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Treating Veterans with Complex Traumagenic Disorders: When Childhood Traumas and Current Traumas Collide

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Abstract

A proposed working approach is delineated as a methodology for treating persons with complex traumagenic disorders. It provides a format and a system of treatment, in order to help reduce the symptom clusters which occur in people who have experienced a combination of childhood trauma, as well as adult trauma, whether as a result of exposure to natural disasters, combat or war. It is argued that traumagenic resolution therapy needs to occur first, before cognitive behavior therapy can be effective. In addition a systems approach is needed to assist the person within the context of their environment, and then tasks such as parenting and other relational interactions will greatly improve. Symptom reduction will then occur, and be maintained, as the feedback loop of positive behaviors is reinforced.

KEYWORDS: traumagenic, traumagenic resolution therapy

Introduction and Historical Considerations

Cognitive-Behavior Therapy (CBT) is framed by the representational models of worldviews for clients (Lazarus, 1978). Lazarus, an early progenitor of CBT, also stated that CBT came about in a time when the social and political forces seemed to be encouraging people to avoid personal responsibility for their actions. Strict behaviorism flourished in America from the 1950's through the 1970's. CBT came about in the 1970's and 1980's and continues to flourish worldwide at the present time (Panzano & Herman, 2005). As opposed to strict behaviorism, CBT made the assumption that the environment was given too much emphasis and that many people were blaming the environment for their own personal behaviors and choices.

Many theoreticians wrote that a balance needed to occur between the self and the environment, which included taking responsibility for one's own actions, as well as pursuing the ability to change the self without changing the environment (Lazarus, 1978). Also, clinicians and researchers seemed to be countering strict behaviorism, which stated that humans were simply

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S>R (stimulus-response) organisms. CBT researchers emphasized that humans have intermediate thoughts/cognitions and devised the model S>C>R (stimulus-cognition-response). Therefore, the premise came about that changing the thought would change the action. This was met with hostility by those who said the only way to change the action was to either to change the gene (nature) or to change the environment (nurture). CBT advocates responded with the idea that limiting the options to only those two extremes was a cognitive error; what needed to take place was to change *both/and* rather than *either/or* and to even find additional options for changing thoughts.

Do our thoughts determine or influence our behaviors? Do the antecedents of an event determine the thoughts that precede the actions people take? Compelling evidence would indicate yes on both accounts (Medin, Ross, & Markman, 2005; Rapp & Goscha, 2005). Consider the example that someone is tailgating you. Two urges emerge. Slam on the brakes to make him back-off or slow down so he will pass. Which choice you take depends upon the thoughts you have about the event itself, as well as what has happened to you in about the last three hours before the event (Berkowitz, 1993). If it has been a relatively good three hours, then you may have the thought that the other driver needs to get to the hospital, or has some other emergency, so you will slow down so he can pass. If it has been a stressful, tense, and conflicted three hours, you may have the thought that the driver tailgating you is a jerk, and so you slam on the brakes to jolt some sense into him. The second option is what defensive driving taught you not to do, but you still think it would feel better to do so. The idea is that we all want the adrenaline spike from the option of more conflict (Berkowitz, 1993). Shaler, Hathaway, Sells, and Youngstedt (2013) found this to be the case with Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans with problematic anger.

In fact, in agitated depression, it turns out that people will pick fights or bully other people in order to get that adrenaline spike (Pruitt & Kim, 2004). One can still change the environment or genes or chemicals to change the action, but many times in life, the environment is what it is and is not able to be readily altered. While chemical alterations may work, they are temporary. Genetic alterations are unethical at this time and in this author's opinion, need to remain unethical. Hence, helping people focus on what can be changed, for example internal thoughts, will help them to devise ways to be responsible and perform positive actions (Medin, Ross, & Markman, 2005). The early researchers like Ellis, Beck, Meichenbaum, and Lazarus, to name a few, were very research-driven and extremely prolific. Some of them still remain to be so. Charles Figley has led the way in helping us to understand veterans and to reduce compassion fatigue since 1989 (Figley, 1989). He was certainly a pioneer in his research regarding treating Vietnam veterans with complex trauma histories.

Traumagenic Resolution Therapy, Cognitive Behavior Therapy, and Systems Approaches in Treating Complex Traumagenic Disorders

Celano, Hazzard, Campbell, and Lang (2002) stated that traumagenic resolution therapy (TRT) was a set of techniques, developed in the 1990's, used with children who had been sexually abused, in which the therapy countered the effects of attribution and self-blame. These children had a set of mental images and representations that were pre-cognitive and seemed to resist treatments. Further, Houston, Shevlin, Adamson, and Murphy (2011) noted that co-

occurring traumas tend to cluster symptoms to an inexpressive realm, and thus, for effective TRT, the individual would need an expressive person-centered approach in therapy, prior to the use of cognitive behavior therapy (CBT). The individual would then deal with that which is inexpressive first, helping it to emerge, then finding words for it, and then finally dealing with that which has become expressed. Hansen (2005) issued a strong plea for counselors to again note and treat inner subjective experiences (ISEs) as much as the cognitive experiences. I would argue that it is especially important to treat the ISEs prior to the cognitions in people with complicated traumas (Sarno, 2009). Resolution of the childhood traumas needs to occur, prior to using the approach of cognitive behavioral treatment, as well as resolution of current traumas in adults. TRT employs a wide range of expressive therapies including the use of projectives, drawing, sculpting with materials, family of origin sculpting, and play therapy with adults, all with the aim of resolving childhood traumas.

The idea that how one thinks will influence how one acts is not new. There are proverbs and admonitions in the Old and New Testaments of the Judeo-Christian Scriptures (which are about 2000 to 3500 years old) that advise the readers of that truth. We are cautioned of how to think and about with whom we associate, because of the thoughts they can speak into our lives. It would seem then, that Cognitive Behavior Therapy (CBT) is based upon time-tested principles, which are now being tested again in a more scientific fashion by those of a philosophical Western mindset and worldview. Thus, it is quite beneficial for those of us who are Christian counselors or chaplains, to use both our familiarity with the Scriptures, as well as the present day scientific literature, when working with Veterans and combat stress survivors. It would seem that there is a great deal of benefit in helping our Veterans to recapture inner subjective experiences (ISE's) as well (Dees, 2011; Hansen, 2005).

Hence, CBT is based upon solid research and evidence-based practices, which are important for the counselor/educator and counselor as well as others in the field of human services (Panzano & Herman, 2005; Rapp & Goscha, 2005). The client has beliefs that shape the actions and behaviors which are desired. Conversely, other beliefs produce actions and behaviors that are undesirable. Helping the Veteran client who has seen combat to look out a new belief window or representational model of life will change the undesirable behaviors into productive ones (Dees, 2011; Jones, 1986). The theory of cognition is complex and by no means unified. For fullest efficacy of treatments, any childhood traumas need to be resolved prior to utilizing another therapeutic approach. The paradigm that this author has adopted will be discussed later in this paper.

But first, the question that needs to be asked is: Does TRT or CBT work the same for women as for men? Paludi (1998) stated yes, despite differences in communication styles between genders. Women seem to ask more tag questions and qualifiers, make longer requests, and use more fillers in their speech. This is noted internal and external dialogue. Women seem to use more words to get across their feelings and men tend to suppress feelings. Therefore, the intermediary thoughts of women may have more uncertainty than those in men, as women are more flexible than men. Women smile more than men, but women also have more negative self-talk than men. That could be why women suffer from depression more readily than men, in addition to the fact that men mistreat women more often than men mistreat men.

Paludi (1998) pointed out that successful cognitive readjustment of beliefs needs to include coping, learning, adapting, self-confidence, honesty, and strength. There is a way to teach all people relational intimacy with the self, which includes those cognitive corrections from the old cognitions. Furthermore, the cognitive distortions of magnification of the negative, using imperatives, all-or-nothing thinking, mind reading, and negative forecasting need to cease and be replaced with cognitive corrections.

Both genders are at risk of using the distortions, so corrections are best accomplished by using the theory of thought substitution (Fredrickson, Tugade, Waugh, & Larkin, 2003). The replacements for the distortions listed above are: realistic strategizing, permission from self to relax, both-and thinking, asking from and clarifying to others, and positive creative realistic visioning. Greenberger and Padesky (1995) wrote about how these negative cognitive automatic thoughts keep us from coping. We need to understand the negative automatic thoughts in order to help us to cope. People need to think about the negative, not to believe the negative, but to change it. Coping, according to CBT theory, is thinking about the negative in a framework of how to change it and not believe it (Seligman, 2006). Thinking about negative thoughts in order to change them and not to believe them, is a strategy that is most effective. Journaling and thought logs are important tools in the theory which drive CBT.

Systematic desensitization is one means to overcome fear (Seligman, 2006). All fears are worth overcoming, but for the purposes of this paper, we are focusing on the fear of failure and the fear of success. CBT is considered a treatment system requiring goal-setting and action. One criticism of CBT is that it accomplishes only superficial and temporary gains, but many will attest that the gains are long-lasting (Fredrickson, Tugade, Waugh, & Larkin, 2003). Positive emotions which replace negative emotions, in a type of build and broaden theory, are indicative of rather permanent resiliency and long-term change. Build upon the small amount of positives which the person states to already possess, and broaden the positive emotions from a type of funnel model, into a cylinder. The person's range of emotions was meant to be a cylinder, yet due to childhood abuse, a funnel of protection and survival occurs, in which the same negative emotive response is given for many situations. Thus, TRT and CBT can be used in multiple settings, and can also be considered treatment in one context, and education in another; it can be utilized with veterans, as well as with their family members, or in various social support settings. It might be used theoretically when teaching students about overcoming their fears, or when supervising practicum students or soon-to-be-licensed interns regarding their fears, or clients over their fears, or even me in overcoming mine. Fear of success is a nasty cognitive construct that gets in the way for so many of us, often just as much as the fear of failure. Processing trauma with TRT is important in the process of finding safety and acceptance before launching into CBT in order to reduce the symptoms.

A fear which was quite familiar to me as a kid was the fear of, "being in trouble." As an adult, when I have not been in trouble, dread can still overtake me with the thought that something bad will happen any second. I might as well be afraid to succeed. For me, it is really a fear of getting in trouble before I succeed; this is often seen in survivors of childhood abuse. Putting that into a cognitive construct sounds like this, "I'm going to get into trouble any second, so let me do the bashing for you." The thought occurs and a self-degrading statement is made. People seldom like someone putting themselves down. So the success is averted since negative

reactions from others follow the self-degrading statement. And, yes, once again, success eludes me.

In CBT theory, the thought, "I'm going to get into trouble any second, so let me do the bashing for you," is replaced with a positive thought. This can be done in a systematic manner, so as to desensitize the behavior. This works just like the concept of self-rating cards which are used to help someone with public speaking, for example. For a month, I would think, "I'm going to get into trouble any second or maybe not." The next month, it is replaced with, "I don't think I will get into trouble today." The next month, "I think I will get a reward for great work today." Intermediate thoughts need to gradually get to the goal. Someone can't skip the steps in the process, as the brain will reject it as being beyond reality. A series of successful approximations towards the truth must be unveiled and also accepted in steps. Then the fear of success or failure in public speaking, or whatever the fear is about, will be abated.

That is another important part of the theory as well. When you deal with one area, all of the surrounding areas are improved upon as well. This brings us to this author's application of the theory. Generally, there are four old beliefs that form at various ages of development that need changing. At age five, "I'm no good" develops. When working with children, it is interesting to note that many around that age often stop bringing drawings home to be put up on the fridge, as the child will often report that his drawing is not as good as "others." At age eight, the "I can't trust anyone, not even my parents, not even myself" belief develops, due to broken promises made by parents, as well as those made to oneself. At age 10, mechanistic thinking develops, and the, "I get what I deserve" complex ensues. When bad things happen, that proves three of the old beliefs. At age 12, most children have a great deal of stored up anger which hasn't been discharged with healthy anger management skills, so the belief, "anger is bad" appears on the old belief window (Berkowitz, 1993). So by age 14, most people have addictions and relational problems as a result (Brendtro & Shahbazin, 2004; Kirby, Baucom, & Peterman, 2005).

A new belief window or representational model of life will have four new beliefs that can be viewed when events occur. For our Veterans and families in treatment, Dees (2011) referred to this as deploying with the right mindset. Teaching people to look out of the new window is vital, since the old window is there. It should be pointed out here that whatever we learn before age 12 is the hardest to change. The old window does not go away. The new window is constructed alongside it and then the client is taught to look out the new window for reality. Wolin and Wolin (1993) noted that the internal image of the survivor as one who prevails, is a key component in resiliency for those from troubled families, also known as toxic families, or as those with child abuse and neglect present. Many Veterans are from troubled families (Figley, 1989). Combat Veterans quickly lose the sense of war's certitude (Bradley & Powers, 2000). Perhaps, combat stress gets them looking out the old window again and no longer as one who prevails. Treatment needs to assist combat Veterans and their families in looking out the "I will prevail" window again. We perceive reality through one of the windows, and thus our actions correspond. When an event occurs, look out the old window and a negative action will follow. With the same event, look out the new window and a desirable behavior will follow (Pruitt & Kim, 2004). Resiliency can be seen as changing the view from, "victim to victor, trash to treasure, from survivor to thriver."

One way this author expresses the new window to clients with complex traumas is to say that it contains the four corresponding, counteracting new beliefs of "I like me," "I can trust myself and some people," "I do have powerful influence over outcomes" and "anger is good." Clients are to journal a cognitive log that shows what thoughts led to a behavior set after an antecedent event. The client is to then journal the level of desirability of the outcome. Next, the new cognitive beliefs are journaled to produce a new behavior set, if needed. When a positive outcome occurs, the client journals positive compliments about the way the event sequence was handled. Helping people to be complimentary of self is difficult to achieve and at times that is the target set of behaviors to first explore. It is quite rewarding when achieved and quite an invigorating process to use. Success rates in excess of 75% are often reported (Panzano & Herman, 2005; Pruitt & Kim, 2004).

One theory about human behavior which has been disproven by the empiricism of logical positivism is that human beings cannot change. The old school postulated about humans that, "you can't teach an old dog new tricks." Now we know that anything we learn before age 12 is the hardest to change but it can be changed! Childhood trauma complicated by combat stress/trauma will leave one feeling empty and despairing of life (Figley, 1989). Whether in teaching students or in counseling people, this author benefits from the advances of science and technology in the process of helping people change. What helps combat Veterans the most depends on their age, the context of treatment and the condition of their childhood. Logical positivism looks at those variables within specific settings to inform the clinician which techniques to employ, including when and where (Tebes, 2005).

Creswell (2003) and Crotty (2005) promote logical positivism as a means of knowing what we know and why we need to know it. Dees (2011) and Koenig (2006) use a religious response approach of spiritual understanding with Veterans who have a spiritual paradigm or are seeking one. We do not really need to know why, nor can we really know why. It is interesting that in CBT, we steer people away from asking why. In the classroom, we teach the humility that we cannot really know why. After all, we cannot really 'explain' anything, we can only "describe." We can label and we can relate what we label to our experiences (Thomas, 1997). As soon as other experiences enter in, we need to change the label.

Underwood and Lee (2004) proposed using logical positivism as a means to finding the best practices for the social sciences and within educational settings. When there is so much diversity to what we do, narrow science is not applicable. We can use diverse methods to find out approximations of the truth which can be applied to diverse populations, including combat Veterans and their families/social support systems. Elmes, Kantowitz, and Roediger (2003) elucidated relational research as ex post facto (after the fact) with results that were related and happened because of naturally occurring events. The assumptions of logical positivism permit this type of science, whereas if scientific manipulation of all the variables is required, the educator or social scientist is at a loss. For example, it is widely agreed upon that there are over 150 chemicals which make up the brain. We can only measure about 20 of them in a living person. It is just as scientific to have someone describe their anger for a definition of anger, as it is to base the definition of anger on certain chemical levels. The operational definition sets the parameters of the scientific technique. One is not better than the other.

Hence, there is a need for traumagenic resolution therapy (TRT) for childhood and present trauma to occur in the treatment of combat Veterans before utilizing CBT in the treatment of present traumagenic disorders. When the patient's conclusions are revealed, this may assist in the cessation of the behaviors. The conclusions based upon traumas need to be processed in a different fashion than those based upon learning and recitation in daily developmental living and process. Similarly, Antonovsky's sense of coherence theory (as cited in Joachim, Lyon, & Farrell, 2003) described people's behaviors as purposefully maintained coping mechanisms in an attempt to achieve balance and coherence in their lives. I argued in my dissertation (Sarno, 2009), that if harmful coping skills are utilized due to the patient's distorted conclusions, traumagenic compulsions may become life-threatening, but the purpose of the behaviors need to be explored before the behaviors can be gradually decreased. Thus, Joachim, Lyon, and Farrell stated that treatment which is research-based needed to go beyond what most modalities provide, in order to help patients find coherence using non-compulsive coping mechanisms, and to achieve traumagenic resolution with relief by expressive modalities. In fact, they found that some treatments may leave the patients with other problems to contend with and that is not considered to be successful treatment.

BEST IDEAS

The following is a TRT /CBT and systems approach that this author has used since 1985 (adopted, expanded, and modified from Lazarus, 1978) and most recently with combat Veterans and their families/social support system, for the last ten years. It allows for flexibility, with the content being modified and updated throughout those years. It is especially helpful as a journaling guide for persons new to journaling or for long-term journalers as well. It has been used in a wide variety of settings and with a wide diagnostic spectrum, and especially for those with complex traumagenic disorders.

B.E.S.T. I.D.E.A.S.

B	**E**	**S**	**T**
BEHAVIORS	**EMOTIONS**	**SPIRITUALITY**	**THOUGHTS**
What observable behaviors do you want to change?	How do you want to feel about the new behaviors?	What spiritual principle will help you?	What new thoughts do you want to think?

I	**D**	**E**	**A**	**S**
INTERPERSONAL RELATIONS & INTER-DEPENDENCY	**DRUGS/DIET**	**ENVIRONMENT**	**ATTITUDE**	**SUPPORT**
Who can help you in this process?	What changes do you need to make in what you "take in"?	What do you want from those around you to help you?	What will be your "attitude saying"?	Will you stay positively and actively involved in your support systems?

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PART I

Generally, this author advises people, like combat Veterans and their families, to start with three behaviors and no more. One of those behaviors needs to be to increase humor in order to release endorphins and to help the brain change, since anything we learn before age 12 is the hardest to change. Next, we need to tell the self how to feel about each behavior change, while being under the influence of emotions. Then, we address what spiritual component will assist in the process. For some who avoid spiritual issues, I will have them use moral or ethical principles instead. Next, the individual will state and journal what new thoughts will be thought to replace each of the old thoughts.

The next area to address is interpersonal relations and who can help in an interdependent fashion. The longer the list, the better. The core of this is relational intimacy and spending time with people in self-disclosure, while at the same time learning to compliment and enjoy the mystery of relationships. Giving and receiving compl*i*ments (with an i) is an important pro-social tool. Overcoming the fear of relating is a key component here. Also, learning to compl*e*ment (with an e) people with differences is a crucial pro-social tool as well. Our attention then turns to drugs/diet. Drugs that are addressed are both exogenous drugs/chemicals and endogenous drugs/chemicals. Humans have 52 diets in terms of what we "take in" which is the Latin meaning of diet. We look at food, but also work, play, music, touch, compliments, love, sex, creativity, money, sex, communication, language… and throughout the entire menu of 52 diets. What needs to be increased and what needs to be decreased? Next, we deal with the environment and what we want from others around us. We talk about how to prompt people when we want them to listen and to prompt them when we want advice. This avoids the mind reading cognitive error game of making people guess at what we want and when. Then, I help them adopt a personal, "attitude saying" that fits them individually (like a bumper sticker) which will encourage them along the way. They are to journal this and put signs up in many places to help them in this task. Finally, the question: Will you stay positively and actively involved in your support systems? If they say yes, or even maybe, the behavior changes will occur, if they say no, then the changes will not occur. But, asking them this question last is important, as then they know what is involved, so they can answer a well-informed question.

PART II

Developmental counseling and therapy (DCT), developed by Allen Ivey, Sandra Riagazio-DiGilio, and their associates, is a type of traumagenic resolution therapy and is a type of integrated and eclectic phenomenology (as cited in Seligman, 2006). It is philosophically rooted in Plato and Hegel, in that people understand and operate in the world helped and hindered by levels of cognitive development with social units and systems. Four cognitive developmental orientations emerge over time, though some may never reach the third or fourth level. The levels are respectively: sensorimotor, concrete, formal operations and dialectic/systemic. Therapy is to help the person arrive at the fourth level.

Hansen (2005) and Hage (2006) both agreed that it is important to help clients develop to the fullest potential, and for families as well as societies to play a role in positive change. Further, change is experienced in developmental increments in the phenomenologic perspective

as seen in Vygotsky (1978) and Polanyi (1967). It is important to move victims to victors and survivors to thrivers.

This is different than the developmental hermeneutic of Oyama (1985), Buber (1970), and Fromm (1956). We grow towards love and change by saying we will. We grow from self-centeredness towards other-centeredness. It occurs as we say it. The difference of phenomenology with the philosophical orientation of hermeneutics is that perhaps hermeneutics is assisting the client in saying that they will get there is success in and of itself. Rather, to get the client to the point of change, it is sufficed and change will occur simply by getting a client to contextually say they will get to the point of change. Saying it will occur is as significant a change event as it actually occurring is a change event (Leff, 2005). Behavior will follow what has been said, and that is quite important for a hermeneutical understanding of behavior change (Elmes, Kantowitz, & Roediger, 2006; Creswell, 2003; Crotty, 2005). Many therapists will say that awareness of a problem and admission of the problem is half of the battle. Insight therapists are of the same thought, in that insight does produce change. Hence, they would be taking more of a hermeneutic position than a phenomenological one, as the latter means one has to get there to change. The former states that the statement is a sufficient change in and of the context spoken.

Narrative talk is the coding of a language connection for intrapersonal and interpersonal communication. Whether the talk is in pictures or in words, thinking is a complex task that leads to metacognition. When the metacognition phenomenon becomes distorted, all of the relationships within and outside of the self become impaired. This hermeneutic reality is an event that historically has been conveyed for over 6000 years of recorded history. Humans do not endure impaired relating for very long (Fromm, 1956; Hage, 2006). Hansen (2005) and Leff (2005) are quite explicitly rigorous in coding and rating inner subjective experiences (ISE's). The reasons for the coding and ratings are to give objective descriptions to subjective events. The objectivity does not validate the subjective experiences, but rather provides a type of narrative communication which is equal to other types of communication. The depths to which a person loves someone or the behaviors of love are shown are all equally important in the narrative that describes love (Buber, 1970; Polanyi, 1967).

Oyama (1985) provided a conceptual tool for describing the experiences of love in an informational manner of narration in order to convey meaning and truth. Human experience relies on love for survival, as well as for the essence of living life at every level. Love is a narrative tool in living life, just as food is a physical tool in living life. Survival depends upon having both among many other facets of meaningful events. Could it be that meaning has escaped the combat veteran and now the veteran needs to recapture meaning in life? Love is an ongoing event, just as eating is an ongoing event. Events can be observed and measured in qualitative, quantitative, or mixed methods (Creswell, 2003; Crotty, 2005; Elmes, Kantowitz, & Roediger, 2006). Any means to scientifically study a phenomenon as an event is conducive to the most scientific rigor.

Seligman (2006) described the events of love of self and love of others as crucial in rigorous, present, integrative and eclectic therapies, and when considered are being shown as highly effective in treating all of the disorders in the DSM-IV-TR. Vygotsky (1978) described

the events of love in the organic learning that all humans exhibit. These events scaffold in an unfolding process that is evident in all living organisms. The unfolding itself is a narrative that is meaningful. If an organism is not unfolding or scaffolding, the organism is dying. Events of love fuel the unfolding process that connects humanity within interdependent survival.

The forte of this argument is that if the highest aesthetic and ideal of love is scientifically verifiable, then so is everything else. Without succumbing to reductionism, Vygotsky (1978) noted that there are brilliant researchers who give love an elevated place in existence, yet also provide a framework for human experience to be studied. By so doing, life can be enriched and the therapeutic processes can be compared, so the best approach can be paired with each recipient. The resulting matrix and rubric of events to study and compare within this context yield rich valid results that the participants can readily understand, as well as the researchers. That is a very important distinction in this methodology. Participants are the informal researchers and as equal and important to the formal researchers. Narratives have been here longer than science and perhaps narratives contain valid information in a different way than science. Perhaps, both are necessary, side by side, in order to advance the human race, which sometimes seems to be bent upon self-destruction due to the absence of love. It is important to move "victims to victors, trash to treasure, and survivors to thrivers."

Two Case Studies

James (a pseudonym), once an Army medic, now in his thirties, served two extended deployments, one in Iraq (OIF) and one in Afghanistan (OEF). During both deployments, he experienced combat and related traumas, as well as trauma from treating other warriors. When he sought out my services, his symptoms were quite debilitating. He carried a diagnosis of posttraumatic stress disorder (PTSD), with which I concurred. He had difficulty concentrating and intrusive thoughts, as well as thoughts of impending doom always present. With gentle probing and expressive work, and after talking with him about my approach, childhood physical and sexual abuse surfaced, both of which he had never disclosed to anyone. He had thoughts of these events with considerable downrange. He commented that he probably had enlisted out of anger over his past abuse, but had never given it much thought. He did not have any childhood therapy, to his recollection.

Thus, TRT and systems approaches helped to resolve some of those childhood traumas. We had earlier completed the BEST IDEAS chart. He stated that not knowing how to proceed, the BEST IDEAS format assisted him greatly. The first of his three behaviors was improved upon significantly within 90 days, with only one day a month at the local pub, as opposed to the previous daily stays. The second behavior was to spend more time with his family, which he did as well. The third behavior was to become enrolled in and complete college courses, thus making progress towards his goal of getting a degree in a helping profession. He began to enjoy tranquility and serenity as emotions. He made self-directed improvements in each of the areas and enjoyed journaling in each area. Thoughts of impending doom, as well as other intrusive thoughts subsided significantly. He stated he was being faithful to his wife as well. His improvements continued as noted one year later in a follow-up.

Sanchez (a pseudonym), a female in her thirties, once an Airman, sought my services for complicated traumas, which included pervasive childhood sexual abuse, and later in her late teens, as she had experienced two separate date rape incidents by different perpetrators, and as well as having OIF combat trauma as an adult. She also carried a diagnosis of PTSD. She had not received treatment for the childhood or adolescent traumas. As treatment with me unfolded, she told me "things I have not said or talked about to anyone else." Using TRT and systems approaches we treated her childhood and adolescent traumas and family of origin abuse issues. Her symptoms of PTSD were also pervasive and complicated. Concomitantly, her BEST IDEAS behaviors were to make it in to work for at least three weeks, without missing a day. She was then in her fifth job in a year. Next, she wanted to laugh more in life each day. Third, she wanted to take better care of herself, which we narrowed down to specific behaviors. As she journaled her BEST IDEAS for 90 days, her PTSD symptoms greatly subsided and her progress was still present at the one year follow up session. She was in a job/career she thoroughly enjoyed, not missing any work days for "a long, long time." She reported she is dating "carefully." Her laughter is now contagious.

Proposed Future Research

The combination of traumagenic resolution therapy (TRT) and cognitive behavior therapy (CBT) with systems approaches (ST) requires future research with the use of the BEST IDEAS format. It will, no doubt, describe how the use of externalizing behaviors (EXT) will be reduced to an occurrence rate of less than 10% of the time in persons who have received traumagenic resolution therapy (TRT), systems therapy (ST), cognitive-behavior therapy (CBT), or all three. By the end of the study, persons will receive TRT, ST, and CBT, but measurements will be taken at different times and the therapies will be done in differing orders. This is an approach much like the one proposed by Figley (1989). The most notable limitation is that multiple or multimodal approaches are difficult to research.

The proposed initial sample could be 20 persons who have a high rate of EXT based upon the same type of measures used by Verona and Sachs-Ericsson (2005). Pre-test measures will be obtained as to verify the high rate of EXT. Randomly, the 20 persons will be assigned to four groups of five persons each. Group A will receive four sessions of ST, EXT will be measured, and then four sessions of TRT then CBT, after which EXT will be measured. Group B will receive four sessions of CBT, EXT will be measured, then four sessions of ST, and then CBT will be measured. Group C will receive alternating ST and TRT/CBT sessions, with only one post EXT measure at the end. This will be done to hopefully rule out any test effects elevating the EXT scores in Groups A and B. Group D will receive alternating CBT first, then TRT, and then ST sessions with only one post EXT measure to see if the order of initial type of therapy might produce any extraneous or spurious data.

In addition, a six-month measure of EXT would be accomplished to test for maintenance of the hopeful changes in the reduction of EXT behaviors. Further, narrative information would be collected and rated to see what the participants would say about the process and to help with future research directions. In the situation of any persons not showing any improvement in the reduction of EXT scores, future therapy would be available to help them in the process. All therapy would be free and the participants could not receive a fee for their involvement since that

could skew the data. Perhaps, it may be found that all treatments have equal efficacy, because ST can be construed as a type of TRT/CBT, especially when dealing with changes in role behaviors. Combat Veterans need to think of themselves differently, as being in different roles moving towards optimal balance which produces change. The key phrase I have used repeatedly in counseling, and in this article, is assisting our combat Veterans in "moving from trash to treasure, from victim to victor, from survivor to thriver." And in so doing, they will treat their families better as a result and get the social support they need as do we all.

References

Berkowitz, L. (1993). *Aggression: Its causes, consequences, and control.* Boston, MA: McGraw-Hill.

Bradley, J., & Powers, R. (2000). *Flags of our fathers*. New York: Bantam Books.

Brendtro, L., & Shahbazin, M. (2004). *Troubled children and youth: Turning problems into opportunities*. Champaign, IL: Research Press.

Buber, M. (1970). *I and thou*. New York, NY: Scribners.

Celano, M., Hazzard, A., Campbell, S. K., & Lang, C. B. (2002). Attribution retraining with sexually abused children: Review of techniques. *Child Maltreatment, 7*(1), 65-76. Retrieved from http://search.proquest.com/docview/197286474?accountid=12085

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Crotty, M. (2005). *The foundations of social research: Meaning and perspective in the research process.* Thousand Oaks, CA: Sage.

Dees, R.F. (2011). *Resilient warriors*. San Diego, CA: Creative Team.

Elmes, D. G., Kantowitz, B. H., & Roediger, H. L. III (2006). *Research methods in psychology (8th ed.)*. Pacific Grove, CA: Thomson.

Figley, C. R. (1989). *Helping traumatized families*. San Francisco, CA: Jossey-Bass.

Fredrickson, B. L., Tugade, M. M., Waugh, C. E., & Larkin, G. (2003). What good are positive emotions in crises?: A prospective study of resilience and emotions following the terrorist attacks on the United States on September 11th, 2001. *Journal of Personality and Social Psychology, 84,* 365 – 376.

Fromm, E. (1956). *The art of loving: An inquiry into the nature of love*. New York, NY: Harper Colophon Books.

Greenberger, D., & Padesky, C. A. (1995). *Mind over mood: Change how you feel by changing the way you think.* New York, NY: Guilford Press.

Hage, S. M. (2006). Profiles of women survivors: The development of agency in abusive relationships. *Journal of Counseling & Development, 84*, 1, 83-94.

Hansen, J. T. (2005). The devaluation of inner subjective experiences by the counseling profession: A plea to reclaim the essence of the profession. *Journal of Counseling & Development, 83*, 4, 406 - 415.

Houston, J. E., Shevlin, M., Adamson, G., & Murphy, J. (2011). A person-centered approach to modelling population experiences of trauma and mental illness. *Social Psychiatry and Psychiatric Epidemiology, 46*(2), 149-57. doi: 10.1007/s00127-009-0176-4

Joachim, B., Lyon, D.D., & Farrell, S.P. (2003). Augmenting treatment of obsessive-compulsive disorder with Antonovsky's Sense of Coherence Theory. *Perspectives in Psychiatric Care, 39*(4), 163-168.

Jones, D. P. H. (1986). Individual psychotherapy for the sexually abused child. *Child Abuse & Neglect, 10*, 3, 377 – 385.

Kirby, J. S., Baucom, D. H., & Peterman, M. A. (2005). An investigation of unmet intimacy needs in marital relationships. *Journal of Marital and Family Therapy, 31*, 4, 313-325

Koenig, H. G. (2006). *In the wake of disaster: Religious responses to terrorism & catastrophe*. Philadelphia, PA: Templeton Foundation Press.

Lazarus, A. A. (1978). *Multimodal therapy*. New York: Basic Books.

Leff, H. S. (2005). Evidence in intervention science. In R.E. Drake, M. R. Merrens, and D. W. Lynde (Eds.), *Evidence-based mental health practice.* New York, NY: W. W. Norton.

Medin, D. L., Ross, B. H., & Markman, A. B. (2005). *Cognitive psychology* (4th ed.). Hoboken, NJ: Wiley.

Oyama, S. (1985). *The ontogeny of information: Developmental systems and evolution.* Cambridge: Cambridge University Press.

Paludi, M. A. (1998). *The psychology of women*. Upper Saddle River, NJ: Prentice Hall.

Panzano, P., & Herman, L. (2005). Developing and sustaining evidence-based systems mental health services. In R. E. Drake, M. R. Merrens, & D. W. Lynde (Eds.), *Evidence-based mental health practice: A textbook.* New York, NY: W. W. Norton.

Polanyi, M. (1967). *The tacit dimension*. Garden City, NY: Anchor Books.

Pruitt, D. G., & Kim, S. H. (2004}. *Social conflict: Escalation, stalemate, and settlement* (3rd ed.). Boston, MA: McGraw-Hill.

Rapp, C. A., & Goscha, R. J. (2005). What are the common features of evidence-based practices? In R. E. Drake, M. R. Merrens, & D. W. Lynde (Eds.), *Evidence-based mental health practice: A textbook.* New York: W. W. Norton.

Sarno, A. (2009). *A phenomenological study of clinicians treating traumagenic compulsions resulting from childhood sexual abuse*. (Doctoral Dissertation). Retrieved from ProQuest. (84D06ADC-B401-11DE-8BE9-D8193012225A).

Seligman, L. (2006). *Theories of counseling and psychotherapy: Systems, strategies, and skills* (2nd ed.). Upper Saddle River, NJ: Pearson Education.

Shaler, L., Hathaway, W., Sells, J., & Youngstedt, S. (2013). Correlates of anger among Operation Enduring Freedom and Operation Iraqi Freedom veterans. *Journal of Military and Government Counseling, 1*(3), 136-151.

Tebes, J. K. (2005). Community science, philosophy of science, and the practice of research. *American Journal of Community Psychology, 35*, 213 – 231.

Thomas, G. (1997). What's the use of theory? *Harvard Educational Review, 67*(1), 75-104.

Underwood, R., & Lee, M. (2004). Research models in human services. In H. S. Harris, D. C. Maloney, & F. M. Rother (Eds.), *Human services: Contemporary issues and trends*, (3rd ed.) (pp. 237-256). Boston, MA: Pearson Custom.

Verona, E., & Sachs-Ericsson, N. (2005). The intergenerational transmission of externalizing behaviors in adult participants: The mediating role of childhood abuse. *Journal of Consulting and Clinical Psychology, 73* (6), 1135-1145.

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Edited by M. Cole, V. John-Steiner, S. Schribner, & E. Souberman. Cambridge, MA: Harvard University Press.

Wolin, S.J, & Wolin, S. (1993). *The resilient self: How survivors of troubled families rise above adversity*. New York: Villard.