divorces compared to civilian populations (Jordan, Marmar, Fairbank, et al., 1992; Kulka et al., 1990). A study by Riggs, Byrne, Weathers, et al. (1998) found that 70% of partners of those with PTSD demonstrate significant clinical issues requiring intervention related to their experiences dealing with their loved one’s symptoms.

PTSD is also associated with serious medical conditions. Stapleton, Asmundson, Woods, Taylor and Stein (2006) found medical conditions associated with PTSD to include “depression, hypertension, difficulty concentrating, headaches, cold, flu, fatigue, cardiovascular problems, gastrointestinal problems, back pain, sinusitis, asthma, joint pain, irritable bowel syndrome, chronic pain, sexual dysfunction, dermatological conditions, and even cancer” (p.562). Fontana, Hyra, Godfrey, and Cermark (1999) explained
psychological stress and physiological reactivity due to PTSD led to coronary heart disease. Other associated medical issues include immunological diseases such as arthritis and psoriasis (Kubzansky, Koenen, Spiro, Vokonas, & Sparrow, 2007).

1.6. Protective Factors and Risk Factors

In order to provide an effective approach to pre-deployment training, protective factors and risk factors must be firmly established. Pre-existing protective factors will be enhanced and enabled through programmatic design. Risk factors must be diminished and offset through training. Though research exploring these factors is relatively recent, they are empirically identified through several meta-analyses. Additionally, only factors which may be impacted by training will be addressed by this program. Protective factors identified by researchers are: Internal Locus of Control; Self-efficacy; Optimism; Coping strategies, including problem focused coping and emotional focused coping; and Social Support. Research relevant to each factor is presented as either a personal factor or an environmental factor.
Hotopf (2000, p.280) reported “Post traumatic stress reactions and illness are multi-factorial and complex in genesis”. To think otherwise is “naïve” according to Hotopf, thus, the presentation here is both multi-factorial and complex and requires comprehensive investigation due to exhaustive research and exploration and association multiple interactions of risk factors and protective factors. Risk factors for PTSD involve five arenas: genetics; individual risk factors, including family background; personality factors; cognitive style; and information processing identified by Agaibi and Wilson (2005) in an exhaustive meta-analysis literature review on the protective and risk factors associated with PTSD. Pre-deployment psychological pathology is associated with post-deployment PTSD symptoms (Agaibi & Wilson, 2005; Freidman, 2000; Garmezy & Masten, 1991; Wilson & Drozdek, 2004; Yehuda, 1998).

Brewin, Andrews, and Valentine (2000) strongly defended the application of a unique model of resiliency to military populations as compared to a civilian model of post traumatic resiliency. They indicated that trauma severity and lack of social support were most highly correlated with Post Traumatic Stress Disorder in military populations and this was inconsistent with civilian risk factors (Brewin, Andrews, & Valentine, 2000). In his study of protective factors, Rutter (1990) identified three protective variables: personality coherence; family cohesion; and social support, which are incorporated by Agaibi and Wilson’s individual risk factors and family background. Prior to that research, Ozer, Best, Lipsey, and Weiss (2003) conducted a thorough meta-analysis of predictive factors of PTSD and focused on two categories: personal characteristics
supporting psychological processing and functioning, and intensity of the traumatic event or related events. Peri-traumatic responses and peri-traumatic dissociation were strongly correlated with PTSD symptomology that same study (Ozer, et al., 2003). Furthermore, stressful life events following trauma has been shown to be significantly predictive of symptoms and this has been supported in cross-sectional and longitudinal research (Dirkswagger, Bramsen, & Van der Ploeg, 2003; Fontana & Rosenheck, 1994; King, King, Foy, Keane, and Fairbank, 1999, Sharkansky et al., 2000). Seigel (1995) reported that PTSD is related to faulty traumatic event processing in an individual’s memory.

Factors shown to be associated with PTSD symptoms and which may be addressed by a training program are this program’s focus. Genetics and other pre-existing factors are not effectively impacted by intervention, so a strengthening of variable factors will be endorsed. Using a medical model, an individual may be genetically predisposed for diabetes, however, a preventative exercise and diet program may offset that factor and provide increased resistance to pathology. In their research on protective factors, Dirkswagger et al. (2003) identified two broad categories supporting increased psychological resilience, which will be maintained here: personal factors, including internal locus of control, self-efficacy, optimism, and coping skills, and environmental factors, such as social support.
1.7. Personal Resources

This program serves to strengthen existing personal resources. These factors provide increased psychological resiliency and are directly controlled by the military member. For this program, personal resources are Internal Locus of Control, Self-efficacy, Optimism, and Coping skills, including problem focused coping and emotion focused coping. These factors combine to provide combat veterans powerful approaches to addressing and processing their combat experience.

1.7.1. Internal Locus of Control

Locus of Control is a well substantiated predictor of PTSD, and internal locus of control (the belief that the self powerfully influences events and outcomes) is significantly associated with decreased PTSD symptomatology and psychopathology (Agaibi & Wilson, 2005; Auerbach, 1986; Folkman, 194; Harel, Kahana, & Wilson, 1993; Rotter, 1966; Strentz & Auerbach, 1988; Wilson, 1995; Wilson, 1989; Wilson, Harel, & Kahana, 1989; Wilson & Raphael, 1993; Zakin, Solomon, & Neria, 2003; Zeiss & Dickman, 1989). Dr. John Krystal, Director of the National Center of PTSD Laboratory of Clinical Psychopharmacology, explains that an individual’s propensity of PTSD is directly proportional to how helpless they feel during a catastrophic event (Goleman, 1995). He reported that those who feel they have even slight control are more emotionally stable.
following trauma, and it is the individual’s subjective interpretation of their helplessness that becomes overwhelming (Goleman, 1995). Dr. Krystal indicated that brain chemistry is altered the moment an individual believes their life is in peril and they can do nothing to intervene (Goleman, 1995). Those trauma survivors with an internal locus of control are better able to find meaning in their experience, can form attachments and bonds with others, and enhance their resources to address emotional, social and economic issues (Zakin et al., 2003). External locus of control (the belief that others powerfully control one’s life) is associated with anxiety, maladaptive adjustment, and increased psychopathology (Agaibi & Wilson, 2005; Harel et al., 1993; Strentz & Auerbach, 1988; Wilson, 1989; Wilson et al., 1989).

Clearly, a program providing psychological resiliency would train military members to apply internal locus of control paradigms to their deployment experience, in order to augment their adjustment ability, decrease their psychopathology, and expand their personal resources. Military members may augment their existing internal locus of control by reappraising their self-selected, voluntary military service, and self-determined excellence as indications of internal locus of control. Additionally, within the military, promotion to a higher rank is dependant on each soldier’s performance (which again in self-determined). Thus, using a strengths based approach to training, each military member already possesses some level of internal locus of control.
1.7.2. Self-Efficacy

Self efficacy, as defined by Bandura (1994), is the assessment of an individual’s ability to "produce designated levels of performance that exercise influence over events that affect their lives" (Bandura, 1994, p. 71). This influences functioning in five areas: self supporting or self destructive thinking; motivation and perseverance; emotional stability and susceptibility to stress and depression; resiliency following trauma; and decision making at critical life junctures (Benight & Bandura, 2004).

Self efficacy affects stress reactions and coping abilities by providing a personal assessment of coping abilities (subjective determination of the level of environmental threat in light of personal resources); the insight to take action to transform a detrimental situation to a more positive one (enables and sustains coping abilities); and provides thought control and emotional regulation (either self inflicted magnification of stress or stress management) (Benight & Bandura, 2004). Solomon and his fellow researchers studied the effects of perceived self efficacy on Israeli combat soldiers longitudinally and found that self-efficacy beliefs were more highly associated with PTSD symptoms long-term than trauma severity (Benight & Bandura, 2004). Symptoms of PTSD including the ability to control intrusive thoughts (compartmentalizing), offset emotional instability, and cope with stressors (coping skills) are associated with high levels of self-efficacious beliefs (Benight & Bandura, 2004). In fact, Benight (1999) supported a model for self efficacy which demonstrates self-efficacy as a mediator of the impact of resource loss following trauma, optimism, and social support on PTSD.
symptoms (Benight & Bandura, 2004). Clearly, self-efficacy influences an individual's perception of how equipped they are to address trauma and cope with their post traumatic adjustment.

1.7.3. Optimism

Optimism has been shown to increase resilience, serves as a protective factor, and enables effective coping following traumatic experiences. (Agaib & Wilson, 2005; Folkman, 1997; Folkman & Moskowitz, 2000; Fredrickson 1998, 2001; Tugade & Fredrickson, 2004). Two pessimistic and erroneous cognitions strongly, empirically correlated with PTSD symptomology are the beliefs that the world is unsafe and threatening, and that the individual is incompetent, including the conviction others would have been able to prevent the traumatic event and PTSD symptoms demonstrate weakness (Foa & Jaycox, 1999). Negative cognitions such as self-blame and negative beliefs regarding the world were found to be more significant than the traumatic experience in the development of PTSD (Foa & Jaycox, 1999). In research conducted by Harper, Schmidt, Beacham et al. (2007) optimism was empirically correlated with increased positive psychosocial behavior.

Optimism is a foundational concept incorporated into Hope Theory, first introduced by Frank (1961, 1968, and 1975). In this approach, hope is the basis for all cognitive behavioral interventions, and required for successful results (Frank, 1961, 1968, and 1975). In order to motivate and engage hope, Snyder, Hardi, Cheaven, Michael, Yamhure, and Sympson, (2000) postulated that an
individual must assess an outcome is valuable enough to merit effort, and that
the result is realistically achievable. Agency and pathways are the two goal
oriented courses associated with hope (Snyder et al., 2000). Agency is the mental
process of engaging motivation required to achieve a goal (determination), and
pathway is the process of planning to meet a goal (Snyder et al.). Their research
emphasized client’s need for “expert” help, and reminded those providing
intervention, that the client was seeking help because they had exhausted their
resources and still not successfully reached their goal (Snyder et al.). Their
research also identified improvement dependent on hope-inducing interventions
and proved these strategies provide psychologically protective properties (Snyder
et al.).

In *Learned Optimism*, Seligman, 1999, introduces specific methodology to
increase optimism and reviews how optimism supports all successful endeavors
requiring risk and personal investment. Seligman is attributed with the
beginnings of positive psychology, which postulates the medical model of
psychological deficiency is detrimental to clients, and a strengths’ based, positive
approach serves both client and provider more powerfully (Seligman, 1999).
Similiarly, Frederickson 2001 presents a broaden and build theory, which
identifies positive approaches as enabling and serves to assist the ability to
simultaneously assess alternative options and solutions. This program is largely
based on these theories of positive emotions providing increased resiliency and
coping abilities.
1.7.4. **Coping Strategies**

An additional protective factor against PTSD is an individual’s application of coping strategies, defined as the ability to apply cognitive and functional resources to manage internal or external stressors which require adjustment in order to maintain mental, emotional, and social stability (Dirkswagen et al., 2003; Lazarus, 1993). Coping strategies are considered a personal resource, similar to internal locus of control, optimism, and self-efficacy (Dirkswagen et al., 2003). Certain coping mechanisms such as avoidance, wishful thinking, and taking responsibility are predictive of significant psychopathology (Agaibi & Wilson, 2005; Benotsch, Brailey, Vasterling, & Sutker, 2000; Dirkswagen et al., 2003; Nemeroff et al., 2006; North et al., 2001). These coping approaches disable pro-active problem focused coping mechanisms, helpful in conditions where the individual operates in an environment where they have a great deal of control (Strentz & Auerbach, 1988).

Active coping skills, as opposed to avoidance, provide resilience to PTSD (Sharkansky, King, King, Wolfe, Erikson, & Stokes, 2000). Folkman and Moskowitz (2000) identified three different coping styles: positive re-appraisal (re-framing); problem focused coping (taking action); and the capacity to create meaning. Two widely studied coping strategies applied to post traumatic adjustment are problem-focused coping (actively applying a corrective action to the situation) and emotional coping (emotional regulation and reassessment processes) (Bulman & Wortman, 1977; Dirkswagen et al., 2003; Folkman,
Lazarus, 1983; Lazarus, Gruen, & DeLongis, 1986; Kaloupek & Stoupakis, 1985; Kaloupek, White, & Wong, 1984; Mills & Krantz, 1979; Roth & Cohen, 1986; Sharkansky, King, King, & Wolfe, 2000; Solomon, 1995; Strentz & Auerbach, 1988; Sutker, P.B., Davis, J.M., Uddo, M., & Ditta, S.R., 1995). Much research supports problem-focused coping mechanisms as being more protective against PTSD symptoms than emotional focused coping strategies (Agaibi & Wilson, 2005; Dirkswagger et al., 2003; Folkman & Moskowitz, 2000; Sharkansky et al., 2000; Solomon et al., 1988; Strentz & Auerbach, 1988; Sutker et al., 1995; Wilson et al., 1988; Wilson & Raphael, 1993; Zeidner & Ben-Zur, 1994; Zeidner & Endler, 1996). However, other researchers found the incorporation of both these strategies supported lower stress levels (Folkman & Lazarus, 1980; Martelli, Auerbach, Alexander, & Mercuri, 1987).

Studies of former POWs indicate that both emotional coping and problem-focused coping skills were successfully used to increase resiliency to PTSD (Brill, 1946; Nardini, 1962; Schmolling, 1984; Strentz & Auerbach, 1988). In their study, Strentz and Auerbach (1998) indicated emotional based process are most effective for intense, time-limited, low-control situations, and problem focused coping skills are less productive under those same conditions. They also specifically identified emotion based coping skills as relaxation, attention redirection, denial, wishful thinking, minimization of threat and seeking social support and included techniques such as deep breathing, thought stopping, muscular relaxation, and directed fantasy applied in order to offset emotional reactions to traumatic events (Strentz & Auerbach, 1988).
Problem focused coping skills involve the application of behaviors or cognitive activity requiring taking action and problem solving and leading to alleviation of the traumatic stressor (Strentz & Auerbach, 1988). They found individual’s employing emotional based coping demonstrated the lowest anxiety levels, lowest distress levels, and the most behavioral adaptation (Strentz & Auerbach, 1988). According to Dirkswagger et al. (2003), coping strategies are more predictive of PTSD symptoms initially, and less protective two years following trauma. Indicating that coping skills impact initial functioning following deployment and this is important for veterans seeking employment, returning to school, and dealing with interpersonal readjustment. However, long term functioning is affected by other factors, such as internal locus of control, self-efficacy, optimism, and social support.

1.8. Environmental Factors and Social Support

Social support, of all protective and risk factors, is most strongly correlated with PTSD symptoms (Benotsch, Brailey, Vasterling, & Sutker, 2000; Brewin, et al., 2000; Cohen & Ashby-Wills, 1985; Dirkswagger et al., 2003; Flannery, 1990; Green, Grace, Lindy, Gleser, & Leonard, 1990; King, King, Keane, & Adams, 1998; Ozer, Best, Lipsey, & Weiss, 2003; Sarason & Sarason, 1985;). For those military members involved in combat situations (for returning Operation Iraqi Freedom and Operation Enduring Freedom veterans this is essentially all deployed members), lack of social support is two times more predictive of debilitating symptoms than for civilian populations. (Ozer et al., 2003).
Dirkswagger et al. (2003) found social support to be an environmental protective resource. In their research, Ozer et al. (2003) identified lack of social support as a distinct vulnerability for enduring psychopathology and a lack of psychological resilience following trauma. The findings on sufficient social support indicate less psychological distress (Cohen & Ashby-Wills, 1985; Dirkswagger et al., 2003; Flannery, 1990; Green et al., 1990; King et al., 1998; Sarason & Sarason, 1985). In studies conducted with military veterans, negative social interactions seemed to affect psychological health more strongly than positive social interactions (Dirkswagger et al., 2003). Two models of social support, the main effect model and the buffering model, were initially presented by Cohen and Ashby-Wills (1985). They contrasted a main model of social support in which social support is protective regardless of the circumstances an individual faces and the buffering effect model, in which social support is protective only in times of stress (Cohen & Ashby-Wills, 1985). Extremely important were the findings of Ozer et al. (2003) which emphasized the most powerful effects of social support on PTSD symptomology occurred three years following trauma, and indicates the cumulative influence of social support becomes more powerful as time passes, rather than initially following trauma. It was found than personal traits and coping mechanisms were more highly correlated with PTSD symptoms immediately following trauma, and social support was more predictive longitudinally, suggesting that other factors may be initially protective (Ozer et al., 2003).
CHAPTER 2.

EVIDENCE-BASED PRACTICE

2.1. Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) programs have been shown to be short, inexpensive and effective (Gohner & Schlicht, 2006). CBT focuses on correcting cognitive distortions by “normalizing” and “reframing”, and developing skills necessary to successfully adjust behavior (Bandura, 1997, 2004; Meichenbaum & Jaremko, 1983; Norlander, Bergman, & Archer, 2002). In research conducted by Norlander et al. (2002), CBT successfully increased dispositional optimism. Another CBT program using guided mastery and coping skills reestablished individuals’ realistic cognitive assessment (Bandura, 1997, 2004). Cognitive behavioral training theory presents coping as a result of cognitive appraisal of two assessments, a primary appraisal (what is at risk?), and a secondary appraisal (what are my resources?). Following assessment, a coping strategy, either problem-focused or emotion based, is chosen and applied (Norlander et al., 2002). A cognitive behavioral training program developed specifically to address stressful situations is Stress Inoculation Training.
Stress Inoculation Training is an evidence based CBT program successful in addressing anxiety (Jaremko, 1984; Meichenbaum & Genest, 1983; Meichenbaum & Jaremko, 1983, Meichenbaum & Turk, 1982; Turk, Meichenbaum, & Genest, 1985). In SIT, both physical activity and reassessing stressful events are encouraged (Jaremko, 1984). Individuals develop a cognitive framework for preparing, confronting, and coping with a potential stressful event, followed by performance evaluation (Turk et al., 1983). Cognitive processes successfully applied to stressful situations include redirection or distraction, and problem solving strategies (Jaremko, 1984). An additional skill emphasized in SIT is the replacement of disabling thoughts or images with coping skills (Jaremko, 1984). According to Jaremko (1984), SIT has three stages: re-evaluation of stress (restoring power and control to the individual); training for specific coping skills; and gradual practical application of these new skills to stressful events. Fontana, Hyra, Godfrey, and Cermark (1999) designed a cognitive behavioral training program based on SIT methodology, which included six 45 minute training sessions. They focused on three processes: presenting psycho-educational information regarding the psychological and physiological impact of stress; skills training and practice, which included relaxation, deep breathing exercises, cognitive restructuring, time management, and problem focused coping skills; and application of these skills and assessment of their effectiveness (Fontana et al., 1999). SIT emphasizes that if a coping strategy is unsuccessful– another should be applied, and be approached as an ongoing
process, rather than a singular event (Meichenbaum & Jaremko, 1983). Research supports the effectiveness of Stress Inoculation Training as an intervention for mitigating stress (Fontana et al., 1999; Marlatt, 1982; Meichenbaum, 1985)

2.2. Resiliency

Psychological resiliency following a traumatic episode has been defined in research based on behavioral factors, functioning, personality traits, and coping approaches. Block and Kremen (1996) focused on the multi-dimensional aspects of resiliency and identified performance, cognitive processes, and the ability to apply resources- personal and social- to specific situations. They also emphasized an individual’s ability to compartmentalize and detach, in addition to intellectual exploration and curiosity (Block & Kremen, 1996). Other researchers have reported that resiliency requires sustained competence, self-efficacy, internal locus of control, positive beliefs, and cognitive feedback (Agaibi & Wilson, 2005; Weisaeth, 1995, Wilson & Drozdek, 2004). According to Felsman and Vaillant (1982), psychological resiliency requires the ability to assess and reassess experiences and features the increased ability to recover from traumatic events, restore personal resources, and gain mastery over circumstances. Agaibi and Wilson (2005) added the requirement of periods of active processing, rest, and gradual development of coping skills. Lazarus and Folkman (1984), the foremost investigators of stress and coping abilities, indicated that strength and
flexibility were additional formative components of resiliency. The definition of psychological resiliency for this program is:

The ability to maintain and eventually increase psychological and social functioning following a potential destructive event, requiring personal strength and purposeful development of resources.

2.3. Psychological Annealing and Post-Traumatic Growth

Traumatic events do not only debilitate individuals, but also provide the opportunity for positive outcomes (Al-Naser, Ridha, & Figley, 2005; Seligman, 1999; Tedeshi, Park, & Calhoun, 1998). Five major areas of post-traumatic growth that have been investigated by researchers are: “greater appreciation of life and changed sense of priorities; warmer, more intimate relationships; greater sense of personal strength; recognition of new possibilities or paths in one’s life; and spiritual development”. (Tedeschi & Calhoun, 2004). According to Janoff-Bulman (1992), traumatic experiences require reassessment of individual and global beliefs. “In the aftermath of these extreme experiences, coping involves the arduous task that requires a delicate balance between confronting and avoiding trauma, feelings, and images.” (Janoff-Bulman, 1992, p.169).

Eventually, after a period of reconstructing their beliefs (cognitive reappraisal), trauma survivors are able to continue with their lives (Janoff-Bulman, 1992, 2004). In their studies of military veterans, Elder and Clipp (1989) found that those who experienced intense combat demonstrated increased resiliency and less helpless longitudinally compared to civilian counterparts.
Aldwin and Levenson (2004) postulate “the more resilient have the ability to withstand major stressors without developing serious adverse problems (like Post Traumatic Stress Disorder or substance abuse problems) and may be more likely to perceive benefits and grow from stress.” (p.21). The implications relative to an psychological inoculation and resiliency program are that not only do those with an identified risk and predisposition to psychology have the opportunity to augment their ability to withstand stress, but those with no psychopathology may derive even greater benefits. The process of annealing metal may be applied to this psychological growth following trauma. Just as metal develops improved strength following repeated exposure to high temperatures, psychologically repeated exposure can either have a “steeling effect” or a “prior vulnerability” (Agaibi & Wilson, 2005, p.204). This program’s focus will be increasing the positive influence of the “steeling effect” and altering or offsetting a “prior vulnerability”.
CHAPTER 3.

IMPlicATING FACTORS FOR PROGRAM DESIGN

3.1. Stigma

Only 4.1% of active duty military members with PTSD symptoms seek treatment (Friedman, 2004). The other 94.9% do not seek treatment due to issues related to stigma; those most in need of help are resistant for the same reason (Freidman, 2004, Hoge et al., 2004). Fears of jeopardizing their careers, lack of confidentiality, friends, fellow military members, and commands reactions, and the embarrassment of being weak prevented many from seeking help (Hoge et al., 2004). Friedman reported that having PTSD symptoms as a military member implies deficiency, weakness, and failure (Freidman, 2004). Hoge, et al. (2004) recommended a monumental educational program which he believed would alter military culture which has existed for hundreds, even thousands of years. By presenting this psychological training program before deployment, stigma is largely avoided by reframing seeking help as positive, adaptive, and pro-active. In addition, normalizing a period of adjustment and recovery following deployment would adjust cognitive expectations and decrease the stigma attached to manifesting PTSD symptoms.
3.2. Program Requirements

Researchers have identified factors in PTSD treatment programs which support successful outcomes. An inoculation and resiliency program would foster these factors so they may be applied when required. Instead of approaching a traumatic event with deficits, military members would have a “toolbox” of protective strategies with which to address their event processing and adjustment following trauma. In addition to the above internal and external resources, several processes must be fostered in order to provide resiliency. Wilson (1995) found seven protective factors to support successful treatment of PTSD:

- Locus of control (a sense of efficacy and determination)
- Self-disclosure of the trauma experience to significant others
- Sense of group identity and sense of self as a positive survivor
- Perception of personal and social resources to aid in coping in the
  Post-traumatic recovery environment
- Altruistic or prosocial behaviors
- Capacity to find meaning in the traumatic experience
- Connection, bonding, and social interaction within a significant community of friends and fellow survivors.
Additionally, Agaibi and Wilson (2005) identified additional general factors promoting resilient functioning which were:

- Internal factors (internal locus of control)
- Cognitive attributions of being a strong survivor and a firm sense of
- Personal identity as being a survivor
- Coping factors (perception of personal and social resources, and
- Ability to find meaning)
- Behavioral factors (appropriate self-disclosure, pro-social behaviors, bonding and fellowship with other survivors).

Other program design considerations implicated by previous research determine presenter characteristics and indicate behavior is more successfully incorporated if the presenter is liked, respected, regarded as competent, credible, and relevant (Fontana, Hyra, Godfrey, & Cermak, 1999; Lefkowitz, Blake, & Mouton, 1955). Additionally, shared personal characteristics such as age and background (in this case, cultural understanding is a key issue) predict credibility and relevance (Fontana, Hyra, Godfrey, & Cermak, 1999; Kazdin, 1994).

An inoculation program activates motivational processes due to the participants’ expectations that the resiliency program would successfully provide protective qualities thus improving learning and application of cognitive processes and coping mechanisms (Bandura, 1977; Fontana, Hyra, Godfrey, & Cermak, 1999).
3.3. Implication for Policy, Practice, and Research

“Posttraumatic resilience can be learned”; and “Post traumatic resilience can be implemented through a training program to reduce the effects of traumatic exposure.” (Agaibi & Wilson, 2005, p.212.). Resiliency training increases psychological, emotional, and social functioning for those with PTSD symptoms and those without psychopathology. Foundational factors important to psychological inoculation are internal locus of control, self-efficacy, optimism, social support, and coping skills. Cognitive behavioral training provides an effective evidence based approach to enhancing psychological resiliency.

An inoculation program intercepts disabling factors such as stigma, the medical and mental health system’s inability to provide adequate care to increasing numbers of veterans, and stress on social, economic, and legal systems. Decreasing the incidence of PTSD would strengthen social stability and community safety by decreasing veterans’ substance abuse, legal involvement, and community services to victims of domestic violence and families impoverished due to divorce. Mental health systems will not require radical revision and education systems delivering services to the children of these families will be less taxed and veterans and their family’s ability to thrive would be increased. Financial independence would be normative for these veterans and their families and they would be less dependent on social systems for basic needs.

Human pain and suffering of those susceptible to PTSD and their families will be lessened, and those already functioning well will increase their abilities to excel. Finally, not only deployed military members experience traumatic
situations. The implications for young children, and indeed society at large, may benefit from this intervention/prevention approach, and we will find growth does not require traumatic stress—only psychological preparation (inoculation).
CHAPTER 4.

PROGRAM DESIGN

This program design is based on Rapp and Poertner's program design and evaluation model, which they credit Taber and Finnegan (1980) for their basic framework (Rapp & Poertner, 1992). This programmatic design follows their model closely. Important elements, according the Rapp & Poertner (1992), are:

- Analyze the social problem.
- Determine who is the direct beneficiary of the program.
- Determine the social work theory of helping.
- Specify the helping environment.
- Describe the actual helping behaviors.

Each element is explored and presented in order provide specific guidelines to inform program development and implementation. Ongoing evaluation of efficacy and effectiveness are designed as program elements, and are critical to program success.
4.1. Direct Beneficiary of the Program

The primary direct beneficiary of this psychological inoculation and resiliency training (PIRT) program is the individual military member. Although secondary beneficiaries including, society at large, DOD, local communities, and family members, gain significantly from military members’ increased mental stability and adjustment following deployment, this program focuses narrowly on providing a cognitive framework which profits the member and requires each military member’s engagement. Service before Self, a highly regarded military value, is detrimental when psychological functioning is at risk. Thus, the direct and powerful benefit for each military member will be the intense focus here. Any additional secondary benefit will be welcomed, but not be primary. Internal locus of control, self-efficacy, optimism, social support and coping skills all increase an individual’s functioning emotionally, socially, economically, and psychologically regardless of environmental situations (in theater or otherwise). This program increases leadership qualities, management ability, elevates interpersonal communication effectiveness, and increases available problem solving abilities for those having served in combat, far after their wartime service. Again, the motivation for fully implementing this program is the benefit to the individual, both militarily and personal. This same ethic directs the program’s focus and supports the selection of the primary beneficiary, the individual service member.
4.2. General Population

The general population, for this program, would be all individuals who serve in the United States Armed Services. This encompasses 1.4 million active duty service members and 1.1 million Reserve and National Guard personnel, totaling 2.5 million individuals serving in the United States Armed Forces (DOD 101, 2006).

4.3. At-Risk Population

Those at-risk for mental health issues following military service would be members who have been deployed, or are likely to be deployed (in essence, all active duty, Reserve, and National Guard members). At this time, over 1.4 million have been deployed and are susceptible adjustment issues (Bilmer, 2007).

4.4. Target Population

The target population would be the 94.9% of military members who demonstrate PTSD symptomology, or other psychological issues, but do not seek treatment (Freidman, 2006). The client population for this program actually exceeds the at risk population, which is common for prevention programs. The advantages of prevention rather than treatment indicate a larger target population, and in this program, personal application of this training benefits all those participating, regardless of combat service.
The coping skills and cognitive framework presented may be applied to business interactions, social situations and interpersonal relationships. Additionally, the augmentation of military members' psychological stability and functioning enhances in-theater performance of professional military duties and will decrease the number of military members removed from combat due to psychological dysfunction.

4.5. Client Population

The client population would be any military member slated for deployment (although this appears to be 2.5 million individuals, it is considerably less, due to multiple deployments, and actual military members “in country” at any given time). Relevant pragmatic considerations would be the sheer volume of individuals needing psychological resiliency training, however, this is countered by the ethical requirements that each member be as prepared for combat as possible prior to deployment. Finally, client capabilities will be infinitely variable, and range from highly resilient without training to predisposed to psychological dysfunction, according to identified risk factors. These risk factors include previous psychological difficulties, external locus of control, low self-efficacy, pessimism, lack of social support, and underdeveloped coping skills. No individual would be disqualified from PIRT training except
those who would also be prohibited from carrying out their military duties. According to Department of Defense Directives- this would be those demonstrating active psychosis or active suicidal or homicidal ideations. All other members will be served.


The social work theory of intervention applied in this program is a client centered, strengths based approach. The program maintains that individuals self selecting to be military members demonstrate certain qualities innately, although to varying degrees. It is the augmentation of these inherent qualities which not only supports psychological resiliency during and following deployment, but also promotes post-traumatic growth. (See Figure 1.) Although many programs claim to be “strengths based”, this program first reframes every military member with a positive presentation of inherent strengths. Throughout the program, military members receive consistently beneficial approaches, and their military service is respected, and demonstrated to be enabling, and proactively enhancing their abilities and skills. An important component to this approach, Wilson (1995) identified a “steeling effect” in combat veterans, which provided increased mental stability. This is supported by research completed by Elder and Clipp (1989) which indicated combat veterans who have intense wartime experiences are more
likely to be more pro-active, less helpless, and demonstrate increased psychological resiliency compared to civilians their same age. Military members are presented with this enhancing and positive approach throughout the program, and reframe their reference to their military service as a result.

Figure 1: Psychological Inoculation and Resiliency Training Program Theory of Helping
It is this positive, pro-active, strengths-focused approach which absolutely distinguishes this program from any other psychological inoculation and resiliency training program. The approach of this program is unwaveringly, realistically positive. According to Frank (1961, 1968, and 1975), a positive attitude is the basis for all cognitive behavioral interventions, and required for successful results. This program aspires to provide every military member that ability.

4.7. Client Outcome Goal

Goals for PIRT include initial, short, and long term goals for military members. These parameters also serve all secondary beneficiaries. Long lasting impacts resulting from PIRT equally serve individuals, families, local communities, society at large, and the military. As with Vietnam veterans, initial individual problems are not as visible as the long term impact of an entire generation of veterans' re-adjustment issues. This program seeks to avoid many of the acute and chronic problems experienced by former combat veterans.

Initial goals for the PIRT program will be a ten percent increase in scores on the post test measures of Locus of Control (Rotter, 1966), Life Orientation Test-Revised (Scheier & Carver, 1985), Multi-dimensional Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988), Self-efficacy (Chen, Gully, & Eden, 2001), and Coping Skills (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986) measure tested directly after the program is completed. Short and long term goals for primary clients would be a twenty-five percent decrease in the
rates of PTSD, depression, and anxiety within the first year following deployment compared to current incidence rates. Currently, over 30% of returning combat veterans seek mental health services within the first year following deployment (Hoge et al., 2004). Additional short term goals include a twenty five percent decrease in incidence rates of divorce, substance abuse, legal involvement, unemployment, and homelessness within two years post deployment compared to current rates. Secondary short term goals would be a twenty five percent decrease in provision of both acute and non-acute mental health services for military members in theater and psychological evacuation rates from the theater of operations compared to the evacuation rates prior to this program.

4.8. Objectives

Objectives for this program are ambitious but not unrealistic. While a decrease in human anguish and suffering will certainly improve combat veterans’ quality of life, it is an ambiguous term. This program specifically addresses quality of life issues by decreasing suicide rates by twenty five percent. It also provides increased social and economic stability by a twenty five percent decrease in military and civilian legal involvement, mental health service provision, use of Social Services, and Compensation and Pension payments. Finally, this program will provide a twenty five percent increase in the United States’ armed forces stability (evacuation rates from theater), reliability (mental health provision in
theater), and retention rates as compared to those rates currently. Most importantly, this Psychological Inoculation and Resiliency Program will foster and augment a new generation of national leaders with military combat experience.

4.9. **Client Expectations**

Requirements and expectations of military members undergoing the PIRT program are few, and intentionally non-exclusive. Military members clearly understand the utility and benefit for pre-deployment psychological training. Their engagement and absorption of training material will determine the program’s effectiveness. Since this is true of any training program, interactive Socratic dialogue will engage military members, and group psychodynamic processes will increase personal investment in goals and outcomes. The setting of shared group expectations and behavior both in theater and after returning from combat, provides individual members peer supported goals and improves engagement, rather than dictation of “Formal” goals set by others. Following each training session, those seeking additional interaction will be able to access trainers for at least one hour. The purpose of these optional sessions provide individuals with questions, or lacking confidence in their understanding of material presented, direct answers and clarification. Additional requirements include attendance at all ten modules, and demonstration of understanding and application of information during training. At the completion of each module, a short questionnaire will be administered in order to assess each individual’s
grasp of the training provided for that module. Those lacking mastery will be required to attend the additional supportive sessions. Each military member will be fully responsible for the proficient application of the training material, and will be provided ample opportunity to demonstrate their proficiency.

4.10. Provider Expectations

Since the trainer for this PIRT program is NOT a military member, expectations are equivalent to any professional trainer. Providers should be knowledgeable and excellent public speakers with a personable, engaging style. They should demonstrate respect and understanding of military culture, customs, and courtesies. A clear grasp of a strength based approach to military culture along with an understanding of the inherent obstacles is required. Trainers must have a strong sense of purpose, the ability to direct group discussion, and an obvious sense of humor. Modeling psychological resiliency is an important component and will result in increased program effectiveness. Trainers will complete sessions on time, cover requisite material, and conduct post test following each session. Finally, trainers will be available for “remedial” sessions following each module. Figure 2: Military member and presenter expectations presents clear and specific requirements for successful program completion and training.
4.11. Other Objectives

Training facilities available will strongly affect the efficiency of this program. A comfortable, relaxed environment where members may discuss material without interruption is important. Military members are accustomed to operating under extreme conditions, and if necessary, trainers should adjust to training military members under whatever conditions are present. Once again, this models resiliency.

Intentionally, there are few requisite requirements for service provision, and providers should train understanding the importance of this program and retain that focus. See Figure 2.
<table>
<thead>
<tr>
<th>Factor</th>
<th>Possible Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Professional Ethics</td>
<td>1. Program will be presented from a strengths based approach, with the military members' roles as &quot;expert&quot; and presenter as &quot;helper&quot;. Command will be informed if any military member demonstrates psychosis, or suicidal and homicidal ideations.</td>
</tr>
<tr>
<td>2. Client Needs</td>
<td>2. Presenters will be culturally competent, demonstrate respect, and understand military culture, customs, and courtesies. They will be engaging, positive, and adept public speakers able to maintain military members attention and interest throughout each module</td>
</tr>
<tr>
<td>3. Modeling Resiliency</td>
<td>3. Presenter will model the characteristics, cognitive framework, and coping skills they present to military members</td>
</tr>
<tr>
<td>4. Program Consistency</td>
<td>4. &amp; 5. All material for each module will be thoroughly presented and a post test will be given at the conclusion of each module</td>
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<tr>
<td>5. Client Proficiency</td>
<td></td>
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<tr>
<td>6. Program Policy</td>
<td>6. Military members will attend all ten consecutive modules of training</td>
</tr>
<tr>
<td>7. Foundational Philosophy</td>
<td>7. Military members will clearly be presented the utility and benefit of PIRT program</td>
</tr>
<tr>
<td>8. Program Effectiveness</td>
<td>8. Military members engagement in setting personal goals and outcomes, absorption and application of material indicates members' personal investment in maintaining psychological resiliency</td>
</tr>
<tr>
<td>9. Customized Programming</td>
<td>9. Additional information and training will be available for an hour following each module for remediation of those requiring clarification or supportive instruction</td>
</tr>
</tbody>
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*Figure 2: Military Member and Presenter Expectations*
4.12. Specified Service Procedures

Psychological Inoculation and Resiliency Training requires the following procedures:

1. Assessment (Pre-Test)
2. Training (10 modules/ two hours each)
3. Module effectiveness and remediation
4. Client evaluation of program
5. Assessment (Post-test)
6. Evaluation of Program Effectiveness (short term)
7. Monitoring of long term parameters.

4.13. Key Persons Required to Produce Client Benefits

The PIRT program requires several critical persons to fully engage and actively support this training. Commanders' directives stating the value and utility of this program are absolutely essential to the program's success. Soldiers will be more likely to process and apply information from the program if attendance and engagement is endorsed by Senior Officers and Non-Commissioned Officers. This would include incorporating the PIRT program as a portion of pre-deployment training and encouraging the application of PIRT training before, during, and after deployment. Additionally, the provision of facilities will be at these leaders discretion. Department of Defense endorsement
will be secured by briefing senior leaders regarding the benefits and processes unique to PIRT training, and obtaining full support from all levels of military leadership.

Other key players are the military members, “battle buddies”, military families, and the presenter. Military members’ full engagement with the program is necessary for them to gain full benefit from the coping skills and cognitive framework presented during training. This will be accomplished by presenting the personal long and short term applicability of PIRT training for each military member. Additionally, battle buddies provide extra support in instances where the military member is experiencing difficulties applying PIRT training skills.

Once again, the benefit of entire units universally employing PIRT training increases military effectiveness, and minimizes disruption of units due to psychological evacuations from in theater. Military families’ understanding and encouragement of the skills are also protective factors to psychological instability. Families will be given information regarding PIRT training benefits and approaches, and ideally, they will eventually undergo similar PIRT training before their family member is deployed.

Finally, and importantly, the presenter of the PIRT program faces great responsibilities. They are required to maintain military members’ attention throughout each module, model resiliency characteristics, thoroughly present all material, test members’ understanding of material, and provide remedial sessions following each module. Most importantly, presenters must maintain professional mental health ethics, and will inform commanders if any military
member demonstrates psychosis, or suicidal and homicidal ideations during training. In order to ensure program consistency and quality, presenters will be intensively trained, tested, and members will report on the effectiveness of the presenter at the conclusion of each training program. Key players important to the PIRT program are presented in Table 1: Key Players.

<table>
<thead>
<tr>
<th>Description</th>
<th>Behavior Required</th>
<th>How to Elicit Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>External</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Funding for development of pilot program  
3. Training facilities | A. Present PIRT program to DOD command and secure full endorsement |
| B. Military members | B. Full engagement with program with demonstrated application of skills | B. Provide PIRT program including remediation and educate military members on benefits of PIRT program in all aspects of their lives |
| C. Battle buddies | C. Support of comrades, reinforcement of skills and cognitive framework | C. Maintain open communication between battle buddies to provide increased support to those experiencing difficulties maintaining psychological resiliency |
| **Internal** |                   |                        |
| D. Personnel for training, supervision and evaluation | D. Hire and train personnel to provide PIRT program to military members | D. 1. Establish specific hiring criteria requirements for presenters  
2. Maintain rigorous standards for presenters based on military members’ comprehension, skills application, and satisfaction |
| E. Supply acquisition | E. Furnish presentation equipment and material for presentation staff | E. Establish supply relationships for ongoing acquisition of materials required for PIRT program presentation |

Table 1: Key Players
4.14. Specify the Helping Environment

The physical requirements of this program are minimal so that it may be presented under almost any environmental conditions. Ideally, training will take place in conjunction with military pre-deployment training, so that the principles inherent in PIRT may be practiced during similar conditions experienced during combat. If that is not possible, PIRT training may be included in drill weekends for National Guard and Reserve units. Groups should remain small enough to encourage participation, although the interaction between battle buddies is most important. Unit training is expected and may range up to 100 military members. The helping environment, while still military, will be informal, conversational, and interactive, thus a sound system may be necessary for larger groups. It is especially important that presenter adjust to environmental challenges, model resiliency, and focus instead on creating an atmosphere of open interaction, inquisitiveness, engagement, and positive affect. If the presenter is not fully focused on training, the military members will likewise resent the requirement to attend and deem the information irrelevant. The PIRT program helping environment is positive, informal, and adjusts to physical limitations using those same characteristics.

More importantly than the physical environment, the military unit/group environment is powerful. Peer social support, a foundational characteristic of psychological resiliency, is strongly improved by unit cohesion during and following combat service. Comrades’ ability to encourage PIRT program use during extreme stress, or during transitional phases, increases each military
member’s ability to maintain stability. Just as physical training for combat takes place as a unit, the psychological training, likewise, will be presented to units. The approach of the trainer as “helper”, and the military member as “expert” is important to the philosophy of PIRT training. Military members’ goals for psychological resiliency are much more powerful than a trainer listing their ideas of post deployment stability, growth, and resiliency. With members as expert, they increase their investment in both training and application of knowledge and skills. The result will be increased psychological resiliency and growth.
CHAPTER 5.

CONCLUSION

The Psychological Inoculation and Resiliency Training Program will provide increased application of coping skills, an effective cognitive framework, and offers a pre-deployment strengthening of each military member’s inherent abilities and characteristics. Currently, the Department of Defense has active programs addressing PTSD, depression, and anxiety following deployment, and has joined with the Department of Veterans’ Affairs to provide mental health intervention and treatment. Unfortunately, this does nothing to decrease the number of deployed military members experiencing mental health issues. The PIRT program increases social, economic, and psychological stability for individuals and families, decrease the burden on mental health, social service, and legal systems, and decrease human anguish and suffering following military combat service. Additionally, the skills and cognitive approach presented by the PIRT program will increase individuals’ quality of life, leadership abilities, and post deployment growth, both within the military and after, as a civilian. Military members and their families sacrifice much in the service of their country, sometimes including the ultimate sacrifice, their lives. Our armed forces is
physically the best trained, equipped, and supported military force and it is only moral and ethical to provide them the equivalent level of psychological preparedness prior to combat. The Psychological Inoculation and Resiliency Training Program will strengthen our military members before, during, and after their combat service (see Table 2: Program Logic Model).

<table>
<thead>
<tr>
<th>Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short-Long Term Outcomes</th>
<th>Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Defense (DOD) Command Approval and Support</td>
<td>Coordinate program implementation and provision with DOD personnel</td>
<td>Military members will complete 20 hours of psychological resiliency training</td>
<td>Decrease psychological evacuation rates from theater of operations</td>
<td>Decrease Human Anguish and Suffering</td>
</tr>
<tr>
<td>Funding for development of pilot program</td>
<td>Procure training staff, facilities, equipment, and materials</td>
<td>Military members will demonstrate a 25% increase in Internal Locus of Control, Self-efficacy, Optimism, Social Support, and application of Coping skills following training</td>
<td>Decrease provision of both acute and non-acute mental health services in theater</td>
<td>Decrease suicide rate</td>
</tr>
<tr>
<td>Personnel for training, supervision and evaluation</td>
<td>Coordinate collection with DOD personnel</td>
<td>Military members will self-report a 25% increase in &quot;combat readiness&quot;</td>
<td>Incidence rates of PTSD, depression, and anxiety will decrease 25% within the first year following deployment.</td>
<td>Decrease burden on military and civilian Mental Health systems</td>
</tr>
<tr>
<td>Military members</td>
<td>Pre-test Locus of Control, Self-efficacy, Optimism, Social Support, and Coping skills</td>
<td></td>
<td>Decrease in incidence rates of: divorce, substance abuse, legal involvement, unemployment and homelessness by 25% within 2 years post deployment</td>
<td>Decrease encumbrance on military and civilian Legal System</td>
</tr>
<tr>
<td>Training facilities</td>
<td>Administer 20 hours of resiliency training using 10-two hour modules</td>
<td></td>
<td></td>
<td>Decrease Compensation and Pension</td>
</tr>
<tr>
<td>Equipment and materials for presentation staff</td>
<td>Post-test Locus of Control</td>
<td></td>
<td></td>
<td>Increase social and economic stability</td>
</tr>
<tr>
<td></td>
<td>Self-efficacy, Optimism, Social Support, and Coping skills following training</td>
<td></td>
<td></td>
<td>Decrease reliance on Social Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Foster and Augment New Generation of National Leaders</td>
</tr>
</tbody>
</table>

Table 2: Program Logic Model
CHAPTER 6.

PSYCHOLOGICAL INOCULATION AND RESILIENCY TRAINING

6.1. MODULE OVERVIEW

MODULE# 1: PROGRAM INTRODUCTION: FOUNDATIONAL RE-FRAMING/
INTRODUCTION BREATHING

MODULE# 2: ANNEALING STEEL & SETTING EXPECTATIONS

MODULE# 3: YOURS, MINE, & OURS: INTERNAL LOCUS OF CONTROL &
SELF- EFFICACY

MODULE# 4: OPTIMISM

MODULE# 5: SOCIAL SUPPORT

MODULE# 6: COPING SKILLS- INTRODUCTION

MODULE# 7: COPING SKILLS- APPLIED

MODULE# 8: COMPARTMENTALIZING

MODULE# 9: MULTI-THINK & OPTIMISM

MODULE# 10: CONCLUSION/POST TEST
6.1.1. Module 1 -- Program Introduction

MODULE #1- PROGRAM INTRODUCTION: FOUNDATIONAL RE-FRAMING/INTRODUCTION TO RELAXATION/BREATHING

I. INTRODUCTION- 30 MINUTES.

A. “Who I am”-(presenter’s perspective) promise of why this program-demonstration of different information.


C. “Who are you?” Ask several in crowd. How you label yourself/others’ perception.

Addresses: Optimism, Locus of Control, Self-efficacy, Social support

II. INHERENT STRENGTHS OF MILITARY MEMBERS- 30 MINUTES.

A. Socratic discussion/ reframing

1. Discipline

2. Leadership (especially social support)

3. Perseverance

Addresses: Locus of Control, Self-efficacy, Optimism, Social Support, and Coping skills
III. FOCUS- 25 MINUTES.

A. Physical demonstration- “go toward what you want”

1. Forward blindfolded
2. Forward blindfolded with help
3. Forward looking backward
4. Forward looking backward with help
5. Forward looking forward

Addresses: Locus of Control, Coping skills, Self efficacy, Social support, and Optimism

5 MINUTE BREAK

IV. GOALS- 15 MINUTES.

A. People spell out!

B. Followed by Socratic discussion-what does it look like?

1. Before they deploy
2. While deployed
3. When they return

Addresses: Locus of Control, Self-efficacy, Optimism, Coping skills, and Social Support

V. RELAXATION/BREATHING DEMONSTRATION- 15 MINUTES.

A. Intense physical exertion

B. Breathing

C. Reframing reactions

VI. WHY THIS PROGRAM?
MODULE 2 – Annealing Steel and Setting Expectations

MODULE #2- ANNEALING STEEL & SETTING EXPECTATIONS

I. REVIEW PREVIOUS SESSION- 10 MINUTES.

II. BIOGRAPHIES OF POWS/DISCUSSION- 20 MINUTES.
   A. Admiral Stockdale
   B. McCain

II. REFRAME COMBAT EXPERIENCE AS A POSITIVE TEST!- 30 MINUTES.
   A. Socratic discussion of what is required? How can this be positive?
   B. Proper Prior Preparation Prevents P--- Poor Performance
      Oxygen Mask example
      1. Myself- legal, economic, social, physical, and mental
      2. Family- legal, economic, social, physical, and mental
      3. Buddies-support above!
   C. While Deployed- social, physical, and mental
   D. When Returning- mental, economic, physical, social, legal

      5 MINUTE BREAK

III. PROCESS OF ANNEALING METAL- 30 MINTUES.
   A. Demonstration
   B. Each has piece of annealed and non-annealed steel.
   C. Break
   D. Discussion
IV. ANCHORING-15 MINUTES.
   A. Tug of war with anchor person

V. RELAXTION/BREATHING- 15 MINUTES.

6.1.3. Module 3 – Yours, Mine and Ours

MODULE #3- YOURS, MINE, & OURS: INTERNAL LOCUS OF CONTROL &
SELF-EFICACY WITH UNLOADED WEAPON

I. REVIEW PREVIOUS SESSION- 10 MINUTES.

II. WHO IS IN CONTROL OF YOU?- 30 MINUTES.
   A. Socratic discussion

III. BREAKDOWN/REASSEMBLE WEAPON- 15 MINUTES.

IV. WHAT CAN YOU CONSISTENTLY CONTROL?- 10 MINUTES.
   A. How?
   B. Ours?
   C. Yours? (Someone else)

V. STRENGTHS YOU ALREADY POSSESS- 10 MINUTES.

VI. DEVELOPING STRENGTHS- 10 MINUTES.

5 MINUTE BREAK

VII. WHAT DO YOU GAIN BY CONSISTENTLY CONTROLLING
     YOURSELF?- 10 MINUTES.

VIII. WHAT DO YOU LOSE?- 10 MINUTES.

IX. RELAXATION/BREATHING & WHO ARE YOU?- 10 MINUTES.
6.1.4. **Module 4 – Optimism**

**MODULE #4: OPTIMISM**

I. REVIEW PREVIOUS SESSION- 10 MINUTES.

II. MINDSET- POSITIVE BELIEFS- 20 MINUTES.
   A. Obstacle course
   B. 10 mile runs
   C. Basic training
   D. Sports (from their experience)

III. CONFRONTING DEFEATIST THOUGHTS- 20 MINUTES.
   A. In self
   B. In other soldiers
   C. Mental discipline- focus (from Module #1)

IV. “CATCHING OPTIMISM/PESSISISM”- 10 MINUTES.
   A. Cold/Flu model

5 MINUTE BREAK

V. APPLICATION BEFORE, DURING, AND AFTER DEPLOYMENT- 20 MINUTES.
   A. What does optimism look like/sound like/outcomes?

VI. EXPANSION OF ABILITIES WHILE OPTIMISTIC- 20 MINUTES

V. RELAXATION/BREATHING- 15 MINUTES.
6.1.5. Module 5 – Social Support

MODULE#5- SOCIAL SUPPORT

I. REVIEW PREVIOUS SESSION- 10 MINUTES.

II WHAT MAKES YOU A GREAT PERSON?- 15 MINUTES.

A. Different roles/ different expectations

III. WHAT MAKES THE PEOPLE AROUND YOU GREAT?- 10 MINUTES.

IV. ROWING THE BOAT IN THE SAME DIRECTION- 10 MINUTES.

A. Demonstration-

V. WHAT DO YOU CHOSE PRESENTLY?- 10 MINUTES.

A. Same Values for both parties involved

5 MINUTE BREAK

VI. WAYS TO ROW TOGETHER!- 20 MINUTES.

A. Check wind speed, temperature, currents

B. Communicate openly without malice- “How can I help?”

C. Maintain self-imposed standards

VI. RELAXATION/BREATHING- 10 MINUTES.
6.1.6. Module 6 – Coping Skills

MODULE#6- COPING SKILLS- INTRODUCTION

I. REVIEW PREVIOUS SESSION- 10 MINUTES.

II. MOVE IT –V- USE IT- 30 MINUTES

A. Introduction to Problem focused coping- Move it

B. Introduction to emotion focused coping- Use it

III. DEMONSTRATION- MOVE IT- 20 MINUTES.

A. Large guy- small guy- how does the little one get the big one above his head?

1. Emphasis on problem solving-

2. Different answers-

3. Little guy goes lower

4. Big guy goes up steps

5 MINUTE BREAK

IV. DEMONSTRATION- USE IT- 20 MINTUES.

A. Large guy held by many, many people.

1. Emphasis on emotional focused coping.

2. Options-

   a. Review focus

   b. Review relaxation/breathing

V. INTRODUCTION- APPLICATION OF COPING SKILLS- 20 MINUTES.
A. Before deployment- Emotion focused and problem solving

B. During deployment- Emotion focused

C. Following deployment- Both

VI. RELAXATION/BREATHING- 15 MINUTES.

6.1.7. Module 7 – Applied Coping Skills

MODULE#7- COPING SKILLS- APPLIED

I. REVIEW PREVIOUS SESSION- 20 MINUTES.

II. BEFORE DEPLOYMENT- 20 MINUTES.

   (High control environment)

   A. Problem solving preparation.

   1. Logistical issues

   2. Financial, family, etc.

   B. Emotion focused preparation

   1. Mind set

   2. Increase abilities- this program

III. DURING DEPLOYMENT- 20 MINUTES.

   (Low control environment)

   A. Anchors

   B. Good Avoidance- distraction,

   C. Minimal problem focused- but what would they be?

IV. AFTER DEPLOYMENT- 20 MINUTES.

   (High control environment)
A. Apply pre-deployment problem solving preparation.

B. Maintain emotional focused skills

C. Develop additional problem solving solutions

5 MINUTE BREAK

V. PRACTICE SENARIOS- 20 MINUTES.

A. Present actual veterans stories illustrating success and “failure” in applying coping skills

B. Socratic questioning- what went well- what did not.

VI. RELAXATION/BREATHTHING- 15 MINUTES

6.1.8. Module 8 – Compartmentalizing

MODULE#8- COMPARTMENTALIZING

I. REVIEW PREVIOUS SESSION- 20 MINUTES.

II. INTRODUCTION TO COMPARTMENTALIZING- 10 MINUTES

A. What is compartmentalizing?

B. How does it serve you?

C. How does it disable you? (avoidance/obsession)

III. DEMONSTRATION WITH BOXES- 30 MINUTES

A. Boxes previously decorated by children chosen by soldiers.

B. Paper with those things most precious to soldier placed in box.

C. Meaning of box and contents shared with “battle buddy”.

5 MINUTE BREAK
IV. COPING SKILLS WITH EXTREMELY PAINFUL ISSUES- 25 MINUTES.
   A. Previous experiences which were very painful and avoided.
   B. Processing skills for those experiences- emotion focused.
   C. Meaning.- Victor Frankl.

V. HELPING YOURSELF-HELPING OTHERS- 15 MINUTES.
   A. Measuring how you are doing?- Socratic questioning- observable behavior.
   B. How is your buddy doing? Same observables.

VI. RELAXATION/BREATHING WITH SELF-EFFICACY/LOCUS OF CONTROL- 15 MINUTES

6.1.9. Module 9 – Multi-Think and Optimism

MODULE#9- MULTI-THINK & OPTIMISM

I. REVIEW PREVIOUS SESSION- 10 MINUTES.

II. INTRODUCTION TO MULTI-THINK- 20 MINUTES.
   A. Black/white thinking
   B. Best case/worst case/most likely case
   C. Many things happen/still able to execute and process

III. OPTIMISM APPLIED- 30 MINUTES.
   A. Problem focused- how to increase likelihood of best case?
   B. Emotion focused- how to deal with all three options.
      1. Failure
2. Meeting challenge

3. Success

5 MINUTE BREAK

IV. HOLDING DIFFERENT OPTIONS SIMULTANEOUSLY- 15 MINUTES.

A. Expanding ability to remain “mindful” and calm- emotion focused.

B. Define “in control”.

C. Remaining realistic

D. Retaining emotional balance

V. DEMONSTRATION- MULTI-THINK- OUTCOME FOCUSED-30 MINUTES

A. Separating/Prioritizing

B. FOCUSING IN ORDER

C. Physical stress/emotional stress/mental stress
   1. stand on one leg
   2. irrelevant emotional information
   3. logical problem

Lessons: solving physical problems so that you can solve others

Focus on solvable issues

Ability to sort out multiple problems and not be overwhelmed.

Recognizing overlapping problems

Building confidence (self-efficacy) in problem solving
6.1.10. Module 10 – Conclusion/Post-Test

MODULE #10- CONCLUSION/POST TEST

I. REVIEW PREVIOUS SESSION- 10 MINUTES.

II. REVIEW SOLDIERS’ STRENGTHS & FOCUS- 15 MINUTES.

III. SOLDIERS REVIEW- THEIR IMPRESSIONS- AND WHAT IS IMPORTANT TO THEM- 30 MINUTES.

5 MINUTE BREAK

IV. QUESTIONS FROM SOLDIERS- 20 MINUTES
   
   A. How will they apply training?
   
   B. What do they think will work?
   
   C. How can they help each other?

V. POST TEST- 30 MINUTES

VI. THANK YOU- 10 MINUTES
APPENDIX A:

PRE- AND POST-TEST QUESTIONNAIRE
A.1 Demographic Information

Please complete the following questions:

Name: ___________________________  Social Security#: ___________________________

Branch of Service: ___________________________

Gender:  □ Male  □ Female

Current Rank: ___________________________

Military Occupational Specialty (MOS): ___________________________

Current Educational Level:
   □ GED       □ High School Diploma
   □ Some college  □ 2-year degree  □ 4-year degree
   □ Some post graduate credit  □ Graduate degree or PhD

Years of Military Service: ___________________________

Race/Ethnicity: ___________________________

Marital Status:
   □ Single/Never Married  □ Married
   □ Divorced/Single  □ Divorced/Remarried

Are you:
   □ Living alone  □ Living with Significant Other
   □ Married/Living with Spouse  □ Married/Separated from Spouse

Do you have children?  □ Yes  □ No

Do you have step children?  □ Yes  □ No

How many children live in your home?  _____________

How many children do you support financially?  _____________

If you are divorced, please rate the relationship between you and your former spouse.

   □ Extremely Hostile  □ Hostile  □ Neutral  □ Friendly  □ Extremely Friendly
A.2 Life Orientation Test, Revised

(Scheier & Carver, 1985)

Please read each item below and indicate to what extent you agree with each statement. Rate each statement using the scale below and indicate your responses by circling the appropriate number to the right of the question.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>In uncertain times, I usually expect the best.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It is easy for me to relax.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>If something can go wrong for me, it will.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am always optimistic about my future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I enjoy my friends a lot.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It is important for me to keep busy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I hardly ever expect things to go my way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I do not get upset too easily.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I rarely count on good things happening to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Overall, I expect more good things to happen to me than bad.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### A.3 Multi-Dimensional Perceived Social Support

(Zimet, Dahlem, Zimet, & Farley, 1988)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a special person with whom I can share my joys and sorrows.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My family really tries to help me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I get the emotional help and support I need from my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have a special person who is a real source of comfort to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My friends really try to help me out.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can count on my friends when things go wrong.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can talk about my problems with my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have friends with whom I can share my joys and sorrows.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There is a special person in my life who cares about my feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My family is willing to help me make decisions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can talk about my problems with my friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### A.3 Self-Efficacy

(Chen, Gully, & Eden, 2001)

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>When facing difficult tasks, I am certain that I will accomplish them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>In general, I think that I can succeed at most any endeavor to which I set my mind.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I will be able to successfully overcome many challenges.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am confident that I can perform effectively on many different tasks.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Compared to other people, I can do most tasks very well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Even when things are tough, I can perform quite well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
A.5  Locus of Control

(Rotter, 1966)

Please choose one statement from each pair that best describes how you feel.

1. □ Children get into trouble because their parents punish them too much.
   □ The trouble with most children nowadays is that their parents too easy with them.

2. □ Many of the unhappy things in people's lives are partly due to bad luck.
   □ People's misfortunes result from the mistakes they make.

3. □ One of the major reasons why we have wars is because people do not take enough interest in politics.
   □ There will always be wars, no matter how hard people try to prevent them.

4. □ In the long run, people get the respect they deserve in this world.
   □ Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. □ The idea that teachers are unfair to students is nonsense.
   □ Most students do not realize the extent to which their grades are influenced by accidental happenings.

6. □ Without the right breaks, one cannot be an effective leader.
   □ Capable people who fail to become leaders have not taken advantage of their opportunities.

7. □ No matter how hard you try some people just do not like you.
   □ People who cannot get others to like them do not understand how to get along with others.

8. □ Heredity plays the major role in determining one's personality.
   □ It is one's experiences in life which determine what they are like.
9. □ I have often found that what is going to happen will happen.
   □ Trusting fate has never turned out as well for me as making a decision to take a
definite course of action.

10. □ In the case of the well prepared student, there is rarely if ever such a thing as an
    unfair test.
    □ Many times exam questions tend to be unrelated to course work studying is
    really useless.

11. □ Becoming a success is a matter of hard work.
    □ Getting a good job depends mainly on being in the right place at the right time.

12. □ The average citizen can have an influence in government decisions.
    □ This world is run by the few people in power, and there is not much the little guy
    guy can do about it.

13. □ When I make plans, I am almost certain that I can make them work.
    □ It is not always wise to plan too far ahead because many things turn out to be a
    matter of good or bad fortune anyhow.

14. □ There are certain people who are just no good.
    □ There is some good in everybody.

15. □ In my case, getting what I want has little or nothing to do with luck.
    □ Many times, we might just as well decide what to do by flipping coin.

16. □ Who gets to be boss often depends on who was lucky enough to be in the
    right place first.
    □ Getting people to do the right thing depends on ability, luck has little or nothing to
    do with it.

17. □ As far as world affairs are concerned, most of us are victims of forces we can neither
    understand or control.
    □ By taking an active part in political and social affairs, the people can control
    world events.

18. □ Most people do not realize the extent to which their lives are controlled by
    accidental happenings.
    □ There is really no such thing as “luck”.
19. □ One should always be willing to admit mistakes.
□ It is usually best to cover up one's mistakes.

20. □ It is hard to know whether or not a person really likes you.
□ How many friends you have depends upon how nice a person you are.

21. □ In the long run, the bad things that happen to us are balanced by the good ones.
□ Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. □ With enough effort, we can wipe out political corruption.
□ It is difficult for people to have much control over the things politicians do in office.

23. □ Sometimes, I cannot understand how teachers arrive at the grades they give.
□ There is a direct connection between how hard I study and the grades I get.

24. □ A good leader expects people to decide for themselves what they should do.
□ A good leader makes it clear to everybody what their jobs are.

25. □ Many times, I feel that I have little influence over the things that happen to me.
□ It is impossible for me to believe that chance or luck plays an important role in my life.

26. □ People are lonely because they do not try to be friendly.
□ There is not much use in trying too hard to please people -- if they like you, they like you.

27. □ There is too much emphasis on athletics in high school.
□ Team sports is an excellent way to build character.

28. □ What happens to me is my own doing.
□ Sometimes I feel that I do not have enough control over the direction my life is taking.

29. □ Most of the time, I cannot understand why politicians behave the way they do.
□ In the long run, the people are responsible for bad government on a national as well as local level.
## A.6 Ways of Coping

(Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986)

Please read each item below and indicate, by circling the appropriate category, to what extent you used it in the situation you just described.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not Used</th>
<th>Used Somewhat</th>
<th>Used Quite a Bit</th>
<th>Used a great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Just concentrated on what I had to do next -- the next step.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I tried to analyze the problem to better understand it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Turned to work or substitute activity to take my mind off things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I felt that time would make a difference- the only thing to do was wait.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Bargained or compromised to get something positive from the situation.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I did something which I did not think would work, but at least I was doing something.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Tried to get the person responsible to change his or her mind.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Talked to someone to find out more about the situation.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Criticized or lectured myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Tried not to burn my bridges, but leave things open somewhat.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hoped a miracle would happen.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Went along with fate; sometimes I just have bad luck.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Not Used</td>
<td>Used Somewhat</td>
<td>Used Quite a Bit</td>
<td>Used a great deal</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------</td>
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<td>------------------</td>
</tr>
<tr>
<td>Went on as if nothing had happened.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I tried to keep my feelings to myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Looked for the silver lining, so to speak; tried to look on the bright side of things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Slept more than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I expressed anger to the person(s) who caused the problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Accepted sympathy and understanding from someone.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I told myself things that helped me to feel better.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I was inspired to do some-thing creative.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I tried to forget the whole thing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I got professional help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Changed or grew as a person in a good way.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I waited to see what would happen before doing anything.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I apologized or did some-thing to make up.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I made a plan of action and followed it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I accepted the next best thing to what I wanted.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I let my feelings out somehow.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I realized I brought the problem on myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I came out of the experience better than when I went in.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Talked to someone who could do something concrete about the problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Not Used</td>
<td>Used Somewhat</td>
<td>Used Quite a Bit</td>
<td>Used a great deal</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------</td>
<td>----------</td>
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<td>------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Got away from it for awhile; tried to rest or took a vacation.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Tried to make myself feel better by eating, drinking, smoking, using drug or medications.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Took a big chance or did something very risky.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I tried not to act too hastily or follow my first hunch.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Found new faith.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Maintained my pride and kept a stiff upper lip.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Rediscovered what is important in life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Changed something so things would turn out right.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Avoided being with people in general.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Did not let it get to me; refused to think too much about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I asked a relative or friend I respect for advice.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Kept others from knowing how bad things were.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Made light of the situation; refused to get too serious about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Talked to someone about how I was feeling.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Stood my ground and fought for how I was feeling.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Took it out on other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Drew on my past experiences; I was in a similar situation before.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I knew what had to be done, so I doubled my efforts to make things work.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Activity</td>
<td>Not Used</td>
<td>Used Somewhat</td>
<td>Used Quite a Bit</td>
<td>Used a great deal</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------</td>
<td>---------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Refused to believe that it had happened.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I made a promise to myself that things would be different next time.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Came up with a couple of different solutions to the problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Accepted it, since nothing could be done.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I tried to keep my feeling from interfering with other things too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Wished that I could change what had happened or how I felt.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I changed something about myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I daydreamed or imagined a better time or place than the one I was in.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Wished that the situation would go away or somehow be over with.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Had fantasies or wishes about how things might turn out.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I prayed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I prepared myself for the worst.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I went over in my mind what I would say or do.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I thought about how a person I admire would handle this situation and used that as a model.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I tried to see things from the other person’s point of view.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I reminded myself of how much worse things could be.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I jogged or exercised.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
I tried something entirely different from any of the above. (Please describe).
### A.7 PTSD Checklist, Military version

(W.E. Weathers, Huska, and Keane, 1991)

**Instructions:** Below is a list of issues that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an “X” in the box to indicate how much you have been bothered by that problem in the last month.

<table>
<thead>
<tr>
<th>Response</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeated, disturbing <em>memories, thoughts, or images</em> of a stressful military experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeated, disturbing <em>dreams</em> of a stressful military experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suddenly <em>acting</em> or <em>feeling</em> as if a stressful military experience were happening again (as if you were reliving it)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling <em>very upset</em> when <em>something reminded</em> you of a stressful military experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having <em>physical reactions</em> (e.g., heart pounding, trouble breathing, or sweating) when <em>something reminded</em> you of a stressful military experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid <em>thinking about</em> or <em>talking about</em> a stressful military experience from the past or avoid <em>having feelings</em> related to it?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid <em>activities</em> or <em>situations</em> because they <em>remind</em> you of a stressful military experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble <em>remembering important parts</em> of a stressful military experience from the past?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response</td>
<td>Not at all</td>
<td>A little bit</td>
<td>Moderately</td>
<td>Quite a bit</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Loss of <em>interest in things that you used to enjoy?</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling <em>distant</em> or <em>cut</em> off from other people?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling <em>emotionally numb</em> or being unable to have loving feelings for those close to you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling as if your <em>future</em> will somehow be <em>cut short</em>?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble <em>falling</em> or <em>staying asleep</em>?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling <em>irritable</em> or having <em>angry outbursts</em>?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having <em>difficulty concentrating</em>?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being <em>“super alert”</em> or watchful on guard?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling <em>jumpy</em> or easily startled?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
LIST OF REFERENCES


