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EVALUATING THE LEGACY PROGRAM OF THE MIGHTY
OAKS FOUNDATION: A MIXED-METHOD STUDY

A Dissertation
Presented to
the Faculty of
The Southern Baptist Theological Seminary

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by
Curtis Wayne Solomon
May 2020

APPROVAL SHEET

EVALUATING THE LEGACY PROGRAM OF THE MIGHTY
OAKS FOUNDATION: A MIXED-METHOD STUDY

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To the men and women of the Mighty Oaks Warrior Foundation

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PREFACE

First and foremost, all praise, glory, and gratitude are due to my Lord and Savior Jesus Christ, “For from Him and through Him and to Him are all things. To Him be the glory forever. Amen” (Rom 11:36).

My beloved bride, Jenny, is next in line for acknowledgement and thanks. Without her encouragement, tremendous support, sacrifice, insight, and edits, this dissertation would not have come to be.

Reid and Dashiell, our boys, thank you for giving up so much time with me so that I might research and write. After a bit of catch up, I’m looking forward to far more play and far fewer naps.

My parents, Jim and Sharon, who provided a firm foundation of faith, hope, and love. You gave me a deep appreciation for education and hard work. You were the first instruments in our Redeemer’s hands to help mold and shape me into the man I have become. Thank you.

Dr. Jeremy Pierre, my doctoral advisor and friend, thank you for giving me so many opportunities. You graciously accepted me as a student, and then took a risk on me with this project. In addition to all that, you threw a big wrench into our lives by encouraging me to pursue the opportunity of a lifetime as Director of the Biblical Counseling Coalition. Thank you, brother.

Dr. Joseph Harrod, thank you for serving on the dissertation committee and for your encouragement with this project and for your love and support of the military community.

Dr. Robert Jones, your service on this dissertation committee is the least of reasons I have to be thankful for you. Your writing, teaching, and counseling ministries

have served, encouraged, and blessed my family and me far beyond what any of us can fathom. Thank you, brother.

Dr. Eric Johnson, even though you could not sit on the dissertation committee your teaching, encouragement, and friendship have meant a great deal to me. Your keen mind and gracious manner helped shape me as a student, author, biblical counselor, husband, father, and man. Thank you.

To the Biblical Counseling Coalition, especially the Board of Directors, thank you for your patience and allowing me the time to continue and complete this dissertation.

Cornerstone Community Church, thank you for allowing me the chance to begin this study while serving with you all. There are far too many of you who have blessed and continue to bless my family to mention. John Marc, your leadership was exemplary, and your pastoral ministry was truly transformative in my life.

Special thanks to Rajah Chacko and Rob Bandy, who offered advice and analysis on the statistical research. You helped this biblical counselor navigate the foreign waters of statistics.

Mike Borland, thank you for all the time and energy you gave to designing and maintaining the website and database. That work was central to this entire project. I could never pay you what you are worth. So as my grandmother would say, “Thanks until you’re better paid.”

Kristen Borland, thank you for all your help editing various portions of my work and making the world a better place one comma at a time.

To the Board of Directors of the Biblical Counseling Research Institute (BCRI), your friendship and support are invaluable to me. Without your help with this project would never have been able to get off the ground.

Nathan MacFarlane, thank you for the work you did to create such an aesthetically pleasing and functional website for BCRI.

Thank you to the Fitzgerald family for your assistance with the research project. Your quick minds and fast fingers saved me a great deal of time and helped maintain the integrity of the research.

Wayne and Nancy Reigel, thank you for allowing me the use of your cabin on a few occasions to hide away and study/write. Those weeks of isolation were a fruitful blessing.

Thank you to all the donors who gave to fund this research. God has already and will continue to multiply your gifts. There are men and women whose lives have been changed and in some cases saved because of the work of Mighty Oaks. Sometimes those men and women were saved from death by their own hands and for many they have been saved from eternal death. Our prayer is that many more will have the chance to be helped because of this study. I'd especially like to mention Fellowship North West Arkansas and the Jordan family for your generous support.

To the men and women of the Mighty Oaks Foundation, past, present and future, your sacrificial service both on and off the battlefield are inspirational. Thank you for serving our nation and the King of kings. Chad and Jeremy, thank you for the opportunity and your patience awaiting the results of this study. Branden, Luis, Jamie, Bill, Robert, and Reed, thank you for all you do for the ministry and for making my time in the Legacy Program unforgettable. John Foldberg, thank you for making the connection between Cornerstone and Mighty Oaks. That relationship has changed lives. Thank you for your leadership and example of biblical manhood and for your friendship. Jonny Benton, thank you for exemplifying true brotherhood to me and many others.

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Louisville, Kentucky

May 2020

CHAPTER 1

RESEARCH CONCERN

The mission of the Mighty Oaks Warrior Programs is to reach the brokenhearted with a specific calling to assist our nation's Military Warriors and Families to find a new life purpose through a hope in Christ after enduring hardship through their service to America. Mighty Oaks Warrior Programs works to restore the broken families of our nation's Warriors by building the men that lead them, equipping their spouses to deal with the unique challenges of the military wife and encouraging their children. Those not yet leading a family of their own can experience healing that will allow them to begin those relationships whole. This is accomplished by having an encounter with Christ that allows each person to live within their God-given design.¹

Introduction

Over twenty veterans a day commit suicide in the United States.² While the exact motivation for each suicide is impossible to discern absolutely, it is certain that many veterans who commit suicide have also suffered from Post-Traumatic Stress Disorder (PTSD).³ Vast resources are being spent to ebb the tide of veteran suicides in our nation. The Department of Veterans Affairs and many other organizations and schools are attempting to utilize virtually every possible solution imaginable. Many attempts to resolve the struggles associated with PTSD focus on cognitive and physiological interventions, but there is a growing recognition of a spiritual component to

¹ Mighty Oaks Warrior Program promotional print materials (Mighty Oaks Warrior Program, 2017).

² Janet Kemp and Bossarte, Robert, "Suicide Data Report, 2012" (Department of Veterans Affairs: Mental Health Services, Suicide Prevention Program), accessed May 8, 2015, <http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf>; Office of Suicide Prevention, "Suicide Among Veterans and Other Americans 2001-2014," August 2017, <https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf>.

³ Throughout this dissertation I will utilize both PTSD and PTS (post-traumatic stress) to refer to the phenomenon at the center of this study. I will use PTSD when referencing official diagnosis of the disorder recognized in the *DSM* (either in literature or when referencing a person's diagnosis) and I will use PTS when referring to the phenomenon itself. The full rationale will be given in chapter 2 on pages 66-67.

the struggle.⁴ While many agencies are developing a recognition for spirituality, the driving factor for the Department of Veterans Affairs is whether or not the proposed treatment is backed by empirical research.⁵ Those treatments backed by research are categorized as evidence-based treatments.

The Mighty Oaks Foundation (MOF) operates The Mighty Oaks Warrior Programs (MOWP). MOWP are a group of programs designed to help those who are struggling with PTSD in the aftermath of severe trauma experienced in military service. The programs offer faith-based alternative treatment that is centered on the person and work of Jesus Christ and grounded in biblical teaching. The flagship program of MOWP is the Legacy Program. This program is offered in gender specific variations—one for men and one for women. At the date of this writing, over 2,700 men and women have graduated from the program since it began eight years ago and there has only been one suicide in all the alumni.⁶

The study at the center of this dissertation is an empirical evaluation of the Legacy Program for men. The Legacy Program is a faith-based, peer-to-peer, weeklong, residential, intensive treatment program. It focuses on introduction to the Christian faith and challenges participants to align their lives with the God given design they were created to live by following wisdom gleaned from the Bible. It integrates recreational elements as well as an emphasis on building strong relationships among participants and their instructors, and a minimal amount of psychoeducation. Providing participants a

⁴ J. Irene Harris et al., “The Effectiveness of a Trauma Focused Spiritually Integrated Intervention for Veterans Exposed to Trauma,” *Journal of Clinical Psychology* 67, no. 4 (April 2011): 425–38. Gino L. Collura and Daniel H. Lende, “Post-Traumatic Stress Disorder and Neuroanthropology: Stopping PTSD before It Begins,” *Annals of Anthropological Practice* 36, no. 1 (May 2012): 134. Irwin A. Hyman and Ari S. Yares, “Trauma, Treatment, and Religion: Dealing with Children’s Fears Since the World Trade Center Attacks,” *Journal of Religious & Theological Information* 5, no. 1 (January 2002): 7–29.

⁵ Michael J. Ostacher and Adam S. Cifu, “Management of Posttraumatic Stress Disorder,” *Journal of the American Medical Association* 321, no. 2 (January 15, 2019): 200–201.

⁶ John Foldberg, conversation with author, October 20, 2018; Chad Robichaux, email message to author, June 10, 2019.

“new life purpose through hope in Christ” is central to the Legacy Program.⁷ The central tenant of this dissertation is that healing from the deleterious effects of trauma comes through changes to a person’s perception of his traumatic experiences. Specifically, a person’s perception consists of their thoughts, emotions, desires, and choices related to both the traumatic event itself and to the meaning of life as a whole. As they come to a truer understanding of both, they will experience a renewed sense of purpose in the present. The three primary treatment modalities recognized by the Department of Defense and the Department of Veterans affairs all employ a similar concept. The Legacy Program is able to take individuals much further because it brings divine authoritative truth to bear on a person’s life and situation. It can provide purpose and meaning that comports with the purpose for which the participants were created.

Those who are familiar with the program observe its effectiveness, but no research has been done to demonstrate its effectiveness empirically. While the MOWP are able to help many men and women, certain doors of opportunity are closed to them because of the lack of empirical evidence demonstrating the effectiveness of the programs. The Mighty Oaks Effectiveness Study (MOES) is a mixed-method research study incorporating extensive literature review, a quantitative pre/post-test survey of participants in the Legacy Program, a retrospective alumni survey with quantitative and qualitative questions, alumni interviews as well as personal observation of the program.

Research Purpose

The reality of veteran suicide is gaining awareness in our country. However, awareness of the problem is not a solution. The Mighty Oaks Warrior Programs (MOWP) is a Christ-centered ministry that has helped thousands of veterans and active duty service members deal with the difficulties associated with Combat Trauma and Post Traumatic

⁷ Mighty Oaks Warrior Program promotional print materials.

Stress Disorder (PTSD). While the program's founders do not claim to have *the* solution to the problem, the low suicide rate as well as the life changes they have seen in many graduates of the program indicate that what they are doing is effective.

The goals of this dissertation are multifaceted. The first goal is to demonstrate the effectiveness of the MOWP Legacy program at reducing participants PTSD symptoms. The second goal is to demonstrate that the program is effective in establishing or raising participants strength of religious commitment to the Christian faith. Third, the research seeks to demonstrate a strong correlation between the growth of religious commitment and the reduction of PTSD symptoms. The fourth goal is to identify key elements of the Legacy Program that make it effective and can be adapted by counselors or other ministries.

A distinct, yet related, goal for the dissertation as a whole is to demonstrate the value empirical research has to enhance and advance biblical counseling and to encourage the expansion of its use in the biblical counseling movement. Until recently, no empirical studies have been conducted by biblical counselors to demonstrate the effectiveness of our theories or practices. Some biblical counselors have expressed disinterest or even distrust of empirical research. While a full defense of empirical research is beyond the purview of this dissertation, appendix 17 offers a cursory argument to spark thought and discussion on the topic. My desire is that this research project will inform our movement of the benefits of empirical research and inspire others to utilize it as one apologetic tool to advance biblical counseling.

This dissertation answers the following research questions and offers great insight into the solutions God's Word offers to help people suffering in the aftermath of horrific events. The research shows that the Legacy Program of the Mighty Oaks Foundation is effective and reducing the PTSD symptomology of those who participate in the program. Simultaneously, those who attend the program tend to develop or grow in strength of religious commitment. These two results are negatively correlated. That is, as

one's strength of religious commitment rises, one's PTSD symptoms decline. The Legacy Program is on par with the effectiveness of other evidence-based treatments recommended by the VA and DoD for treatment of combat related PTSD. Elements of the program that contribute to its effectiveness include biblical teaching on various topics, the use of combat veterans who have experienced PTS and Post Traumatic Growth as instructors in a peer-to-peer format, education on the nature of PTS, and utilizing a comfortable, quiet, secluded environment for the program. While some of these elements can be adopted or adapted for care in a traditional counseling setting, other elements will not directly translate into that format. The primary aim of the program is to help participants develop a proper biblically informed framework for interpreting their life and their trauma. When participants leave the program, they are equipped with this framework to help them understand their past, inform their present, and move forward to their future.

Research Questions

1. Is there a correlation between attending the Legacy Program and the reduction of Post Traumatic Stress Disorder (PTSD) symptoms?
2. Is there a correlation between attending the Legacy Program and a growth in one's strength of religious commitment?
3. Is there a correlation between the strength of one's religious commitment and the severity of one's PTSD symptoms?
4. What elements of the Legacy Program do participants find most helpful?
5. How does the Legacy Program compare to other treatment programs for PTSD?

Research Hypotheses

Four primary hypotheses were tested with the pre/post-test portion of this study. The first hypothesis is that the Legacy Program is an effective treatment for reducing the symptoms of PTSD in those who complete the program. The second is that

the Legacy Program impacts the strength of religious commitment of those who attend in a positive way. The third hypothesis being tested is that there is a strong negative correlation between one's PTSD symptoms and the strength of one's religious commitment. It is believed that the research will demonstrate that those who experience an increase in the strength of their religious commitment will also experience a decrease in their PTSD symptoms. The final hypothesis is that the Legacy Program is at least as effective at treating PTSD symptoms as other forms of treatment.

Procedural Overview

The Mighty Oaks Effectiveness Study (MOES) is a mixed method study consisting of both quantitative and qualitative surveys, participant/alumni interviews, literature review, and personal observation of the program. The pre/post-test study combined two previously validated instruments into a survey that was given to participants prior to attending the Legacy Program and then again six months after completion of the program. One instrument the PTSD Checklist-5 (PCL-5) measured participants PTSD symptoms while the other the Santa Clara Strength of Religious Commitment Questionnaire (SCSRCQ) measured their strength of religious commitment.⁸ The retrospective alumni survey was created for this study and asked questions about the participants' perception of the impact of the Legacy Program on their PTSD symptoms and questions about what elements of the program were particularly helpful to the participants. All research instruments used in this dissertation were performed in compliance with and approved by the Southern Baptist Theological

⁸ Thomas Plante and Marcus T. Boccaccini, "The Santa Clara Strength of Religious Faith Questionnaire," *Pastoral Psychology* 45 (May 1, 1997): 375–87; "PTSD Checklist for DSM-5 (PCL-5) - PTSD: National Center for PTSD," General Information, accessed April 18, 2019, <https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>; "Using the PTSD Checklist for DSM-IV (PCL)," *VA National Center for PTSD*, January 2014, <http://www.ptsd.va.gov/professional/pages/assessments/assessment-pdf/pcl-handout.pdf>; Wortmann JH, "Psychometric Analysis of the PTSD Checklist-5 (PCL-5) among Treatment-Seeking Military Service Members.," *Psychological Assessment* 28, no. 11 (2016): 1392–1403.

Seminary Research Ethics Committee.

Analysis of the data was conducted using Excel, SPSS and Survey Monkey's built-in analytical tools. Overall score totals, means, and standard deviations were calculated using Excel and Survey Monkey. SPSS was utilized to conduct paired *t*-tests, Wilcoxon analysis, Spearman Correlations, and Pearson Correlations.

In addition to the surveys, I also attended the Legacy Program to experience the program firsthand. This allowed me to understand the nature of the program, determine the quality of biblical instruction during the program and to gain insights into what elements offered the most help.

I also conducted interviews with a number of alumni and staff of MOWP to get their insights on the program and to provide firsthand accounts of the battle with PTSD.

A review of a wide range of literature on the topic of PTSD was also conducted. The literature reviewed included literature published by the Mighty Oaks Foundation, literature they use in their program, biblical counseling literature on the topic of PTSD, and resources related to the history of, diagnosis/description of, and treatment of PTSD. Particular attention was given to treatments that are considered evidence-based treatments and are prioritized by the Department of Defense (DoD) and Department of Veterans Affairs (VA). The next chapter will detail insights gleaned from the literature review.

CHAPTER 2

PRECEDENT LITERATURE

Type the initials “PTSD” into a Google or EBSCO search engine and you will receive an avalanche of books and journal articles. An avalanche is an appropriate analogy, because you will be standing at the base of a mountain buried under resources that have accumulated in a relatively short time. Dr. Bessel van der Kolk, author of the book *The Body Keeps the Score*, recounts his first experience with literature on PTSD at a VA clinic in Boston in 1978: “I went down to the medical library to look for books on war neurosis, shell shock, battle fatigue, or any other term or diagnosis I could think of that might shed light on my patients. To my surprise the library at the VA didn’t have a single book about any of these conditions.”¹ Fast forward just twenty-six years to 2004 and the National Center for Post-Traumatic Stress Disorder has a database with more than twenty thousand articles, books and reports.² Given the overwhelming number of resources available on the topic it would be impossible (as well as unnecessary) to review them all for a single dissertation. For this dissertation I limited my research to a few categories of resources: First, resources on PTSD from a biblical counseling background. Second, leading resources on the topic of PTSD generally. Third, resources directly related to combat trauma. Fourth, literature produced by the Mighty Oaks Foundation. Fifth, efficacy studies of various forms of treatment for PTSD that were not exclusively

¹ Bessel A. Van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (New York: Penguin Books, 2015), 10. In addition to this book Dr. Van der Kolk is the founder and medical director of the Trauma Center in Brookline, Massachusetts, professor of psychiatry at Boston University School of Medicine, and director of the National Complex Trauma Treatment Network.

² Ethan Watters, *Crazy Like Us: The Globalization of the American Psyche* (New York: Free Press, 2010), 72.

pharmacological. Within these studies specific preference was given to studies involving veterans exposed to combat trauma and those which utilized similar measurements to ones used in the MOES research.

History of PTSD

The diagnosis of PTSD was not officially recognized as a psychological disorder until the publication of the *DSM-III* in 1980. As we will see, all revisions of the *DSM* since that time have modified the criteria and description of the disorder.³ It was largely due to observation of combat veterans following the Vietnam Conflict that PTSD became a recognized problem. Much of the research in the area of PTSD has centered around combat veterans. This is likely due to the accessibility of a large population of persons who have faced significant trauma to researchers coupled with money and institutional structures afforded through the Department of Defense and the Department of Veterans Affairs. Since that time, research has expanded to include other populations of trauma sufferers: rape victims, survivors of vehicle accidents, emergency first responders, as well as those who have been taken captive and/or tortured.

The actual diagnosis of PTSD is relatively recent, but most people recognize that the phenomenon described in the pages of the *DSM* have existed for most of human history. Various terms have been applied to what happens psychologically to many soldiers on the battlefield. In the 1600's, the Swiss had a term for it which meant "nostalgia." German and French doctors coined terms in their own languages that both roughly translate to "homesickness." While the Spanish used the term *estar roto* which

³ American Psychiatric Association (APA), Task Force on Nomenclature and Statistics, *Diagnostic and Statistical Manual of Mental Disorders: DSM-III*, (Washington, DC: American Psychiatric Association, 1980), 238; American Psychiatric Association, ed., *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*, 4th ed. (Washington, DC: American Psychiatric Association, 1998), 427–28; American Psychiatric Association, ed., *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*, 4th ed., text revision (Washington, DC: American Psychiatric Association, 2000), 467–68; American Psychiatric Association (APA) and DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (Washington, DC: American Psychiatric Association, 2013), 271–72.

means “to be broken,”⁴ “DaCosta’s Syndrome,”⁵ “Combat Stress Reaction,”⁶ “battle fatigue, soldier’s heart, combat neurosis and shell shock,”⁷ are all terms that have been used throughout various military conflicts to describe what is identified as PTSD today. In U.S. history, there are records of psychological distress in combatants at least as far back as the Civil War.⁸ Jonathan Shay, M.D., Ph.D., is a staff psychiatrist with the Department of Veterans Affairs and author of *Odysseus in America* and *Achilles in Vietnam*. He has worked closely with Vietnam combat veterans and recognizes parallels between their stories and various characters in Homer’s classic Greek epics. Shay believes combat veterans have a better grasp and understanding of the accounts of men like Achilles in the *Iliad* because of their own experiences in combat. Through their testimonies and those given by many other combat veterans, it appears that the account of Achilles is an ancient depiction of PTSD.⁹ If one accepts Shay’s thesis, then accounts of PTSD go back at least as far as the eight century BC when Homer wrote his epic poems.

Diagnosing PTSD

Diagnosis of PTSD¹⁰ first requires that a person be exposed to “actual or

⁴ Christopher B. Adsit, *The Combat Trauma Healing Manual: Christ-Centered Solutions for Combat Trauma* (Newport News, VA: Military Ministry Press, 2008), loc. 801, Kindle.

⁵ J. Douglas Bremner, *Does Stress Damage the Brain? Understanding Trauma-Related Disorders from a Mind-Body Perspective* (New York: W.W. Norton, 2002), 27.

⁶ Chad M. Robichaux and Jeremy M Stalneck, *The Truth about PTSD* (Manassas, VA: Making Life Better Publishing, 2017), 47.

⁷ Terence M. Keane, Jessica Wolfe, and Kathryn L. Taylor, “Post-Traumatic Stress Disorder: Evidence for Diagnostic Validity and Methods of Psychological Assessment,” *Journal of Clinical Psychology* 43, no. 1 (January 1987): 32–43.

⁸ Keane, Wolfe, and Taylor, "Post-Traumatic Stress Disorder," 33.

⁹ Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York: Scribner, 2003), xxi.

¹⁰There are separate diagnostic criteria for children six years of age and under. Since this dissertation is focused primarily on combat trauma I am not going to explain or address the variations for early childhood PTSD.

threatened death, serious injury, or sexual violence.”¹¹ Exposure to these types of incidents is known as Criterion A. The exposure can happen in four different ways: First, exposure occurs if someone directly experiences any of these traumatic events. Second, exposure happens when someone witnesses these events in person. The third way a person can be exposed is by learning about one of these traumas happening to a family member or close friend. If the trauma is death of a loved one, it must have been accidental (thus the term sudden unexpected death or SUD) or have been a violent death (while most of these will also be sudden and unexpected there are occasions such as the execution of hostages or prisoners that are violent but pre-planned). The fourth way someone meets Criterion A exposure is: “Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).”¹² Some prefer to use the terminology “Potentially Traumatic Events” (PTE) to refer to the types of events described in Criterion A.¹³ This preference relates to the nature and definition of the word trauma which will be discussed later in this dissertation. For now, I will occasionally use this terminology to refer to the horrific types of events described in the Criterion A diagnostic language.

In addition to meeting Criterion A, if someone is going to be diagnosed with PTSD they must manifest certain symptoms after exposure to the traumatic event or events. Those symptoms are grouped around four different categories of symptoms or symptom clusters. These symptom clusters are Criterion B-E of the diagnostic criteria: B—intrusion symptoms, C—avoidance symptoms, D—negative alterations in cognition

¹¹ American Psychiatric Association and *DSM-5* Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 271.

¹² American Psychiatric Association and *DSM-5* Task Force, 271.

¹³ Frank W. Weathers and Terence M. Keane, “The Criterion A Problem Revisited: Controversies and Challenges in Defining and Measuring Psychological Trauma,” *Journal of Traumatic Stress* 20, no. 2 (April 2007): 111.

or mood, and E—alterations in arousal reactivity.¹⁴

Intrusion symptoms include the following:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).¹⁵

One or more of these symptoms must begin sometime after the PTE occurs.

Criterion C for diagnosis of PTSD is met if one or both of the following avoidant symptoms persists following exposure to Criterion A PTE.

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).¹⁶

Two or more of the following Criterion D symptoms altering mood or cognitive function must be present in relation to the Criterion A PTE.

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world.
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g. fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).¹⁷

¹⁴ Weathers, and Keane, “Criterion A Problem Revisited,” 271-72.

¹⁵ American Psychiatric Association and DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 271.

¹⁶ American Psychiatric Association and DSM-5 Task Force, 271.

¹⁷ American Psychiatric Association and DSM-5 Task Force, 271–72.

Criterion E symptoms include the following:

1. Irritable behavior and angry outburst (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects. 2. Reckless or self-destructive behavior. 3. Hypervigilance. 4. Exaggerated startle response. 5. Problems with concentration. 6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).¹⁸

There must be two or more of these symptoms for the diagnosis of PTSD.

Criterion F for diagnosis is that symptoms described in Criterion B-E persists for more than one month.

Criterion G states that the symptoms must cause “significant distress or impairment in social, occupational, or other important areas of functioning.”

Criterion H clarifies that none of these symptoms can be attributed to physiological effects of substances or some other medical condition.¹⁹

The *DSM-5* (using *DSM-IV* criteria) lists a projected lifetime prevalence of PTSD diagnosis at 8.7 percent in the United States population at age 75.²⁰ Other studies have been conducted which show a lifetime prevalence of 3.6 percent among men and 9.7 percent among women in the United States.²¹ When similar studies focus on veteran populations the prevalence rates increase dramatically. One study of Vietnam era veterans found a lifetime prevalence of 30.9 percent. For men and 26.9 percent for women.²² The highest rates of prevalence occur among survivors of rape, military combat and captivity, ethnically or politically motivated internment, and genocide. Among these groups the prevalence is between one third to over one half of the population exposed.²³

¹⁸ American Psychiatric Association and DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 272.

¹⁹ American Psychiatric Association and DSM-5 Task Force, 272.

²⁰ American Psychiatric Association and DSM-5 Task Force, 276.

²¹ “Epidemiology of PTSD,” National Center for PTSD, accessed October 30, 2015, <http://www.ptsd.va.gov/professional/PTSD-overview/epidemiological-facts-ptsd.asp>.

²² “Epidemiology of PTSD.”

²³ American Psychiatric Association and DSM-5 Task Force, 276.

These numbers indicate that trauma happens in this world and it has an effect on people. Those who are in populations where exposure to PTE's is elevated face increased levels of negative symptoms. Others who face trauma often experience one or more of the symptoms associated with PTS.

Almost anyone who has been in a car accident, been assaulted, or faced down an enemy in combat will have intrusive thoughts about the trauma or experience hyper-arousal—especially when confronted with stimuli that reminds him of the trauma. If these reactions mimic those of PTS but resolve within a month the person might be diagnosed with Acute Stress Disorder, rather than PTSD. Prevalence of this disorder ranges from 6 percent to 50 percent of people who go through a significant traumatic experience depending on the type of trauma they face.²⁴

What can be gleaned from this data is that negative effects are prevalent among people who experience significant trauma. Additionally, there are millions of people who still struggle in the aftermath of PTE's even if they never receive a diagnosis of PTSD.

The Nature of PTSD

Until the most recent edition of the *DSM*, PTSD was categorized as an anxiety disorder.²⁵ The *DSM-5* introduced a whole new category of disorders labeled, “Trauma- and Stressor-Related Disorders.”²⁶ PTSD now falls under this new category. The shift does not indicate that PTSD is unrelated to anxiety. Rather it demonstrates a move to further distinguish certain phenomena from others. The name post-traumatic *stress* disorder indicates that it is related to anxiety, but it stems from a particular event or set of events. The connection to an event or events leads some to argue that it should be treated

²⁴ American Psychiatric Association and *DSM-5* Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 280–84.

²⁵ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 2000, 21.

²⁶ American Psychiatric Association and *DSM-5* Task Force, xix.

as an injury rather than an illness, which is the way most disorders in the DSM are addressed.²⁷ The symptoms associated with the injury demonstrate the complexity of the phenomenon being described. They are troubling symptoms that impact the person's whole life including physical, social and spiritual aspects. Later, in this paper, I will investigate the impact of PTSD on these particular spheres of life. First, it is important to establish the nature of trauma.

Defining Trauma

According to the *DSM-5*, Criterion A for diagnosis of PTSD is exposure to trauma. But what is trauma? In common vernacular, the word trauma is used in a variety of ways. Merriam-Webster's online dictionary definition demonstrates the confusing nature of the word. The first definition is broken down into physical and psychological definitions: 1a is "an injury (as a wound) to living tissue caused by an extrinsic agent, and" 1b is "a disordered psychic or behavioral state resulting from mental or emotional stress or physical injury." The real challenge comes in definition 2: "an agent, force, or mechanism that causes trauma."²⁸ These extreme variations in the semantic domain of the word lead people to use the term to describe both the cause and the effects of intense suffering.

The *Baker Encyclopedia of Psychology and Counseling* demonstrates the complexity of this word even within the psychological community:

A certain event, force, or mechanism that causes malfunction or severe personal damage. Trauma can be experienced on a physical, mental, behavioral, emotional, or communal level. It may be the result of deep injury, sudden shock, major violence, or significant loss. Trauma has elements of terror, humiliation, impairment, and pain.²⁹

²⁷ Sethanne Howard and Mark W. Crandall, "Post Traumatic Stress Disorder: What Happens in the Brain?," *Journal of the Washington Academy of Sciences* 93, no. 3 (Fall 2007): 5.

²⁸ *Merriam-Webster Online Dictionary*, s.v. "trauma," accessed April 23, 2018, <https://www.merriam-webster.com/dictionary/trauma>.

²⁹ N.-Hashem Abi, "Trauma," in *Baker Encyclopedia of Psychology & Counseling*, (Grand

The definition begins by pointing to an external event, force, or mechanism that causes damage; then it goes on to discuss trauma as having “elements of terror, humiliation, impairment and pain.” The first three descriptions in the definition discuss the cause of something as trauma then shift to describe the effects of that cause as the trauma. So which is it, the cause or the effect? As the argument unfolds, I will demonstrate that trauma is necessarily a complex mixture of both cause and effect. Trauma is a certain type of effect that comes from a limited category of events.

The word “trauma” comes from the Greek word τραῦμα (*trauma*) meaning “wound.”³⁰ Most people are familiar with this usage. Think of the “trauma ward” in a hospital. This is where people go when they have experienced a severe injury—often caused by an accident or violent act. The psychological community adopted this terminology to discuss “wounds” to the psyche that are also caused by extreme or violent acts. People who have gone through an extreme, often life-threatening event can be described as traumatized or as having experienced a trauma (either referring to the event or the remaining effect on the soul).

Ever since PTSD entered the mental health world as a diagnosable disorder there has been a great deal of discussion and some debate over the nature of trauma. According to the *DSM*, a clinician must first establish that the patient meets Criterion A standards to receive a diagnosis of PTSD.³¹ First and foremost, Criterion A addresses the question of whether or not someone has actually been exposed to a “potentially traumatic event” (PTE).³²

Rapids: Baker Books, 1999), 1229.

³⁰ James Swanson, *Dictionary of Biblical Languages with Semantic Domains: Greek New Testament* (Oak Harbor: Logos Research Systems, 1997).

³¹ American Psychiatric Association and *DSM-5* Task Force, *Diagnostic and Statistical Manual of Mental Disorders*.

³² Weathers and Keane, “The Criterion A Problem Revisited,” 111.

Each new edition of the *DSM* has altered the wording of Criterion A. The *DSM-III* uses the very basic and broad language of “existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.”³³ In its further description of PTSD, more clarification is given on the types of stressors that would qualify: “The stressor . . . would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict.”³⁴

The *DSM-III* lists examples of possible stressors including: rape, assault, military combat, natural disasters, car accidents with serious physical injury, airplane crashes, large fires, bombing, torture, and death camps.³⁵ Right away there was push back against these Criterion A parameters. Numerous problems plague this language including its emphasis on the rarity of such events occurring. For many people throughout human history, as well as today, the horrors that we attempt to quantify as traumatic stressors are all too common. War has plagued mankind for most of our existence. Rape has been an unfortunate reality in every culture throughout human history.

The *DSM-III-R* (a revision of the *DSM-III*) altered the language significantly.

The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one’s life or physical integrity; serious threat or harm to one’s children, spouse, or other close relatives and friends; sudden destruction of one’s home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.³⁶

The text goes on to add a few other important modifiers to Criterion A. First, it adds the statement that the stressor is “usually experienced with intense fear, terror, and

³³ American Psychiatric Association, Task Force on Nomenclature and Statistics, *Diagnostic and Statistical Manual of Mental Disorders: DSM-III*, 236.

³⁴ American Psychiatric Association, *DSM-III*, 236.

³⁵ American Psychiatric Association, *DSM-III*, 236.

³⁶ Weathers and Keane, “The Criterion A Problem Revisited,” 109.

helplessness.” Second, it adds the possibility that learning of serious threat or harm to a close friend or relative can also qualify as an adequate stressor.³⁷

Adding the possibility of experiencing indirect exposure to PTE through learning about a PTE involving a loved one added another category of stressor to Criterion A. This was a controversial move.³⁸ Indirect exposure has remained a category of potential stressors in subsequent editions of the *DSM*. For those who wrestle with the idea, imagining the following scenario can help clarify the inclusion of indirect exposure. Imagine learning on the evening news about a pedestrian that was struck and killed by a motor vehicle during the morning commute. Now imagine, instead of a random stranger, that the person killed in the accident was your spouse. How would your reaction differ?

As the *DSM* underwent subsequent updates, the language around Criterion A has continued to change. The *DSM-IV* and *DSM-IV-TR* (Text Revision) minimized Criterion A:

The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person’s response involved intense fear, helplessness, or horror.³⁹

This edition’s definitions were also problematic. The language indicating some kind of fear response accompanying the stressor (feelings of intense fear, helplessness, or horror) did not match the experience of many people otherwise meeting the diagnostic criteria for PTSD. This is certainly true of combat veterans. Many men recount experiences in combat where they felt exhilaration rather than fear in the midst of a firefight.⁴⁰ The most recent *DSM*, *DSM-5*, completely removes any fear response

³⁷ Weathers and Keane, “The Criterion A Problem Revisited,” 109.

³⁸ Weathers and Keane, 112–13.

³⁹ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 2000, 467.

⁴⁰ *Korengal*, directed by Sebastian Junger (Gold Crest Films, Outpost Films, 2014); *Restrepo*,

language from Criterion A and attempts to clarify what qualifies as an adequate stressor:

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1. Directly experiencing the traumatic event(s). 2. Witnessing, in person, the event(s) as it occurred to others. 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. 4. Experience repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).⁴¹

These continued shifts in what qualifies as a PTE have been attempts to address the true nature of the events that lead PTSD sufferers to wrestle with the symptoms associated with the diagnosis. All of these revisions point to two fundamental realities. One, it is incredibly difficult to define trauma. Not only is there confusion regarding the question of whether or not trauma refers to the event or the aftermath of the event, there is also difficulty in defining what types of events would qualify as potentially traumatic.

The second fundamental reality is this: While there have been a great many ways of describing this phenomenon, there has also been a great deal of consistency in limiting the types of stressors that would qualify. Throughout the revisions of the *DSM*, Criterion A stressors have been limited to incidents that negatively impact life or the integrity of one's person (death, severe injury, or sexual assault).

Importance of Narrowly Defining Trauma

Putting limits upon what qualifies as a potentially traumatic event is a monumental task, but it is important that those limits exist. In everyday speech, people use the term traumatized to describe how they feel after a breakup, loss of a job, or watching a favorite competitor on a reality TV contest get voted out. There are some who advocate for a completely subjective definition of potentially traumatic events by arguing

directed by Tim Hetherington and Sebastian Junger (National Geographic Entertainment, 2010).

⁴¹ American Psychiatric Association and *DSM-5* Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 271.

that what someone finds to be traumatic is entirely up to himself. However, the majority of people working in the mental health field do not advocate for this expansion. They recognize that it would undermine the very concept of PTSD and could potentially trivialize the suffering faced by those who have experienced such catastrophic events.⁴²

Relatively minor stressors should not elicit the same stress response as those that threaten life or limb. Most people can sympathize with a rape victim who struggles with being in a crowd, but have difficulty extending the same concern to a man whose favorite mug fell off the counter and shattered. When someone responds to stressors that are not threatening life or limb with the same level of severity as PTSD the secular therapeutic world has a separate diagnosis for them—Adjustment Disorder. Adjustment Disorder is diagnosed when people have “Marked distress that is out of proportion to the severity or intensity of the stressor.”⁴³ This distinction highlights the reality that there are appropriate responses of the soul to varying degrees of suffering. Seeing a broken mug or a dead animal should not have the same effect on a person as the sight of a dead human being.

Interpretive Component and Meaning-Making

Anyone who pays attention to the news regularly learns of sudden unexpected deaths. Why, then, does learning of the sudden unexpected death of a close loved one qualify as a potentially traumatic event (PTE) while learning of the death of a stranger does not? We interpret the meaning and significance of a death differently based on the closeness of our relationship to the person. If a crowd of people were standing on a sidewalk and all witnessed a bus collide with and kill a pedestrian, they would all qualify

⁴² Weathers and Keane, “The Criterion A Problem Revisited,” 114.

⁴³ American Psychiatric Association and DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 286.

as having been exposed to a PTE. However, if the pedestrian was the spouse or parent of one of the onlookers, the likelihood greatly increases that the event would result in a PTSD diagnosis for that person. The level of response to events varies in accordance to the significance people assign to them.

Relational interpretation also influences the nature of trauma when someone is attacked by another person. The severity and durability of the PTSD is influenced by the nature of the attack. If the attack is intentional (vs. accidental or perceived self-defense) or of a more personal nature (sexual assault, torture), this tends to increase the severity of the PTSD symptoms. If the perpetrator is a stranger it is still traumatic; if the person is a loved one, an authority, or caregiver the impact tends to be more severe.⁴⁴

Some authors argue that PTSD largely results from how one interprets reality.⁴⁵ Interpretation of events is influenced by a vast array of considerations including the context of the event, one's relationship to the event or people involved in the event, one's perception of the details of the event, and the meanings one ascribes those perceptions.

The diagnostic criteria in the *DSM* hint at this interpretive element when it places limits on various events that qualify as a Criterion A stressor. The context of an event can radically change how one responds to very similar stimuli. The surgeon who cuts open the chest cavity is going to have a very different reaction than the man who was haunted by the act of mutilation he inflicted on the corpse of a dead Viet Cong soldier who cut open the dead man's chest partly out of malice and partly because he wanted "to

⁴⁴ American Psychiatric Association and DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 275, 278.

⁴⁵ Greg E. Gifford, *Helping Your Family through PTSD* (Eugene, OR: Wipf and Stock Publishers, 2017), 21; Charles Hodges, "PTSD—When Your Past Is Your Present" (March 9, 2013), accessed December 18, 2015, <https://ibcd.org/ptsd-when-your-past-is-your-present/>; Gino L. Collura and Daniel H. Lende, "Post-Traumatic Stress Disorder and Neuroanthropology: Stopping PTSD before It Begins," *Annals of Anthropological Practice* 36, no. 1 (May 2012): 131.

see what his lungs looked like.”⁴⁶ Both people cut open a human body and see the internal organs exposed (similar stimuli), but the knowledge that one scenario is conducted in order to facilitate healing while the other is motivated by malice and inhuman curiosity changes the impact of the experience of the individuals involved.

The *DSM* has always noted a distinction between someone who is wounded in an accident or natural disaster versus a person who is wounded in an assault by another human being.⁴⁷ The internal distress that occurs is more challenging not because of physical wounds that are inflicted, but because of the source of the wounds and the emotional distress associated with assault. Violence enacted by human beings make us question our understanding of the nature of humanity, evokes a sense of injustice, and incites a desire for retribution. Natural disasters do not involve the same internal struggles. Those who are theistic may wrestle with the nature and goodness of a divine being; those who are committed naturalists have to consider the incident a consequence of random acts of nature or an effect of an untraceable series of causes. The point remains that PTSD contains an interpretive element.

Then there is the ever-present question of why different people who experience the exact same situation respond differently. Sometimes horrific events seem to make some people stronger while the same scenario causes great distress for others.⁴⁸ There are many influential factors that influence the impact of events on an individual, but how that person interprets the event and the level of significance, meaning, and purposed assigned to the events is key.

This interpretive nature is somewhat a double-edged sword. If understood

⁴⁶ Shay, *Achilles in Vietnam*, 117.

⁴⁷ American Psychiatric Association, Task Force on Nomenclature and Statistics, *Diagnostic and Statistical Manual of Mental Disorders: DSM-III*, 236; American Psychiatric Association and DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 278.

⁴⁸ Robichaux and Stalneck, *The Truth about PTSD*, 41.

inappropriately it can be used as a source of blame/shame for the person who is diagnosed with PTSD. The inappropriate line of thinking goes something like, “If I was just stronger mentally then this wouldn’t be happening to me.” There is an element of truth to this statement but it is faulty because it fails to consider influencing factors that vary from one individual to another. Some of these factors will be discussed in the following section.

The other edge of the sword is that there is great hope. If the struggle is influenced by, though not entirely dependent upon, the way one thinks, then a shift in thinking can bring about benefits and potentially resolve some symptoms.

Factors that Influence the Development of PTSD

There are various factors that play a role in the development and progression of PTSD. Broadly speaking, those factors are divided into Pretraumatic, Peritraumatic, and Posttraumatic factors.⁴⁹

Pretraumatic Factors

Pretraumatic factors are those elements of a person’s life which are present before the traumatic event or events that ultimately lead to a diagnosis of PTSD. The *DSM-5* breaks down pre-traumatic factors into three subcategories: temperamental, environmental, and genetic/physiological.⁵⁰ Temperamental factors listed in the *DSM* include childhood emotional problems manifesting by six years of age as well as prior mental disorders. Environmental factors include exposure to prior trauma, lower

⁴⁹ American Psychiatric Association and *DSM-5* Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 277–78. An interesting note from my research is that the categories of these contributing actors can be identified even in the way pastors have offered care and counsel to people who suffer greatly. My first encounter with the concept of pre-, peri-, and post-traumatic factors came while reading Richard Baxter’s accounts of caring for people who face intense suffering. He offered counsel on how to prepare for suffering, what to do in the midst of suffering, and how to respond in the aftermath of suffering.

⁵⁰ American Psychiatric Association and *DSM-5* Task Force, 277.

socioeconomic status, lower education, childhood adversity, lower intelligence, minority racial/ethnic status, and family psychiatric history. On the flipside, a strong social support network prior to traumatic exposure helps protect someone from developing PTSD.

Recognized genetic/physiological factors are being female and being exposed to trauma at a younger age. The *DSM* indicates that certain genotypes could possibly increase risk of development of PTSD or protect against it.⁵¹ This concept is reported by research that indicates genetic factors are one element that increase susceptibility to PTSD.⁵²

Family upbringing is a significant pre-traumatic factor that influences how one will respond to potentially traumatic events. Those who have loving supportive families tend to be more resilient while those who come from troubled families are underprepared for intense suffering.⁵³

One's cultural background is also a factor that plays into how one responds to potentially traumatic events. Culture can influence what is perceived as traumatic, what are acceptable responses to trauma, and even symptom manifestation.⁵⁴ Within the United States, after adjusting for traumatic exposure and demographic variables; Latinos, African Americans, and American Indians have higher rates of PTSD than whites while Asian Americans have lower reported rates of PTSD.⁵⁵

Perhaps the most significant pre-traumatic factor which influences whether or not someone will develop PTSD is prior exposure to traumatic stressors.⁵⁶ Research

⁵¹ American Psychiatric Association and *DSM-5* Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 277.

⁵² J. Douglas Bremner, *Does Stress Damage the Brain? Understanding Trauma-Related Disorders from a Mind-Body Perspective* (New York: W.W. Norton, 2002), 64, 98.

⁵³ Hyman and Yares, "Trauma, Treatment, and Religion," 23.

⁵⁴ American Psychiatric Association and *DSM-5* Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 278; Watters, *Crazy like Us*, 76–77, 90–91.

⁵⁵ American Psychiatric Association and *DSM-5* Task Force, 276.

⁵⁶ Bremner, *Does Stress Damage the Brain?*, 151.

demonstrates that those who are exposed to highly stressful events early in life have a higher likelihood of developing PTSD if they are exposed to additional traumatic events later in life.⁵⁷

As the previous section indicates, much of what influences the likelihood of whether or not a person will be diagnosed with PTSD following a PTE or multiple PTE's occurs before they ever face the difficult scenario. The next section will look at influential factors that are interwoven in the event/s leading to the diagnosis.

Peritraumatic Factors

Peri-traumatic factors describe those elements present at the time of the trauma. In other words, what elements of the actual traumatic experience influence whether or not someone is more or less likely to develop PTSD? These factors include external environmental factors, the person's behavior during the traumatic event, as well as the person's internal state during the event.

The *DSM-5* couples factors that are separate from the individual and the individual's behavioral responses under one category called "Environmental" factors.

These include severity (dose) of the trauma (the greater the magnitude of trauma, the greater the likelihood of PTSD), perceived life threat, personal injury, interpersonal violence (particularly trauma perpetrated by a caregiver or involving a witnessed threat to a caregiver in children), and, for military personnel, being a perpetrator, witnessing atrocities, or killing the enemy. Finally, dissociation that occurs during the trauma and persists afterward is a risk factor.⁵⁸

A close look at these demonstrates a slight acknowledgement that internal reactions are also peritraumatic factors in the potential development of PTSD. One's "perceived life threat" is certainly an internal reaction more than an environmental one. And "dissociation that occurs during the trauma" also involves the internal workings of

⁵⁷ American Psychiatric Association and DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 277.

⁵⁸ American Psychiatric Association and DSM-5 Task Force, 278.

the individual which can manifest externally.

Others describe what are known as “peritraumatic stress reactions.” These reactions include: “the different stress-associated behavioral, emotional, cognitive, and physiological symptoms during and immediately following a traumatic event.”⁵⁹ Examples of these reactions include: “fear of dying, fear of losing emotional control, tachycardia, sweating, shaking, dizziness, dissociative symptoms, reduction of awareness, etc.”⁶⁰ These reactions have been shown to have strong correlation with the development of PTSD.⁶¹

The earlier discussion of the interpretative element of PTSD also points to the influence of peritraumatic factors and the influence they have on the development and severity of the diagnosis. Those factors include: The nature of the event as man-made versus a natural disaster, whether the incident was intentional vs. accidental, the relationship between the person who developed PTSD and other individuals involved in the incident. All of those elements are peritraumatic factors.

Posttraumatic Factors

Post-traumatic factors listed by the *DSM* are categorized as temperamental and environmental. Temperamental factors include having negative appraisals, utilization of inappropriate coping strategies, and the development of acute stress disorder. The environmental factors listed include the following:

subsequent exposure to repeated upsetting reminders, subsequent adverse life events, and financial or other trauma-related losses. Social support (including family stability, for children) is a protective factor that moderates the outcome after trauma.⁶²

⁵⁹ Agorastos Agorastos et al., “The Peritraumatic Behavior Questionnaire: Development and Initial Validation of a New Measure for Combat-Related Peritraumatic Reactions,” *BMC Psychiatry* 13, no. 1 (April 2013): 2.

⁶⁰ Agorastos Agorastos et al., “The Peritraumatic Behavior Questionnaire,” 2.

⁶¹ Agorastos Agorastos et al., 2.

⁶² American Psychiatric Association and DSM-5 Task Force, *Diagnostic and Statistical*

How one responds to a PTE both behaviorally and through internal processing influences the development and severity of PTSD symptoms. In addition, external factors like further stressful encounters and whether or not one has a loving supportive network of relationships are significant influencing factors.

Some of these influencing factors play a role at each phase. Two primary factors that are present throughout the pre-, peri-, and posttraumatic timeframes are one's internal perceptions and beliefs, and the strength of one's social support networks. Having a loving, supportive family is a factor that can mitigate the negative impact of trauma at any phase. It acts like a vaccine which prepares people well to face tremendous suffering.⁶³

The powerful influence of one's interpretation of the events at each phase of suffering is key. If those interpretations separate those who are likely to develop PTSD symptoms from those who are less likely that points to the potential for great help and healing through the modification of those interpretations.

Personal Perception and Presuppositions

Post-Traumatic Stress Disorder offers an excellent example of the importance of one's personal perceptions in the medical and mental health fields. The nature of the issue, the procedure for diagnosis, and, most of all, the proposed treatments for PTSD are all dramatically influenced by the perceptions and presuppositions held by researchers, clinicians, counselors, and PTSD sufferers.⁶⁴

Meaning-making is an essential component of addressing PTSD. People want to know that the sacrifices they have made, the things they have done, and the

Manual of Mental Disorders, 278.

⁶³ Hyman and Yares, "Trauma, Treatment, and Religion," 23.

⁶⁴ Watters, *Crazy like Us*, 73.

suffering/loss they have experienced hold purpose. Neuroanthropologists argue that the source of meaning-making comes from building cultural connections. These cultural connections are relationships or points of contact between individuals and those around them. For military personnel these connections include ones from pre-military life, fellow servicemen, civilians in the theater of combat, etc. The hope is that these connections will provide a framework that offers meaning and purpose to the war the soldier is fighting and all the suffering that goes along with it.⁶⁵

For those who hold to a purely materialistic worldview, meaning-making provides a significant challenge.⁶⁶ If everything happens by seemingly random chance or is merely mechanistic out working of cause and effect, there is little hope for finding answers to questions of “Why?” Religions generally, and in particular Christianity, can answer these deeply important questions in a much more meaningful way.

J. Douglas Bremner, M.D., is Director of the Emory Center for Positron Emission Tomography at Emory University Hospital, and Director of Mental Health Research at the Atlanta VAMC. He has authored and edited numerous works and also conducted many clinical trials and experiments to better understand PTSD. His book, *Does Stress Damage the Brain*, provides research-based insights about the nature of various stress disorders and their impacts on the brain. The primary thesis of the book is that PTSD and other trauma-related psychological diagnoses are in fact rooted in physiological changes. From that premise he postulates the development of a spectrum of trauma-related disorders that are diagnosed through physiological examination (rather than a solely behavioral diagnosis). He further posits that treatments for said psychological diagnoses should address physiological pathologies. Countering those

⁶⁵ Collura and Lende, “Post-Traumatic Stress Disorder and Neuroanthropology,” 139.

⁶⁶ Harris et al., “The Effectiveness of a Trauma Focused Spiritually Integrated Intervention for Veterans Exposed to Trauma.”

physiological pathologies would include treatment of the heart, brain, immune system, metabolic disorders, etc., rather than just psychological difficulties.⁶⁷ While Bremner discusses a variety of physiological impacts of PTSD and other trauma-related difficulties, his primary focus is neurological.

Bremner approaches humanity from a perspective that assumes evolutionary origins.⁶⁸ He has a materialistic view of man and blames Christianity for the invention of an immaterial element of humanity. “The dualistic way of thinking engendered by Christianity underlies our current false dichotomy between mind and brain—psychology and biology.”⁶⁹

Another leading author and researcher in the area of PTSD is Bessel Van der Kolk, M.D. He is the founder and medical director of the Trauma Center in Brookline, Massachusetts and professor of psychiatry at Boston University School of Medicine. He also works as director of the National Complex Trauma Treatment Network.⁷⁰ Van der Kolk has authored numerous scientific articles and a bestselling book detailing the impact of trauma titled *The Body Keeps the Score*. In this work, Van der Kolk discusses the neurological impact of PTSD. He moves a step further than Bremner and dives deeply into the other physiological impacts of PTSD. The book also describes diagnostic tools and interventions to address PTSD with a whole-body approach.

Van der Kolk, like Bremner, holds evolutionary, materialist presuppositions⁷¹ and at times seems hostile toward any form of religion.⁷² These presuppositions shape his

⁶⁷ Bremner, *Does Stress Damage the Brain?*, 99.

⁶⁸ Bremner, 15, 76, 78, 108, 129, 164, 268.

⁶⁹ Bremner, 15; also see p. 272, where he reiterates the false dichotomy between physical and mental disease in relation to treatment.

⁷⁰ Van der Kolk, *The Body Keeps the Score*.

⁷¹ Van der Kolk, 55.

⁷² Van der Kolk, 27, 156, 177, 299.

understanding of the nature of human beings. He views humans as organisms whose primary concern is survival—both at the individual level and ultimately as a species. This prioritization of survival effects Van der Kolk’s understanding of humanity. It guides his perception on the nature and purpose of humans. It also influences how he views individual parts of the human organism, including the brain, its development, and its function. It also impacts how Van der Kolk prioritizes care of individuals.⁷³

According to this evolutionary perspective the chief end of man is to live long enough to transmit his/her DNA. Therefore the stress response system at the root of PTSD is an evolutionary adaptation. It encourages survivability long enough to reproduce and ensure that one’s offspring are able to live long enough to reproduce thereby perpetuating the transmission of the individual’s genetic material.⁷⁴

Materialistic, evolutionary presuppositions lead Bremner, Van der Kolk, and others to understand the nature of PTSD and its remedies as purely biological. Van der Kolk promotes the use of yoga as an intervention to help people with PTSD. While this may seem like an acknowledgement of the spiritual, he is focused solely on the physical benefits associated with the practice.⁷⁵ As much as Bremner would like to focus entirely on biology, he inexplicably references spiritual health⁷⁶ and what he calls “neurological-spiritual effects” when trying to explain the placebo effect. He uses this terminology to describe elements of our existence that “may transcend our ability to understand the effects of treatments as we know them.”⁷⁷ It is also interesting to note that while Bremner acknowledges that various forms of guilt are problematic for sufferers of PTSD, he never

⁷³ Van der Kolk, *The Body Keeps the Score*, 55.

⁷⁴ Bremner, *Does Stress Damage the Brain?*, 268.

⁷⁵ Van der Kolk, *The Body Keeps the Score*, 263–76.

⁷⁶ Bremner, *Does Stress Damage the Brain?*, 13, 276.

⁷⁷ Bremner, 251.

discusses how the proposed interventions are designed to address guilt. As we will see later, issues of guilt are best addressed through spiritual means.

By way of contrast, *The Combat Trauma Healing Manual* by Chris Adsit approaches the issue of PTSD through a worldview that embraces the spiritual nature of humanity, the existence of spiritual beings, and a divine creator. The author leads with establishing the “Spiritual Context of Your Trauma.”⁷⁸ This chapter is dedicated to addressing the difficult question of the nature of evil. It addresses the Question: How can evil exist in a universe created and ruled by an all-powerful and all-loving God?

Adsit does not deny or ignore the physical realities of PTSD. He addresses them directly in the book. He discusses the complex nature of PTSD including a biological and theological understanding of the disorder in a section titled, “The Physiology, Psychology and Theology of PTSD.”⁷⁹

Adsit’s presuppositions that include spiritual and physical realities lead him to offer solutions to PTSD that address more than biology. He addresses issues of confession and forgiveness, promotes the role of prayer, Scripture reading, involvement in the church, and other Christian practices as part of the healing process. In Adsit’s view, God takes an active role in the process of overcoming PTSD, it is not something left to the sufferer and a therapist alone.

I do not agree with all of Adsit’s theology or proposals for addressing PTSD, but this resource is widely used among Christian groups seeking to address PTSD due to combat trauma. This book serves as an example of how perceptions and presuppositions influences the understanding and treatment of PTSD.

The preceding sections have demonstrated the complex nature of PTSD. They have also shown how one’s presuppositions about the world influence understanding of

⁷⁸ Adsit, *The Combat Trauma Healing Manual*, loc. 471, Kindle.

⁷⁹ Adsit, loc. 877, Kindle.

the PTSD diagnosis and its treatment. The following sections will discuss how PTSD impacts various aspects of the lived experience of those who wrestle with it.

Neurological Impact of PTSD

God created human beings with an amazing system designed to aid in survival. It is an adaptive-learning-security system that integrates multiple parts of the human brain and almost every system of the human body.

Trauma affects the entire human organism—body, mind, and brain. In PTSD the body continues to defend against a threat that belongs to the past. Healing from PTSD means being able to terminate this continued stress mobilization and restore the entire organism to safety.⁸⁰

This security system goes by many names; the fear/threat/stress response system, fight or flight system, sympathetic nervous system, limbic system, etc.⁸¹ One biological aspect of PTSD is disruption of the proper functioning of this system and resulting consequences of that disruption. Before we discuss the negative impact of PTSD on this system, it is helpful to have a basic understanding of how the system functions when working properly.

Normal Threat Response

God designed creation, including our bodies, to operate at a certain level of normalcy called homeostasis.⁸² Homeostasis in the human body is maintained by the interaction between the sympathetic and parasympathetic nervous systems, the two

⁸⁰ Van der Kolk, *The Body Keeps the Score*, 53.

⁸¹ Rand S. Swenson, “Chapter 9: Limbic System,” in *Review of Clinical and Functional Neuroscience*, Online Version (Hanover, NH: Dartmouth Medical School, 2006), https://www.dartmouth.edu/~rswenson/NeuroSci/chapter_9.html; Emily B. Ansell et al., “Cumulative Adversity and Smaller Gray Matter Volume in Medial Prefrontal, Anterior Cingulate, and Insula Regions,” *Biological Psychiatry* 72, no. 1 (July 1, 2012): 57–64; Howard and Crandall, “Post Traumatic Stress Disorder: What Happens in the Brain?,” 6–7; Christian Gostečnik et al., “Trauma and Religiousness,” *Journal of Religion and Health* 53, no. 3 (2014): 694; Van der Kolk, *The Body Keeps the Score*, 205.

⁸² Benno Roozendaal, Bruce S. McEwen, and Sumantra Chattarji, “Stress, Memory and the Amygdala,” *Nature Reviews Neuroscience* 10, no. 6 (June 2009): 423; Van der Kolk, *The Body Keeps the Score*, 56.

branches of the autonomic nervous system. The autonomic nervous system controls life preserving activity that takes place without conscious thought (breathing, circulation, digestion, etc.). The sympathetic nervous system is responsible for arousal activities including the fight-or-flight response. When engaged the sympathetic nervous system triggers the adrenal glands (sitting atop the kidneys) to secrete adrenaline, shunts blood to the muscles for quick action, speeds the heart rate, and increases blood pressure. The parasympathetic nervous system balances the sympathetic nervous system and engages systems related to long term preservation like digestion and wound healing. It slows down the arousal response with the release of acetylcholine reducing heart rate, lowering blood pressure, relaxing muscles and returning breathing to normal.⁸³

This survival system encompasses all the systems of the body. As with most other bodily functions, the brain is the control center of it all. Van der Kolk describes the human brain as consisting of three basic parts: the brain stem, the limbic brain, and the prefrontal cortex (PFC, also known as the neocortex).⁸⁴ The first part, the brain stem (which he and others holding to an evolutionary perspective call the “reptilian brain”) manages basic housekeeping functions including; arousal, sleep/wake, hunger/satiation, and breathing. The limbic brain (old-mammalian brain) is the second part and is responsible for mapping the relationship between the individual and his surroundings, emotional relevance, categorization, and perception. The limbic system is the name given to a variety of structures and functions in the brain that work together for self-preservation, as well as species preservation.⁸⁵ Third is the PFC (mammalian brain) which is responsible for planning and anticipation, sensing time and context, inhibition

⁸³ Van der Kolk, *The Body Keeps the Score*, 232.

⁸⁴ Van der Kolk, 59; Howard and Crandall, “Post Traumatic Stress Disorder: What Happens in the Brain?,” 7.

⁸⁵ Swenson, “Chapter 9: Limbic System,” 1.

control, and empathetic understanding.⁸⁶ In one sense, the functions of these parts can be broken down into thinking and non-thinking parts. The brain stem and limbic system make up the non-thinking part and the PFC the thinking part.⁸⁷ Within these larger sections of the brain are numerous distinguishable parts. There is no need to discuss them all; a few play vital roles in the fear response system (and its malfunction in the case of PTS), so a brief overview of their function is necessary.

The thalamus is a portion of the brain that houses many components. It functions as a major transfer station of information. Primarily it carries information between sensory organs and correlating regions of the brain.⁸⁸

The hypothalamus is the primary output node for the limbic system. It also has many inputs. It communicates with the autonomic system—gathering information like temperature, balance, blood pressure, and blood sugar levels. It also brings in data from the sensory organs (especially smell and sight). It also has various hormone receptors. The hypothalamus plays roles in a variety of functions including autonomic regulation, endocrine management, sexual responses and sleep/wake patterns (incorporating circadian rhythms to the day-night cycle).⁸⁹

The amygdala plays vital roles in processing survival responses, emotions, and memories. It helps interpret incoming sensory data for threats. It is involved in activating emotional responses and it helps to store the emotional component of memories.⁹⁰

⁸⁶ Van der Kolk, *The Body Keeps the Score*, 59; Howard and Crandall, “Post Traumatic Stress Disorder: What Happens in the Brain?,” 7.

⁸⁷ Howard and Crandall, 7–8.

⁸⁸ Daniel J. Siegel, *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are* (New York: Guilford Press, 1999), 10; Rand S. Swenson, “Chapter 10: The Thalamus,” in *Review of Clinical and Functional Neuroscience*, Online Version (Hanover, NH: Dartmouth Medical School, 2006), https://www.dartmouth.edu/~rswenson/NeuroSci/chapter_9.html; Van der Kolk, 60.

⁸⁹ Van der Kolk, *The Body Keeps the Score*, 60–61; Howard and Crandall, “Post Traumatic Stress Disorder: What Happens in the Brain?,” 7; Swenson, “Chapter 9: Limbic System,” 1–2.

⁹⁰ Van der Kolk, *The Body Keeps the Score*, 60; Howard and Crandall, “Post Traumatic Stress Disorder: What Happens in the Brain?,” 11; Roozendaal, McEwen, and Chattarji, “Stress, Memory and the

The hippocampus is another part of the limbic system. It plays key roles in the formation and retrieval of memories. It also has important functions in helping beings understand their spatial relationships to the surrounding environment.⁹¹

In a normally functioning brain, information comes from our sensory organs into the thalamus and is passed in two directions. The first path is to the amygdala which is responsible for evaluating information for emotional significance and survival needs. The second pathway travels through the PFC for rational interpretation of the data. The first path is milliseconds faster than the second. The amygdala and the PFC are both checking in with the hippocampus (*remember* it is involved in memory making and storage) for historic data related to the incoming stimuli.⁹²

The two pathways of stimulus interpretation are something most humans are quite familiar with through lived experience. When something triggers the sensation of a threat we often sense it before we recognize it cognitively. Just think about the last time someone jumped out at you when you walked around a corner in a dark basement. When that happened sensory data traveled to the amygdala and the PFC. Since the amygdala received the signal slightly faster it initiated the limbic system to engage a threat response before the signal had even reached the PFC. That threat response included a signal from the hypothalamus to the pituitary gland signaling the need for action hormones like norepinephrine (adrenaline) from the adrenal glands. The hypothalamus also engaged other systems through the autonomic nervous system's sympathetic nervous system, and

Amygdala," 423.

⁹¹ Van der Kolk, *The Body Keeps the Score*, 60, 69; Howard and Crandall, "Post Traumatic Stress Disorder: What Happens in the Brain?," 11; Swenson, "Chapter 9: Limbic System," 3–4; Yana Lokshina and Israel Liberzon, "Enhancing Efficacy of PTSD Treatment: Role of Circuits, Genetics, and Optimal Timing," *Clinical Psychology: Science & Practice* 24, no. 3 (September 2017): 299.

⁹² Van der Kolk, *The Body Keeps the Score*, 60–61; Howard and Crandall, "Post Traumatic Stress Disorder: What Happens in the Brain?," 11–12; Amy F. T. Arnsten et al., "The Effects of Stress Exposure on Prefrontal Cortex: Translating Basic Research into Successful Treatments for Post-Traumatic Stress Disorder," *Neurobiology of Stress* 1 (October 27, 2014): 90.

then you were prepared for action—fleeing or fighting in order to destroy or avoid the threat in your basement.

When we perceive the threat has ended (a function of the PFC), a signal is sent to the limbic system halting the sympathetic nervous system and engaging the parasympathetic nervous system. This initiates recovery and a return to homeostasis.⁹³ If your rational brain, PFC, recognizes that the person who jumped around the corner at you was your son playing a trick, it signals shutdown of the limbic system. However, you will already be experiencing the initiation of that system through more rapid heartbeat, changes in breathing, and perhaps a little shakiness from the adrenaline release. If, however, the PFC perceives the individual as a threat, the system stays engaged until you once again feel safe.⁹⁴

This system is a learning system. One of the key elements of a learning system is the connection between emotion and memory. Highly emotional situations, both positive and negative, embed themselves as memories to a much greater extent than regular everyday activity. These memories are often easier to recall and come back to us with greater clarity and detail.⁹⁵ Most humans will quickly attest to this. You may not remember what you had for lunch yesterday (unless it was amazing or the company was particularly delightful), but you probably remember highlights from your wedding day, the birth of your children, or the scariest moment of your life (unless that moment happens to be a traumatic event, in which case you may not remember it at all). Each event that engages the limbic system is stored away for future reference so that individuals can respond accordingly if they encounter similar circumstances later in life.

There are four “normal” responses to a threatening situation. Most people

⁹³ Van der Kolk, *The Body Keeps the Score*, 54.

⁹⁴ Van der Kolk, 62.

⁹⁵ Roozendaal, McEwen, and Chattarji, “Stress, Memory and the Amygdala,” 423.

recognize the first two, fight or flight, as positive adaptive responses. The second two, freeze and faint, are not as widely known and are often considered maladaptive or abnormal responses to a fearful situation. Freezing occurs when someone stops moving in the stress inducing moment—they hold still as though frozen in place. Fainting encompasses both actual loss of consciousness and dissociative episodes in which someone might remain conscious yet, in some sense, be separated from reality. Dissociative episodes include depersonalization, derealization, dissociative amnesia, out-of-body experiences, emotional numbness, and altered time perception.⁹⁶ Rather than viewing freezing or fainting as maladaptive responses, Van der Kolk argues that all four responses are adaptive responses derived through evolution. In his opinion, freezing is a mechanism mammals utilize to survive. Fainting is an extreme example of the freeze response in Van der Kolk's description. This response takes place when the organism at risk is unable to defend itself or flee the attack. In such a scenario, it separates its internal self from the external suffering through dissociation or losing consciousness.⁹⁷

Whether or not one agrees with Van der Kolk's inclusion of freezing and fainting as adaptive responses to threats, it is difficult to deny those responses are common among survivors of traumatic events. Having established the normal response of bodily systems when faced with danger we are now equipped to investigate the negative impacts associated with PTSD.

Modern technological advances have enabled researchers and clinicians to gain more intricate knowledge of the workings of the human brain. These insights and technologies can also be used to help identify problems that arise in the functioning of the brain. Brain function is extremely complex. It is the intricate and delicate interplay of

⁹⁶ Johanna Thompson-Hollands, Janie J. Jun, and Denise M. Sloan, "The Association between Peritraumatic Dissociation and PTSD Symptoms: The Mediating Role of Negative Beliefs about the Self," *Journal of Traumatic Stress* 30, no. 2 (April 2017): 190–94.

⁹⁷ Van der Kolk, *The Body Keeps the Score*, 82–83; Howard and Crandall, "Post Traumatic Stress Disorder: What Happens in the Brain?," 13, also describes dissociation as a beneficial reaction.

chemicals, currents of energy, structures within the brain, and the communication networks that connect them. Modern research, empowered by advances in technology, has identified negative impacts on each of these elements of the brain for those who have been diagnosed with PTSD.

Howard and Crandall offer a helpful summary of the common disruptions that occur in life due to the neurological impact of PTSD and a description of those impacts. They use the term trauma to refer to the events that, to this point, have been described as PTEs. In their description of the impact of PTSD on the brain, they point to the cause of PTSD as trauma that is “prolonged, extreme or repetitive.”⁹⁸ When a person undergoes experiences like this his or her brain is injured and the limbic system malfunctions in three primary ways: 1. the fight or flight response gets stuck in the on position, 2. the memories of the trauma are not appropriately “time stamped” so they can intrude and appear to be current reality, and 3. the ability to distinguish between relevant and irrelevant data goes off-line leading to inappropriate activation or inaction of the fight or flight response.⁹⁹ Each of these responses is linked to deleterious impact on particular portions of the brain involved in the fight/flight response, primarily the hippocampus, amygdala, and prefrontal cortex (PFC).¹⁰⁰

Modern PET scans and fMRI’s have enabled researchers to examine the brain in ways that were unavailable to previous generations. One of the key areas of the brain that undergoes structural and functional changes is the hippocampus. As noted earlier, the hippocampus is integral to memory formation and recall. Studies have shown that people diagnosed with PTSD tend to have decreased hippocampal volume compared to the

⁹⁸ Howard and Crandall, “Post Traumatic Stress Disorder: What Happens in the Brain?,” 14.

⁹⁹ Howard and Crandall, 14–15.

¹⁰⁰ Sara Antunes-Alves and Thea Comeau, “A Clinician’s Guide to the Neurobiology Underlying the Presentation and Treatment of PTSD and Subsequent Growth,” *Archives of Psychiatry & Psychotherapy* 16, no. 3 (September 2014): 10.

general population.¹⁰¹ This is especially true of those who were exposed to early childhood trauma, experienced repeated exposure to trauma, or have been struggling with PTSD for a long period of time.¹⁰²

Damage to the hippocampus influences memory. PTSD symptoms associated with this damage include traumatic amnesia resulting in a person's inability to remember aspects of the traumatic event or the event in its entirety.¹⁰³ It can also disrupt the storage of the memories making linear recall of the trauma as a continuous narrative difficult. Instead, the memory, if available at all, is available in scattered fragments that are not chronologically associated. Because of the role the hippocampus plays in memory and tying memory temporally and spatially, damage here can impact the ability to know the correct time and special context of a memory.¹⁰⁴ The hippocampus works with the DLPFC (dorsolateral prefrontal cortex) to place events in time contexts. When people have flashbacks, fMRI scans show the DLPFC going off-line. This contributes to the difficulty of intrusive memories feeling as though they are being relived in the present.¹⁰⁵

The hippocampus is a source of historical information for both the PFC and the amygdala. This data is used to determine if incoming stimuli pose a threat. PTSD is associated not only with a smaller hippocampus, but also with decreased connectivity to these other portions of the brain.¹⁰⁶ This dysconnectivity relates to the difficulty PTSD

¹⁰¹ Bremner, *Does Stress Damage the Brain?*, 61, 133.

¹⁰² Bremner, 61; Ansell et al., "Cumulative Adversity and Smaller Gray Matter Volume in Medial Prefrontal, Anterior Cingulate, and Insula Regions," 58, 61–62; Roozendaal, McEwen, and Chattarji, "Stress, Memory and the Amygdala," 430; Arnsten et al., "The Effects of Stress Exposure on Prefrontal Cortex," 90.

¹⁰³ Arnsten et al., "The Effects of Stress Exposure on Prefrontal Cortex," 90.

¹⁰⁴ Einat Levy-Gigi et al., "Association among Clinical Response, Hippocampal Volume, and FKBP5 Gene Expression in Individuals with Posttraumatic Stress Disorder Receiving Cognitive Behavioral Therapy," *Biological Psychiatry* 74, no. 11 (December 1, 2013): 797.

¹⁰⁵ Van der Kolk, *The Body Keeps the Score*, 68–69.

¹⁰⁶ Lokshina and Liberzon, "Enhancing Efficacy of PTSD Treatment," 299; Bremner, *Does Stress Damage the Brain?*, 63; Levy-Gigi et al., "Association among Clinical Response, Hippocampal Volume, and FKBP5 Gene Expression in Individuals with Posttraumatic Stress Disorder Receiving

sufferers have in filtering out relevant and irrelevant data. This can lead to the initiation of the fight or flight system when it is not needed as well as to lack of initiation during a truly threatening situation.

While the hippocampus tends to atrophy, shrink, and be less effective in people diagnosed with PTSD, the amygdala can experience dendrite growth and increased activity. The increased activity of the amygdala is highly involved with the stress response system including activation of the sympathetic nervous system, inducing the freeze response, and increasing startle response. Simultaneously, the overactive amygdala loses connectivity with the PFC which, under normal circumstances, overrides the amygdala and extinguishes the fear response when appropriate.¹⁰⁷ This negative interaction can manifest itself in the fight or flight system being turned on far longer than necessary and triggering at times when it is not needed.

The extended fear response is also facilitated by the other side of the mPFC/amygdala interaction. At the same time the amygdala is being turned up, the mPFC is being turned down. There is dendrite loss, causing atrophy in the PFC of the brain of someone struggling with PTS and chronic stress.¹⁰⁸

The combination of these structural and functional changes in the brain result in people who struggle to accurately interpret threatening situations, are thus induced to fear when they should not be, and sometimes fail to respond appropriately when threatened. The typical function of squelching the fear response is also inhibited so the person will remain at a heightened state of fear and alertness when the threat has long

Cognitive Behavioral Therapy,” 797.

¹⁰⁷ Arnsten et al., “The Effects of Stress Exposure on Prefrontal Cortex,” 89.

¹⁰⁸ Arnsten et al. “The Effects of Stress Exposure on Prefrontal Cortex,” 89; Erik B. Bloss et al., “Evidence for Reduced Experience-Dependent Dendritic Spine Plasticity in the Aging Prefrontal Cortex,” *Journal of Neuroscience* 31, no. 21 (May 25, 2011): 7831–39; H. Barbas et al., “Relationship of Prefrontal Connections to Inhibitory Systems in Superior Temporal Areas in the Rhesus Monkey,” *Cerebral Cortex* 15, no. 9 (September 1, 2005): 1356–70.

since passed preventing a return to homeostasis. It can also trigger memories that were improperly time-stamped in the first place and thus still feel like a present reality rather than a distant memory.

Why Biblical Counselors Should Know the Physiological Impacts of PTS

Biblical counselors will benefit greatly if they gain a basic understanding of the physiological impacts of PTS. Those who are diagnosed with PTSD gain comfort from knowing that their experiences are grounded in reality and that there are physiological explanations for the symptoms they have been suffering. Contemporary culture is saturated with science and scientific explanations for virtually everything. People coming for counseling have likely been exposed to some scientific or medical explanation for their problems. Knowing that the counselor is aware of these concepts gives the counselee greater confidence in the counselor's ability to help. Counselors also need to communicate these realities to the counselee to mitigate any of the counselee's unrealistic expectations. Frustration can arise in a counselee who is not experiencing change as quickly as he would like. Counselors who clearly communicate the challenges associated with this diagnosis can help to prevent or alleviate frustration. Having a wholistic understanding of the impacts of PTS can also help the counselor develop compassion for the person he is counseling.

Learning of the physiological impacts of PTS may tempt counselees to develop faulty interpretations of their situation. For instance, it may lead to a sense of hopelessness. The counselee may be thinking, "Since I went through an experience that altered the way my brain operates now I am stuck. There is no hope of changing or reversing the impact of my trauma." Biblical counselors armed with Scripture and scientific research can counter such thinking. The wonderful news both of these resources is that growth, healing, and change are possible even when our brain structure/function has been altered. The science actually shows that the negative alterations to brain

function are reversible and that these changes can be elicited through simple “talk-therapy.”¹⁰⁹ Faulty function can be reordered and regrowth of neurons can take place through a process called neurogenesis. If secular talk therapy can be effective at changing a person’s brain function, then imagine how much more hope can be given through the counsel provided in the Word of the One who created the human brain.

Understanding the neurological impact of PTSD can also help the biblical counselor gain compassion. First Thessalonians 4:15 ends by telling us to “be patient with all men.” Leading up to those words we are instructed to approach different categories of people with attitudes and methodologies appropriate to their particular situations. We are to “admonish the unruly, encourage the faint-hearted, help the weak.” Sometimes the actions and behaviors of those who struggle with PTS appear to come from an “unruly” heart when, in fact, they may be responding from a place of weakness. Consider a scenario that plays out fairly often in bedrooms of veterans impacted by PTSD.¹¹⁰ The veteran is asleep in bed. His spouse gets up in the middle of the night to get some water or use the restroom. Upon returning to the bedroom, the wife unintentionally startles the husband awake. Within an instant the husband has the wife pinned to the wall or the floor with his hands around her throat. Thankfully, many of these instances end when the veteran is brought to his senses and he releases his wife before any lasting harm is done. Understanding the nature of this man’s struggle helps those who are intervening in the situation treat him accordingly. While abuse has taken place he is not demonstrating the heart of an abuser. He should not be treated like the “unruly” abusive husband who chokes his wife every time she does not clean the dishes to his satisfaction.

¹⁰⁹ Levy-Gigi et al., “Association among Clinical Response,” 796–97; Barbas et al., “Relationship of Prefrontal Connections to Inhibitory Systems in Superior Temporal Areas in the Rhesus Monkey,” 1368; Arnsten et al., “The Effects of Stress Exposure on Prefrontal Cortex,” 89–91; Ansell et al., “Cumulative Adversity and Smaller Gray Matter Volume in Medial Prefrontal, Anterior Cingulate, and Insula Regions,” 57, 62.

¹¹⁰ I have personally interacted with multiple veterans who recounted these types of events.

Instead, he is treated differently because his heart, his motivations, and his capacities are all influenced by a real weakness that was inflicted upon him. Let me be clear, this does not mean that there are no repercussions or that he is completely without responsibility. There are steps the family will need to take to rectify the situation and prevent future incidents. He needs to take responsibility for his actions including measures to reconcile any relational damage with his wife. Most of all he should pursue counseling that will address the underlying issues that have resulted in this behavior. The counselor must treat him with compassion. His counsel must take into consideration these underlying physiological realities.

Considering the biological impact of trauma bolsters the counsel given not only by informing the counselor's compassion, but also by helping to manage expectations and inform methodology. Counselors need to be sure they have as full an understanding of the situation as possible—including the diagnosis of PTSD and any other comorbid diagnoses. Traumatic Brain Injury (TBI) is a fairly common comorbid diagnosis with PTSD especially among veterans of the recent conflicts in Iraq and Afghanistan (Iraq and Afghanistan Veteran is often abbreviated IAV in the literature or IAVA for Iraq and Afghanistan Veterans of America).¹¹¹ Counselors should take into consideration the potential impact of these traumatic experiences on the brain and limit the amount of cognitive homework that is assigned. Some common symptoms of PTS are difficulty concentrating, difficulty learning new things, problems with memory, etc. In biblical counseling, reading books as well as reading/memorizing Scripture are common

¹¹¹ Erin P. Finley et al., "Characteristics Associated With Utilization of VA and Non-VA Care Among Iraq and Afghanistan Veterans With Post-Traumatic Stress Disorder," *Military Medicine* 182, no. 11 (November 2017): 1892; Michael Schreiber and Geoffry Phillips McEnany, "Stigma, American Military Personnel and Mental Health Care: Challenges from Iraq and Afghanistan," *Journal of Mental Health* 24, no. 1 (February 2015): 54; David Daugherty, "Veterans in Messianic Judaism: An Examination of Transition From Military to Civilian Life" (Savannah, GA: South University, 2018), 64. Other common terms used to refer to veterans of the recent conflicts in Afghanistan and Iraq are GWOT (Global War on Terror) vets, and OEF or OIF veterans (referring to Operation Enduring Freedom or Operation Iraqi Freedom).

interventions. While these can still be effective tools for growth in the counseling process they might not be relied on as heavily as they would be for someone without these potential cognitive impairments. Again, each person is going to have a unique blend of symptoms and challenges, so counselors need to gather all the pertinent data early on in the counseling process and not base any aspect of counsel on assumptions. The neurological impact of trauma may also lead to a slower process of growth and change. Counselors, in general, should not put arbitrary timeframes on improvement. If they are accustomed to resolving most cases in less than 15 sessions, then they need to prepare themselves for potentially longer cases when dealing with PTS.

This is not to say that growth cannot happen quickly. One of the things that Mighty Oaks Foundation has noted is how rapidly participants in their program change. The men and women who go through the Legacy Program are only there for one week. By the time they leave the program, many would attest to having already experienced tremendous amounts of growth. The research conducted as a part of this dissertation demonstrates significant reduction of PTSD symptoms when tested six months after the program. We can never forget the fact that we are living and functioning in a world created by God Who works in mysterious and miraculous ways. No amount of physical damage can impede His plan.

Social Impact of PTS

The primary social impact of PTS is isolation of the person who is struggling. There are a litany of reasons for this isolation. Avoidance symptoms are a key component of the diagnosis of PTSD for many people. Most people who struggle with PTS are in the habit of avoiding people, places, scenarios, and any other stimuli that might remind them of the trauma or elicit distressing responses.¹¹² This active avoidance automatically limits

¹¹² American Psychiatric Association and DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 271.

the amount of social interaction one can have. Avoidance responses are compounded as the person experiences distressing symptoms in a growing number of situations and scenarios. For instance a trip to the local grocery store might never have been distressing prior to the experience of trauma. For a person who has been diagnosed with PTSD seemingly mundane activities like this can turn into a great source of stress and anxiety—possibly leading to dissociative episodes. Once someone has a response like this to an environment, it can become difficult for the person to revisit that environment. The grocery store can become a triggering stressor even if that environment had nothing to do with the initial traumatic event/s that led to the PTSD diagnosis (although sometimes there are parallel stimuli, i.e., crowds of people). The more negative experiences the person has the wider the array of stressors grows, and therefore the world in which they feel safe continues to shrink.

Feelings of shame can also contribute to isolation. People may feel embarrassed about the reactions they have associated with their PTS. Having a panic attack or other dissociative episode in public is often felt as humiliation and can cause the person never to want to be in public.

Shame regarding one's thoughts or actions can cause a person to isolate in another way. Many veterans report resistance to openly sharing their thoughts and experiences with family and friends, because they believe these revelations will lead people to view them as monstrous.¹¹³ Whether or not these thoughts are legitimate is irrelevant. The thoughts themselves keep the sufferer from having genuine relationships; they feel isolated even if friends and family are present on a regular basis.

The extreme nature of the suffering experienced by the person diagnosed with PTSD can lead him to the conclusion that no one else can truly understand what he has been through or is currently experiencing. This false belief also contributes to the

¹¹³ Shay, *Achilles in Vietnam*, xix, xxii, 33, 82–83.

temptation to isolate from relationships.

Criterion D symptoms can also greatly contribute to a person's isolation:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs). 2. *Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world.* 3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that *lead the individual to blame himself/herself or others.* 4. Persistent *negative emotional state* (e.g. fear, horror, anger, guilt, or shame). 5. *Markedly diminished interest or participation in significant activities.* 6. *Feelings of detachment or estrangement from others.* 7. *Persistent inability to experience positive emotions* (e.g., inability to experience happiness, satisfaction, or loving feelings).¹¹⁴ (emphasis added)

In addition to the shame one feels towards oneself, negative views about others and the world will lead to further isolation. If a person thinks that everyone is out to get her, everyone hates her, and that the world is only full of evil men, then she is not likely to pursue relationships—especially with the opposite sex. The experience of trauma often adds an additional layer of mistrust and suspicion atop all the normal barriers to deep, interpersonal connection. Many have been betrayed or violated by people they trusted or who were respected authorities in their lives (clearly this is true for those who have been assaulted or abused by family, coaches, pastors, etc.). Others have blamed various authorities or even God as a source of their trauma, finding them culpable for not intervening (e.g. military commanders for ordering certain operations or not providing requested support).¹¹⁵ This can create another barrier if you, the counselor, are perceived as some type of authority figure. The need for Christ-like humility and love is heightened in these relationships.

For members of the military and first responders, negative views about others leads to a significant reduction in relationships which they consider to be significant. These men and women face the temptation of believing that no one else can understand

¹¹⁴ American Psychiatric Association and *DSM-5* Task Force, *Diagnostic and Statistical Manual of Mental Disorders*, 271–72.

¹¹⁵ Shay, *Achilles in Vietnam*, 154.

what they have been through or how they live every day. They often form the opinion that “everyone else” has a faulty view of the world and does not understand life the correct way. Ironically, this can lead many military personnel to have an us-versus-them mentality toward the civilian population they swore to defend. Real and perceived betrayals by other members in the military or first responder agencies causes the circle of trust to shrink even farther. Only those close to the individual, who work alongside him, and see the world the way he does are considered trustworthy and worth fighting for.¹¹⁶

Not wanting to participate in significant activities one once found enjoyable will also reduce likelihood of developing or fostering relationships. Detachment and the inability to experience positive emotions also contribute to isolation. These things do not just cause the person to pull away from others, but often lead friends and family to remove themselves from the person struggling with PTS.

When close relationships begin to be negatively impacted or erode completely the person diagnosed with PTSD may conclude that he is the source of the problem. He may withdraw from these relationships in an attempt to mitigate or limit the damage he presumes his life is inflicting on others. In extreme cases this can lead one to suicidal ideation or action.¹¹⁷ As author, public speaker, and expert on extreme suffering Joni Eareckson Tada states, “Community breeds life. Isolation leads to death.”¹¹⁸

Loss of Work

The relational challenges listed above can make it difficult for a person to maintain employment. Difficulty relating to coworkers and superiors, poor attendance or

¹¹⁶ Shay, *Achilles in Vietnam*, 23–24; Kevin M. Gilmartin, *Emotional Survival for Law Enforcement: A Guide for Officers and Their Families* (Tucson, AZ: E-S Press, 2002).

¹¹⁷ Cngemi, Heather, “Fighting for Your Life,” video of personal testimony, Mighty Oaks Foundation, Paso Robles, CA, 2015.

¹¹⁸ Joni Eareckson Tada, “Emotions in the Face of Suffering,” a lecture presented at the annual conference of the Cristian Counseling and Educational Foundation, Chattanooga, TN, October 14, 2016.

performance at work due to severe struggles associated with PTS, and other challenges associated with PTS can lead to a person's termination. It is not legal to discriminate against individuals based solely on a diagnosis of PTSD. However, if persons are unable to perform the jobs for which they were hired or threaten the safety of the workplace due to their symptoms, then they can be terminated.¹¹⁹

Homelessness is an extreme negative social outcome. It is not surprising that those who have difficulty holding down work and maintaining relationships might end up homeless. One recent study found that a diagnosis of PTSD is a significant risk factor for OEF-OIF (Operation Enduring Freedom, Operation Iraqi Freedom) veterans ending up homeless.¹²⁰ In addition to the veteran population, other studies point to the correlation between PTSD or exposure to trauma and homelessness.¹²¹

The social consequences felt by those who wrestle with PTS are significant and can lead to loss of life. Even for those who do not ultimately take their own lives, the isolation they experience along with the difficulty they face both in building or maintaining relationships and interacting during regular societal function can lead them to doubt the value of the life they continue to live. Next we will examine the negative religious impact that often accompanies PTS.

¹¹⁹ "Depression, PTSD, & Other Mental Health Conditions in the Workplace: Your Legal Rights," U.S. Equal Employment Opportunity Commission, accessed November 6, 2019, https://www.eeoc.gov/eeoc/publications/mental_health.cfm.

¹²⁰ Stephen Metraux et al., "Risk Factors for Becoming Homeless among a Cohort of Veterans Who Served in the Era of the Iraq and Afghanistan Conflicts," *American Journal of Public Health* 103, no. S2 (December 2, 2013): 259.

¹²¹ Alison B. Hamilton, Ines Poza, and Donna L. Washington, "'Homelessness and Trauma Go Hand-in-Hand': Pathways to Homelessness among Women Veterans," *Women's Health Issues* 21, no. 4 (July 2, 2011): S203–9; Angela Browne, "Family Violence and Homelessness: The Relevance of Trauma Histories in the Lives of Homeless Women," *American Journal of Orthopsychiatry* 63, no. 3 (July 1993): 370; Julia Woodhall-Melnik et al., "Men's Experiences of Early Life Trauma and Pathways into Long-Term Homelessness," *Child Abuse & Neglect* 80 (June 2018): 216–25; John Coates and Sue McKenzie-Mohr, "Out of the Frying Pan, into the Fire: Trauma in the Lives of Homeless Youth Prior to and during Homelessness," *Journal of Sociology and Social Welfare* 37 (2010): 65; Benjamin R. Davies and Nicholas B. Allen, "Trauma and Homelessness in Youth: Psychopathology and Intervention," *Clinical Psychology Review* 54 (June 2017): 17–28.

The Religious Impact of PTS

For the purposes of this dissertation, the religious impact of PTS will refer to two primary aspects of a person's life: his religious experience and practice, and the internal beliefs associated with his stated religion.

One way to describe the negative religious impacts associated with PTS is "religious strain." Religious strain includes ". . . feeling alienated from one's Higher Power, shame, guilt, or fear related to sin or perceived sin, expectations of punishment or abandonment from a Higher Power, or difficulties in relationships with leadership or peers in a faith community."¹²² One's relationship to God (or whatever Higher Power one believes in) is a vital and essential component of one's religious experience. Feeling alienation, abandonment, betrayal, or condemnation from God or from those one worships alongside will significantly impact one's life. Those who see their higher power as a source of hope and support tend to handle trauma better and grow amidst suffering. Those who see their god as a source of condemnation struggle to recover after a traumatic experience. The same is true for one's experience with his faith community.¹²³ These perceptions can impede a person's participation in religious activities, communities, and practices.

The internal struggles that a person faces in the aftermath of trauma are also components of the religious impact of trauma. A few common internal spiritual struggles involve a sense of being out of control, a loss of hope, and struggles with forgiveness.

Feelings of guilt and shame are significant struggles for many who have been through traumatic events. Forgiveness is the solution offered through some religions to address these negative feelings, thoughts, or states of existence. But, forgiveness is complicated. For combat veterans, it is not always clear if those feelings of guilt or shame

¹²² Harris et al., "The Effectiveness of a Trauma Focused Spiritually Integrated Intervention for Veterans Exposed to Trauma."

¹²³ Harris et al.

are legitimate.

In the “fog of war,” the perception of how events occur can leave Marines and sailors yearning to be forgiven for *real or imagined* mistakes or even events for which they share no blame. The effect of forgiveness can even go deeper when individuals hold deep anger against enemies who killed their friends in combat. The intense emotions of combat and trauma seem to color the worldview of PTSD veterans...¹²⁴ (emphasis added)

One example of a faulty source of shame is known as survivor’s guilt. It is common among combat veterans. Survivor’s guilt occurs in a number of situations. There is a general survivor’s guilt felt by combat veterans because they survived when so many others were killed in the same war in which they fought. The focus also narrows if the survivor was engaged in a particular battle where many were killed. There are additional examples of very acute survivor’s guilt when one soldier traded place with another on a particular mission and the person they traded places with ends up being killed.

False guilt and shame are not limited to combat veterans.¹²⁵ Some victims of rape feel guilty, believing they were somehow responsible for the crime committed against them. This is compounded if they were engaged in inappropriate behavior leading up to the attack. No matter what a person has done prior to being raped she does not bear the responsibility and guilt for the violation perpetrated against her.

Survivor’s guilt and the guilt of some rape victims are just two examples of false guilt and shame. But then there are instances where the guilt/shame question cannot be answered so easily. Some veterans I have counseled struggled because they felt guilt and shame over incidents that were not so cut and dry. They have been involved in shootings that were technically justifiable under the rules of engagement (ROE) but may

¹²⁴ William Everett Middleton, “Ears to Hear: Preaching to a Military Community during a Time of War and PTSD” (PhD, diss., Pittsburg Theological Seminary, 2012), 9.

¹²⁵ The term “false guilt” is not the most helpful way to distinguish various reasons people have feelings of guilt and shame. I choose to use it because it is widely used in the literature and I want to address the issue without distracting from the main arguments. An excellent discussion of alternative categories can be found in the following article: Robert Jones, “Distinguishing Between Guilt and Guilt,” *Biblical Counseling Coalition* (blog), July 18, 2017, <http://biblicalcounselingcoalition.org/2017/07/18/distinguishing-between-guilt-and-guilt/>.

have led to the death of innocent people. Others have been responsible for bombings that killed the primary target but also killed non-combatants. The mental calculus military commanders have to employ in combat determining the value of lives saved over those taken does not always ease the consciences of those involved in the killing.

Each person will respond to these things differently. How one's conscience is informed influences whether or not you will feel guilt or shame related to certain experiences. For instance, one veteran shared that the first time he killed someone in combat he was conflicted because he was going against a lifetime of teaching that "thou shall not kill."¹²⁶ Whereas another veteran said, "It's never about the killing."¹²⁷

Then there are the incidents where the person who is struggling with guilt and shame were clearly in the wrong and those feelings are completely justified. He feels guilt because he is guilty.

Some forms of therapy address false guilt. For instance, Cognitive Processing Therapy (CPT) helps the client coming for counseling by challenging or confronting certain "stuck points" in their thinking. A common "stuck point" is false guilt. Jamie Lowe recorded her own experience with CPT. In her counseling the counselor confronted her on specific thoughts she had that contributed to her having a sense of guilt related to an incident where she was sexually assaulted.¹²⁸ In her case, and many others changing their perception of the circumstance leads to tremendous relief. But what if the "stuck point" is real guilt? What if the person is guilty of a crime? What hope is there for them?

Secular therapeutic models cannot address guilt and shame like religion can. Religions offer various solutions to rid one of guilt and shame often revolving around

¹²⁶ Eugene Cuevas, *Honoring the Code: Warriors and Moral Injury*, DVD (Crosswinds Foundation, 2016).

¹²⁷ The Mighty Oaks Warrior Program, "Interview: USN Seal Lt. Mark L. Donald (Ret.)," 56:00, accessed July 14, 2017, <http://www.mightyoaksprograms.org/mighty-oaks-podcast-show-003/>.

¹²⁸ Jamie Lowe, "Ten Sessions," This American Life, n.d., <https://www.thisamericanlife.org/682/ten-sessions>.

forgiveness. Christianity offers the guilty forgiveness for sin. The forgiveness is not merely overlooking or pardoning sin. Christianity requires payment of a just penalty for the crime. But that payment is not paid by the one being forgiven, it was paid by Jesus Christ. Substitutionary atonement satisfies both the just wrath of God as well as the guilty conscience of the forgiven satisfying the God given understanding of justice.

Many of those impacted by trauma, regardless of the nature of the traumatic events, report experiencing a sense of absolute loss of control.¹²⁹ This feeling often remains with individuals long after the traumatic event has stopped. They can be left with an extreme sense of fear wondering when the next traumatic event will occur. This fear undoubtedly accounts for some aspect of individual states of hyper-alertness. Another feeling they might experience is a sense of helplessness. For some this stance of hyper-alertness may be grounded in the belief that if I can anticipate the next threat, then I will be able to prevent it. For others the feelings of helplessness overwhelm them and they give up on attempts to live in the world either through isolation or suicide.

Helplessness has a companion: hopelessness. Those who have been through intense suffering often lose a sense of hope. Two common ways this manifests is a loss of a view that things will work out or a belief that there tends to be more bad in the world than good. This is common among combat veterans who come face-to-face with humans enacting great evil in the world.¹³⁰

For some the traumatic experiences they have lived through do not just challenge aspects of their faith but can threaten to undermine their faith all together. Sometimes this is described as a crisis of faith.¹³¹ The testimony of Captain Matt Meyer

¹²⁹ David Powlison, "Gripping Fears" (address given at the of the Association of Certified Biblical Counselors conference, "The Gospel & Mental Illness," Sun Valley, CA, 2014).

¹³⁰ Middleton, "Ears to Hear," 4; Lieutenant General Jerry Boykin, Telephone interview by author, October 23, 2017; Chad M. Robichaux, *An Unfair Advantage: Victory in the Midst of Battle* (Manassas, VA: Making Life Better Publishing, 2017).

¹³¹ Paul Randolph, "Post-Traumatic Distress," *The Journal of Biblical Counseling* 25, no. 3

demonstrates this point well. Captain Meyer served as Company Commander over “Chosen Company” during the battle of Wanat—one of the worse days of combat in U.S. Army history. To give some context, Jason Hovater was a strong Christian who encouraged the faith of his fellow soldiers and kept his entire unit laughing with antics and impersonations. His life was cut short a month from his twenty-fifth birthday when an enemy round deflected off the night vision mount on his helmet and into the center of his face.

Matt Myer saw the foundations of his belief in God and Christianity shaken to the core after the horrors of Wanat. He had been raised with the faith that Jesus died for everyone’s sins and believing in Him was an avenue to paradise. There was a contract with God which held that a good person doing good deeds would see blessing and favor. But he knew that Jason Hovater lived this kind of life, and Myer could not forget the image of that young soldier’s destruction. It would be years of thought and contemplation, part of that time spent working with an Army chaplain, before Myer began to reconcile those religious contradictions. He found solace in the book *When God Weeps*, by Joni Eareckson Tada, a woman confined for decades to a wheelchair who discusses how a loving God allows suffering and the opportunity to appreciate unexpected blessings.¹³²

One significant pre-traumatic factor that played a role in Meyer’s religious experience was his faulty understanding of the Christian faith. He believed that being a good Christian would lead one to blessings in this life (including protection in combat) in addition to blessings in the life to come. This idea conflicts with the Bible’s teaching that Christians will suffer greatly (Matt 10:16-39, John 15:18-25, 1 Pet 4:12-19), but that God intends that suffering to foster spiritual growth in us and to bring glory to His name (Rom 5:3-5; 8:28-30, Jas 1:2-4). His faith might not have been so shaken had he been raised to understand the world through a correct biblical understanding. Captain Meyer’s previous religious beliefs came into conflict with the reality he perceived through his experience. When something like this occurs, a person must choose either to abandon or adapt their prior deeply held belief or abandon or adapt their perception of reality. Fortunately for

(Summer 2007): 10.

¹³² Gregg Zoroya, *The Chosen Few* (Boston, Da Capo, 2017), 349.

Captain Meyer, he kept pursuing resolution and was brought to a renewed faith.

Unfortunately for others, the resolution to the internal conflict is abandonment of their faith.

While this section has focused on the negative religious impact of trauma, there are some who have an opposite response. The next section will address what has become known as post-traumatic growth.

Post-Traumatic Growth

Examining all the deleterious effects of PTSD can leave one feeling helpless, hopeless, and with a very pessimistic outlook of the future. However many, even in the secular community, are now promoting the concept of post-traumatic growth. This is the idea that one can move past the distress caused by trauma and go forward into growth. The term post-traumatic growth is relatively recent but the concept dates back thousands of years.¹³³ There is an ever-growing body of research supporting this concept in the field; more publications are being released on the topic every year.¹³⁴

Treatments for PTSD

This section will describe various treatments of PTSD. It would be impossible to list or evaluate all the possible treatments for PTSD in a single dissertation. Therefore,

¹³³ Jocelyn A. Lee et al., “Confirmatory Factor Analysis of the Posttraumatic Growth Inventory with a Sample of Soldiers Previously Deployed in Support of the Iraq and Afghanistan Wars,” *Journal of Clinical Psychology* 66, no. 7 (July 2010): 814.

¹³⁴ Bret A. Moore and Walter Penk, eds., *Treating PTSD in Military Personnel: A Clinical Handbook*, 2nd ed. (New York: The Guilford Press, 2019); Moore and Penk, 415; Lee et al., “Confirmatory Factor Analysis of the Posttraumatic Growth Inventory with a Sample of Soldiers Previously Deployed in Support of the Iraq and Afghanistan Wars”; J Irene Harris et al., “Coping Functions of Prayer and Posttraumatic Growth,” *The International Journal for the Psychology of Religion* 20, no. 1 (January 2010): 26–38; Sena Moran, Judy Schmidt, and Eileen J. Burkner, “Posttraumatic Growth and Posttraumatic Stress Disorder in Veterans,” *Journal of Rehabilitation* 79, no. 2 (April 2013): 34–43; Muriel A. Hagenars and Agnes van Minnen, “Posttraumatic Growth in Exposure Therapy for PTSD,” *Journal of Traumatic Stress* 23, no. 4 (August 2010): 504–8; Anne C. Wagner et al., “The Role of Posttraumatic Growth in a Randomized Controlled Trial of Cognitive-Behavioral Conjoint Therapy for PTSD,” *Journal of Traumatic Stress* 29, no. 4 (August 2016): 379–83; Lawrence G. Calhoun and Richard G. Tedeschi, eds., *Handbook of Posttraumatic Growth: Research and Practice* (Mahwah, NJ: Lawrence Erlbaum Associates, 2006).

this section will discuss the primary evidence-based treatments approved by the DOD and VA, and some spiritually based interventions. These categories of treatment will give a good sample of what is being utilized and provide comparative data for the research that is original to this dissertation.

Evidence Based Treatments

A wide range of treatment options are being explored in an attempt to address the epidemic of PTSD diagnoses especially among the veteran population. *Treating PTSD in Military Personnel: A Clinical Handbook* summarizes various treatments that have gained approval (for use among military and veteran populations) by the VA and the DoD.¹³⁵ This resource provides an overview of the treatments, a review of research supporting the effectiveness of each one, and strengths and weaknesses of each treatments application within the military community. I will utilize this resource, supplemented by others, to explain the primary treatments offered to military personnel.

Some studies have indicated that pharmacological interventions can provide help for those with PTSD but current research indicates that the benefits of these drugs, especially for combat veterans, do not outweigh the negative side effects. Thus the VA does not recommend pharmacotherapy as a first-line treatment option for veterans diagnosed with PTSD.¹³⁶ Therefore, pharmacological interventions will not be discussed.

¹³⁵ Moore and Penk, *Treating PTSD in Military Personnel: A Clinical Handbook*, 2nd ed.; Joseph Maio and Kendra Jorgensen-Wagers, “Efficacy of Group Cognitive Processing Therapy in an Intensive Outpatient Trauma Program for Active Duty Service Members with Posttraumatic Stress Disorder,” *Best Practice in Mental Health* 14, no. 2 (Fall 2018): 65. Bret A. Moore and Walter Penk, *Treating PTSD in Military Personnel: A Clinical Handbook* (New York: The Guilford Press, 2011).

¹³⁶ Michael J. Ostacher and Adam S. Cifu, “Management of Posttraumatic Stress Disorder,” *Journal of the American Medical Association* 321, no. 2 (January 15, 2019): 200–201; Kathleen Brady et al., “Efficacy and Safety of Sertraline Treatment of Posttraumatic Stress Disorder: A Randomized Controlled Trial,” *Journal of the American Medical Association* 283, no. 14 (April 12, 2000): 1837–44; Jonathan R. T. Davidson et al., “Multicenter, Double-Blind Comparison of Sertraline and Placebo in the Treatment of Posttraumatic Stress Disorder,” *Archives of General Psychiatry* 58, no. 5 (May 1, 2001): 485–92; B. A. van der Kolk et al., “Fluoxetine in Posttraumatic Stress Disorder,” *The Journal of Clinical Psychiatry* 55, no. 12 (December 1994): 517–22; R. D. Marshall et al., “Efficacy and Safety of Paroxetine Treatment for Chronic PTSD: A Fixed-Dose, Placebo-Controlled Study,” *The American Journal of Psychiatry* 158, no. 12 (December 2001): 1982–88; Bessel A. Van der Kolk et al., “A Randomized Clinical Trial of Eye Movement Desensitization and Reprocessing (EMDR), Fluoxetine, and Pill Placebo in the

Instead this section will focus on non-pharmacological treatments that have gained wide acceptance and approval by the DoD and VA.

The most recent VA protocols recommend the use of “individual, manualized trauma-focused psychotherapy (TFP) that has a primary component of exposure and/or cognitive restructuring” over the use of pharmacological interventions.¹³⁷ As of the fall of 2018, three treatments were considered to have met these guidelines for the DoD: prolonged exposure therapy (PE), cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR).¹³⁸ Because of the acceptance of these treatments the review of treatments will be limited in scope to a review of them. There have been many studies conducted to verify the effectiveness of these treatments. Tables eight and nine include summary information from some of these studies to offer a comparison to the data gleaned from the MOES research.

Cognitive Behavioral Therapies

Cognitive Behavioral Therapy (CBT) is a broad term that includes a variety of psychological treatments that focus on changing the patient’s thinking as the key component of therapy. Trauma-Focused CBT (TFCBT) tends to involve at least one (or some mixture of) the following elements: exposure therapy, cognitive restructuring, or stress inoculation training.¹³⁹ The three therapies that will be examined below all seek to help the person by changing some aspect of his thinking. The goal is to help the client confront, reprocess, or change faulty thinking to align with some new, better, or more

Treatment of Posttraumatic Stress Disorder: Treatment Effects and Long-Term Maintenance,” *Journal of Clinical Psychiatry* 68, no. 1 (2007): 37; Bremner, *Does Stress Damage the Brain?*, 249–55.

¹³⁷ Ostacher et al., “Management of Posttraumatic Stress Disorder.”

¹³⁸ Maio and Jorgensen-Wagers, “Efficacy of Group Cognitive Processing Therapy,” 65.

¹³⁹ Elizabeth A. D. Lee, “Complex Contribution of Combat-Related Post-Traumatic Stress Disorder to Veteran Suicide: Facing an Increasing Challenge,” *Perspectives in Psychiatric Care* 48, no. 2 (April 2012): 111.

adaptive thinking. The therapies will often include an element of meaning-making relating to the trauma the client encountered.

Exposure therapy. Exposure Therapy is thought to be effective because it helps individuals overcome impaired extinction of conditioned feared responses.¹⁴⁰ It is supposed to help a person regain the ability to calm down when his fear response is activated.

Prolonged Exposure Therapy (PE) is a cognitive-behavioral therapy (CBT) that integrates the principles of exposure therapy into the framework of emotional processing theory. It is a manualized treatment that has four primary components. These are administered in ten to twelve, 90-minute, individual treatment sessions. Sessions happen once or twice weekly. Homework assignments are given between treatments. The primary components include (1) education about common reactions to trauma, (2) repeated recollection of traumatic memories through imaginal exposure during treatment sessions, (3) repeated exposure to troubling stimuli the patient has been avoiding through *in vivo* exposure homework assignments, and (4) training in breathing techniques.¹⁴¹

The rationale behind PE is that survivors of trauma have been overwhelmed by their trauma to a point where they are no longer able to distinguish between dangerous and safe scenarios. The belief is that negative thoughts about the world and about one's self lead to excessive fear. Confronting those fears rather than avoiding them will allow one to replace maladaptive cognitions with adaptive ones, thus allowing the person to return to a place where she can experience proper emotional responses to given circumstances.

In the early stages of treatment, work is done to build rapport with the client as

¹⁴⁰ Kim Felmingham et al., "Changes in Anterior Cingulate and Amygdala After Cognitive Behavior Therapy of Posttraumatic Stress Disorder," *Psychological Science* 18, no. 2 (February 2007): 127.

¹⁴¹ Moore and Penk, *Treating PTSD in Military Personnel*, 2019, 42-43.

the clinician discusses the rationale for treatment and describes the process.

Psychoeducation includes discussion of the rationale behind PE, practices and procedures that will be implemented in the treatment, as well as common responses to trauma. As rapport is established, the clinician is also gathering data on the patient's traumatic history. One purpose is to identify particular traumatic memories that will later be targeted in the treatment program. Each session is carefully controlled and scripted in the clinician's manual. Patients also have a corresponding workbook to utilize in sessions and for homework.¹⁴² Other aspects of the treatment described early on include the purpose of prolonged exposure therapy and the introduction of methods including breathing, SUD scale (Subjective Units of Distress), *in vivo* exposure (exposure in life), and imaginal exposure (reimagining specific traumatic events).¹⁴³

Early sessions identify traumatic memories as well as common stress inducing triggers in the person's life. The clinician develops a hierarchy of stressful situations and traumatic memories to be targeted. The sessions will contain a significant amount of imaginal exposure with the clinician supportively walking the client through reimagining particular traumatic memories. The client recalls the events and with the help of the clinician gauges levels of distress using the SUD scale (the scale ranks the clients subjective experience of stress on a ten-point scale from no stress to severe stress). Homework often involves listening to recorded sessions and *in vivo* exposure during which the client is forced to confront stress inducing situations in real life and monitor distress with the SUD scale. The hope is that as treatment goes on SUD scores will decrease. Clients can continue to utilize breathing, *in vivo*, and imaginal exposure with

¹⁴² Edna B. Foa, Elizabeth Ann Hembree, and Barbara Olasov Rothbaum, *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences: Therapist Guide*, Treatments That Work (New York: Oxford University Press, 2007).

¹⁴³ Moore and Penk, *Treating PTSD in Military Personnel*, 2019, 46.

the SUD scale after sessions end to further reduce symptoms.¹⁴⁴

Research demonstrates that PE had wonderful results including large effect sizes, a majority of individuals achieving remission, and clinically significant reduction in PTSD symptoms. As of 2019 the majority of randomized controlled trials (RCTs) on Exposure Therapy had been conducted on civilians. There is a growing number of these studies being conducted on the military population but the results are much more modest than those found in the civilian studies.¹⁴⁵

Cognitive processing therapy. Cognitive Processing Therapy (CPT) is based on the cognitive theory of PTSD. This theory posits six core themes or schemas (safety, trust, power and control, self-esteem, intimacy, and blame and responsibility) by which humans process and organize incoming information.¹⁴⁶ Disruptions to these schemas take the form of “stuck points” which are faulty self-statements that often disrupt preexisting positive beliefs or reinforce negative ones about self and others. The goal of CPT is to identify, confront, and change those faulty stuck points into true positive impact statements.¹⁴⁷

CPT is a manualized treatment that is thoroughly structured. There are three primary phases of the care (typically spread out over 12 weeks) with one 60-minute session per week and one follow up session a month after the main treatment has ended. Treatment can be extended but it is recommended that it be completed within 20 weeks total time.¹⁴⁸ The treatment has been tested in different modified formats by compressing

¹⁴⁴ Moore and Penk, *Treating PTSD in Military Personnel*, 2019, 46.

¹⁴⁵ Moore and Penk, 2019, 46.

¹⁴⁶ Maio and Jorgensen-Wagers, “Efficacy of Group Cognitive Processing Therapy in an Intensive Outpatient Trauma Program for Active Duty Service Members with Posttraumatic Stress Disorder,” 66.

¹⁴⁷ Moore and Penk, *Treating PTSD in Military Personnel*, 2019, 63.

¹⁴⁸ Kristen H. Walter et al., “Evaluation of an Integrated Treatment for Active Duty Service Members with Comorbid Posttraumatic Stress Disorder and Major Depressive Disorder: Study Protocol for

the schedule and conducting sessions individually or in groups.¹⁴⁹

The three phases of CPT include: Phase 1 where information is gathered to identify stuck points (sessions 1-4). Phase 2 is the challenge phase and takes place during sessions 5-7. Phase 3, change, takes place during sessions 8-12. Here the stuck point is replaced with an accurate understanding of the event along with corresponding appropriate emotions and responses.

More and more studies are being conducted to determine the effectiveness of treatments for PTSD among the military population. A recent study that is one of the largest published using a military population, compared group and individual CPT. The study found that both individual and group CPT are effective at reducing PTSD symptoms but that the individual CPT is more effective.¹⁵⁰

Eye movement desensitization reprocessing (EMDR).

EMDR is an exposure treatment in which patients perform saccadic eye movements while thinking about a traumatic experience. Rather than providing a chronological narrative of the details of the traumatic event, as is done in CBT, EMDR patients are encouraged to follow their own course, moving freely backward and forward in time, attending to inner sensations and cognitions omitting verbal communication about content if they wish.¹⁵¹

This treatment has gained significant interest but has also been met with a great deal of skepticism. Watching the treatment sessions of some individuals fuels the skepticism because it can look like the therapist is simply moving a finger back and forth in front of the client's face. The client follows the movement with her eyes and may or may not talk about what she is thinking.

a Randomized Controlled Trial,” *Contemporary Clinical Trials* 64 (January 2018): 153.

¹⁴⁹ Moore and Penk, *Treating PTSD in Military Personnel*, 2019, 63.

¹⁵⁰ Patricia A. Resick et al., “Effect of Group vs Individual Cognitive Processing Therapy in Active-Duty Military Seeking Treatment for Posttraumatic Stress Disorder: A Randomized Clinical Trial,” *Journal of the American Medical Association Psychiatry* 74, no. 1 (January 1, 2017): 28–36.

¹⁵¹ Van der Kolk et al., “A Randomized Clinical Trial of Eye Movement Desensitization and Reprocessing (EMDR), Fluoxetine, and Pill Placebo in the Treatment of Posttraumatic Stress Disorder,” 2.

EMDR is a treatment that has been shown to be effective even though the mechanism for change and the underlying theory are works in progress.¹⁵² Francine Shapiro developed this treatment and hypothesizes that the psychopathology, PTSD in this case, results from dysfunctional neural storage of memories. This concept is known as adaptive information processing (AIP). When a person has an improperly stored memory, especially a traumatic one, it causes difficulty in life. AIP posits that focusing on some internal stimuli like an image, thought, emotion, or sensation, while at the same time giving a level of attention to rhythmic external stimuli known as bilateral stimulation (BLS) such as eye movements, auditory tones, or kinesthetic vibrations triggers a mechanism in the brain that enables the memory to be stored properly.¹⁵³

EMDR is not manualized and has been reported to be effective for some after just one session. Studies involving combat veterans have shown effectiveness with as few as four back-to-back sessions and up to eight with those wounded in combat.¹⁵⁴ The treatment consists of eight phases: Phase I is a standard data gathering phase. Phase II prepares the client for treatment teaching him about the process, helping him be comfortable, testing eye movement, and coaching him in certain therapeutic skills. Phase III, assessment, seeks to identify target memories by asking the client to be aware of the trauma and its sensations, images, thoughts, or other stimuli associated with the traumatic memory. SUDS scale is used to determine a baseline for the level of distress experienced by the client at this time. During assessment the client also develops a “preferred positive cognition” (PC), which is an adaptive self-statement related to the traumatic memory. A scale called the Validity of Cognitions Scale (VoC) is used to assess the perceived truthfulness of the cognition between 1—completely untrue to 7—completely true.

¹⁵² Moore and Penk, *Treating PTSD in Military Personnel*, 2019, 78.

¹⁵³ Moore and Penk, 2019, 78.

¹⁵⁴ Moore and Penk, 2019, 78.

Evaluation of the VoC is ascertained with this question, “When you think of the incident, how true do these words (repeat the positive cognition) feel to you now on a scale of 1-7, where 1 feels completely false and 7 feels completely true?”¹⁵⁵ A baseline rating of the PC is established with the VoC during assessment as well. Phase IV is the desensitization phase. In this phase the client focuses on the chosen stimuli associated with the trauma while the clinician initiates BLS for 24 back and forth rhythms in around 10 seconds. After the BLS the clinician asks a very open-ended question like, “What are you aware of now?” If there is some change or movement in the person’s perception, then another round of BLS is conducted. This cycle repeats until there is no movement or a SUDS score of 0-1 is achieved signaling desensitization. If there is no movement then the clinician may utilize some intervention to unblock movement (switching direction of BLS, CBT type intervention, etc.). Phase V is called installation. This phase switches from processing out the troubling memory to installing a preferred one. The client focuses on the PC while undergoing BLS. A similar cycle to that above is initiated, until the client reaches a score of 6-7, on the VoC.

Some critics of EMDR come from the PE world. They argue that the effective mechanism in EMDR is not the eye movement or other physical distractors but the fact that the person is undergoing exposure therapy, by recounting their traumatic experiences, in the treatment. One key study that purports to demonstrate the extreme effectiveness of EMDR may have been “contaminated” with Exposure Therapy because “all subjects in this study were exposed to 2 personalized trauma scripts that involved intense confrontation with their traumatic memories.”¹⁵⁶ This adds fuel to the claims of Exposure therapists that the effective element of EMDR is exposure and not the eye

¹⁵⁵ Louise Maxfield and Roger M. Solomon, “Eye Movement Desensitization and Reprocessing (EMDR) Therapy,” <https://www.apa.org>, accessed November 13, 2019, <https://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing>.

¹⁵⁶ Van der Kolk et al., “A Randomized Clinical Trial of Eye Movement Desensitization and Reprocessing (EMDR), Fluoxetine, and Pill Placebo in the Treatment of Posttraumatic Stress Disorder,” 8.

movement.

Despite the growing interest in EMDR and the number of studies that are being conducted to validate it, neither the VA nor DoD have conducted any RCT to determine its effectiveness in the military population since 1998.¹⁵⁷ Numerous RCT's have been conducted within the civilian population and other research methods have been employed for military personnel to include case studies, non-randomized-uncontrolled-trials, and archival record review. These studies demonstrate significant evidence that EMDR is effective at treating PTSD in the military population and should inspire RCT's to validate these claims in the future.¹⁵⁸

Common themes and weakness. As mentioned above the three treatments just discussed have many similarities. While the theory undergirding the problem and the mechanisms of change are different they all rely on changing thoughts. EMDR is trying to help someone correctly process memories, CPT is challenging “stuck points” that are faulty maladaptive thoughts that need to be replaced with correct adaptive ones, and Exposure Therapy is helping someone replace maladaptive cognitions related to certain stimuli or memories with adaptive cognitions.

The goal of each of these modes of treatment reinforce the central theme of this dissertation that helping a person correctly understand her life and the traumatic experiences she encountered is at the heart of providing hope and help to overcome PTS.

One of the potential weaknesses with the treatments given above is that there is little to no standard of veracity for the positive/adaptive cognitions that are to replace the maladaptive ones. The replacement thoughts are provided by the counselor or the client and are completely subjective. There is actually no requirement that they comport with

¹⁵⁷ Moore and Penk, *Treating PTSD in Military Personnel*, 2019, 78.

¹⁵⁸ Moore and Penk, 2019, 78.

reality.

Spiritual/Religious-Based Treatments

How one defines spirituality or religion will greatly influence what one regards as a spiritual or religious intervention. One study of spirituality in the health field offers the following definition for spirituality: “having meaning, purpose in life, transcendence, or connectedness to a higher being, force or energy.”¹⁵⁹ Religion is defined in another article as, “A set of fixed beliefs and practices held by a specific group or tradition.”¹⁶⁰ Working from these definitions one group of researchers attempted a meta-analysis of spiritual/religious treatments that have been empirically tested for the treatment of PTSD among the veteran population.¹⁶¹ After initially identifying 385 studies, they eliminated all but eight from inclusion in their study. Of those eight that made the cut, five were studies of mantram repetition, one evaluated Shamanic healing, one involved a CBT like intervention called Impact of Killing (IOK), and the final evaluated Building Spiritual Strength (BSS). They had no studies evaluating the effectiveness of things like prayer, church attendance, confession, or the study of religious texts.

Another system review study narrowed their records from 6,555 abstracts to 43 studies on spirituality and the benefits to veterans with mental health difficulties.¹⁶² These findings revealed a number of challenges with the data. It also demonstrated the difficulty of trying to utilize spirituality in the mental health field, and, then assessing it. One

¹⁵⁹ Lyren Chiu et al., “An Integrative Review of the Concept of Spirituality in the Health Sciences,” *Western Journal of Nursing Research* 26, no. 4 (June 1, 2004): 405–28.

¹⁶⁰ Peter C. Hill and Kenneth I. Pargament, “Advances in the Conceptualization and Measurement of Religion and Spirituality. Implications for Physical and Mental Health Research,” *The American Psychologist* 58, no. 1 (January 2003): 64–74.

¹⁶¹ Zachary P. W. Smothers and Harold G. (Harold George) Koenig, “Spiritual Interventions in Veterans with PTSD: A Systematic Review,” *Journal of Religion and Health* 57, no. 5 (October 2018): 2033–48.

¹⁶² Lorraine Smith-MacDonald et al., “Spirituality and Mental Well-Being in Combat Veterans: A Systematic Review,” *Military Medicine* 182, no. 11 (November 2017): 1920-40.

significant difficulty is the challenge of parsing out spiritual concerns from psychological ones.

Spirituality is often commandeered within a family of mental health resources, rather than being recognized as a separate health domain. A related problematic issue is the conflation and sublimation of spirituality with psychological concepts such as moral injury, mindfulness, post-traumatic growth, and resiliency.¹⁶³

It is easy to understand how the two concepts could be conflated or sublimated depending on the presuppositions of the relevant parties. Those who genuinely believe in a spiritual realm and man's spiritual nature will see many of these issues as distinct, while those who have a materialistic perspective will only see spirituality as a manifestation of a biologically rooted thought life.

Another challenge facing research on religious or spiritual interventions is the minimal amount of quality research in the field. Research in the field has been classified as "preliminary low-medium quality evidence."¹⁶⁴

While the research was not of the highest quality, the authors of the meta-analysis were confident to conclude that spiritual interventions can have an ameliorating effect on negative mental health challenges like PTSD. One thing they highlighted was that the evidence pointed to a "double effect." The "double effect" is first, positive spiritual coping was associated with increases in mental wellbeing, and second negative spiritual coping was associated with (in a more statistically significant way) decreases in mental health.¹⁶⁵ For issues like moral injury, guilt, forgiveness, and shame, spiritual interventions have a more profound effect than traditional treatments of CBT and pharmacology.¹⁶⁶

Attempting to evaluate spiritual and religious treatments by reviewing secular

¹⁶³ Smith-MacDonald et al., "Spirituality and Mental Well-Being in Combat Veterans," 1937.

¹⁶⁴ Smith-MacDonald et al., 1938.

¹⁶⁵ Smith-MacDonald et al., 1937.

¹⁶⁶ Smith-MacDonald et al., 1938.

research is riddled with challenges. Secular research is not attempting to evaluate the validity of truth claims made by the practitioners of various spiritual interventions. It is merely attempting to demonstrate effectiveness in reducing symptoms. The purpose of including a discussion of the studies of spiritual treatments is primarily for comparative value. Therefore, evaluation of each treatment will not be included in this dissertation. Tables eight and nine, found in chapter five, compile a summary of numerous effectiveness studies for comparison.

Biblical Counseling and PTS

The modern biblical counseling movement was launched in the 1970's when Jay Adams first published *Competent to Counsel*.¹⁶⁷ The movement is driven by the belief that both the theory and methodology of biblical counseling are founded on and directed by the Bible.

One of the primary motivations for this author to engage the topic of Post-Traumatic Stress Disorder (PTSD) in this dissertation was the dearth of literature, on the topic, from a biblical counseling perspective. At the beginning of my PhD studies, there were only a couple of journal articles,¹⁶⁸ a handful of mini-books,¹⁶⁹ and one self-published book¹⁷⁰ purporting to handle the topic from a biblical counseling perspective.

In the last few years, a few more resources have come on the scene including

¹⁶⁷ Jay E. Adams, *Competent to Counsel: Introduction to Nouthetic Counseling*, The Jay Adams Library (Grand Rapids: Ministry Resources Library, 1986); Heath Lambert, *The Biblical Counseling Movement after Adams* (Wheaton, IL: Crossway Books, 2011).

¹⁶⁸ Randolph, "Post-Traumatic Distress,"; Andrew Selle, "The Bridge over Troubled Waters: Overcoming Crippling Fear by Faith and Love," *Journal of Biblical Counseling* 21, no. 1 (Fall 2002).

¹⁶⁹ Timothy S. Lane, *PTSD: Healing for Bad Memories* (Greensboro, NC: New Growth Press, 2012); Jeremy Lelek, *Post-Traumatic Stress Disorder: Recovering Hope*, The Gospel for Real Life (Phillipsburg, NJ: P&R Publishing, 2013).

¹⁷⁰ Angie Fried, *A Nouthetic Approach to Healing Posttraumatic Stress Disorder: A Biblical Approach to Overcoming PTSD*, (Self-published, 2011).

another self-published book,¹⁷¹ two more mini-books,¹⁷² and a book to help families deal with a loved one suffering from PTSD.¹⁷³ Recently a journal produced by the Association of Certified Biblical Counselors was released. It is focused on the topic of PTSD. There are four articles included. The content is derived from a colloquium held a year prior where I and four others presented papers on various aspects of PTSD.¹⁷⁴ None of these have offered an extensive biblical theological evaluation of PTSD and its treatment but they still offer valuable insights into the phenomenon and how to care for those who wrestle with it. Some common themes arise in both the description of PTSD as well as how those who struggle can be cared for or care for themselves.

When it comes to the nature of PTS, biblical counselors offer some important additions to the conversation. The primary element that is added by biblical counselors is the emphasis on the spiritual elements of this battle. While spirituality is addressed by other groups, it is often seen as a peripheral issue. However, biblical counseling makes the spiritual cause and aftermath of PTS central.¹⁷⁵ For the most part, biblical counselors do not deny the biological implications of PTS.¹⁷⁶ They recognize the real physiological

¹⁷¹ John Babler, *Biblical Crisis Counseling: Not If, but When* (Fort Worth, TX: Self-published, 2014).

¹⁷² Barrett Craig, *Help! I've Been Traumatized by Combat* (Wapwallopen, PA: Shepherd Press, 2015); Henry Beaulieu, *PTSD Biblical Perspective for Hope and Help* (Bemidji, MN: Focus Publishing, 2018).

¹⁷³ Greg E. Gifford, *Helping Your Family through PTSD*. (Eugene, OR: Wipf and Stock Publishers, 2017).

¹⁷⁴ Curtis W. Solomon, "Counseling Post-Traumatic Stress Disorder: Plotting the Course," *ACBC Essays 2* (2019): 43–56; Jim Fain, "Facing Giants by Fixing Gaze: Eyes on the Covenantal King Rather than Self as the Means to Victory in Terrifying Circumstance," *ACBC Essays 2* (2019): 19–41; Greg E. Gifford, "Helping Marriages through Post-Traumatic Stress Disorder," *ACBC Essays 2* (2019): 5–17; John Babler, "PTSD, Memories, and Biblical Counseling," *ACBC Essays 2* (2019): 57–73.

¹⁷⁵ Lelek, *Post-Traumatic Stress Disorder*, 12; Craig, *Help! I've Been Traumatized by Combat*, 13–22; Solomon, "Counseling Post-Traumatic Stress Disorder: Plotting the Course"; Babler, "PTSD, Memories, and Biblical Counseling"; Randolph, "Post-Traumatic Distress."

¹⁷⁶ Lelek, *Post-Traumatic Stress Disorder*, 9–10; Craig, *Help! I've Been Traumatized by Combat*, 10–12; Randolph, "Post-Traumatic Distress," 14; Solomon, "Counseling Post-Traumatic Stress Disorder: Plotting the Course," 45.

difficulties associated with the phenomenon but the focus of care is placed on the spiritual aspects of life.

Some biblical counselors are hesitant or even resistant to any terminology, theory, or methodology that even slightly resembles secular psychology. This resistance includes the use of diagnostic terminology and labels used in the secular mental health field. Some see the label of PTSD as misleading by tending toward a medical model of psychological problems.¹⁷⁷ Those who are opposed to accepting these labels believe they take responsibility away from the individual and turn him into a victim.¹⁷⁸ The more extreme version of this view is to declare virtually all the negative impacts and struggles associated with a PTSD diagnosis as rooted in sinful responses to terrifying events.¹⁷⁹

There are others (including myself) in the movement who dislike the label PTSD and prefer to describe the phenomenon as post-traumatic stress (PTS) removing the word disorder. This is not a denial of challenges that have been inflicted upon those who have suffered greatly. Those who prefer this usage are neither seeking to deny biological challenges nor alleviate personal responsibility. By way of contrast, this is an acknowledgement of the many negative consequences of PTS as being natural responses to extreme circumstances, rather than disordered/unnatural responses to normal life.¹⁸⁰

Biblical counseling is able to look backward at trauma and help provide meaning and purpose to some of the worst events anyone will ever live through. Secular therapeutic models recognize the value of “meaning-making,” providing purpose and

¹⁷⁷ Beaulieu, *PTSD Biblical Perspective for Hope and Help*, 1, 4.

¹⁷⁸ Beaulieu, 5; Babler, “PTSD, Memories, and Biblical Counseling,” 65.

¹⁷⁹ Fain, “Facing Giants by Fixing Gaze: Eyes on the Covenantal King Rather than Self as the Means to Victory in Terrifying Circumstance”; Beaulieu, *PTSD Biblical Perspective for Hope and Help*, 13.

¹⁸⁰ Craig, *Help! I've Been Traumatized by Combat*, 4–5, 10, 53; Randolph, “Post-Traumatic Distress,” 11; Babler, “PTSD, Memories, and Biblical Counseling,” 66; Solomon, “Counseling Post-Traumatic Stress Disorder: Plotting the Course,” 44–47.

meaning to the suffering one has endured. Scripture affords us the chance to help people understand their suffering was not in vain. God uses all aspects of life to shape and mold His children into the image of Jesus (Rom 5:3-5; 8:28-30, Jas 1:2-4).¹⁸¹ While secular therapeutic models aim to eliminate suffering, at almost all costs, biblical counseling draws an appreciation of suffering from the pages of Scripture. Romans chapter five, for instance, encourages Christians not only to accept suffering but to “exult in tribulations.” James chapter one instructs Christians to “count it all joy” when they encounter all kinds of suffering. Christians do so, not as masochists but as those who recognize the benefit that is afforded to us when we suffer. These passages and others remind us that God is using suffering, trials, temptations, and tribulations for our good. The good that is described, as mentioned above, is transformation into the likeness of Jesus. While the secular world has embraced the concept of post-traumatic growth, I have begun labeling this idea, for Christians, as post-traumatic sanctification.¹⁸² If we have the hope that all things work for our benefit and that benefit is sanctification then the truth is that trauma and traumatic events are instruments in God’s hands intended to make us more like Jesus.

One of the key components of the secular interventions listed above is the importance of thought in a person’s life. All forms of CBT hold the central tenant that a person’s thinking influences her moods and actions. Biblical counselors agree with this proposition. Scripture is clear that a person’s thoughts are essential to his life and will lead him down either a path of destruction or a path of life. True change in a person’s life begins with his thinking (Rom 12:1-2, Eph 4:17-23, 2 Cor 10:5-6). Practitioners of CBT uncovered truth that was imbedded, by our Creator, through common grace.¹⁸³ When we

¹⁸¹ Lelek, *Post-Traumatic Stress Disorder*, 44–50; Randolph, “Post-Traumatic Distress,” 13; Solomon, “Counseling Post-Traumatic Stress Disorder: Plotting the Course,” 53.

¹⁸² Curtis Solomon, “Helping the Individual through PTSD” (IBCD 2018 Pre-Conference: Ministering to PTSD, Escondido, CA, June 21, 2018), <https://ibcd.org/Series/ministering-to-ptsd/>. To my knowledge this is the first time anyone used this language.

¹⁸³ Heath Lambert, *A Theology of Biblical Counseling: The Doctrinal Foundations of*

help someone struggling with PTS, renewing (redeeming) his thoughts will be essential.¹⁸⁴ However, the best manifestations of biblical counseling recognize that true care involves dealing with more than cognition. The human heart described in Scripture involves cognitive, affective, and volitional aspects.¹⁸⁵ What helps a person most is aligning her whole heart with truth. Scripture is the Word of God. Therefore, it is the absolute greatest source and standard of truth. That is why biblical counselors rely on Scripture to realign all aspects of a counselee's life.

Each of the biblical counseling resources on PTSD have all sought to align the thinking of a person struggling with PTS with biblical truth. They offer biblical truth on broad general principles as well as practical daily instruction. It is important for counselees to have a proper view of God, humanity and God's redemptive plan.¹⁸⁶ It is also vitally important that they have a proper theology of suffering.¹⁸⁷ It is essential that they receive specific counseling that will address their particular needs and struggles.¹⁸⁸ All of this counsel is most effective when given and received in a community of Christians who work as a team to care for the individual struggling with PTS.¹⁸⁹

One of the unique elements of biblical counseling's treatment of PTS is the willingness to hold people responsible for thoughts, choices, and actions leading up to,

Counseling Ministry (Grand Rapids: Zondervan, 2016), 22, 97.

¹⁸⁴ Lelek, *Post-Traumatic Stress Disorder*; Beaulieu, *PTSD Biblical Perspective for Hope and Help*, 15, 18–25; Paul Randolph, “Post-Traumatic Distress,” 12–13; Craig, *Help! I've Been Traumatized by Combat*, 43–45; Solomon, “Counseling Post-Traumatic Stress Disorder: Plotting the Course,” 50–52.

¹⁸⁵ Jeremy Pierre, *The Dynamic Heart in Daily Life: Connecting Christ to Human Experience* (Greensboro, NC: New Growth Press, 2016), 17.

¹⁸⁶ Lelek, *Post-Traumatic Stress Disorder*, 5; Craig, *Help! I've Been Traumatized by Combat*, 16.

¹⁸⁷ Lelek, 19–25; Gifford, “Helping Marriages through Post-Traumatic Stress Disorder,” 6; Lambert, *A Theology of Biblical Counseling*, 247–73.

¹⁸⁸ Randolph, “Post-Traumatic Distress,” 12.

¹⁸⁹ Beaulieu, 19, 21; Craig, *Help! I've Been Traumatized by Combat*, 49; Solomon, “Counseling Post-Traumatic Stress Disorder: Plotting the Course,” 48.

during, and in response to potentially traumatic events. There is virtually no discussion of this in secular literature. While there is an acknowledgement that guilt and shame are often factors involved in the distress around PTS, secular modalities offer no response to it. Most secular therapeutic models are formulated in a materialistic worldview. Therefore they are ill equipped to address issues of shame and guilt because they are within the domain of spiritual concerns. Those therapies that involve cognitive reprocessing deal with guilt and shame by seeking to minimize them, explain them away, or even trying to undermine a person's religious beliefs by targeting religion as the source of the problem. According to this view, it is preferable to tell someone that he is holding onto false thinking that is inappropriately making him feel shame rather than confronting the possibility that the person may actually be guilty.

Biblical counselors see responsibility and accountability as great sources of hope and empowerment. We recognize that guilt and shame are often legitimate because of the sins people do commit. People can sin in a way that causes a traumatic event, sin in the midst of a traumatic event, or respond in sinful ways in the aftermath of a traumatic event. In each case, the sin should be acknowledged and dealt with biblically. Many veterans I have spoken with struggle more with things they did than things that were done to them. They question actions they took which resulted in the deaths of non-combatants. They question whether or not the shootings they were involved in were morally right, even though lethal force was justified under the rules of engagement. They struggle with actions they committed which were technically legal and the "right thing to do in the circumstance" because they know their motives were driven by revenge or some other selfish motivation. Simply trying to get them to change their minds will ultimately be unfruitful because believing falsehood is not right or helpful. A God given conscience and conviction cannot be easily overruled.

Emphasizing responsibility gives hope and power because it affords opportunities for corrective/redemptive action and reminds them that they have control

over certain aspects of their trials. Good biblical counselors will help people diagnosed with PTSD parse out, as well as they are able, the parts of the event and its aftermath that were within the person's control from those elements that were not. Learning to trust God with the things that are outside one's control is an important aspect of dealing with anxiety, confused guilt, distorted shame, and difficult questions that often do not have answers in this life. Survivor's guilt is common among combat veterans and others who have survived natural disasters, mass attacks, and large accidents. Survivor's guilt needs to be addressed by recognizing the sovereign will and power of God. We are not in control of the number of days anyone lives but God our heavenly Father is the sovereign giver of life (Ps 139:16).

Once we separate components that are outside a person's control from those that are within, we can begin to work on the challenges associated with personal responsibility. If he did sin in a way that instigated some aspect of the trauma or if he sinned during the traumatic event, he can receive forgiveness from God for that sin. God is willing to forgive all sin (1 John 1:9). Laying the burden of sin on Jesus takes it off the back of the one who committed the sin. Forgiveness is the only appropriate resolution to guilt apart from personally paying the penalty for the sin committed. This is why Christian faith and biblical counseling are the only true sources of hope and resolution for issues of guilt and shame.¹⁹⁰

Biblical counselors are not victim blaming or shaming but speaking the truth in love. True guilt cannot be resolved by ignoring or denying it. Sin can only be removed through blood payment offered by Jesus Christ. Every biblical counseling piece written on the topic of PTSD points people to Jesus Christ for several important reasons. Jesus is shown as an example of suffering well (1 Pet 2-3). He is also a fellow sufferer who

¹⁹⁰ Lelek, *Post-Traumatic Stress Disorder*, 25–30; Beaulieu, *PTSD Biblical Perspective for Hope and Help*, 15, 18, 30.

empathizes with the sufferings of those He loves. Jesus knows what it means to suffer in every way, beyond what any of the rest of humanity will ever face. Even so His own personal suffering does not cause Him to look down on fellow sufferers and belittle them for their inability to handle suffering that is a fraction of His own. Instead, His experience with human suffering gives Him compassion. He cares as a loving friend who can be accessed at any moment (Heb 4:15-5:10). The primary role of Jesus, though, is Savior. He came to earth, lived perfectly, died for our sins, and rose again. He is victorious over sin and death so those who believe in Him can experience forgiveness and eternal life. This is the greatest hope any sufferer can gain.¹⁹¹

Once people have salvation in Jesus Christ, they are equipped to have hope in every situation because they can look forward to a future free of pain and sorrow. However, this assured blessed existence is not guaranteed in this life. We cannot promise sufferers that their suffering will cease prior to heaven. Telling a woman whose husband and children were abducted by ISIS that her faith in Jesus will ensure her safety and the safe return of her family is foolish. There is no guarantee that those things will happen. In fact her earthly suffering may increase. Even so she can still hope in eternity with Christ.¹⁹²

The same is true when counseling a person struggling with PTS. The counselor cannot promise a future free of suffering and further trauma, but he can offer meaning, significance, and purpose to the rest of a person's life. Discussing the future of this present life is an important aspect of biblical counseling. One thing that biblical counselors do in every counseling situation is to point people to the ultimate purpose of counseling, which is also the ultimate purpose of life, bringing glory to God (Rom 8:28-

¹⁹¹ Lelek, *Post-Traumatic Stress Disorder*, 14, 36; Beaulieu, *PTSD Biblical Perspective for Hope and Help*, 15, 29–30; Craig, *Help! I've Been Traumatized by Combat*, 24–25; Randolph, "Post-Traumatic Distress," 13–14; Babler, "PTSD, Memories, and Biblical Counseling," 71–72; Solomon, "Counseling Post-Traumatic Stress Disorder: Plotting the Course," 51.

¹⁹² Lelek, *Post-Traumatic Stress Disorder*, 51.

30; 11:36, 2 Cor 5:9).¹⁹³ No matter the person's situation, he can pursue this mission. Each day moving forward from trauma can have great purpose and meaning when we realize that we are living for the greatest and most grand purpose of all.

¹⁹³ Jay E. Adams, *The Christian Counselors's Manual: The Practice of Nouthetic Counseling*, The Jay Adams Library (Grand Rapids: Zondervan Pub, 1986), 35–36, 235; Lelek, *Post-Traumatic Stress Disorder*, 18; Beaulieu, *PTSD Biblical Perspective for Hope and Help*, 16.

CHAPTER 3

THE MIGHTY OAKS FOUNDATION

History of the Mighty Oaks Foundation

The Mighty Oaks Foundation (MOF), which operates the Mighty Oaks Warrior Programs (MOWP), is a Christian, faith-based organization (see appendix 14 for their statement of faith) that seeks to help veterans, active military members and others who struggle with PTS. The ministry began with the testimony of one couple, Chad and Kathy Robichaux. Chad is a decorated law enforcement officer and a veteran Force Recon Marine who was medically discharged from service because of a diagnosis of severe PTSD. Initially Chad sought to mask the internal turmoil caused by PTS by throwing himself into mixed martial arts (MMA). His success in this arena came with could not resolve the struggle but led to more challenges. He struggled with suicidal thoughts, pursued illicit relationships and spiraled downward spiritually. Chad's struggle with the aftermath of trauma nearly ended his marriage and his life. The Lord graciously brought Chad back from the edge of suicide and divorce, restored his marriage and faith, and gave him a new mission to help others with the help he had been given. Chad took what he learned through a year of discipleship and formatted it into a weeklong retreat for veterans. That retreat has become the Legacy Program. The key to the program's effectiveness is that it helps participants develop a proper, biblically informed, framework for interpreting their life and their trauma. When participants leave the program they are equipped with that framework to help them understand themselves and the life they have been called to live and it gives them purpose to move forward.

At the lowest point in Chad's life, he was confronted by his wife with divorce

papers and the question, “How could you quit on what matters most in life?” Chad had fought for his country and had fought to win world titles in MMA but was giving up on his family and his faith. That question caught Chad’s attention. So he accepted the challenge to receive counsel and discipleship from men and his church. After a year of intense discipleship, Chad was experiencing great victory over PTSD and had a restored marriage and renewed faith. Confronted with the high veteran suicide rate and other challenges facing fellow warriors, Chad felt compelled to do something about it. He took the discipleship program he had gone through and began to work with the leadership of his church, WoodsEdge Community Church in Spring, Texas to develop a program to share what he had learned with other veterans. The first program was conducted in 2011 in Westcliffe, Colorado alongside the Dave Roevers Foundation.¹

In 2012, Mighty Oaks Warrior Programs also began reaching a wider range of individuals. Initially it focused on those separated from military service, but the testimony of its effectiveness began to spread to those who were still on active duty. The primary connection came through the Wounded Warrior Battalion West, just a few hundred miles down the California coast. After one year of working with the Dave Roevers Foundation, the program was growing so rapidly that Dave Roevers introduced Chad to B. Wayne Hughes Jr. The introduction led to Mighty Oaks relocating to El Paso De Robles, California and becoming a veteran’s ministry component of Mr. Hughes’ philanthropic organization Serving California (now Serving USA). Providentially, El Paso De Robles is Spanish for “the path of the oaks.” Mr. Hughes built a facility to host veteran programs on his property, SkyRose Ranch. This facility became home to MOWP treatment programs in 2012. As the ministry has expanded they have added locations at Blaylock Ranch in Junction, Texas; Warrior Retreat at Bull Run in Haymarket, Virginia;

¹ Chad M. Robichaux, Jeremy M Stalneck, and John A. Mizerak, *Path to Resiliency*. (Manassas, VA: Making Life Better Publishing, 2017), 77–78.

and The Wilds in Columbus, Ohio.² Along with geographical expansion, the program widened its audience to include women, both veterans and spouses of veterans struggling with PTS, and then it broadened further to invite first responders who struggle in the aftermath of trauma.

Resiliency Programs

Another expansion of the Mighty Oaks Foundation has come in the form of resiliency training. Resilience can be difficult to define because it is a term that is often used to describe various aspects of perceived favorable responses to stress. According to one article in the *Handbook of Post Traumatic Growth*, resilience is a term that has been used to describe three different facets of the ability to maintain or return to normal functioning after a stressful incident. The three primary facets described are recovery, resistance, and reconfiguration. Recovery is the ability to return to some pre-stress state. Resistance describes one's ability to maintain some sense of normalcy and withstand any negative alterations before, during, and after stressful incidents. Reconfiguration describes a person who has made some adaptation because of a stressful incident that enabled her to regain normalcy as well as prepare them to better handle future stressful incidents.³

The Mighty Oaks leadership are invited to speak at resiliency training events with various branches of the military and to distribute their book *Path to Resiliency*. Depending on the audience, resiliency training can be preventative or reparative. Preventative training involves speaking to new recruits or others who are about to deploy in an effort to prepare them to face traumatic events and come through them without

² Robichaux, Stalneck, and Mizerak, *Path to Resiliency*, 78–79.

³ Stephen J. Lepore and Tracey A. Revenson, “Resilience and Posttraumatic Growth: Recovery, Resistance, and Reconfiguration,” in *Handbook of Posttraumatic Growth: Research and Practice* (New York: Lawrence Erlbaum Associates, 2006), 25–27.

facing PTS or at least equipping individuals to “bounce back” more quickly. These conferences seek to equip military personal for spiritual resilience around the three pillars of mind, body and spirit. “Our Military Resiliency Programs are designed to properly equip our nation’s Warriors on the front end of conflict, so they and their families can have a true ‘*Spiritual Resiliency*’ and a mindset that is preventative of the hardships that many of them face.”⁴ When the audience members are combat veterans the emphasis is on recovery and what it takes to regain a sense of normalcy in life after combat trauma.

The Mighty Oaks Foundation offers a variety of military resiliency programs including: Pre-Deployment Briefings for Warriors and Families, Combat Resiliency Training Conferences, Post Combat Reintegration Conferences, Suicide Prevention Conferences, and Marriage Conferences.⁵

The Legacy Program

The Legacy Program is a faith-based, peer-to-peer, weeklong, residential, intensive treatment program. “Each day is filled with a variety of classes, or presentations, on a wide range of topics. And yet, all the topics mesh together into a detailed mosaic creating a total vision of what living with your legacy in mind looks like.”⁶ Classes are led by fellow combat veterans who also serve as Team Leaders guiding “Breakout” discussion times after each class. The secluded locations, first-class accommodations, confidential interactions, and transparent leaders foster an atmosphere that promotes full, honest disclosure of the participants struggles leading to remarkable healing and life change. A more detailed description of the Legacy Program will be given

⁴ Robichaux, Stalneck, and Mizerak, *Path to Resiliency*, 76.

⁵ “Programs,” accessed September 18, 2019, <https://www.mightyoaksprograms.org/veteran-programs/>. During the initial phases of research the MOWP also included Marriage Advance a program for couples who had attended the Men’s and Women’s Legacy Programs and wanted to come back together for further training and help with their marriage. The MOF has since partnered with Family Life Ministries to send couples to the Weekend To Remember marriage getaway.

⁶ “Programs.”

later when I relay my own personal experience attending the program.

Mighty Oaks Foundation Understanding of PTSD

In order to understand the why the program functions the way it does, it is important to comprehend this ministry's understanding of the phenomenon known as PTSD.

Taking the D out of PTSD

The title of *The Truth about PTSD* may initially appear to have a typographical error. Post-traumatic stress disorder is abbreviated PTSD, but the leadership of Mighty Oaks intentionally used a lowercase “d” to make a point. They want to communicate to readers and participants in the program is that PTSD is not an abnormal response to normal life. Rather, it is a normal reaction to extreme life events.⁷ In practice, the Mighty Oaks team often refers to the phenomenon as post-traumatic stress or PTS, leaving off the initial or the word disorder entirely. In one section of *The Truth about PTSD* they rely heavily on the testimony of Viktor Frankl, a Holocaust survivor who wrote about his experience in *Man's Search for Meaning*. They quote Frankl, “An abnormal reaction to an abnormal situation is normal behavior.”⁸

The word “disordered” is problematic for a number of reasons according to Mighty Oaks.⁹ First, because the medical community has struggled to identify the nature

⁷ Chad M. Robichaux and Jeremy M Stalnecker, *The Truth about PTSD* (Manassas, VA: Making Life Better Publishing, 2017) 33–34. MOWP is not alone in this view. Many others take a similar position including: Powlison, “Gripping Fears”; Christopher B. Adsit, *The Combat Trauma Healing Manual: Christ-Centered Solutions for Combat Trauma* (Newport News, VA: Military Ministry Press, 2008), loc. 832, Kindle; Barrett Craig, *Help! I've Been Traumatized by Combat* (Wapwallopen, PA: Shepherd Press, 2015) 4–5; Richard Baxter, *The Practical Works of the Rev. Richard Baxter*, ed. William Orme, vol. 11 (London: James Duncan, 1830), 409.

⁸ Victor Frankl, *Man's Search for Meaning*, in Robichaux and Stalnecker, *The Truth about PTSD*, 77. While this quote offers a helpful corrective to faulty views of PTS it exemplifies one of the weaknesses within the MOF. They often offer uncritical citations of questionable sources if the quotation supports their immediate purpose. This will be addressed in the section offering recommendations to MOF.

⁹ The Mighty Oaks Foundation recognizes there is some value and, in certain contexts, necessity for using the term disorder. For instance, those who seek to get help through the medical and mental health fields need to have some type of diagnosis and diagnostic code to describe the problem, and

of PTSD, its origin and any real cure; the label “disorder” communicates a lack of hope to those who receive the diagnosis. “The implication [of the word disordered]: instead of PTSD being something that can be addressed and overcome, the sufferers are destined—because they are disordered—to struggle for the rest of their lives. . . .When hope of moving beyond the trauma is removed, there is very little motivation to continue.”¹⁰

A second problem with the concept of PTSD as a disorder is that it communicates to the person diagnosed that he is somehow broken, a victim, or that this experience is somehow abnormal/uncommon.¹¹ Rather than robbing hope from those diagnosed with PTSD, Mighty Oaks believes its perspective gives hope to sufferers and helps put them on a path of growth.

Along these lines, Mighty Oaks raises the question of whether or not the response identified as PTSD is not actually a more “normal” response. They reference Viktor Frankl again who claims that it would be abnormal not to struggle with serious life traumas.¹²

Reframing the very terminology used to describe the difficulty participants face is the first step in helping them reinterpret their current life context and the traumatic experiences that have brought them to this point.

Context of Creation

As stated above, MOWP views PTSD not as an abnormal response to normal life but a natural response to very abnormal circumstances. Mighty Oaks understands PTSD to exist because events have entered into life that are not in accordance with God’s creation

utilize the insurance system. Sethanne Howard and Mark W. Crandall, “Post Traumatic Stress Disorder: What Happens in the Brain?,” *Journal of the Washington Academy of Sciences* 93, no. 3 (Fall 2007): 3.

¹⁰ Robichaux and Stalnecker, *The Truth about PTSD*, 54–55.

¹¹ Robichaux and Stalnecker, 60.

¹² Robichaux and Stalnecker, 77.

plan, and men and women often do not respond to the trials and tribulations of this life in a way that God would intend, thus leading to lives that are radically misaligned from God's will. This leads them to understand the goal of their program as well as the methodology for helping participants of the program is to communicate what God's will is for their lives and to point them down a path toward realigning with God's plan and purpose for their lives.

The problem in the context of creation. Understanding humanity in the context of Creation brings understanding of some of the root cause behind PTS. Why did God create man? What was man created to do? What was the intended experience of mankind supposed to be?¹³ Answering these questions and then recognizing that the history of mankind deviated dramatically from the pattern set forth in the Garden of Eden helps us begin to uncover the nature of PTS and why it occurs. For instance, God did not create men to kill one another. Commenting on claims that the nature of warfare shifting from swords and spears to rifles and bombs changes the personal impact of combat killing, Allen West states, "I would refute that assertion; it is still challenging to pull that trigger, regardless of the distance resulting in the loss of life of another."¹⁴

There have been times when "dehumanization training" has been employed by our military to help military members overcome the psychological barriers to killing.¹⁵ Dehumanization training entails various methods of convincing combatants that their enemy is somehow less than human or somehow deserving of death. If combat soldiers

¹³ The concept of God's intention in Creation here is not intended to undermine the sovereignty of God. The description of what God intended to occur with His creation, what was supposed to happen, does not mean that God lost control or that His sovereign will did not take place. These comments are stated in light of the teaching of God's two wills as found in John Piper, "Are There Two Wills in God?," in *Still Sovereign: Contemporary Perspectives on Election, Foreknowledge and Grace* (Grand Rapids: Baker Books, 2000), 107–32.

¹⁴ Congressman Allen West, Lieutenant Colonel US Army Retired, in the foreword to Robichaux and Stalnecker, *The Truth about PTSD*, 21.

¹⁵ Matt Heidt, US Navy SEAL Senior Chief (retired), Iraq Veteran, Bronze Star recipient for combat valor, telephone conversation with author, November 15, 2017.

are able to justify in their minds that the people they are killing are not worthy of living then, in theory, it makes killing them easier. Dehumanization can take the form of an ontological argument; the enemy is a lesser form of humanity than us. The Nazis employed this kind of argument as grounds for exterminating the Jews. Dehumanization can also take on a moral argument; the enemy does not deserve to live because they are barbarians or terrorists who deserve to be killed because of their evil nature or evil deeds.

Humanity was never meant to experience rape, maiming, or bodily mutilation. Nor was death, on a grand scale, supposed to be part of our history; whether it comes at the hands of men—through combat, weapons of mass destruction, or genocide or through nature—famine, plague, and other natural disasters.

Part of understanding the problem in the context of creation involves an explanation for where sin, suffering, and evil come from. If God created everything perfect and we were not originally created to experience suffering (especially not the traumas that can result in PTS) then where did sin, suffering, and evil come from? Mighty Oaks holds to the biblical teaching that mankind fell into sin through the sin of Adam in the Garden of Eden and through Adam's sin all man and all creation were cursed.¹⁶ Sin and suffering entered the world through the Fall and now suffering is a regular expected part of life. "It is imperative to remember that as long as we are living, we *will* struggle. Not because of trauma, but because living is hard!"¹⁷

Acknowledging the physiological impact. Chad's own testimony demonstrates the physiological impact of PTS. While Chad was deployed in Afghanistan he began to have unexplained physical problems, "...I noticed my arms and cheeks of my face would go numb, and I felt as if my throat were swelling shut. There were moments

¹⁶ Robichaux and Stalnecker, *The Truth about PTSD*, 102.

¹⁷ Robichaux and Stalnecker, 91.

when I felt my heart was going to stop...There were many times I thought I was having a heart attack. Other times I felt out of my body and started to have lapses in memory...I couldn't recall much of the prior two weeks."¹⁸

Mighty Oaks acknowledges the neurological impact of PTSD and instructs participants in the Legacy Program on the basics of how the brain can be impacted by trauma. "Hope can be removed when we are unwilling to acknowledge that the brain and the systems that support it, as well as the individual emotional makeup of a person, can be profoundly impacted by traumatic events."¹⁹

The section of *The Truth about PTSD* which describes the neurological interaction with PTSD and of the teaching at the Legacy Program derives from the article "Post Traumatic Stress Disorder: What Happens in the Brain?"²⁰ This article was published in 2007 in the *Journal of the Washington Academy of Sciences* and is intentionally "light handed" and intended for popular level consumption "not to demean but to promote understanding."²¹ The principle fact that Mighty Oaks highlights is distinction between the frontal lobe (another name for the prefrontal cortex) and the limbic system. They describe the frontal lobe as the location of logical thought while the

¹⁸ Robichaux and Stalnecker, *The Truth about PTSD*, 29–30.

¹⁹ Robichaux and Stalnecker, 57.

²⁰ Howard and Crandall, "Post Traumatic Stress Disorder: What Happens in the Brain?"

²¹ The article is not overly academic or technical, which in some ways makes it an excellent source to explain the basics of the neurological impact of PTSD. However, for those well versed in neurology, PTSD, and scientific research it has some drawbacks. My two primary critiques of the article are that it often makes claims without any citation to support the claim, even claims that mention academic research. For instance, the following statement doesn't even cite the study mentioned, "The best epidemiologic or population studies indicate that about 7 percent of Americans have had or will have PTSD at some point in their lives, and that about 5 percent have PTSD at any given time." My final concern with this source is that in the introduction it leaves open the idea that trauma can result from virtually any upsetting event including the loss of a job. This is later contradicted in the article itself and is something that goes against the *DSM* definition and the predominant view of trauma in the literature related to PTSD. Howard and Crandall, "Post Traumatic Stress Disorder: What Happens in the Brain?" 4; American Psychiatric Association (APA) and DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (Washington, DC: American Psychiatric Association, 2013), 271; Frank W. Weathers and Terence M. Keane, "The Criterion A Problem Revisited: Controversies and Challenges in Defining and Measuring Psychological Trauma," *Journal of Traumatic Stress* 20, no. 2 (April 2007) 114.

limbic system is where instinctual function takes place, most pertinent to PTS the fight or flight response.²²

The description of the limbic system in *The Truth about PTSD* describes the system as part of God's design to help us survive.

God has built within us an incredible mechanism to provide safety and a high level of proficiency as we do the things that He has designed us to do. He does not intend to hurt us; rather, He equips us to be the very best that we can be, to have the freedom to accomplish everything that He sets in front of us.²³

The limbic system latches onto data about dangerous and traumatic events to equip the person to respond to similar situations in the future “without conscious thought.”²⁴ The limbic system stores every ounce of information about the event from every source of input; sight, taste, sounds, smell, touch, emotion, and internal responses like adrenaline secretion, heart rate, etc. This information is stored and can become what are known as “triggers” that initiate the fight or flight response system. The problem with PTS is that these “triggers” can be obvious things like the sights and sounds of combat or seemingly innocuous or unrelated input.²⁵ Chad and Jeremy use the example of a veteran who lost a friend in Iraq during a mortar attack because he did not evacuate the area with a sense of urgency. His friend was killed because he was taking his time tying his boots. Years later this man bursts out in anger at his young daughter because she is not moving quickly to tie her shoes when the family is trying to get out the door. Chad and Jeremy are clear to indicate that such a response is unacceptable, but also point to the fact that the extreme response is connected to the initiation of the fight/flight response when the man experienced similar sensations of frustration with someone who was not hustling to get

²² Robichaux and Stalnecker, *The Truth about PTSD*, 48–50.

²³ Robichaux and Stalnecker, 72.

²⁴ Robichaux and Stalnecker, 50.

²⁵ Robichaux and Stalnecker, 50.

out the door.²⁶

The limbic system is activated when people participate in any activity that requires habituated, unconscious activity. This can be anything from tying shoes, executing a play on the football field, performing moves in a martial arts match, or reloading and firing a weapon on the battlefield. “The limbic system is being trained so that these movements that take place in fractions of a second can happen with precision and speed, without the obstacle of conscious thought.”²⁷

The military taps into this God given ability and seeks to shape it so that soldiers, sailors, airmen and Marines will respond with action (fight) rather than freezing or running away in the midst of very intense/stressful situations. The training is designed to initiate the trainee’s fight or flight system but then instill in the recruit the ability to control his response. Stress inducement is intended to teach military members how to encounter stress and then respond with appropriate action rather than mere reaction. The nature of military work is inherently stressful, and servicemen and women need to be prepared to handle stress and still be able make good decisions and execute the mission they have been tasked with. Fight is the response that is encouraged, flight, freeze and faint will only result in injury or death to the individual or those around him in combat. The result of this type of training is helpful during combat but, can be extremely detrimental in other contexts.²⁸

Problems created by wrong responses. Mighty Oaks recognizes that many of the problems participants face that lead them to attend the Legacy Program are not a direct result of trauma. There are certainly some negative impacts from trauma, but the

²⁶ Robichaux and Stalnecker, *The Truth about PTSD*, 45–46.

²⁷ Robichaux and Stalnecker, 64.

²⁸ Robichaux and Stalnecker, 66.

majority of problems participants face result from wrong interpretations about their circumstances or inappropriate decisions they have made or actions they have taken. The leadership of MOWP identify seven inappropriate mindsets or responses to PTS. The goal is to identify the faulty interpretations and responses and reframe them with a proper biblically informed understanding. The seven faulty mindsets are as follows:

First, symptoms of hypervigilance and aggression which are appropriate in combat theaters manifest when no danger is present.²⁹ Being in an active theater of combat operations requires a constant state of alertness for survival. Additionally, combat veterans are trained to close in on threats with overwhelming force. These responses ensure survival in combat, but are not acceptable ways to live in peaceful, civil society. These kinds of reactions are often very damaging relationally. God created mankind with the instinct and capabilities to survive and protect others. Those abilities vary from context to context and when misapplied can have the opposite effect. Veterans who respond with rage and violence in their home or workplace are responding to stress inducing situations with destructive rather than protective behavior. That behavior divides relationships rather than binding them together.

Second, allowing one's self to be enslaved by a moment in time rather than allowing that memory to better equip one to serve others.³⁰ The past has a strong influence on the present but it does not determine the present or the future. While some may assert that people struggling with PTS are victims of their past and unable to move forward, Mighty Oaks disagrees. They believe there is power to choose to move forward, learning from past experiences without allowing them to control you. God's plan for sinners is repentance, justification, and progressive sanctification. Progressive sanctification is a process that incorporates all of life's experiences to move someone

²⁹ Robichaux and Stalnecker, *The Truth about PTSD*, 66–67.

³⁰ Robichaux and Stalnecker, 67–68.

forward on the path toward Christlikeness (Rom 8:28-30, Phil 1:6). Getting stuck in the past is not what God intends for His people.

Third, using trauma and difficulty as an excuse for bad behavior.

. . . many think because they were hurt, abusing drugs and alcohol, chasing illicit relationships, and generally being a jerk are acceptable. They blame a PTSD diagnosis for their problems when really it is the bad decisions that they made following the trauma that have cause the majority of their difficulties.³¹

Very few therapeutic models would allow for this kind of direct confrontation and accountability, but Mighty Oaks believes that owning responsibility for your actions is empowering whereas victimization robs the victim of hope and the power to change.

Fourth, identifying with their diagnosis.

Since our knowledge of PTSD is constantly evolving there is little hope for the person who has been diagnosed of ever getting 'better.' And so, instead of identifying the trauma as a serious life event and learning how to move beyond it, many will allow that event to define who they are.³²

Mighty Oaks recognize that some veterans see their PTSD diagnosis as "...a badge of honor or as proof that they did something important and got hurt."³³

Mighty Oaks recognizes that identity and purpose are two interwoven realities that play a major role in PTS. Those who choose to identify with their disordered diagnosis will not move forward in life and experience healing and growth. Those who choose to find a deeper identity and purpose will press on. God has called humanity to identify with Him, to become His children (joint heirs with Christ), and to be united with Him as the Bride of Christ as part of the body of Christ. We are no longer to live as isolated individuals but identified with our risen Savior (Gal 2:20). With this new identity we are to live for the purpose of bringing glory to God (1 Cor 10:31). Identifying with a diagnosis of PTSD undermines true identity and thwarts efforts to live for a God given

³¹ Robichaux and Stalnecker, *The Truth about PTSD*, 68.

³² Robichaux and Stalnecker, 54.

³³ Robichaux and Stalnecker, 69.

purpose.

Fifth, there are those who hold onto the diagnosis because of the benefits that come with it.³⁴ One has to be very careful not to falsely accuse someone of this, every military member who has suffered injury or illness due to their military service is entitled to the compensation and treatment provided, in gratitude, by our country. However, fear of losing a disability check should not hold someone back from experiencing true growth and healing.

Sixth, those who use the defense, “You don’t know what I’ve been through” to build a wall around themselves which keeps anyone from holding them accountable. Many combat veterans believe that only another combat veteran has the right to speak into their lives.³⁵ God created us for relationships (Gen 2:18). We are not intended to go through life as isolated individuals or isolated groups of individuals. His body is made up of people from every tribe, tongue and nation (Rev 7:9). When we allow anything to divide us into segmented groups we are violating God’s created intention for us.

Seventh, the last wrongheaded mindset is a subset of the previous one. The veteran with this perspective does not want to change because he has created an environment in which he can get away with whatever he wants and those closest to him cater to all his needs. He has selfishly turned his family and friends into caregivers.³⁶

Outside of the veteran world, those who suffer trauma do their best to find some sense of normalcy as quickly as possible, but many times veterans act like the kid with the broken arm who wants to leave his cast on because of the attention it gets him.³⁷

God calls His people to put others before themselves, not to manipulate friends and family toward self-serving ends (Phil 2:3-4). Flipping God’s intended plan upside

³⁴ Robichaux and Stalnecker, *The Truth about PTSD*, 70.

³⁵ Robichaux and Stalnecker, 70–71.

³⁶ Robichaux and Stalnecker, 72.

³⁷ Robichaux and Stalnecker, 69.

down leads to greater struggle and it is necessary to realign with His way of doing life if we are to experience true flourishing under His created order.

These faulty mindsets are common among participants in the Mighty Oaks programs. These mindsets also hold people back from the growth that is available to them if they align their lives with the plan and purpose for which God has created them. The Mighty Oaks Foundation's approach to solving the problem is to point men and women to God's revealed will for their lives. The Legacy Program outlines what God has created them to be. Then a path is laid for aligning or realigning with man's created purpose.

The solution in the context of creation. The Mighty Oaks Foundation gets its name from Isaiah 61 which describes God's work of taking those who mourn, are afflicted, brokenhearted, and captive and turning them into mighty oaks of righteousness. Isaiah 61:3 says, "So they will be called oaks of righteousness, The planting of the LORD, that He may be glorified." The ministry is driven by the understanding that mankind was created with the ultimate purpose of bringing glory to God. "We fulfill our purpose of glorifying God by living our lives in relationship and faithful service to Him."³⁸ This vision and purpose drive everything about the Mighty Oaks Warrior Programs—from their vision and understanding of the nature of PTS to the solution for it.

The necessity of the gospel. Mighty Oaks makes no attempt to hide the fact that it is a Christian, faith-based organization. At the outset of the Legacy Program participants are informed of this philosophy. It is also evident in every book they write. When addressing PTS they begin by explaining that all people are created by God for a purpose and that PTS exists because mankind in general and the particulars of each person's life do not align with that plan. Then the program lays out God's purpose and

³⁸ Chad M. Robichaux, *An Unfair Advantage: Victory in the Midst of Battle* (Manassas, VA: Making Life Better Publishing, 2017) 63.

plan for life so the participants in the program can see how reorienting their lives to that plan will result in change and growth. At some point in the communication (be it an appendix in the books or midweek at the Legacy Program) they explain that this realignment is not possible unless the person desiring to change has a relationship with God through the work of Jesus Christ.³⁹

There is only so much the physical world can do to heal an ailing spirit. Actually, there is nothing it can do. What is required is to trust in our Lord and Savior Jesus Christ. What is and always has been necessary is for that God shaped hole in all of us to be filled not with man's remedies, but the healing Spirit of the Lord.⁴⁰

The Power of Choice

The importance of choice is prominent in the Mighty Oaks literature and program teaching. Choice is a key determination of what will occur in someone's life all through the struggle of PTS. It is necessary for the struggler to choose to get on the path to growth. Subsequently, it is necessary for him to choose to continue to take one step after another to progress down that path.

The leadership of the Mighty Oaks Foundation are often asked how they are able to take men and women who have sometimes been through six-month treatment programs with very little result and radically change that same person's life in just one week. They respond that the change does not occur over a week of "treatment" but in a moment. That moment is one of decision where the individual chooses to move forward walking in God's will for his life.⁴¹

Change happens in an instant, but true growth is not a single moment. It is a series of choices that move an individual forward. Chad's personal testimony points to

³⁹ Robichaux and Stalnecker, *The Truth about PTSD*, 99–106; Robichaux, Stalnecker, and Mizerak, *Path to Resiliency*, 67–70; Chad M. Robichaux, *An Unfair Advantage: Victory In The Midst of Battle*, 159, 167, 182–84.

⁴⁰ Congressman Allen West in the foreword to Robichaux and Stalnecker, *The Truth about PTSD*, 22.

⁴¹ Robichaux, *An Unfair Advantage: Victory In The Midst of Battle*, 173.

the choices he made to repent of his destructive behaviors and begin making God-honoring decisions, “I was shown the way forward through the restoration of my faith, mentorship, and coming to the understanding that my future is not based on the past events in my life, but the choices I make moving forward.”⁴²

Veterans must learn that they are not victims of PTS in the sense that they are helpless in the change process. Nor are they helpless victims when situations arise in life that “trigger” PTS symptoms. One author states it this way, “Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.”⁴³ Each experience in life that requires or offers a chance for us to respond is an opportunity to choose. PTS does not rob anyone of that opportunity. It may make it more difficult. It might make the choice seem beyond our control, but those perceptions and difficulties do not thwart our ability to choose to respond in a productive way rather than a harmful one.

The emphasis of choice by Mighty Oaks could easily be misinterpreted. MOWP does not teach change as simple or easy. Nor do they believe that all someone has to do to improve is try harder or just get over it. They specifically reject this claim in their teaching.⁴⁴ The process that leads to growth is difficult and can take time, but it necessarily begins with the choice to move forward in a growth-oriented direction.

Other Steps in the Process

Mighty Oaks places the choice to move forward as the first and central step to the process of overcoming PTSD. After participants make that decision, they are offered a number of other practical steps to help in the process.

⁴² Robichaux and Stalnecker, *The Truth about PTSD*, 32.

⁴³ Viktor Frankl, *Man’s Search for Meaning*, in Robichaux and Stalnecker, 79–80.

⁴⁴ Robichaux and Stalnecker, *The Truth about PTSD*, 57.

The first step after making the decision to move forward is to talk about your struggle. They encourage people to verbalize their struggles to someone else or a group of people. This includes recounting the trauma, the person's response to the trauma, and how they have been handling life since the trauma. They specifically encourage each person to be forthright and honest about his own sin in, citing Psalm 32:3 in support of this advice. They also encourage the person to continue to talk about their experience, but not to keep repeating the same story, as though they are stuck, but continue to modify their telling as they grow and change. Mighty Oaks encourages this disclosure by informing them that many people get great relief from telling their story. They also point to the benefit it gives to organize one's thoughts about the trauma and to bring them to light.⁴⁵ It is important to examine one's thoughts about the trauma so that an individual can truly understand the interpretation he is giving to the situation. Many trauma survivors who can articulate the facts of what happened often do not realize the meaning or significance they are assigning to event. Having them share their stories enables them to begin this process.

Mighty Oaks recognizes that this process can be very difficult. They recognize that those who face intense suffering find it difficult to open up to those who have not been through similar experiences. This is one of the reasons the Legacy Program employs a peer-to-peer strategy. All the instructors are combat veterans who have been through the program. The testimonies of the instructors and leadership of the program quickly surmounts the defensive obstacle of participants who have walled off sources of help with the accusation, "You don't understand. You haven't been through what I've been through." The program acknowledges that it is also important to build significant relationships with those who are not part of the veteran population. Opening up to a fellow combat veteran is often a first step in that direction. Early in my interaction with

⁴⁵ Robichaux and Stalneck, *The Truth about PTSD*, 80–82.

the ministry's leaders they acknowledged that this is one of the more difficult challenges they face. Helping veterans to open up and connect with non-veterans is difficult. It is something they seek to do in the Aftercare portion of the program, but they have not had great success.⁴⁶ It is possible for veterans to make these kinds of connections and to open up to non-veterans in the early stages of healing. Chad Robichaux's personal testimony is evidence of this. The mentor who disciplined Chad for over a year and helped him in the early stages of fighting PTS, Steve Toth, is a civilian.⁴⁷

The second step offered is one that needs to be repeated often and is the flipside of choosing to move forward—"Refuse to allow the past to define you." This step specifically counteracts faulty mindset number two from above (people allowing themselves to be enslaved to one particular moment in time). Mighty Oaks warns people that they will face their own internal voices of accusation telling them they should be embarrassed, angry, or depressed because of something that happened in the past. They are encouraged to confront those thoughts and not listen to them.⁴⁸ "They need to diligently and deliberately fill those moments with positive thoughts and actions instead of allowing an event to define their lives."⁴⁹ It is an application of the counsel from 2 Corinthians 10:5 to take thoughts captive in obedience to Christ and Philippians 4:8 to cause our minds to dwell on the truth.

As we look back at our past, we must come to our own realization that however tragic (or heroic) those events may have been, they are not what led us to where we are today. Instead, it's our daily choices. When we can bring ourselves to that realization and take responsibility for our past and future, only then can we move forward into a future of restoration, hope and new purpose.⁵⁰

⁴⁶Jeremy Stalneker, Foldberg, John, and Chris Carlisle, Mighty Oaks Leadership, conversation with author, San Miguel, CA, April 10, 2015.

⁴⁷ Robichaux, *An Unfair Advantage: Victory In The Midst of Battle*, 119–20.

⁴⁸ Robichaux and Stalnecker, *The Truth about PTSD*, 82.

⁴⁹ Robichaux and Stalnecker, 68.

⁵⁰ Robichaux and Stalnecker, 34–35.

Third, “Replace your bad behaviors with good ones.”⁵¹ This is advice has three components: (1) Recognize the habituated responses from the trauma or perhaps your training that is appropriate in one context, but not another. Identify the appropriate response in your current context and begin to do the later rather than the former. This step counteracts the first faulty mindset listed above. (2) Stop the wrong behaviors you have been engaging in as a way of dealing with your difficulties. As mentioned earlier, alcohol, drugs and illicit relationships often are used as means of escaping or numbing the pain that often comes with PTS. Learning appropriate, healthy, and good responses to suffering is an essential part of growth. (3) It is often helpful to find activities to keep one’s self busy and distracted in order to avoid sinful pursuits or despairing thoughts.⁵² This helps to fight against faulty mindset number three—using a PTSD diagnosis as an excuse for bad behavior. (4) “Regain purpose and direction by leveraging your story and gifts for the good of others.”⁵³ Not only is it extremely damaging to a person to lose purpose and direction, God has created us for the most important purpose of all—glorifying Himself.

Mighty Oaks instructs PTS sufferers that their gifts, talents and abilities were not given to them for self-glorification but to glorify God through serving others. Having purpose helps combat faulty mindsets 4, 5 and, 7 listed above (4. Identifying with the diagnosis, 5. holding onto the diagnosis because of the benefits it gives you, and 7. disincentivized change).

The fifth and final step given in *The Truth about PTSd* is to restore relationships that have been damaged in the aftermath of trauma. The Mighty Oaks team is well acquainted with the concept that “hurting people hurt people.” Often those close

⁵¹ Robichaux and Stalnecker, *The Truth about PTSd*, 82.

⁵² Robichaux and Stalnecker, 82–83.

⁵³ Robichaux and Stalnecker, 83.

to someone who is struggling after trauma end up being collateral damage. They take the brunt of the hurting doled out by their hurt loved one. Mighty Oaks encourages people not to walk away from those relationships, but to pursue restoration.

Created for Community

Restoring relationships is a key part of the process of healing and growing after someone has struggled with PTS. Having a strong support system can greatly help someone recover after facing trauma. Jeremy Stalnecker acknowledges that a strong support system before and after his time in the military helped him work through the challenges of PTS relatively quickly.⁵⁴ But mere recovery is not the goal for the Christian. Growth, flourishing and bringing honor to God are the goals for every person including those who have been through traumatic experiences. True growth and flourishing requires one to live in community with other believers.

The Legacy Program includes a class titled “Brotherhood.”⁵⁵ This class emphasizes the need for close, same-gender relationships that involve true transparency while affording accountability and support. Sometimes relationships like this can develop between participants at the Legacy Program or between participants and their instructors. However, the alumnus needs to have close relationships, accountability, and community in his local church. The Legacy Program is only one week and the majority of participants are combat veterans so it can be hard to instill in the alumni a need for and the capacity to develop relationships in the life giving community of a local church. This becomes the mission of the Aftercare Program.

The Mighty Oaks Aftercare Program involves attempts by Mighty Oaks leadership and staff to connect each participant with a Bible-believing church in the

⁵⁴ Robichaux and Stalnecker, *The Truth about PTSD*, 39–40.

⁵⁵ Tierce Green, *Fight Club: Some Things Are Worth Fighting For (Mighty Oaks Special Edition)* (The Woodlands, TX: Fresh Bread Resources, 2014), 29–34.

alumnus' community (see appendix 15). They also have established "Outposts" in various churches around the country. Outposts consist of weekly meetings for any active military, veteran or other person who is wrestling with PTS, combat trauma or reintegration. They are led by Legacy Program alumni who have been through Mighty Oaks leadership training. The purpose of these programs is to help alumni apply what they have learned through the Legacy Program, to encourage and equip one another in the ongoing process of growth, to provide accountability, and to be another step towards reintegrating into life within the church.⁵⁶

Not Rejecting Other Treatments

While Mighty Oaks does purport to have found an effective solution to helping veterans overcome PTS, they do not reject the use of other programs nor do they claim these other programs are entirely ineffective. "Some clinical programs for combat trauma are necessary, but these should be pit stops along the road to recovery, not a permanent destination."⁵⁷ Mighty Oaks also recognizes that pharmacological interventions are often helpful in the overall treatment of people who struggle with PTS. It is common for participants in the program to come with over 20 prescribed daily medications. They never advise anyone to stop taking medication, but they do try to encourage participants to evaluate how they think about medication. The perspective they have of medication is that in the right dose and at the right time it can be helpful to get someone into a clear state of mind to make the decisions they need to make in order to get well.⁵⁸ They encourage participants to dialogue with their doctors to understand what they are taking, why they are taking it and what the plan is moving forward. They do express the goal of

⁵⁶ "Our Outposts," accessed September 25, 2019, <https://www.mightyoaksprograms.org/veteran-programs/outposts/>.

⁵⁷ Robichaux and Stalnecker, *The Truth about PTSD*, 33.

⁵⁸ Robichaux and Stalnecker, 58–59.

reducing medication to minimal necessary dosages with the plan to move away from medications entirely if possible. This goal is set forward with the understanding that most medications are used to numb or treat symptoms of PTSD but they cannot ultimately address the root problems that are causing the symptoms in the first place.⁵⁹

Post-Traumatic Growth/Sanctification

A traumatic event is not something that can be forgotten or simply moved past. It can, however, be a catalyst for growth as well as an opportunity to help others who are struggling with trauma. Growth in any area of life often requires pain, but if we are willing to grow through the pain, we will become people we never could have been otherwise. The goal is not to get back to where we were before the trauma; the goal is to grow through it and become more fully equipped to fulfill our God given purpose.⁶⁰

Mighty Oaks believes that God can take the hardship, sin, suffering, and trauma we experience in life and use it to make us stronger and to mold us into the people he wants us to be. Rather than being torn down by trauma we can actually be built up by it. As discussed earlier, this concept is known as Post-Traumatic Growth. Chad exemplifies this concept this way, “I know the struggles I have overcome do not weaken me but have in fact molded me into the man I am today.”⁶¹ The goal of Mighty Oaks is not to return to pre-trauma self. This would actually be undermining God’s intended purposes of your suffering. The goal is to help participants understand God’s *modus operandi* of making wonderful, beautiful, majestic things out of the horrible things that we do or have had done to us. Most people in the world are comfortable with some notion of the idea that everything happens for a purpose. Mighty Oaks utilizes biblical truth to give divine reason to that concept and shows that God is the one who is the ultimate giver of purpose. When people align their lives with His purpose and plan as described in His

⁵⁹ Robichaux and Stalnecker, *The Truth about PTSD*, 59.

⁶⁰ Robichaux and Stalnecker, 59–60.

⁶¹ Robichaux and Stalnecker, 33.

Word then everything that comes into their lives is used to mold and shape them to be more like Jesus.

Helping the participant reinterpret his life through a biblical framework enables him to move forward with renewed purpose and joy. He has been able to address faulty views of his past trauma and replace them with biblically informed understanding. He has also been shown what his God given roles, responsibilities, and relationships are. Then he has been set forward on a new path with the purpose of glorifying God with the life he has been given. This new framework for interpreting life reduces many of the symptoms associated with PTS as someone moves forward without the burdensome faulty understanding of life that has dominated since his traumatic experiences.

CHAPTER 4

METHODOLOGICAL DESIGN

This chapter describes the overall design and implementation of the study conducted to evaluate the Legacy Program of the Mighty Oaks Foundation. The research is guided by and intended to answer the research questions at the heart of this dissertation.

Research Question Synopsis

1. Is there a correlation between attending the Legacy Program and the reduction of Post-Traumatic Stress Disorder (PTSD) symptoms?
2. Is there a correlation between attending the Legacy Program and a growth in one's strength of religious commitment?
3. Is there a correlation between the change of strength of one's religious commitment and the change in severity of one's PTSD symptoms?
4. What elements of the Legacy Program do participants find most helpful?
5. How does the Legacy Program compare to other treatment programs for PTSD?

Research Design Overview

The Mighty Oaks Effectiveness Study (MOES) is a mixed method study consisting of both quantitative and qualitative surveys, participant/alumni interviews, literature review, and personal observation of the program. The quantitative study combined two previously validated instruments (PCL-5 and SCSRFQ) into a pre/post-test survey that participants took prior to attending the Legacy Program and then repeated six months later.¹ One instrument measured participant's PTSD symptoms while the other

¹ “PTSD Checklist for DSM-5 (PCL-5) - PTSD: National Center for PTSD,” General

measured their strength of religious faith. Results from the surveys were evaluated for changes in PTSD symptomology and strength of religious faith. Then results were compared using Paired *t*-Test to determine if a statistically significant change occurred. Wilcoxon analysis was also conducted to be sure that the statistical data was not impaired by any outliers in the data or other factors that impact the assumptions underlying parametric analysis tools. Pearson Correlations tests were utilized to determine if there was a correlation between the changes in PTSD symptoms and changes in strength of religious faith.

A retrospective alumni survey was created for this study (see appendix 12) and then sent to alumni who completed the program. The survey was designed to uncover the implications of various elements to the overall change in PTSD symptomology and strength of religious faith. The qualitative survey is designed to provide insights into the question of why the program is effective, if it is demonstrated to be so.

Interviews were used to further investigate what elements of the program were most important to participants as well as to provide real life accounts of the experience of attending the program and how it impacts one's struggle with PTS.

I attended one session of the Legacy Program in order to have first-hand knowledge of it. Rationale for this component of the research is multifaceted. First, I needed to investigate the content of the program to evaluate the claims that the program was biblically based. Second, I wanted to explore any components of the program that might not be available through interview, literature review, or survey. Third, I wanted to be able to provide a first-hand account of the program. Fourth, direct observation provided the greatest opportunity to give feedback to the leadership of the program.

Information, accessed April 18, 2019, <https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>; Thomas Plante and Marcus T. Boccaccini, "The Santa Clara Strength of Religious Faith Questionnaire," *Pastoral Psychology* 45 (May 1, 1997): 375-87.

Conflict of Interest Disclosures

Currently I serve on the Board of Advisors of the Mighty Oaks Foundation.² The Board of Advisers are not compensated in any way. They do not meet regularly and have no control over the operations of the MOF but offer advice to the staff upon request. The appointment came after the MOES study had been conducted.

The Mighty Oaks Foundation provided a portion of the funding for the research. The majority of funding came through churches or other private individuals.

The MOF played no role in the design, analysis, or interpretation of the data. They did not review, modify, or give input to the creation of this manuscript.

Assumptions, Limitations and Delimitations

Post-Traumatic Stress Disorder has only been identified as a diagnosed psychological disorder since 1980 when it was included in the *DSM-III*.³ The initial focus on the phenomenon was largely due to the work of psychologists with veterans of the Vietnam War.⁴ Since that time people have recognized that PTS is not something that only effects combat veterans, but many people exposed to traumatic events of all kinds. While there are certainly many similarities between the symptoms associated with PTS resulting from combat and other sorts of trauma, there are some that advocate for a distinction between military related PTSD and other kinds.⁵ As research in the field of PTSD expands, variations in the type of traumatic experience people face seem to alter

² Mighty Oaks Foundation, "Board of Advisors," accessed January 20, 2020, <https://www.mightyoaksprograms.org/about/board-of-advisors/>.

³ Nancy C. Andreasen, "Posttraumatic Stress Disorder: A History and a Critique Andreasen PTSD History," *Annals of the New York Academy of Sciences* 1208, no. 1 (October 15, 2010): 67; American Psychiatric Association (APA), Task Force on Nomenclature and Statistics, *Diagnostic and Statistical Manual of Mental Disorders: DSM-III*, (Washington, DC: American Psychiatric Association, 1980), 236–38.

⁴ Bessel Van der Kolk and Lisa M. Najavits, "Interview: What Is PTSD Really? Surprises, Twists of History, and the Politics of Diagnosis and Treatment," *Journal of Clinical Psychology* 69, no. 5 (May 2013): 516.

⁵ Van der Kolk and Najavits, "Interview: What Is PTSD Really?" 518.

aspects of their PTSD symptoms. Because of these variations and the predominance of MOWP participants who struggle with combat trauma generalizations from this study should be limited to those exposed to combat trauma.

This study focuses on a component of the ministry that works with men only. Therefore the findings of this research cannot be generalized to the female population.

The primary limitations of the study result from the program leaders' desire to maintain a non-clinical environment with the program. This impacts the sampling methodology, the selection of measurement tools, and the overall structure of the study.

The selection of instruments was limited to self-report surveys that are brief and can be taken on-line or in person. The use of such surveys without the oversight of clinicians means that a diagnosis of PTSD for the participants was not confirmed clinically. However, the majority of participants in the program are combat veterans who have been in treatment programs with the DoD, VA and other groups. The instrument chosen to measure PTSD symptoms is the PTSD Checklist-5 (PCL-5) and is sufficient for providing a provisional diagnosis of PTSD.⁶

There was no opportunity to review medical records for diagnosis or the existence of comorbid diagnoses. Ignorance of possible comorbid factors does not allow for deselection from the study. Thus, the study could include participants whose comorbid diagnoses impede response to treatment. This does not however disallow the study from demonstrating whether or not participation in the Legacy Program reduces PTSD symptomology.

Due to a number of factors including time, resources, and ethical concerns there was no control group for the study. The program does not maintain a waitlist of perspective participants so it was not possible to have a control group to compare the

⁶ "Using the PTSD Checklist for DSM-5 (PCL-5)" (National Center for PTSD), 1, accessed April 18, 2019, <https://www.ptsd.va.gov/professional/assessment/documents/using-PCL5.pdf>.

results against. The leadership of the MOWP indicates ethical concerns with creating a waitlist for the study, a concern which is also reflected in the literature.⁷ While this will limit the strength by which certain claims can be made it does not prevent the research from demonstrating effectiveness of the program. Other published studies evaluate the effectiveness of programs without the use of a control group.⁸

A non-randomized convenience sample was achieved by inviting all participants of the program to participate in the study. This was in order to achieve as large a sample as possible and to maintain the non-clinical environment of the program. The retrospective alumni survey included both quantitative and qualitative questions. The combination of these elements in a mixed-method study add strength to the conclusions being drawn.

No reassessment of the participants immediately following the program was done. This opens the possibility that they were exposed to other treatments or elements that might have contributed to changes in their scores before the six-month post-treatment assessment. The questions used in the PCL-5 ask participants to evaluate their symptoms related to the past month of life so they would have to include three weeks pre-treatment in their answers.⁹ Additionally, many of the influential elements of the program require time to implement in life once participants return home. Surveys taken immediately after the program may score an exaggerated reduction in PTSD symptoms due to experiencing a temporary “halo” effect from the isolated, care-free environment.¹⁰ Due to these factors,

⁷ H. Gerger et al., “Integrating Fragmented Evidence by Network Meta-Analysis: Relative Effectiveness of Psychological Interventions for Adults with Post-Traumatic Stress Disorder,” *Psychological Medicine* 44, no. 15 (November 2014): 3161.

⁸ Leanne Humphreys et al., “An Intensive Treatment Program for Chronic Posttraumatic Stress Disorder: 2-Year Outcome Data,” *Australian & New Zealand Journal of Psychiatry* 33, no. 6 (December 1999): 848–54; Mayaris Zepeda Méndez et al., “A Five-Day Inpatient EMDR Treatment Programme for PTSD: Pilot Study,” *European Journal of Psychotraumatology* 9, no. 1 (January 2018): 1.

⁹ “Using the PTSD Checklist for DSM-5 (PCL-5)” (National Center for PTSD), 1, accessed April 18, 2019, <https://www.ptsd.va.gov/professional/assessment/documents/using-PCL5.pdf>. “Using the PTSD Checklist for DSM-5 (PCL-5),” 1.

¹⁰ Humphreys et al., “An Intensive Treatment Program for Chronic Posttraumatic Stress

it is unlikely that an evaluation immediately following the program would provide worthwhile feedback. Certain questions in the retrospective alumni survey are intended to investigate some of the limitations with this six-month gap. Specifically, alumni were asked to compare their perceived level of effectiveness of other programs they took before or after attending the Legacy Program.

The use of the PCL-5 as the questionnaire used to determine the level of PTSD symptomology is another limiting factor in the pursuit of comparison data. The PCL-5 was adapted from the PCL-IV after the publication of the *DSM-V* in 2013. Since the PCL-5 is only a few years old, it has not been incorporated into as many studies evaluating various PTSD treatments. This limited the ability to directly compare the MOES with other studies based on a change in PCL-5 scoring. Some studies were found that afforded a direct comparison on change in PCL-5 score.¹¹ Attempts were made to use different measurements like effect size or percentage of score change to compare the effectiveness of the Legacy Program to other treatment programs when the PCL-5 could not be used as a primary measurement (see tables 8 and 9).

Samples

In the pre/post-test portion of the study, a convenience sample was gathered by offering every applicant approved to attend a MOWP Legacy Program two opportunities to take the survey. The first opportunity came through an email sent to everyone who participates in the Legacy Program one to two weeks prior to attendance. During the time

Disorder,” 853.

¹¹ Joseph Maio and Kendra Jorgensen-Wagers, “Efficacy of Group Cognitive Processing Therapy in an Intensive Outpatient Trauma Program for Active Duty Service Members with Posttraumatic Stress Disorder,” *Best Practice in Mental Health* 14, no. 2 (Fall 2018): 64–81; Zepeda Méndez et al., “A Five-Day Inpatient EMDR Treatment Programme for PTSD”; Noah S. Philip et al., “5-Hz Transcranial Magnetic Stimulation for Comorbid Posttraumatic Stress Disorder and Major Depression,” *Journal of Traumatic Stress* 29, no. 1 (February 2016): 93–96; Eliora Porter, Erin G. Romero, and Melissa D. Barone, “Description and Preliminary Outcomes of an In Vivo Exposure Group Treatment for Posttraumatic Stress Disorder,” *Journal of Traumatic Stress* 31, no. 3 (June 2018): 410–18; Robert E. Herron and Brian Rees, “The Transcendental Meditation Program’s Impact on the Symptoms of Post-Traumatic Stress Disorder of Veterans: An Uncontrolled Pilot Study,” *Military Medicine* 183, no. 1/2 (February 1, 2018): 144–50.

of the study, that email included a link to the survey along with a request to participate in the study. That paragraph explained the nature of the study, indicated that it would be confidential, and that it was voluntary (see appendix 9). The second opportunity came when participants were given the chance to take the survey on paper as part of the in-processing procedures for the Legacy Program. At that time, instructors informed the participants of the voluntary nature of the program, the lack of impact the survey would have on their time at the Legacy Program, and its confidential nature. The paper copy also included a paragraph indicating the confidential and voluntary nature of the survey (see appendix 4).

The MOWP was the point of contact with participants in the quantitative surveys. I did not personally have direct contact with participants in this portion of the survey and steps were taken to protect the identity of all participants in the survey. The website conducting the on-line portion of the survey maintained the participants e-mail addresses to enable access to the follow-up portion of the survey and to match the results of the pre-test and post-test surveys. However, I did not have access to that portion of the website. Instead, a random identification number was generated by the website for each participant in the survey and used in the results database to which I had access. For those who filled out the survey in paper form, research assistants were utilized to enter the responses into the on-line survey.

An invitation to participate in the retrospective alumni survey was emailed, through Survey Monkey, to 699 alumni who had participated in the MOWP Legacy Program (see appendix 11). A \$20 Amazon gift card was given to the first 100 participants to complete the survey.

Exclusions

The only form of exclusions were those which limited attendance at the Legacy Program. Participants had to agree not to use alcohol or illegal drugs while

attending the program. This did not rule out the possibility that some participants might have comorbid substance abuse issues. Participants also had to be willing to abide by the rules of the program. Anyone who was not willing to submit to the rules of the program self-excluded from the study as well.

Instrumentation

The PCL-5 is a tool developed by the Department of Veterans Affairs and can be used to diagnose PTSD as well as assess changes in PTSD. It can be filled out by the individual in five to ten minutes or filled out by someone else interviewing the respondent. The PCL-5 is “a 20-item self-report measure that assesses the presence and severity of PTSD symptoms.”¹² The PCL-5 measures 20 symptoms of PTSD on a 5-point Likert scale, ranging from 0 to 4. Respondents rate how much they have been bothered by each of the 20 items in the past month ranging on the following scale: 0 = Not at all, 1 = A little bit, 2 = Moderately, 3 = Quite a bit, and 4 = Extremely. The test is scored from 0-80 by summing the items scored. Since the PCL-5 was updated with the *DSM-5*, cut off scores are still being evaluated, but current research indicates 33 as an appropriate cut-off.¹³ This instrument was chosen partially due to the ease and speed of completion to encourage a higher number of responses from the population being surveyed.

Similarly, the Santa Clara Strength of Religious Faith Questionnaire (SCSRFQ) is a ten-question survey that is easily completed in a short amount of time. Participants are asked to rank 10 statements related to religious commitment and activity using a 4-point Likert scale ranging from 1-4. The scale is: 1 = strongly disagree, 2 = disagree, 3 = agree and 4 = strongly agree. Scores range from 10 (low faith) to 40 (high

¹² “PTSD Checklist for DSM-5 (PCL-5) - PTSD: National Center for PTSD.”

¹³ J. H. Wortmann, “Psychometric Analysis of the PTSD Checklist-5 (PCL-5) among Treatment-Seeking Military Service Members,” *Psychological Assessment* 28, no. 11 (2016): 1392–1403.

faith).¹⁴

These are both reliable, validated self-report instruments that can be completed in a short amount of time and are easily administered via on-line or in person survey tools.

Observing Legacy Program

One element of the research for this dissertation involved my personal attendance in a Legacy Program in order to observe the program first-hand and gain an understanding of participant experience. The following section will describe my experience interacting with the Mighty Oaks Warrior Programs preceding the Legacy program, a description of the time at the treatment program and follow-up communications.

Pre-Attendance Communication

All participants in the program apply on-line via an application portal at www.mightyoaksprograms.org. Applicants receive an email confirming their application has been received and they will be contacted by a member of the MOWP staff (see appendix 6). The follow-up e-mail requests additional information to process the application (see appendix 7). The first piece of information is documentation of the applicant's discharge from military service. The Mighty Oaks Programs primarily serve U.S. military veterans (in recent years they have begun expanding programs to include first responders) so applicants must submit a Department of Defense Form-214 (DD 214) or other discharge documents indicating that the applicant received a discharge of any kind other than dishonorable. Second, the applicant is asked to provide some background

¹⁴ Plante and Boccaccini, "The Santa Clara Strength of Religious Faith Questionnaire,"; Thomas G. Plante, "The Santa Clara Strength of Religious Faith Questionnaire: Assessing Faith Engagement in a Brief and Nondenominational Manner," *Religions* 1, no. 1 (December 2010): 3–8; Marcin Wnuk, "A Psychometric Evaluation of the Santa Clara Strength of Religious Faith Questionnaire among Students from Poland and Chile," *Pastoral Psychology* 66, no. 4 (August 1, 2017): 551–62.

information about what is leading the applicant to apply to the program. A series of questions are listed to help the applicant provide the appropriate information,

Brief military bio regarding MOS [Military Occupational Specialty], duty stations, units, combat deployments locations and count of how many times. Any major accomplishments, awards, accolades. Anything else you may feel is pertinent.

Any injuries sustained?

Struggles that you may deal with due to military service? I.e. Symptoms related to PTSD (Anger/irritability, depressive disorders, withdrawals, suicide attempts?)

What lead you to the point to be interested in attending the Mighty Oaks Foundation Mighty Oaks Warrior Programs?

What do you hope to gain from attending the program and becoming one of the many successful alumni that have graduated?¹⁵

Finally, the applicant is asked if they have a specific timeframe they would like to attend and if they are able to cover transportation to the program (MOWP is a well-funded ministry and is able to cover travel to and from the program so cost is never a prohibitive factor).

After the applicant has responded to this email, MOWP staff contact them via email or phone (I was contacted via telephone) to notify the applicant that they have been accepted into the program and dates for attendance are verified.

Approximately one month prior to the program the applicant has been scheduled to attend, a follow-up e-mail is sent to confirm that he is still planning to attend (see appendix 10).

One week prior to the Legacy Program an informational email is sent with an attached informational letter. The email passes along pertinent information about what to bring, rules of the ranch etc. It also asks for confirmation of travel arrangements. During the MOES study this email also contained the link to the on-line survey with rationale for the survey and notification that the survey was voluntary (see appendices 8, 9).

¹⁵ John Davis, "Mighty Oaks Warrior Programs," e-mail to author, November 1, 2016.

Attending the Legacy Program

I attended the program at the ministry's original site, Sky Rose Ranch, May 8-13, 2017. SkyRose Ranch is a 20,000 acre active cattle ranch. Atop a hill, billionaire philanthropist B. Wayne Hughes Jr. built a retreat center to host the first Fight Club (previous name of the program)/Legacy Programs. The center has a central lodge where meals are served and classes are held. The floorplan also contains a number of rooms to house instructors and participants. Additionally, there is a game room, courtyard, and a few outdoor seating areas. More housing was added to expand the number of accommodations for participants as the ministry grew. This area includes yerts to house veterans as well as a bathrooms and an outdoor shower area.

Participants arrive on Monday afternoon. Check in is supposed to be completed by 3:00 p.m. Participants in the program are assigned to a team and given time to settle into the luxurious accommodations of the program. I was placed in a yurt with four other veterans. The yurt is a round, semi-permanent room with a desk, dresser, dirty cloths bag, comfortable bed with high quality linens and bed coverings, as well as towels and any toiletries the veteran may need. MOWP seeks to provide high quality food and accommodations to participants in the program so that participants can rest, relax and not be burdened or distracted by the basic needs of life. Locations were also designed with disabled veterans in mind. There are handicap accessible accommodations for participants who need them.

The program officially kicks off at 4:30 p.m. with an introduction to the program, overview of rules and instructions about accommodations and logistics during the program. For the veterans this is somewhat akin to "in-processing" briefings that occur when you arrive at a new duty station in the military. For the duration of MOES, the in-processing time was when participants who had not taken the on-line survey were afforded the opportunity to take it on paper, in person.

Monday 5:30 p.m. "Welcome to Legacy Program" informed the participants of

the nature of the program. The MOWP is straight forward about being a Christian organization—drawing on the Bible as a source of wisdom and instruction that guides all of life including the content of the program. Participants do not have to come from any faith background. MOWP accepts all participants with no discrimination based on religion, but it also makes no apologies about being a Christian ministry.

During the welcome, introductions are made by both staff and participants. Instructors/Team Leaders are visibly designated with a uniform of khaki cargo pants, desert combat/work boots, and a black polo with the MOWP insignia. There are also Instructors in training that have various roles (depending on whether they are in Phase I or Phase II instructor training).

Monday night 6:00 p.m. Dinner: Participants get their first taste of all the delicious food to come. As mentioned before the MOWP spares no expense in accommodations or provisions. Each meal is prepared by a local chef and alterations can be made to accommodate any dietary restriction. Participants at load up their plates in the kitchen then sit at one of a few dining tables that help to facilitate a family-style meal setting which encourages conversation among the participants.

Monday 7:00 p.m., Rules and Promises: A different instructor shares the guidelines and expectations for behavior and interaction of the participants. These rules are aimed at behavior and attitudes during the program while the earlier instructions had to do with logistical policies of the ranch (smoking location, picking up trash, etc.).

During the program I attended, this was the first indication of the transition of the Legacy Program from its previous name “Fight Club.” The program was originally named “Fight Club” largely inspired by the testimony of its founder Chad Robichaux who at one point was a world class Mixed Martial Arts (MMA) fighter. Throughout the program, semblances of the previous program’s structure would surface (i.e., the workbook was still titled “Fight Club,” PowerPoint slides would still have the “Fight Club” logo on them).

The “Rules and Promises” lecture outlines five rules of “Fight Club”: 1. You don’t talk about fight club, 2. No man fights alone, 3. Every man must fight, 4. Only true contenders allowed (“Real manhood requires a willingness to be real”) and 5. Maximum reps are required (“Everyman who signs up must show up”).¹⁶ The second half of the lesson lays out “5 Promises for Every Man Who Goes the Distance.”¹⁷

There are twelve lessons in the workbook with a few additional lessons, totaling 16. These are broken up over the program time between Monday and Friday. In the “Fight Club” workbook the lessons are called “Rounds.” Many other analogies are drawn from the world of professional fighting: having “Corner men” (similar to accountability partners), developing “Fight plans,” etc. A full account of each day will not be articulated here, but a schedule of the week’s activities can be found in Appendix 13.

Each lesson begins with the instructor sharing his personal testimony of struggling with PTS, some of the difficulties that lead him to come to MOWP, how he was changed, and ways he has continued to grow since attending the program. This element is an extremely important component of the program. It will be discussed later in the findings and analysis portion of the dissertation.

After each lesson participants gather with their Teams (A “Alpha” Team, B “Bravo” Team, C “Charlie” Team and D “Delta” Team) in order to discuss the lesson as a group. These discussions are led by a Team Leader and a Phase I or Phase II Instructor in Training. This time is intended to foster intimate relationship building by encouraging participants to open up and share about their own personal difficulties.

Each day is structured and planned out in detail beginning with Morning

¹⁶ Tierce Green, *Fight Club: Some Things Are Worth Fighting For (Mighty Oaks Special Edition)* (The Woodlands, TX: Fresh Bread Resources, 2014), 5–6.

¹⁷ Green, *Fight Club*, 7.

Colors/Breakfast at 0700 and typically ending with a team breakout around 2000. Interspersed throughout the days are 16 lessons, team breakouts, 4 daily challenges (similar to devotional talks), meals, recreational activities (horseback riding, ATV trail riding), team building exercises, games and a minimal amount of free time. Every component of the program is intentional—including the structured schedule. Many who wrestle with PTS, especially combat veterans, benefit from having a structured routine.

Brief Description of Classes

Some of the initial classes were described in the preceding section but the remainder will be described briefly here. It is important to note that many of these classes offer biblical instruction on areas of life that are often a source of stress and thus can compound the struggle with PTS.

Testimony “Fighting for Your Life”: Is a recorded video testimony by Heather Cngemi. Heather is a widow of a veteran who committed suicide after a difficult battle with PTS. Initially she attended every Fight Club and shared her story in person, but as the program began to grow this was not feasible. This testimony is intended to challenge those who may be tempted by the thought that their family and friends would be better off if they just ended their lives.¹⁸

“I Am Second” video: This video was recorded by the ministry I Am Second. It is a brief account of Chad Robichaux’s testimony.¹⁹

Round 1—Why Men Need to Fight:²⁰ Attempts to provide a biblical definition of manhood contrasted against many of the false concepts the world promotes about

¹⁸ Cngemi, “Fighting for Your Life.”

¹⁹ *Chad Robichaux*, White Chair Films (I Am Second), <https://www.iamsecond.com/seconds/chad-robichaux/>.

²⁰ All the classes identified as a “Round” follow the workbook given to each participant. Green, *Fight Club*. Classes are not necessarily offered in the order they occur in the workbook (see appendix 13)

masculinity.

Round 2—Character: Offers a biblical definition of character, a defense of the importance of having strong character, and many of the common obstacles to maintaining godly character.

Round 3—Discipline: Provides a biblical description of discipline as well as numerous practical steps for developing and maintaining discipline in one’s life. It closes with a description of some spiritual disciplines participants are encouraged to implement in life.

Round 4—Brotherhood: Describes the importance and value of true biblical friendships. It describes different levels of transparency that exist in relationships and offers suggestions for developing open-honest-transparent relationships with key friends who will mutually encourage and foster growth in one another.

Round 5—Purity: This class points out the incredible dangers associated with sexual immorality and impurity and encourages men to fight for purity in their lives. It offers biblical descriptions of the temptations that men face and steps to take along the path of pursuing purity.

Round 6—The Truth about PTSD: This could be classified as psychoeducation because it informs participants of the nature of the struggle they face. However, it seeks to identify PTSD as “A normal response to an abnormal situation.”²¹

Round 7—Money & Possessions: Recognizing financial difficulty is a major stressor for most people. This class offers biblical principles of how to view and manage personal resources.

Round 8—Margin: This class offers biblical instruction on the stewardship of time and schedules. It offers encouragement and advice on creating space in life for rest and enjoyment.

²¹ Green, *Fight Club*, 41.

Round 9—Our Common Enemy: Offers biblical insight into the spiritual war we are all involved in as well as biblical instruction for fighting that war well.

Round 10—Legacy: Encourages participants to consider the way they will be remembered by their friends and family as a key motivator to live and fight for a life worth living and imitating.

Round 11—Marriage: Provides a biblical understanding of marriage, the roles of husbands and wives, and addresses the issue of divorce.

Round 12—Forgiveness: Describes the biblical understanding of forgiveness, why it is important and steps to take in the process of forgiveness. This is a key concept for those wrestling in the aftermath of significant sin, real or perceived, done by them or against them.

Fight Plan: Is something of an appendix in the *Fight Club* workbook and offers guidance on how to develop personal, specific, intentional plans to fight individual temptations or barriers to walking faithfully with the Lord.

Personal Testimony: The second night of Legacy Program each participant is given the opportunity to share what brings them to the program. It is encouraged, but voluntary. Most participants share a brief introduction including name, branch of service and a what they hope to learn.

Student Personal Testimony: The second to last night participants are encouraged to share their own personal testimony of what God has been teaching them over the week they have been at the Legacy Program.

Baptism and Devotional, How to?: Offers practical instruction on how to have a personal devotional time. It also addresses the purpose and importance of baptism.

Why the Bible: Is either an instructor led class on the nature of the Bible as God's infallible, trustworthy, and authoritative word. Or, like the Legacy Program I attended, it is a video recording of Voddie Baucham's sermon "Why I Choose To Believe the Bible," a powerful, succinct apologetic of the Bible as the Word of God.

Final Challenge: Is given to the participants during the graduation ceremony challenging them to implement the things they have learned as they return home and face all the challenges that are still awaiting them.

Other Important Elements

Daily Challenges: Are offered each morning, taking the form of an instructor lead devotional.

The Gospel Message: The gospel is clearly presented at each Legacy Program and those who are not Christians are encouraged to put their faith in Christ.

Baptism: Baptisms take place on the last day. Those who have put their faith in Christ at the program are encouraged to consider baptism. Others who have not been baptized or want to be rebaptized as an indication of a recommitment to the Christian faith are also baptized.

Reflection Walk: Time is set aside for participants to go for a silent meditative/reflection walk to consider both what they have been learning and challenges they are facing in life. This is a chance to pray, contemplate their fight plans, or anything else they need to think through in silence.

Recreational activities: Throughout the week time is set aside for horseback riding at a nearby ranch, ATV riding, a movie showing, and other activities. There are also team building games/challenges as well as games that can be played in the small amount of free time that is left (pool, cards, cornhole, etc.).

Graduation: Each Legacy Program ends with a graduation ceremony. This includes a final meal together, the Final Challenge, bestowing of a certificate, challenge coin and a rudis (replica of wooden sword awarded to gladiators who were victorious in battle and awarded freedom from slavery). Members of the community are invited to the ranch to observe the ceremony and support the participants in the program. Occasionally, larger graduations are held at a nearby location and large groups from the surrounding

communities attend a BBQ dinner and support the graduates.

After the graduation Friday night, participants are allowed to depart if they have their own transportation. Those who remain depart the next morning after breakfast.

Follow-Up Communication

On Thursday morning of the Legacy Program, participants are contacted by the Aftercare Coordinator via email (see appendix 15). The email includes an introduction and offers participants help locating a good local church, a biblical counselor if desired, a mentor, or an Outpost. The email also has two attachments; one is a 21-day study of the book of John and the other is a file that contains bible verses formatted to print on 3x5 cards for graduates to print and memorize.

The Tuesday following the Legacy Program I received another email from the Aftercare Coordinator providing a “Morale Check” and offering words of encouragement (see appendix 15).

Because Mighty Oaks is a peer-to-peer program and the majority of the instructors serve on a voluntary-as needed basis, they are constantly recruiting new instructors. Current Instructors and Team Leaders make recommendations to the Aftercare Coordinator of participants they believe might make good Team Leaders in the future. Those who are nominated receive an additional follow up email inviting them to consider the opportunity (see appendix 16). The email includes a three-page questionnaire for interested graduates to complete and return.

CHAPTER 5

ANALYSIS OF FINDINGS

The findings of this research are promising. The data give clear, strong answers regarding the correlation between attending the Legacy Program and the reduction of PTSD symptoms and the increase in strength of religious commitment. The data also reveal information regarding elements of the program that participants found beneficial. The quantitative data demonstrate that those who attend the Legacy Program are likely to have a decrease in their PTSD symptoms and an increase in the strength of their religious commitment. The data also demonstrates a negative correlation between those two factors. The qualitative data give insights that reveal the effective component of the Legacy Program is a reframed view of the participants life and understanding of his trauma.

Compilation Protocol

A convenience sample was utilized in both the retrospective alumni survey and the quantitative pre/post-test survey given to participants in Legacy Program. All participants during the survey timeframe were given the option to participate in the MOES study. The retrospective alumni survey was sent to all alumni in the MOF database at the time the survey was conducted. A convenience sample method was utilized in an attempt to gain the largest sample possible.

Pre/Post-Test Compilation

Participants in the study were recruited via communications from the MOF. The pre/post-test survey was made available to all participants of the MOWP Fight Club/Legacy program beginning in March of 2016 and continuing until May of 2017.

Every participant in the Legacy Program had the freedom to participate in the MOES study. A link to the survey was sent in the welcome e-mail with other pertinent information pertaining to the participants upcoming Fight Club/Legacy Program (see appendix 9). Participants were also given the chance to take the survey via paper copy during the inprocessing the first day of their Fight Club/Legacy Program (see appendix 4). Those paper copies were collected by MOWP leadership and delivered to me. Without review, I passed the surveys onto volunteers who entered the data into the on-line survey database. There were 132 participants who completed the pre-treatment survey.

The survey website was also designed with a page to send the follow-up survey six months after the participant took the initial survey. Reminder emails could be sent to participants from this page until a follow-up survey was completed. Of those who participated in the initial survey, 45 completed the six-month follow-up survey ($n=45$). Data from the surveys were compiled into a “results” page on the website and could be downloaded as a CSV file for analysis.

Alumni Survey Compilation

Using Survey Monkey, an invitation to participate in the retrospective alumni survey was e-mailed to 699 alumni who had participated in the MOWP Fight Club/Legacy Program. These alumni attended the program between 2014 and 2017. The initial invitation was sent on July 6, 2017 (see appendix 11). The invitation included a link that would take participants to a web-based survey hosted on Survey Monkey (see appendix 12). Due to technical issues, the survey was closed prematurely, so an additional identical e-mail was sent letting alumni who wanted to participate know that the survey was open again later that day. One reminder e-mail was sent to alumni on July 27, 2017 to encourage alumni who had not participated to take the survey at that time. Of the 699, 177 participants took some portion of the survey, a 25.32 percent response rate.

Of the 177 who took a portion of the survey 147 completed the survey, leaving 30 who only filled out a portion. Survey Monkey compiles results and provides basic analysis of the data, and allows researchers to download the data into CSV or Excel file.

Demographic and Sample Data

The demographic data for the entire research project is divided below between the pre/post-test survey and the retrospective alumni survey.

Pre-Test/Post-Test Survey

The demographic data gathered on the participants of the pre/post-test survey is summarized in table 1. While not identical in percentages, the demographics reflect the breakdown of ethnicities represented in the U.S. Armed Forces: 65 percent White, 12 percent Hispanic, 13 percent Black/African American, 3 percent Asian, 3 percent Multiple, 2 percent Unknown, 1 percent Other, and less than 1 percent American Indian/Alaska Native.¹

The military service of those who participated in the pre/post-test survey is summarized in table 2. The overwhelming majority of participants served in the Army and Marine Corps. This is as one might expect given the majority of service members in combat roles serve in one of these two branches. The inclusion of two participants with no military service indicates a shift in the program as it allowed first responders to attend.

¹ “Total Force Military Demographics” (Department of Defense: Office for Diversity, Equity, and Inclusion), 4, accessed May 22, 2019, <https://diversity.defense.gov/LinkClick.aspx?fileticket=gxMVqhkaHh8%3D&portalid=51>.

Table 1. Demographic data for pre/post-test participants

| Ethnicity | # | % | Age | # | % | Education | # | % |
|-----------------|----|-------|-------|----|-------|---------------------|----|-------|
| Hispanic-Latino | 10 | 22.22 | 18-24 | 2 | 4.44 | H.S. or GED | 5 | 11.11 |
| Other | 2 | 4.44 | 25-34 | 13 | 28.89 | Some College | 19 | 42.22 |
| White | 33 | 73.33 | 35-44 | 16 | 35.56 | Associate Degree | 4 | 8.89 |
| — | — | — | 45-54 | 10 | 22.22 | Bachelor | 9 | 20 |
| — | — | — | 55-64 | 3 | 6.67 | Master | 6 | 13.33 |
| — | — | — | 65-74 | 1 | 2.22 | Professional Degree | 1 | 2.22 |
| — | — | — | — | — | — | Trade School | 1 | 2.22 |

Table 2. Military service

| Branch | # | % |
|--------------|----|-------|
| Army | 17 | 37.78 |
| Air force | 1 | 2.22 |
| Navy | 2 | 4.44 |
| Marine Corps | 23 | 51.11 |
| None | 2 | 4.44 |

Retrospective Alumni Survey

The retrospective alumni survey produced a larger population of participants. Participants were given the freedom to skip demographic questions if they desired, and some questions allowed them to select multiple options so the total number of responses will vary from the total number of participants. The demographics are summarized in table 3.

Military service of those who participated in the retrospective-alumni survey is

summarized in table 4. Participants were able to select more than one option because some who serve in the military will transfer to a different branch of service at some point in their career. Similar to the pre/post-test survey the majority of participants in the survey were from the Army and Marine Corps, this is reflective of the population of participants in the MOWP.

Table 3. Demographic data for retrospective alumni survey participants

| Age <i>n</i> =176 | # | % | Education <i>n</i> =175 | # | % | Ethnicity <i>n</i> =177 | # | % |
|----------------------|----|--------|---------------------------------------|----|--------|-----------------------------------|-----|--------|
| 18 to 24 | 4 | 2.27% | Less than high school | 2 | 1.14% | American Indian or Alaskan Native | 5 | 2.82% |
| 25 to 34 | 57 | 32.39% | High school or equivalent (e.g., GED) | 22 | 12.57% | Asian or Pacific Islander | 7 | 3.95% |
| 35 to 44 | 64 | 36.36% | Some college but no degree | 63 | 36.00% | Black or African American | 8 | 4.52% |
| 45 to 54 | 35 | 19.89% | Associate degree | 28 | 16.00% | Hispanic or Latino | 29 | 16.38% |
| 55 to 64 | 11 | 6.25% | Bachelor degree | 31 | 17.71% | White / Caucasian | 127 | 71.75% |
| 65 to 74 | 5 | 2.84% | Graduate degree | 29 | 16.57% | Prefer not to answer | 5 | 2.82% |
| 75 or older | 0 | 0.00% | | | | Other (please specify) | 7 | 3.95% |

Table 4. Military service alumni survey

| Branch | # | % |
|--------------|----|--------|
| Army | 68 | 38.64% |
| Marine Corps | 81 | 46.02% |
| Navy | 19 | 10.80% |
| Air Force | 9 | 5.11% |
| Coast Guard | 1 | 0.57% |
| None | 18 | 10.23% |

Findings and Displays by Research Question

Research Question 1: Is there a correlation between attending the Legacy Program and the reduction of Post-Traumatic Stress Disorder (PTSD) symptoms?

The data gathered through the research indicates that there is a strong correlation between attending the Legacy Program and a reduction in PTSD symptoms. Utilizing the PCL-5 as the measurement of PTSD symptoms the majority respondents demonstrated a positive response to the program. A measurable response to treatment is a reduction of 5 or more points on the PCL-5 questionnaire. Clinically meaningful response is measured as a reduction in score of 10 or more points.² Of the 45 participants in the MOES survey 32 (71.11 percent) responded to treatment, and 23 (51.11 percent) of those did so to a clinically significant degree. Nine of the 45 demonstrated a +/- score of less than 5 points, meaning there was no measurable response to treatment. Four (8.89 percent) participants manifested a worsening of PTSD symptoms at the six-month post-test (they demonstrated an increase in PTSD symptoms by 5 or more points). Even with those who demonstrated worsening PTSD symptoms at the six-month mark, the mean change in score for the entire group was -14.31 points (SD 16.38).

Of the 32 who responded to treatment the average reduction in PCL-5 scoring was -21.56 points (SD 13.66). A paired *t*-test comparing the PTSD scores before and after treatment reveal a significant correlation ($p = .001$). A Wilcoxon Signed Ranks Test was also conducted to ensure that the results of the paired *t*-test were not influenced by anything that might undermine the assumptions of the parametric test. The Wilcoxon also revealed a *p*-value of .001. A large effect size was indicated by calculating Cohen's *d* = .87.

² "Using the PTSD Checklist for DSM-5 (PCL-5)" (National Center for PTSD), 3, accessed April 18, 2019, <https://www.ptsd.va.gov/professional/assessment/documents/using-PCL5.pdf>.

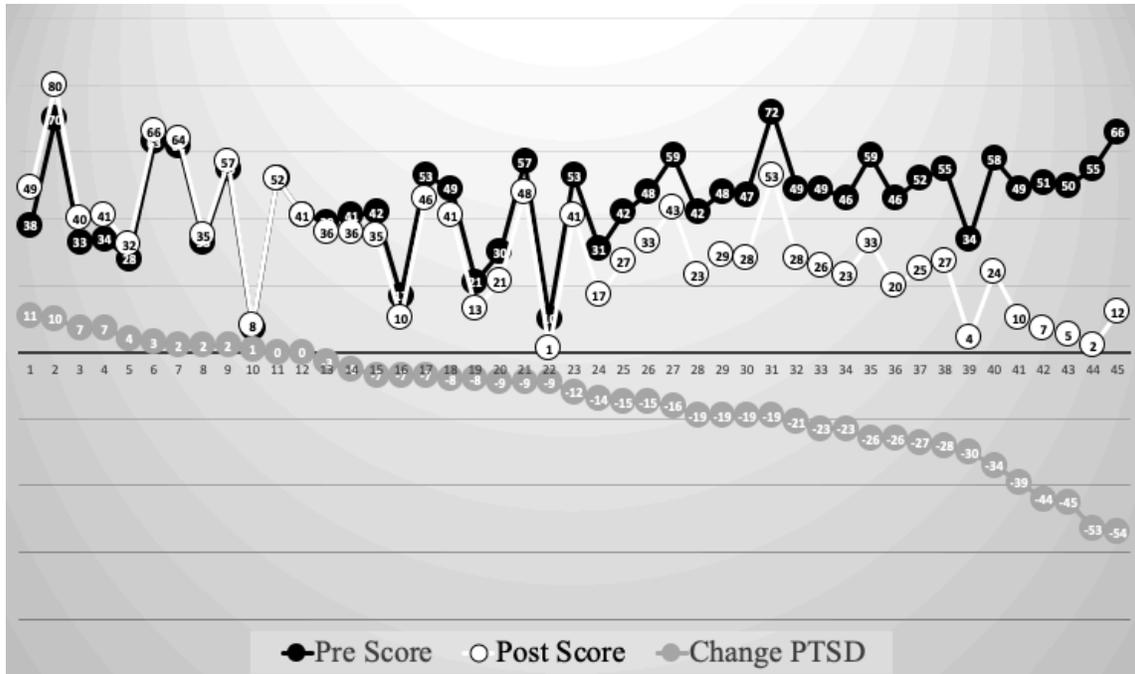


Figure 1. Change in PCL-5 scores from pre to post test

The PCL-5 recommends a cut point of 33 as a provisional diagnosis of PTSD. Based on this cut point, 38 (84.44 percent) of the participants in the pre/post-test survey qualified for a provisional diagnosis of PTSD before attending the Legacy Program. At the time of the post-test survey only 21 (46.67 percent) still qualified for the same provisional diagnosis. Seventeen (37.78 percent) had responded to treatment to the degree that they obtained remission (no longer qualified for a provisional diagnosis of PTSD). These findings demonstrate that there is a strong correlation between attending the MOWP Legacy Program and a reduction in PTSD symptoms. The findings also show that those who are helped demonstrate significant improvement.

Additionally, when the alumni were surveyed about the effect of the Legacy Program on their PTSD symptoms, the majority reported slight to major improvement in their symptoms (see figure 1).

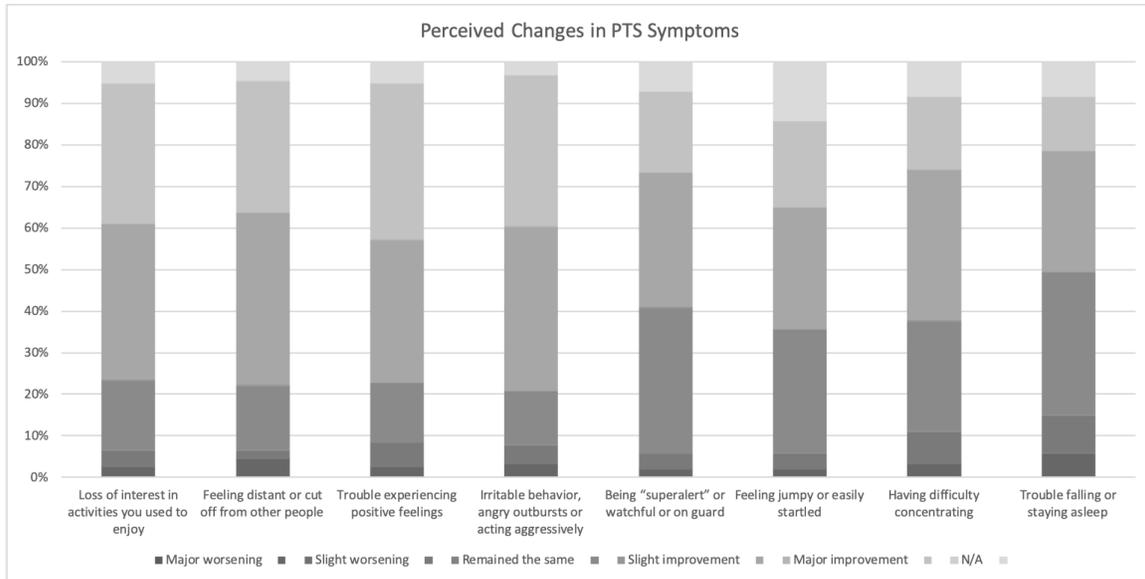


Figure 2. Perceived changes in PTS symptoms from alumni survey

Research Question 2: Is there a correlation between attending the Legacy Program and a growth in one's strength of religious commitment?

Analysis of responses to the Santa Clara Strength of Religious Faith

Questionnaire (SCSRFQ) revealed that the Legacy Program influenced positive growth in the strength of one's religious faith. The mean of the change between pre-test and post-test scores was 3.02 (SD 7.95). The majority of participants, 27 (60%), demonstrated some increase on the SCSRFQ. Those whose faith was bolstered saw an average increase in their score of 6.85 points (SD 5.998). Ten participants (22.22%) had no change in their scores whatsoever. Of those 10, 4 (8.89%) scored the maximum of 40 points on both the pre and post-test surveys. Eight participants had a reduction in the score on the SCSRFQ. Six of those who had a reduction in their score still qualified as having strong faith (between 25 and 36) on the post-test. Of those 8, 3 had a reduction of only 1 point. One participant went from demonstrating strong faith (40) to having very weak faith (10). A paired *t*-test of the pre/post-test scores revealed a *p*-value of .014, and the Wilcoxon test also demonstrated a *p*-value of .001 indicating that the growth in strength of religious

commitment is likely caused by attending the Legacy Program. The correlation coefficient, Cohen's $d = .38$ demonstrates a moderate effect size. These findings demonstrate a strong correlation between attendance at MOWP Legacy Program and a moderate increase in the strength of one's religious faith.

Research Question 3: Is there a correlation between the change of strength of one's religious commitment and the change in severity of one's PTSD symptoms?

In order to test the hypothesis that the reduction in PTSD symptoms was directly related to the increase in the strength of one's faith, the changes in scores on the PCL-5 and the changes in scores on the SCSRFQ were compared in SPSS using a Pearson Correlation. Pearson Correlation demonstrated a significant moderate negative correlation ($r = -.29, p = .054$).

Due to certain concerns with the results found in the SCSRFQ, I chose to do additional analysis on correlation between changes in scores on the PCL-5 and certain elements of the SCSRFQ. As survey results began to come in it became clear that many of the participants scored themselves very high on certain subjective measures in the pre-test. For instance, 21 participants (46.67%) marked "Strongly Agree" (the highest possible answer) on the survey statement, "My religious faith is extremely important to me." This combined with the fact that almost 10 percent of the participants scored the maximum score possible on the survey during the pre-test phase posed a problem to testing the hypothesis related to this research question. With such high scores on the pre-test, it would not be possible to demonstrate any growth for some participants or any type of significant change for the whole population.

Multiple respondents who indicated the maximum score of 4 to the first statement, "My religious faith is extremely important to me" scored themselves lower on more objective measures like, "I pray daily." These observations led me to analyze the correlation between a change in one's PTSD symptoms and a change in two objective measures of strength of faith from the SCSRFQ.

I chose two statements from the SCSRFQ, “I pray daily” and “I consider myself active in my faith or church,” and found the change in score for all participants between the pre-and post-test scores. Analysis of the relationship between the change in PTSD symptomology and the change in score for the two activity-based measures on the SCSRFQ revealed a much stronger moderate negative correlation ($r = -.38, p = .01$). Since the SCSRFQ questions have not been validated for use in this manner conclusions related to this analysis cannot be stated too strongly. However, given the rationale it appears that there may be a stronger correlation between the increase in religious practices and the decrease in PTSD symptoms when looking at more activity-based measures for strength of religious commitment. Further study, perhaps using different instrumentation for strength of religious commitment, would be necessary to make stronger conclusions.

Analysis of the alumni survey also bolsters the correlation between religious practices and reduction in PTSD symptoms. Alumni were asked to rank their perceived change on a variety of PTSD symptoms after attending the Legacy Program. Symptoms were scored on a scale of 1-5: 1-Major Worsening, 2-Slight Worsening, 3-Remained the Same, 4-Slight Improvement and 5-Major Improvement ($n = 154, M = 50, SD = 13.587$). Alumni were also asked to score themselves on follow through with four key elements encouraged at the Legacy Program: 1. Use of Cornermen, 2. Use of Fight Plans, 3. Daily Bible Reading and 4. Regular Church Attendance. Each element was scored on a 1-5 scale: 1-Not at all, 2-Barely at all, 3-Somewhat, 4-Regularly and 5-All the time ($n = 154, M = 13, SD = 4.0304$). A Spearman correlation test was run to see if there as a correlation between attendees follow through on these elements of the program and their perceived reduction of PTSD symptoms. The result demonstrated a clinically significant ($p = .0001$) moderate correlation ($r_s = .328$).

The retrospective alumni survey also demonstrates a strong influence of the Legacy Program on the faith of those who attend it. Of participants who responded to the

survey, 89 percent indicated that the Legacy Program increased their faith. “My faith grew extremely” was selected by 53 percent of the participants (see figure 2).

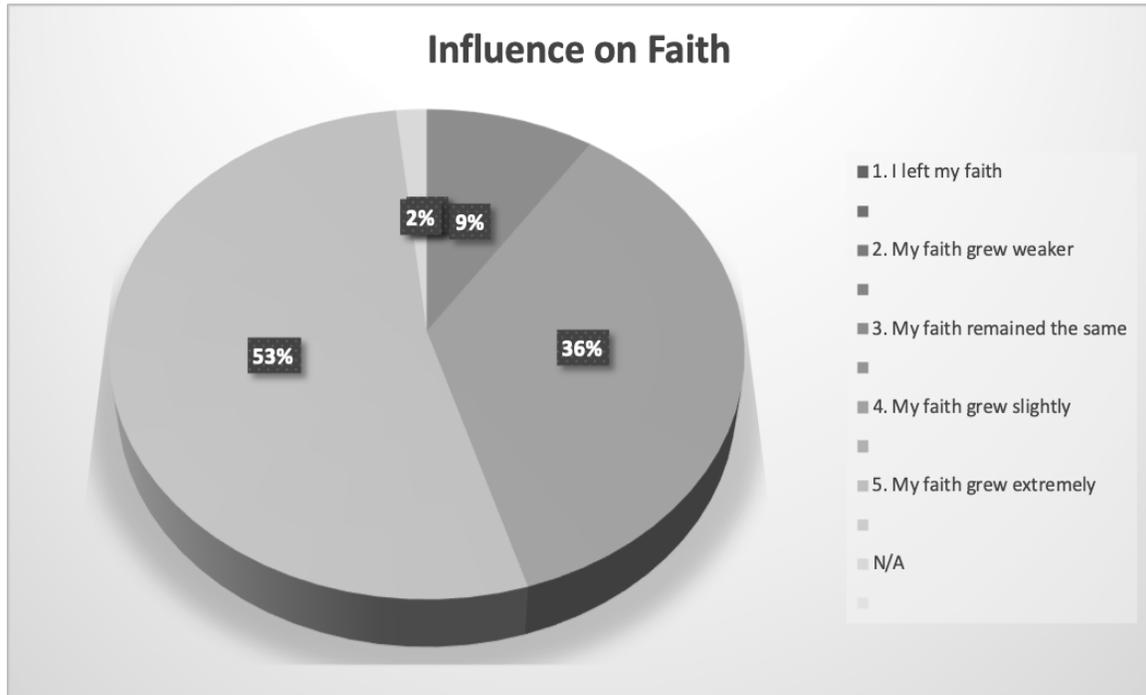


Figure 3. Influence of Legacy Program on faith of alumni

Research Question 4: What elements of the Legacy Program do participants find most helpful?

One hypothesis being tested with the research attempted to demonstrate that the Legacy Program was effective at treating PTSD symptoms by increasing the strength of one’s religious commitment. Additionally, the retrospective alumni survey was designed to investigate particular components of the program to see what things the participants found to be particularly helpful. The data can also be used to help the program leadership improve the program and help other ministries implement helpful components into their programs.

Participants were asked to assess various elements of the program from particular teaching topics to relational dynamics. They were asked to rate the elements with the following question: “On a scale of 1-5 (1 being not important at all and 5 being extremely important) how important were the following elements of the Legacy Program (formerly Fight Club) to helping you improve? Select N/A if you don’t remember” (see appendix 12).

When asked this question related to the 12 teaching topics, most participants ranked the majority of classes towards the extremely important side of the scale. Only two classes fell below 66 percent of the participants ranking it as “Extremely Important.” Those classes were “Margin” and “Money and Possessions.” The two most highly ranked classes were “Legacy” and “Forgiveness.” Table 5 shows a summary of alumni evaluation of the importance of the different classes offered.

Table 5. Importance of class topics

| | 1. Not Important at All | 2 | 3 | 4 | 5. Extremely Important | N/A |
|-----------------------------------|-------------------------|-------|--------|--------|------------------------|-------|
| Round 1, "Why Men Need to Fight": | 0.65% | 0.65% | 2.61% | 11.76% | 82.35% | 1.96% |
| Round 2, "Character": | 0.65% | 0.65% | 5.23% | 16.34% | 75.16% | 1.96% |
| Round 3, "Discipline": | 0.65% | 1.31% | 5.88% | 14.38% | 75.82% | 1.96% |
| Round 4, "Brotherhood": | 0.65% | 0.65% | 1.96% | 17.65% | 77.12% | 1.96% |
| Round 5, "Purity": | 0.65% | 1.31% | 5.23% | 20.92% | 69.93% | 1.96% |
| Round 6, "The Truth about PTS": | 0.65% | 2.61% | 7.19% | 15.03% | 73.20% | 1.31% |
| Round 7, "Money and Possessions": | 1.96% | 4.58% | 14.38% | 24.84% | 52.29% | 1.96% |
| Round 8, "Margin": | 0.65% | 1.31% | 10.46% | 20.92% | 62.75% | 3.92% |
| Round 9, "Our Common Enemy": | 0.65% | 0.65% | 1.96% | 16.34% | 77.78% | 2.61% |
| Round 10, "Legacy": | 0.65% | 0.65% | 1.96% | 10.46% | 83.01% | 3.27% |
| Round 11, "Marriage": | 1.96% | 0.65% | 4.58% | 14.38% | 75.16% | 3.27% |
| Round 12, "Forgiveness": | 0.65% | 0.65% | 0.65% | 15.03% | 82.35% | 0.65% |

The instructional component is essential to the program, but other elements are key in helping the participants accept and adopt what is taught in the program. For veterans who have often been evaluated or treated in clinical settings with the DoD or VA the MOWP offers a very different environment. Most participants in this study stayed at the SkyRose Ranch facility in San Miguel, California. This is a 20,000-acre ranch with luxurious accommodations for the participants.³ Other program locations provide similarly remote and hospitable conditions. The non-clinical setting was ranked as “Extremely Important” by 80.39 percent of participants surveyed (see table 6) and 88.82 percent gave the same ranking to the distraction free environment provided by the program (see table 7).

Table 6. Important factors 1

| | 1. Not Important at all | 2 | 3 | 4 | 5. Extremely Important | N/A |
|--|-------------------------|-------|--------|--------|------------------------|--------|
| The fact that it was held in a non-clinical setting | 3.27% | 3.27% | 2.61% | 9.80% | 80.39% | 0.65% |
| Teaching on the physiological aspects of PTS | 0.00% | 2.61% | 12.42% | 20.26% | 64.05% | 0.65% |
| Comradery developed with fellow Fight Club attendees | 0.00% | 1.96% | 6.54% | 11.76% | 78.43% | 1.31% |
| Comradery with the instructor cadre | 0.00% | 2.61% | 5.23% | 18.95% | 71.90% | 1.31% |
| Testimony of Heather Cangemi | 0.65% | 1.31% | 10.46% | 18.95% | 56.21% | 12.42% |

Shared experience of suffering is a key component of this program. All instructors are combat veterans who have been through the program themselves. The

³ SkyRose Ranch, accessed May 22, 2019, <https://www.skyroseranch.com/>.

single element that received the highest ranking of importance was “Having instructors who had personally experienced PTS”; 90.13 percent of respondents indicated this was “Extremely Important” (see table 7). Developing a sense of closeness with fellow participants and instructors is also key. “Comradery with the instructor cadre” received 71.9 percent of responses as “Extremely Important,” and 78.43 percent said “Comradery developed with fellow Fight Club attendees” was “Extremely Important” (see table 6). Team breakouts are essential for developing relationships at both the peer and instructor level. 75.66 percent of respondents indicated that the team breakouts were “Extremely Important” to them (see table 7). This is consistent with other research that demonstrates the multitude of benefits from peer support as well as the hesitancy of combat veterans in particular to open up to those who have not served in the military.⁴

Table 7. Important factors 2

| | 1. Not Important at all | 2 | 3 | 4 | 5. Extremely Important | N/A |
|---|-------------------------|-------|--------|--------|------------------------|-------|
| Flight Plans | 1.97% | 3.95% | 19.08% | 19.08% | 55.26% | 0.66% |
| Personal Testimonies | 1.32% | 0.66% | 3.95% | 19.74% | 73.68% | 0.66% |
| "Why the Bible?" | 1.32% | 0.00% | 7.89% | 15.79% | 73.68% | 1.32% |
| Reflection Walks | 3.29% | 5.26% | 17.11% | 24.34% | 48.03% | 1.97% |
| Team Breakouts | 1.32% | 0.66% | 3.29% | 19.08% | 75.66% | 0.00% |
| Daily Challenges | 1.32% | 1.97% | 9.21% | 27.63% | 56.58% | 3.29% |
| Presentation of the Gospel | 1.32% | 1.32% | 5.92% | 14.47% | 75.00% | 1.97% |
| Recreational Elements | 1.32% | 3.95% | 15.13% | 23.68% | 55.26% | 0.66% |
| Distraction-free Environment | 1.32% | 0.66% | 2.63% | 6.58% | 88.82% | 0.00% |
| Having Instructors who had personally experienced PTS | 1.97% | 0.66% | 1.97% | 5.26% | 90.13% | 0.00% |

⁴ Natalie E. Hundt et al., “Veterans’ Perspectives on Benefits and Drawbacks of Peer Support for Posttraumatic Stress Disorder,” *Military Medicine* 180, no. 8 (August 2015): 852–53.

Research Question 5: How does the Legacy Program compare to other treatment programs for PTSD?

As noted in the literature review, there is an ever-expanding plethora of treatment options available to people who struggle with PTSD. That expansion is also reflected in the number of articles documenting studies of these various treatments. It would be impossible to review each study on every treatment program available. Even if time allowed for full review of every study, comparing the results of these studies is riddled with numerous difficulties. Studies implement a wide range of instrumentation for measuring various outcomes. In addition, not all studies report the same statistical analysis. For instance, not every study reports the effect size of the results. Very few are willing to share the raw data gathered in the study so that other researchers can run additional analysis on the data. This makes the task of comparing various treatment programs extremely difficult and in some cases impossible.

The present study has additional challenges which make the comparison to other treatment programs difficult. One key challenge is the use of the PCL-5 as the instrumentation to measure changes in PTSD symptoms. The PCL-5 is the most recent edition of the PCL. It was updated to align with the latest description of PTSD found in the most recent edition of the *DSM*. Because the updated *DSM-5* and associated PCL-5 are relatively new, they were not available for use in effectiveness studies until recent years and thus the number of studies utilizing them are relatively few. An EBSCO search of studies utilizing the PCL-5 as an instrument only found eight published articles addressing PTSD in combat veterans. The search found additional studies that have been proposed which will use the PCL-5 but they will likely not be published in time for inclusion in this dissertation.⁵

⁵Walter et al., “Evaluation of an Integrated Treatment for Active Duty Service Members with Comorbid Posttraumatic Stress Disorder and Major Depressive Disorder”; Edna B. Foa et al., “The Implementation of Prolonged Exposure: Design of a Multisite Study Evaluating the Usefulness of Workshop with and without Consultation,” *Contemporary Clinical Trials* 61 (October 2017): 48–54;

In spite of these challenges, a comparison of studies on various treatments does provide some valuable insight. First, while they are few, there are some treatment programs that were evaluated using the same instruments and statistical analysis as the current study. Table 8 offers a summary of the eight studies that utilized the PCL-5 as the primary instrument to measure changes in PTSD symptomology among veteran participants.

The comparison shows that the Legacy Program is on par with many of the other treatment programs in the effect size and the mean score change. It is important to note that the Legacy Program post-treatment measurement is the longest timeframe tested. This is encouraging from the standpoint that the effects of the treatment are demonstrated to last at least up to six months. This does not mean the treatment effects of the other programs would have diminished by this point. Since they did not have a follow up six months out no statement can be made in that regard. However, the Virtual Reality Exposure group did show a worsening of symptoms at the three month follow up. Four of the studies did not conduct follow up assessments so there is no indication of whether or not the effects of treatment will last once the treatment is concluded. It is also interesting to note the size of samples used in these studies. The largest is 46 and the smallest is 4. The pre/post-test sample for the MOES was 45.

Carmen P. McLean et al., "Design of a Randomized Controlled Trial Examining the Efficacy and Biological Mechanisms of Web-Prolonged Exposure and Present-Centered Therapy for PTSD among Active-Duty Military Personnel and Veterans," *Contemporary Clinical Trials* 64 (January 2018): 41–48; Gabrielle H. Saunders et al., "Design and Challenges for a Randomized, Multi-Site Clinical Trial Comparing the Use of Service Dogs and Emotional Support Dogs in Veterans with Post-Traumatic Stress Disorder (PTSD)," *Contemporary Clinical Trials* 62 (November 2017): 105–13.

Table 8. Comparison of treatments evaluated with PCL-5⁶

| Treatment | Effect Size | Effect kind | <i>n</i> | Length of treatment | Treatment Intensity | p value | Mean Score Change |
|---|---------------------------------|-------------|----------|---------------------|---|--------------|---------------------------------------|
| Legacy Program | 0.87 | Cohen's d | 45 | 1 week | Residential | 0.001 | Start-6 months (-14.31) |
| EMDR | At Post TX 0.63 at 21 days 0.91 | Cohen's d | 12 | 5 days | Residential: 2 90-minute sessions a day (4 of the days) | Not Reported | Start-Post TX (-10), 21 Days (-16.42) |
| rTMS | 1.12 | RCI | 10 | 3 weeks | Up to 30 1-hour sessions plus 6 taper sessions. | 0.003 | Start-Post TX (-19.1) |
| Transcendental meditation | -1.93 | | 46 | 1 month | 20 Min/Day once (n=10) or twice daily (n=36) | 0.001 | Start-Post TX (-28.09) |
| EMDR-Integrative Group Treatment Protocol | 1.8 | Cohen's d | 35 | 2 days | 3, 1-hour sessions a day. Total 6 hours. | 0.05 | Start-Post TX (24.38). 90 Days (-27). |
| Yoga | 0.32 | Cohen's d | 9 | 16 weeks | Varied between 1 to 23 1-hour freely chosen sessions | 0.049 | Did not report specifics |

⁶ Zepeda Méndez et al., "A Five-Day Inpatient EMDR Treatment Programme for PTSD"; Philip et al., "5-Hz Transcranial Magnetic Stimulation for Comorbid Posttraumatic Stress Disorder and Major Depression"; Herron and Rees, "The Transcendental Meditation Program's Impact on the Symptoms of Post-Traumatic Stress Disorder of Veterans"; Ignacio Jarero, Martha Givaudan, and Amalia Osorio, "Randomized Controlled Trial on the Provision of the EMDR Integrative Group Treatment Protocol Adapted for Ongoing Traumatic Stress to Female Patients With Cancer-Related Posttraumatic Stress Disorder Symptoms," *Journal of EMDR Practice & Research* 12, no. 3 (July 2018): 94–104; Timothy Avery et al., "Psychological Flexibility and Set-Shifting Among Veterans Participating in a Yoga Program: A Pilot Study," *Military Medicine* 183, no. 11/12 (December 11, 2018): e359–63; Laura Loucks et al., "You Can Do That?!: Feasibility of Virtual Reality Exposure Therapy in the Treatment of PTSD Due to Military Sexual Trauma," *Journal of Anxiety Disorders* 61 (January 2019): 55–63; K. Maya Story and Bolette Daniels Beck, "Guided Imagery and Music with Female Military Veterans: An Intervention Development Study," *Arts in Psychotherapy* 55 (September 2017): 93–102; Ignacio Jarero, Gregory Rake, and Martha Givaudan, "EMDR Therapy Program for Advanced Psychosocial Interventions Provided by Paraprofessionals," *Journal of EMDR Practice & Research* 11, no. 3 (July 2017): 122–28.

Table 8 continued

| Treatment | Effect Size | Effect kind | <i>n</i> | Length of treatment | Treatment Intensity | p value | Mean Score Change |
|--|-------------|---------------------|--|---------------------|---------------------------------------|--------------|--|
| Virtual Reality Exposure Therapy (VRE) | 1.14 | Cohen's <i>d</i> | 11 completed only 9 received adequate dose of TX | 6 weeks | 6 to 12 90-minute sessions | 0.004 | Start for <i>n</i> =11-Post TX (-20.27). Post TX for <i>n</i> =9-3 month (+5.22 worsening) |
| Guided Imagery and Music (GIM) | 1 | Cohen's <i>d</i> | 4 | 3 months | Up to 10 90-minute sessions per week. | Not Reported | Start-Post TX (-13) |
| EMDR IGTP by paraprofessionals | 0.94 | Partial eta squared | 37 | 2 weeks | 4 sessions total | 0.001 | Start-Post TX (-19.43) 90 Days (-27.4) |

One study evaluated a five-day intensive Eye Movement Desensitization and Reprocessing (EMDR) treatment program. The study reports a reduction of mean score measured pre-treatment and then at 21 days post-treatment, on the PCL-5 of 16.42 points. This is a significant reduction in mean score with a large effect size of $d = .91$.⁷ This report utilizes similar measurements and analysis to that of the current study. Likewise, both treatment programs are approximately one week long.

There are some key differences in the studies. First, the current study evaluated participants progress six months after treatment versus 21 days. The long-lasting nature of the effects of care are important when working with any treatment program. It would be interesting to see if the improvements from EMDR were still present at six months like they are with the Legacy Program.

Additionally, the population of those evaluated in the current study was almost

⁷ Zepeda Méndez et al., "A Five-Day Inpatient EMDR Treatment Programme for PTSD," 1, 6.

four times that of the EMDR study. Larger populations tend to provide more reliable statistical evidence. The EMDR study purports to evaluate EMDR, but the program included elements of trauma-informed yoga and supportive talk therapy every day.⁸ The inclusion of these other elements makes it difficult to assess which of them is the mechanism of change. The study also does not provide any *p*-value to demonstrate whether or not the changes in score are likely due to chance. Side-by-side, the effects of the Legacy Program are roughly equivalent to that of the EMDR study, both have large effect size and similarly high reduction in mean score on the PCL-5.

Transcranial Magnetic Stimulation (TMS) is another nonpharmacological treatment that is gaining popularity. One study measuring the effectiveness of 5-Hz TMS, measured changes in PCL-5 scores in a population of 10 participants. The study demonstrated a large effect size of 1.12 with a reduction of 19.1 points in the mean score on PCL-5.⁹ The study reports a strong likelihood that the reduction in PTSD symptoms is related to the treatment ($p = .003$).¹⁰ Again, the population evaluated in this study is significantly smaller than the study conducted in this dissertation ($n = 10$ to $n = 45$). The final evaluation was made at the end of treatment, three weeks after the program began. There was no follow-up testing done to determine the longevity of improvement. Another contrast between this treatment program and the Legacy Program is that the treatment for the TMS study spanned three weeks. One element that is important to those seeking treatment, as well as those impacted by their absence caused by treatment (DoD for active military personnel) is the life disruption during treatment. While the TMS treatments themselves are completed in one hour, the full course offered consisted of 36

⁸ Méndez et al., “A Five-Day Inpatient EMDR Treatment Programme for PTSD,” 4.

⁹ Noah S. Philip et al., “5-Hz Transcranial Magnetic Stimulation for Comorbid Posttraumatic Stress Disorder and Major Depression,” *Journal of Traumatic Stress* 29, no. 1 (February 2016): 95.

¹⁰ Philip et al., 93.

treatments over the three-week period.¹¹ That is a minimum of 36 hours, not counting commute time and any wait time in the clinic preparing for treatment. Comparatively, the Legacy Program takes one week to complete. It is only as disruptive as one week of vacation or sick leave.

Even when comparing studies that are using the same measurements and treating the same diagnosis there are many other variables to consider. Based on effect size and reduction in mean score on the PCL-5 it is fair to say that the Legacy Program is a comparable treatment to the best treatments evaluated in these studies. Considering other factors like impact of life and longevity of effect the Legacy Program may be preferable to other treatments evaluated here.

In an attempt to expand the number of comparative studies I searched for other effectiveness studies that measured treatments for PTSD among veteran populations. It is even more challenging to make comparisons between these programs and the Legacy program since these other studies did not utilize the same measurement instruments. However, comparing effect size of the results from the studies is one way to gain some insight into how various treatments measure up to one another. Table 9 summarizes the results from seven studies compared to the results of the MOES pre/post-test survey. The Legacy Program demonstrated a large effect size (0.87, Cohen's *d*). The large effect size places it in the upper echelon of treatments in regard to effect size.

¹¹ Philip et al., "5-Hz Transcranial Magnetic Stimulation for Comorbid Posttraumatic Stress Disorder and Major Depression," 94.

Table 9. Comparing effect size of other treatments¹²

| Study | Treatment | Effect Size | Effect kind | N | p value | Instruments |
|---|--|-------------|------------------|-----|---------|---|
| Legacy Program | Biblical Counseling | 0.87 | Cohen's <i>d</i> | 45 | 0.001 | PCL-5 |
| TRR's Warrior Camp | EMDR, Equine-Assisted Psychotherapy, yoga | 0.70 | Hedge's <i>g</i> | 85 | 0.001 | Mississippi Scale for Combat-related PTSD |
| “” | | 1.22 | Hedge's <i>g</i> | 85 | 0.001 | Davidson Trauma Scale |
| Effectiveness of Group-Delivered Cognitive Therapy and Treatment Length of Women Veterans with PTSD | Group CPT | 0.54 | | 172 | 0.001 | PCL (17 question version from DSM-IV) |
| Description and Preliminary Outcomes of an In Vivo Exposure Group Treatment for PTSD. | PE In Vivo Exposure group treatment | 0.73 | Cohen's <i>d</i> | 43 | 0.001 | PCL-S |
| Evaluation of an Integrative PTSD Program | Mindfulness, relaxation response, meditation, yoga | 0.55 | Cohen's <i>d</i> | 595 | 0.001 | PCL-M |
| RCT of Accelerated Resolution Therapy (ART) for Symptoms of Combat-Related PTSD | Accelerated Resolution Therapy (ART) | 1.39 | | 26 | 0.001 | PCL-M |
| Outcomes of Prolonged Exposure Therapy for Veterans With PTSD | PE | 1.45 | Cohen's <i>d</i> | | 0.001 | PCL-M |

¹² Emily Steele et al., “TRR’s Warrior Camp: An Intensive Treatment Program for Combat Trauma in Active Military and Veterans of All Eras,” *Military Medicine* 183 (March 2, 2018): 403–7; Diane T. Castillo et al., “Effectiveness of Group-Delivered Cognitive Therapy and Treatment Length in Women Veterans with PTSD,” *Behavioral Sciences* 4, no. 1 (March 2014): 31–41; Porter, Romero, and Barone, “Description and Preliminary Outcomes of an In Vivo Exposure Group Treatment for Posttraumatic Stress Disorder”; Lara G. Hilton et al., “Evaluation of an Integrative Post-Traumatic Stress Disorder Treatment Program,” *Journal of Alternative & Complementary Medicine* 25 (March 2, 2019): S147–52; Kevin E. Kip et al., “Randomized Controlled Trial of Accelerated Resolution Therapy (ART) for Symptoms of Combat-Related Post-Traumatic Stress Disorder (PTSD),” *Military Medicine* 178, no. 12 (December 2013): 1298–1309; Jason T. Goodson et al., “Outcomes of Prolonged Exposure Therapy for Veterans with Posttraumatic Stress Disorder,” *Journal of Traumatic Stress* 26, no. 4 (August 2013): 419–25; Edna B. Foa et al., “Effect of Prolonged Exposure Therapy Delivered Over 2 Weeks vs 8 Weeks vs Present-Centered Therapy on PTSD Symptom Severity in Military Personnel: A Randomized Clinical Trial,” *Journal of the American Medical Association* 319, no. 4 (January 23, 2018): 354–64; Resick et al., “Effect of Group vs Individual Cognitive Processing Therapy in Active-Duty Military Seeking Treatment for Posttraumatic Stress Disorder.”

Table 9 continued

| Study | Treatment | Effect Size | Effect kind | N | p value | Instruments |
|--|----------------|------------------------------|------------------|-----|---------|-------------|
| Effect of Prolonged Exposure Therapy Delivered over 2 Weeks vs. 8 Weeks vs Present-Centered Therapy on PTSD Symptom Severity in Military Personnel | Massed PE | 1.04 | Cohen's <i>d</i> | 110 | 0.001 | PSS-1 |
| “““ | Spaced PE | .87 | Cohen's <i>d</i> | 109 | 0.001 | PSS-1 |
| “““ | PCT | .87 | Cohen's <i>d</i> | 107 | 0.001 | PSS-1 |
| Effect of Group vs Individual Cognitive Processing Therapy in Active-Duty Military Seeking Treatment for Posttraumatic Stress Disorder A Randomized Clinical Trial | Individual CPT | 1.3 (Post TX) 1.2 (6 months) | Cohen's <i>d</i> | 135 | 0.001 | PSS-1 |
| “““ | Group CPT | .7 (Post TX) .9 (6 months) | Cohen's <i>d</i> | 133 | 0.001 | PSS-1 |

Other Significant Findings

One significant finding from the data came in an analysis of the demographic information compared to the participants response to treatment. While the majority of participants in the pre/post-test surveys responded to treatment the response was not consistent among the age categories. Participants were divided into six age brackets: 18-24, 25-34, 35-44, 45-54, 55-64, and 65-74 (see Table 3). There were two participants in the first decade, one responded to treatment the other did not. Of the 11 participants in the second age (25-34) bracket, 9 responded to treatment (81.8%). Those in the third bracket (35-44), 11 of 17 responded to treatment (64.7%). Effectiveness of treatment continues to decline in the next age bracket (45-54) so that a majority are no longer responding to treatment. Only 5 of 11 (45.5%) in this category responded to treatment. By the next decade of life (55-64) none of the 3 (0%) in this age bracket respond to treatment. The data do not provide any indication as to why this is the case. Some research indicates that

age negatively impacts neurogenesis of the brain and would therefore inhibit the ability to recover neurologically from the impact of trauma.¹³ Others believe it is connected to the longevity of the struggle.¹⁴ That is to say, the longer someone has struggled with PTSD the harder it is to overcome it. I hypothesize that this may also be connected to the strength of peer-to-peer relationships in the treatment process. While I was not able to access the ages of the instructors at each program during the time of the study my, subjective observations were that the majority fell into the age range of those who were receiving the most benefit from treatment. It is entirely possible for it to be one or any combination of these factors. The finding in this study may also be related to the small sample size in this age bracket. Further research is necessary to determine what factors, if any, contribute to this trend.

¹³ Arnsten et al., “The Effects of Stress Exposure on Prefrontal Cortex,” 91.

¹⁴ Jeremy Stalneker, telephone conversation with author, January 10, 2019.

CHAPTER 6

CONCLUSIONS

The research that was conducted and the analysis of that research provide some very clear and promising conclusions. The results point to significant findings that can be utilized to help those struggling with PTS in a variety of ways. These insights can also be used to inform and help those who serve or work with those who struggle with PTS.

Research Purpose

This dissertation is based on research that intended to answer the following research questions:

1. Is there a correlation between attending the Legacy Program and the reduction of Post-Traumatic Stress Disorder (PTSD) symptoms?
2. Is there a correlation between attending the Legacy Program and a growth in one's strength of religious commitment?
3. Is there a correlation between the strength of one's religious commitment and the severity of one's PTSD symptoms?
4. What elements of the Legacy Program do participants find most helpful?
5. How does the Legacy Program compare to other treatment programs for PTSD?

The goals of this research are (1) Demonstrating empirically the effectiveness of the Mighty Oaks Foundation's Legacy Program in reducing the participants PTSD symptoms. (2) To demonstrate the positive influence the Legacy Program has on the strength of participants religious commitment. (3) To demonstrate a significant statistical correlation between an increase in strength of religious commitment and a reduction of PTSD symptoms. (4) To identify helpful elements of the program that can be utilized by others.

Conclusions from Pre/Post-Test Survey

The empirical data gathered from the pre/post-test surveys clearly demonstrate that the Legacy Program is effective both at reducing PTSD symptoms and in growing the strength of religious commitment of its participants. The research also demonstrates a negative correlation between PTSD symptoms and the strength of one's religious faith.

Participants who attend the Legacy Program are likely to see a growth in the strength of their religious commitment and a reduction in their PTSD symptoms. These two realities are related. The data demonstrate that even a moderate increase in the strength of religious commitment can result in significant reduction of PTSD symptoms.

Conclusions from Alumni Survey

By reviewing the data collected from the alumni survey, a number of conclusions can be drawn about what was most helpful to participants.

First, relationships are a key component of the treatment program. Data demonstrates that the relationships established both amongst participants and between participants and the instructors was extremely important. These relationships formed quickly largely due to instructors and participants having shared the common experience of facing significant trauma. "Having instructors who had personally experienced PTS" garnered the highest percentage of "Extremely Important" responses than any other single element. There is tremendous value in shared experience. Utilizing combat veterans as instructors manifests the reality of 1 Corinthians 10:13 to people who often feel like no one else has been through the horrors they have faced. The idea that "no temptation has taken you except that which is common to man" is difficult to believe when you have seen, participated in or been victim to some of the worst situations humanity can face. Instructors who have faced combat or other intense traumatic experiences understand what the participants are experiencing on a deeper level. They can connect personally with the participants quickly through that shared experience.

The use of personal testimonies—both instructors sharing their own as well as

encouraging participants to open up about personal struggles is also vitally important. Without transparency participants may be left wondering if they would be truly accepted and loved if they were fully known. Providing an environment where they can open up with men who they believe will understand them is extremely helpful. Openly sharing the experiences also affords the instructors and participants to help one another reframe the experience and the aftermath of those experiences. Sharing your story and seeing others benefit from your sharing offers meaning and significance to that experience.

Relationships play a key role while participants are attending the Legacy Program but they also play a vital role after participants leave. The retrospective alumni survey clearly pointed to the importance of relationships between the participants as well as the important role of the relationship with instructors. The survey also revealed that continuing in relationships with Corner Men and involvement in a church were common practices among the alumni. Relationships with fellow trauma sufferers can help those facing PTS understand and express what is going on in their lives. One significant factor to change is having a trusted friend who can demonstrate a changed life and describe the change process. If an individual is stuck in faulty thinking it is going to require another person to point out where his thoughts are going astray and to help guide him to a proper understanding of his experience. Instructors provide a living example that change is possible and the content helps provide a proper understanding that leads to the change.

Providing a comfortable, distraction free, non-clinical setting is also important for participants. Concentration is often a challenge for people struggling with PTS. The most mundane, everyday tasks of life can seem overwhelming to a person facing PTS. Additionally, many of the things in the person's environment including relationships, house, schedule, employment or lack thereof, all become sources of stress or are associated with feelings of stress. One veteran's testimony may help to demonstrate why this is an important element. He had been diagnosed with PTSD and hospitalized on multiple occasions for suicidal ideation related to PTSD. He indicated that on multiple

occasions what preceded the hospitalization was rapidly escalating stress related to normal everyday life and decision making. Paying bills, coordinating schedules, miscommunication, and other normal stressors of life are amplified for the person wrestling with PTS. Taking them to a peaceful, quiet environment where they have virtually no responsibilities or connection to the stressors in their home life enables them to focus on their own challenges and also on solutions to those challenges.

Cost and availability of treatment have been shown to be significant barriers to veterans receiving care.¹ Because the Mighty Oaks Foundation is a well-funded ministry they are able to provide no-cost care to veterans regardless of where they live. Expanding the number of Legacy Programs around the world is one way to increase availability of this treatment to those who need it. However, expansion of a single ministry comes with a number of challenges. First, expansion means increased staffing and material needs which also increases cost. Thus far the ministry has been able to stay ahead of the curve on fund raising but care must be taken that it does not overextend itself. There is also the danger that the larger the ministry becomes the greater chance it has of becoming diluted or veering away from its mission or methodology.

Another way availability can expand is for other ministries to develop which have a similar mission and methodology as that of Mighty Oaks. As long as the ministries see one another as partners and not competitors in the care of men and women who struggle with PTS, this is an excellent option. Of course there are potential hazards here as well. One hazard would be the creation of organizations that want to adopt some aspects of the program but jettison the faith component. However, this runs the risk of altering the effectiveness of treatment. Based on the research in this dissertation they may see some improvements of PTSD symptoms but will lose out on the significant impact of

¹ Erin P. Finley et al., "Characteristics Associated With Utilization of VA and Non-VA Care Among Iraq and Afghanistan Veterans With Post-Traumatic Stress Disorder," *Military Medicine* 182, no. 11 (November 2017): 1898.

the Christian faith on PTSD.

One of the goals of the research was to identify elements of the program that could be used by others to help individuals struggling with PTS. All of the content taught at the Legacy Program could be adopted by other organizations or individual counselors. The majority of participants identified each class taught as “Extremely Helpful.” However, other elements that were also extremely important to the participants would be much harder to replicate especially in a traditional counseling context. Unless the counselor has experienced trauma in the past and worked through PTS and seen post traumatic sanctification he will face the challenge of convincing the counselee to listen to his counsel. Anecdotally, Chad Robichaux’s testimony demonstrates what one might encounter—resistance to counsel potentially followed by a protracted counseling process that takes much longer. It is not impossible for an individual who has never experienced PTS to counsel someone who has but it will be more challenging.

Another element that would not translate into the private counseling room are the multiple relationships formed during the Legacy Program. It is impossible to know for certain how different the experience would be between a peer-to-peer private counseling relationship and the group dynamic experienced at the Legacy Program. Further research may help to investigate the difference in effectiveness between the group setting and private counseling.

The distraction free environment is also vitally important to the participants. This would be impossible for a traditional biblical counseling situation. There are some ministries that offer intensive counseling retreats that may provide this element but the other factors that make the Legacy Program effective may be missing

Research Implications

Implications from this research are significant. Post-traumatic stress is a significant issue facing humanity in general and the men and women who serve and

defend our nation in particular. Providing information and resources to help men and women effected by PTS is a great need. It is a blessing to be a part of the solution.

This research demonstrates that PTS is not something that only trained clinicians can address. Every person who provides friendship and love to a person struggling in the aftermath of traumatizing horror can be a source of help and healing.

This research also demonstrates that healing from PTS does not require medical or clinical interventions. The men who participated in this study saw significant changes in their struggle with PTS after a one-week program dedicated to introducing them to Christian faith and practice. Groups like the Mighty Oaks Foundation who offer this type of program can play a significant role in reducing the rates of veteran suicide, decreasing the impact of PTS on families and offering life change that is eternal.

The connection between one's strength of religious commitment and PTS symptoms has implications for treatment of those who suffer with PTS symptoms. Additionally, it provides insight into the possibility that one's faith and religious beliefs can influence the likelihood that one might or might not develop PTS symptoms or might influence the severity of those symptoms as well as expedite recovery.

Research Applications

One of the first applications of this research is to publish the results in a peer reviewed journal article enabling the Mighty Oaks Foundation to utilize the findings to increase opportunities to serve and expand the ministry. There have been numerous occasions when the ministry has sought to expand treatment or open their services only to receive pushback from the Department of Veterans Affairs or other agencies demanding evidence to show the program is effective. The results of this study provide such evidence and can be used by ministry leaders to answer questions or charges of this nature.

Second, the findings of this study can be used to inform

organizations/ministries with a similar mission to the MOF on various elements and structures that can be used to help their programs be effective. MOF continues to expand, but the need for these kinds of services far exceeds the supply of treatment opportunities.

A third application, related to the second is that churches and individual biblical counselors should alter expectations and practices when working with individuals who struggle with PTS. Some shifts in practice might include sending counsees (at least strongly encouraging) to attend a Legacy Program, or creating intensive counseling retreat options that preferably include others who have struggled with PTS as advocates. If these alternatives are not available for the counselor they should anticipate a protracted counseling process with a resistant counsee. Recruiting an advocate who has been through trauma, struggled with PTS, and seen growth would also be a helpful addition to any individual counseling process. Churches and individual counselors should be available to welcome back alumni of programs like the Legacy Program. They should seek to integrate the alumnus into the life of the church and offer follow-up biblical counseling. The data suggests this is an important element to an individuals post-traumatic sanctification.

A fourth application from this research is to encourage the adoption and expansion of empirical research in the biblical counseling community. At the very beginning of my PhD studies I was told by leading biblical counselors, “Biblical counselors don’t do empirical research.” The father of the modern biblical counseling movement, Jay Adams, wrote that we should not attempt to validate biblical counseling with empirical research. Obviously, I disagree with these sentiments (see appendix 17). While I do not believe empirical research is necessary to affirm our call to care for souls with the wisdom found in God’s Word, I do believe it can be a helpful tool to grow the influence and reach of the movement. I encountered one other biblical counselor who has

attempted to utilize empirical research methods to study biblical counseling.² Apart from her thesis and my dissertation I am unaware of any other empirical research conducted in the field of biblical counseling.

While pragmatism is not the ultimate reason for adopting practices it is a reasonable aspect of consideration. Students want to know that what they are spending time and energy studying will actually be effective in helping people they hope to serve in the future. Practitioners want to utilize methods of care that they believe will work. Offering evidence that biblical counseling is effective is not necessary, but it can be a helpful apologetic tool to expand the movement.

The fifth application of this research is to offer analysis and insights to the MOF. The research has provided insights into the elements that participants find most helpful and also those which they find to be less so. Like any human institution, there are a few shortcomings or weaknesses found in the program that can be improved. These insights can be utilized by the program to hone and improve treatment offered to our nation's warriors.

Recommendations for Mighty Oaks Foundation

The MOWP Legacy Program certainly helps the majority of its participants overcome the difficulties of PTSD. It is an excellent program that should be emulated. However, it is not without room for improvement.

One of the primary difficulties that many who suffer with PTSD encounter is a difficulty maintaining quality relationships. This is especially true when it comes to carrying through relationships with those who have not encountered trauma.³ Combat veterans, in particular, have a difficult time reintegrating into "normal life." They often

² Denise Ogorek, email message to author, October 15, 2018.

³ Bessel A. Van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (New York: Penguin Books, 2015), 18.

demonstrate renewed exuberance and excitement when they gather together with others combat veterans. The Legacy Program offers an environment where this is possible and they can begin to relate to people again—perhaps for the first time since they experienced trauma. However, the MOWP acknowledges that they have not yet “cracked the code” on how to help alumni reintegrate into civilian life. There is an “us and them” perspective that permeates much of military culture which is often heightened among the population of combat veterans. As the program has developed, this challenge has become a focus of attention. In response, MOWP created a staff position of Aftercare Coordinator. This person reaches out to alumni and seeks to ensure they are participating in local churches and following through with spiritual disciplines while providing follow-up care for those who desire it.

The MOWP also developed Outposts. These are regular gatherings of alumni and other veterans/first responders in local churches for relationship building, mutual accountability and ongoing care. In spite of these efforts, many alumni still indicate difficulty relating to the civilian population.⁴

Two possible recommendations are to emphasize the role that specific civilians have had in helping veterans overcome their struggles with PTS. The founder of the Mighty Oaks Foundation, Chad Robichaux, overcame his fight with PTS through the ministry of Steve Toth who had never served in the military.⁵ Highlighting this relationship in the Legacy Program is one thing the ministry could do to help participants realize the role non-military personnel can play in their lives.

Another recommendation is to help combat veterans and first responders recognize that they are not alone in their survival of trauma and that the suffering they

⁴ Jeremy Stalneker, Foldberg, John, and Chris Carlisle, Mighty Oaks leadership, conversation with author, San Miguel, CA, April 10, 2015.

⁵ Chad M. Robichaux, *An Unfair Advantage: Victory In The Midst of Battle* (Making Life Better Publishing, 2017), 119–21; Chad Robichaux, “Personal Testimony” (Lecture, September 12, 2015).

bore was for the civilian population.

The mentality “no one else can understand what I’ve been through,” is common among survivors of trauma. People generally hate when assumptions are made about them. One thing that infuriates combat veterans is the person who says, “I know how you feel.” However, combat veterans are often guilty of making assumptions about the civilian population around them. They need to be awoken to the reality that there are many people who never served in the military who have faced horrific trauma. They have no idea that the sweet mom of three kids who lives down the street (and seems to have an idyllic life) was actually the victim of childhood sexual assault and was raped when she was in college. The APA estimates a lifetime prevalence of PTSD of 8.75 percent of the US population at age 75 (roughly 28.7 million Americans in 2018). These rates jump dramatically to 30-50 percent of people who are raped or exposed to combat trauma.⁶ Violent crime and rape are unfortunately common occurrences in our nation. Many Americans experience violent crime at some point in their lives and more than twelve million women in our country have been raped, many of those violations occur among girls below the age of 15. Each year roughly three million children are reported as victims of child abuse in the United States. One way of comparing the data indicates that for every soldier serving in a war zone there are ten children who are endangered in their own homes.⁷

Participants in the Legacy Program need to be reminded not to assume that those who never served in combat have easy, trauma-free lives. This reality is easy to bring home to law enforcement personnel. On multiple occasions, I have challenged law enforcement personnel to consider how many perpetrators of violent crime they have

⁶ American Psychiatric Association (APA) and DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (Washington, DC: American Psychiatric Association, 2013), 276.

⁷ Van der Kolk, *The Body Keeps the Score*, 20.

arrested. After giving them a moment to consider, a follow-up statement helps bring this point home: “Each and every one of those perpetrators represents at least one victim. Some of them represent many.” Delivered in a gracious manner that truth brings home the fact that there are many trauma sufferers walking the streets, strolling the aisles of the grocery store, and sitting in churches. Helping combat veterans gain awareness of the reality that they are not the only ones who have suffered greatly or that their level of suffering is not the pinnacle of trauma helps build humility and compassion in them.

Participants in the Legacy Program also need to be reminded that the suffering they endured was, at least partially, on behalf of those whom they often disdain. On one occasion, I remember a certain veteran became greatly irritated at a church small group during the prayer time. His frustration was sparked by a mom who was sharing her prayer request/complaining about the difficult week she had. Her children were misbehaving more than usual and the grocery store where she liked to shop did not have key ingredients she was hoping to buy. In his mind, this veteran was condemning her. He became extremely frustrated that her life was so good that her worst problems that week were grocery supplies and misbehaving children. He was thinking of all the suffering he and his friends had been through in combat, all the men in the past week he had dealt with who were experiencing extreme hardship and remembering those he had counseled out of suicide.

This veteran could be greatly helped if he were challenged on two points: First is the point noted above. He should not assume this woman is unfamiliar with intense suffering. Just because this past week was not particularly difficult doesn't mean she is unacquainted with intense suffering. Victims of trauma do not like to bring up their trauma and discuss it openly all the time. It is possible that this mom has significant trauma and suffering in her past. Last week may not have been particularly challenging or perhaps it was, but she is only comfortable sharing the relatively minor frustrations of her life. Second, he should be reminded that her safe and secure life is partly because of the

work he, his fellow veterans and law-enforcement personnel have done. Living in a relatively safe environment is fruit of their labor. He might not say he served in the military so that suburban moms can whine about grocery stores. However, he would undoubtedly say he fought to protect the freedom of the nation he so dearly loves. Realistically, it should be a source of pride (or at least recognition of a job well done) that this woman's greatest challenge appears to be poorly behaved children rather than fear that some warlord can rape and kill her before abducting and enslaving her children.

The MOF has constantly adapted its ministry, changing and growing to meet new demands while improving the care it provides. As mentioned above, the Aftercare Program underwent significant changes even while I was conducting this research. There has been drastic, positive change, but this is one area with significant room for improvement.

One veteran made the following comment in the alumni survey:

I've lost all hope in your program. Before my attendance and my wife's we were led to believe that aftercare would be there and corner men would also be there. I have found out that it's the attendees that are contacting the leaders with encouragement. . .not the other way around. How do I know this? After repeated text messages, emails, and phone calls that go unanswered is not acceptable to the terms that were agreed to. To claim to care for vets that come through the program and support it everyday when someone asks about that black bracelet or shirt is a hack. To find out there is only 1 aftercare individual to take care of vets that are coming through every other week. . .the logistics don't add up for these vets suffering.

These comments are not indicative of the majority of responses to the program, but for the minority of veterans who have this experience it is quite difficult and damaging. The rapid growth of the program means that the number of alumni who are being cared for by the Aftercare Program is expanding at an exponential rate while the MOF staff cannot expand accordingly. The logistical demands entailed in providing care to that many people are immense. The hope and vision of the ministry is not to be the source of ongoing primary care for the alumni. Instead they desire to partner with local churches that can incorporate the alumni into the care of a local community. MOF has also sought to develop relationships with biblical counseling ministries that can provide

care for alumni who need more focused help after leaving the program. However, the task of identifying and vetting local churches who are willing to partner with MOF, receive necessary training, and commit to caring for program alumni is daunting. While I was researching the program, the Aftercare Coordinator was also responsible for Instructor training, identifying and developing Mentors (a specific type of instructor with more theological/counseling training), and serving as an instructor at a number of programs throughout the year. That division of time and energy limited the capacity of the ministry to care for the alumni of the Legacy Program. I would advise the program to expand the number of staff focused on the Aftercare Program, at least for a season, until they establish a wide network of churches trained and dedicated to caring for the alumni. One staff member could oversee church partnerships while another person focusses on direct communications with the alumni. Instructor and Mentor development should be covered by a staff member who is not overseeing the Aftercare Program. However, this staff member should have regular interaction with the Aftercare team with the goal of incorporating aftercare principles and goals into the instructor/Mentor training. This is especially important since many of the instructors serve on an as needed basis and are living/working out in the communities where these alumni live. The instructors seem to be a natural choice to serve as Outpost Leaders who can train others in the church who are involved in ministry to the veterans. They would also serve as liaisons between church partners and the Aftercare Team.

Another area where the program should improve is the uncritical use of questionable resources. This was pointed out earlier in regard to the quotation from Viktor Frankl (see p. 78). Frankl is the founder of logotherapy a version of psychotherapy that is affiliated with existential and humanistic psychological theories. While the importance of meaning-making is central the Legacy Program and to Frankl's teaching, many of his other teaching would contradict the Christian teachings central to MOF. There is a tendency in the program's literature and presentation material to utilize quotes

that, independent of context, make a point the MOF is trying to make. However, the use of resources without the consideration of the broader context or teaching is problematic. It can appear as an indorsement of authors whose other writings would undermine or contradict the rest of MOF teaching or beliefs. I would recommend a review of the training materials and literature specifically evaluating sources of quotations. Some of these statements could be altered with quotes that have similar ideas but come from more agreeable sources. If they wanted to keep the quotation the MOF could offer a note of caution regarding the broader teachings of questionable sources.

The Legacy Program is a fantastic source of hope and help to men and women suffering in the aftermath of trauma. Those alumni who adopt and incorporate the training they receive in the one week they attend the program have radically changed lives and are put on a trajectory towards flourishing and post traumatic sanctification. The MOF should do everything it can to help these men and women incorporate that training so the faith and knowledge they gained attending the program becomes a regular part of their lives.

Further Research

As with any research study, there are numerous opportunities to gain insights, bolster conclusions, investigate theories, and grow in understanding through further research. The MOES study was a wonderful starting place for investigating the Legacy Program of the MOF but there is still much to be learned about the program. Multiple studies could be done on the Legacy Program as well as the other aspects of the MOWP to glean more information as well as offer further validation of the ministries effectiveness. Other research could be conducted in different spheres to glean insights into questions that linger over the impact of trauma, the effectiveness of treatments, and the mechanisms that make them effective.

Randomized control trials (RCT) are the gold standard in social science

research. They provide the strongest and most generalized results and are less susceptible to errors and critiques. Conducting RCT studies of the Legacy Program would strengthen the claims made in this research, especially if the results found are similar to data gathered in this study. RCT's should be used which incorporate comparisons between the Legacy Program, other faith-based and non-faith-based treatments, as well as a control group (likely waitlist or non-treatment group). There need to be at least two such studies completed before the Legacy Program could be considered a well-established treatment.⁸ Having treatments that came from different faith backgrounds may give insight into whether or not particular religions offer more or less help than others.

Many studies measure changes in evaluations immediately post treatment and then at shorter intervals with a final evaluation typically being six or twelve months after treatment. The MOES study, for reasons indicated above, only evaluated participants at the 6-month mark. It would be helpful, in future studies to have multiple follow up evaluations to see if the trajectory of benefits from treatment. It may demonstrate a peak timeframe from benefits, a plateauing of the benefits, or a timeframe when the benefits begin to diminish.

Utilizing multiple assessments would further strengthen future studies of the Legacy Program. It would afford more data and enable broader comparisons to other treatment studies. However, it could potentially diminish the non-clinical feel of the program and may not gain the participation necessary since participants would be required to spend more time filling out assessments.

The majority of participants attending the Legacy Program experienced exposure to combat trauma. Additionally, many indicated other forms of trauma especially Adverse Childhood Experiences (ACE's). Statistics have not been

⁸ Gerald P. Koocher, John C. Norcross, and Sam S. Hill, eds., *Psychologists' Desk Reference* (New York: Oxford University Press, 1998), 210.

documented, but instructors attest widely to these experiences in their own lives and in the lives of participants. Chad's life story involved trauma prior to joining the Marine Corps. He was abused by his father, abandoned by his parents, and his older brother who was his best friend was murdered when Chad was 14 years old.⁹ Further study is warranted into the implications and potential correlations between ACE's, pre-combat exposure to PTE's, or cumulative trauma exposure and the onset of PTSD in adults exposed to PTE's.

Research literature shows a significant difference in response to treatment between those who have exposure to childhood-onset trauma vs. adult-onset trauma.¹⁰ The MOF has recognized a significant percentage of participants indicating childhood trauma. However, this study did not investigate the background of participants and was thus unable to analyze any variation in outcomes between these two groups of people.

As noted in the analysis above, age may play a factor in how one responds to treatment. Further studies need to be done to determine what if any correlations exist between age of participants and how they respond to the Legacy Program. One possible study to test the hypothesis that peer-to-peer treatment is impacted by shared age would be to acquire the age of instructors used during the time of the study and compare it to the ages of participants and see if there is any correlation.

This study focused on the Legacy Program for men. Conducting research on the Women's Legacy Program would also allow results to be generalized to the female population.

Research that included PET scans or fMRI studies of participants before and

⁹ Chad M. Robichaux and Jeremy M. Stalneck, *The Truth about PTSD* (Manassas, VA: Making Life Better Publishing, 2017), 28.

¹⁰ Bessel A. Van der Kolk et al., "A Randomized Clinical Trial of Eye Movement Desensitization and Reprocessing (EMDR), Fluoxetine, and Pill Placebo in the Treatment of Posttraumatic Stress Disorder: Treatment Effects and Long-Term Maintenance," *Journal of Clinical Psychiatry* 68, no. 1 (2007): 8.

after attending the Legacy Program would be very useful. The cutting edge of PTSD research is focused on the neurological impact of trauma. A study that was able to document neurological benefits to attending the Legacy Program would be strong evidence to demonstrate its efficacy in treating PTSD.

Advancements in technology, especially those that shrink the size of diagnostic equipment open up more and more opportunities for real-time or close to real-time research, evaluation and diagnosis. If there comes a day when researchers can build fMRI or PET scan technology into combat helmets or HRV monitors into body armor then researchers might be able to examine and identify biological impacts of trauma as they occur. This kind of research is currently futuristic and limited by cost and technology, but such barriers are often surmounted with the passage of time.

It would also be of great value to investigate the neurological impact and changes that trauma suffers undergo alongside questions about their thoughts and beliefs at the time of trauma and henceforth. Studies evaluating participants immediately after combat (or some other traumatic exposure) on a physiological, cognitive, and emotional levels; then reevaluated them overtime on each level could provide very helpful insights. If we have already seen incredible results at reversing the impacts of trauma through various forms of CBT, it makes sense that thoughts and beliefs are significant even to one's brain structure. This type of research might also help answer the chicken-egg question that haunts many correlation studies: Are people with smaller hippocampuses more prone to developing PTSD or do trauma/PTSD symptoms alter the shape and size of the hippocampus?

As biblical counselors and other Christians in the mental health/soul-care field employ empirical research, it would be beneficial to develop our own research tools including surveys and validated instruments that specifically evaluate issues we are concerned with addressing. Currently we are dependent on tools and instruments that are

developed by those who come from perspectives that have unbiblical anthropologies and are therefore not concerned with or interested in asking questions that would evaluate someone from a biblical perspective. We need to develop surveys that are biblically informed and ask questions that will help us evaluate Christian faith and spiritual development/sanctification. These types of studies would afford us greater insight into the role true saving faith and development of that faith have in influencing the various struggles people wrestle with.

A full biblical theological understanding of PTSD was beyond the scope of this dissertation. Further research into the biblical and theological nature of trauma and its effects on humanity would be of great value. A rich study of this nature should also seek to draw out implications for care of those who have suffered greatly and still wrestle in the aftermath of great tragedies.

Conclusion

Ultimately, this study has demonstrated the complexity of the issue known as Post-Traumatic Stress Disorder. There is much more that can and should be researched both toward gaining increased understanding of the phenomenon as well as toward improving treatment of the problem. However, the most profound findings of this research are those drawn from the MOES which reveal a strong negative correlation between growth in a person's strength of religious commitment and the reduction of their PTSD symptoms. The Mighty Oaks Foundation's Legacy Program is a very condensed program that utilizes instruction in the principles of Christian faith and practice to care for those who struggle with PTS in the aftermath of trauma. The program helps men who have lost a sense of purpose and meaning largely because they hold onto thoughts, beliefs, desires, and feelings that are not informed by a proper biblically informed understanding. The Legacy Program draws from Scripture to inform men of their God given roles and responsibilities, God's sovereign use of suffering, and His call on their

lives to live for His glory. This program, and others like it, should be promoted and shared with those who struggle so many men and women who struggle with PTS can receive lasting hope and help.

APPENDIX 1
PCL-5 QUESTIONS

Part 3: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

| <i>In the past month, how much were you bothered by:</i> | <i>Not at all</i> | <i>A little bit</i> | <i>Moderately</i> | <i>Quite a bit</i> | <i>Extremely</i> |
|---|-------------------|---------------------|-------------------|--------------------|------------------|
| 1. Repeated, disturbing, and unwanted memories of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 2. Repeated, disturbing dreams of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 3. Suddenly feeling or acting as if the stressful experience were actually happening again (<i>as if you were actually back there reliving it</i>)? | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling very upset when something reminded you of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 5. Having strong physical reactions when something reminded you of the stressful experience (<i>for example, heart pounding, trouble breathing, sweating</i>)? | 0 | 1 | 2 | 3 | 4 |
| 6. Avoiding memories, thoughts, or feelings related to the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 7. Avoiding external reminders of the stressful experience (<i>for example, people, places, conversations, activities, objects, or situations</i>)? | 0 | 1 | 2 | 3 | 4 |
| 8. Trouble remembering important parts of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 9. Having strong negative beliefs about yourself, other people, or the world (<i>for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous</i>)? | 0 | 1 | 2 | 3 | 4 |
| 10. Blaming yourself or someone else for the stressful experience or what happened after it? | 0 | 1 | 2 | 3 | 4 |
| 11. Having strong negative feelings such as fear, horror, anger, guilt, or shame? | 0 | 1 | 2 | 3 | 4 |
| 12. Loss of interest in activities that you used to enjoy? | 0 | 1 | 2 | 3 | 4 |
| 13. Feeling distant or cut off from other people? | 0 | 1 | 2 | 3 | 4 |
| 14. Trouble experiencing positive feelings (<i>for example, being unable to feel happiness or have loving feelings for people close to you</i>)? | 0 | 1 | 2 | 3 | 4 |
| 15. Irritable behavior, angry outbursts, or acting aggressively? | 0 | 1 | 2 | 3 | 4 |
| 16. Taking too many risks or doing things that could cause you harm? | 0 | 1 | 2 | 3 | 4 |
| 17. Being "superalert" or watchful or on guard? | 0 | 1 | 2 | 3 | 4 |
| 18. Feeling jumpy or easily startled? | 0 | 1 | 2 | 3 | 4 |
| 19. Having difficulty concentrating? | 0 | 1 | 2 | 3 | 4 |
| 20. Trouble falling or staying asleep? | 0 | 1 | 2 | 3 | 4 |

LEC-5 (10/27/2013) Weathers, Blake, Schnurr, Kaloupek, Marx, & Keane -- National Center for PTSD

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

APPENDIX 2

SANTA CLARA STRENGTH OF RELIGIOUS FAITH QUESTIONNAIRE

Santa Clara Strength of Religious Faith Questionnaire
Thomas G. Plante and Marcus Boccaccini

Reference: Plante, T.G., & Boccaccini, M. (1997). The Santa Clara Strength of Religious Faith
Santa Clara University
Questionnaire. *Pastoral Psychology*, 45, 375-387

Please answer the following questions about religious faith using the scale below. Indicate the level of agreement (or disagreement) for each statement.

1 = strongly disagree 2 = disagree 3 = agree 4 = strongly agree

- _____ 1. My religious faith is extremely important to me.
- _____ 2. I pray daily.
- _____ 3. I look to my faith as a source of inspiration.
- _____ 4. I look to my faith as providing meaning and purpose in my life.
- _____ 5. I consider myself active in my faith or church.
- _____ 6. My faith is an important part of who I am as a person.
- _____ 7. My relationship with God is extremely important to me.
- _____ 8. I enjoy being around others who share my faith.
- _____ 9. I look to my faith as a source of comfort.
- _____ 10. My faith impacts many of my decisions.

To score, add the total scores. They will range from 10 (low faith) to 40 (high faith)

APPENDIX 3

ONLINE PRE-TEST SURVEY



Participant Questionnaire

Thank you for filling out this 30 question survey as part of your time at Mighty Oaks Fight Club. This survey is part of a study we are conducting to improve our service to veterans and active duty service members and to enable us to reach out to even more people who are fighting Post Traumatic Stress.

In the past month, how much were you bothered by:

| | | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|----|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1 | Repeated, disturbing, and unwanted memories of the stressful experience? | <input type="radio"/> |
| 2 | Repeated, disturbing dreams of the stressful experience? | <input type="radio"/> |
| 3 | Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? | <input type="radio"/> |
| 4 | Feeling very upset when something reminded you of the stressful experience? | <input type="radio"/> |
| 5 | Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? | <input type="radio"/> |
| 6 | Avoiding memories, thoughts, or feelings related to the stressful experience? | <input type="radio"/> |
| 7 | Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? | <input type="radio"/> |
| 8 | Trouble remembering important parts of the stressful experience? | <input type="radio"/> |
| 9 | Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? | <input type="radio"/> |
| 10 | Blaming yourself or someone else for the stressful experience or what happened after it? | <input type="radio"/> |

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Participant Questionnaire

Thank you for filling out this 30 question survey as part of your time at Mighty Oaks Fight Club. This survey is part of a study we are conducting to improve our service to veterans and active duty service members and to enable us to reach out to even more people who are fighting Post Traumatic Stress.

In the past month, how much were you bothered by:

| | | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|----|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 11 | Having strong negative feelings such as fear, horror, anger, guilt, or shame? | <input type="radio"/> |
| 12 | Loss of interest in activities that you used to enjoy? | <input type="radio"/> |
| 13 | Feeling distant or cut off from other people? | <input type="radio"/> |
| 14 | Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? | <input type="radio"/> |
| 15 | Irritable behavior, angry outbursts, or acting aggressively? | <input type="radio"/> |
| 16 | Taking too many risks or doing things that could cause you harm? | <input type="radio"/> |
| 17 | Being "superalert" or watchful or on guard? | <input type="radio"/> |
| 18 | Feeling jumpy or easily startled? | <input type="radio"/> |
| 19 | Having difficulty concentrating? | <input type="radio"/> |
| 20 | Trouble falling or staying asleep? | <input type="radio"/> |

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Participant Questionnaire

Thank you for filling out this 30 question survey as part of your time at Mighty Oaks Fight Club. This survey is part of a study we are conducting to improve our service to veterans and active duty service members and to enable us to reach out to even more people who are fighting Post Traumatic Stress.

Please answer the following questions about religious faith using the scale below. Indicate the level of agreement (or disagreement) for each statement.

| | Strongly disagree | Disagree | Agree | Strongly agree |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 21 My religious faith is extremely important to me. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22 I pray daily. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23 I look to my faith as a source of inspiration. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24 I look to my faith as providing meaning and purpose in my life. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25 I consider myself active in my faith or church. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26 My faith is an important part of who I am as a person. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27 My relationship with God is extremely important to me. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28 I enjoy being around others who share my faith. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29 I look to my faith as a source of comfort. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30 My faith impacts many of my decisions. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Next (Page 3 of 4)



Participant Questionnaire

Thank you for filling out this 30 question survey as part of your time at Mighty Oaks Fight Club. This survey is part of a study we are conducting to improve our service to veterans and active duty service members and to enable us to reach out to even more people who are fighting Post Traumatic Stress.

With your permission, we would like to email you a reminder in 6 months to take the survey again. By taking the survey before and after your time at Mighty Oaks, we hope to measure the impact of the program.

Name:

Email:

APPENDIX 4
PRE-TEST PAPER COPY

**The Mighty Oaks Effectiveness Study
(M.O.E.S.)
Survey**



Thank you for your service to your fellow countrymen. Please take a moment and complete the following 30-question survey. This survey is a part of the Mighty Oaks Effectiveness Study (M.O.E.S). We are conducting this study to expand and improve the efforts Mighty Oaks organization. This will enable the program to help even more of our nations warriors.

Your participation in the study is voluntary and all of your responses will be kept confidential. No personally identifiable information will be associated with your responses in any reporting of this data.

If you agree to participate in the study you will receive an e-mail six months after Fight Club graduation requesting you to complete an identical survey online. Results of the first survey will be compared to the second survey to determine the effectiveness of the Mighty Oaks program.

Thank you for your participation in the study.

Name: _____ **E-Mail:** _____

| In the past month how much were you bothered by: | | | | | | |
|--|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 1 | Repeated, disturbing, and unwanted memories of the stressful experience? | <input type="radio"/> |
| 2 | Repeated, disturbing dreams of the stressful experience? | <input type="radio"/> |
| 3 | Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? | <input type="radio"/> |
| 4 | Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? | <input type="radio"/> |
| 5 | Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? | <input type="radio"/> |
| 6 | Avoiding memories, thoughts, or feelings related to the stressful experience? | <input type="radio"/> |
| 7 | Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? | <input type="radio"/> |
| 8 | Trouble remembering important parts of the stressful experience? | <input type="radio"/> |
| 9 | Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? | <input type="radio"/> |
| 10 | Blaming yourself or someone else for the stressful experience or what happened after it? | <input type="radio"/> |

| In the past month how much were you bothered by: | | | | | | |
|---|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 11 | Having strong negative feelings such as fear, horror, anger, guilt, or shame? | <input type="radio"/> |
| 12 | Loss of interest in activities that you used to enjoy? | <input type="radio"/> |
| 13 | Feeling distant or cut off from other people? | <input type="radio"/> |
| 14 | Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? | <input type="radio"/> |
| 15 | Irritable behavior, angry outbursts, or acting aggressively? | <input type="radio"/> |
| 16 | Taking too many risks or doing things that could cause you harm? | <input type="radio"/> |
| 17 | Being "superalert" or watchful or on guard? | <input type="radio"/> |
| 18 | Feeling jumpy or easily startled? | <input type="radio"/> |
| 19 | Having difficulty concentrating? | <input type="radio"/> |
| 20 | Trouble falling or staying asleep? | <input type="radio"/> |

Please answer the following questions about religious faith using the scale below. Indicate the level of agreement (or disagreement) for each statement.

| | | Strongly Disagree | Disagree | Agree | Strongly Agree |
|----|---|-----------------------|-----------------------|-----------------------|-----------------------|
| 21 | My religious faith is extremely important to me. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22 | I pray daily. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23 | I look to my faith as a source of inspiration. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24 | I look to my faith as providing meaning and purpose in my life. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25 | I consider myself active in my faith or church. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26 | My faith is an important part of who I am as a person. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27 | My relationship with God is extremely important to me. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28 | I enjoy being around others who share my faith. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29 | I look to my faith as a source of comfort. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30 | My faith impacts many of my decisions. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

APPENDIX 5

POST-TEST ONLINE SURVEY



Follow-up Questionnaire

Thank you for completing this survey a second time as part of your time at MIGHTY Oaks Fight Club. This survey is part of a study we are conducting to improve our service to veterans and active duty service members and to enable us to reach out to even more people who are fighting Post Traumatic Stress.

In the past month, how much were you bothered by:

| | | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|----|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1 | Repeated, disturbing, and unwanted memories of the stressful experience? | <input type="radio"/> |
| 2 | Repeated, disturbing dreams of the stressful experience? | <input type="radio"/> |
| 3 | Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? | <input type="radio"/> |
| 4 | Feeling very upset when something reminded you of the stressful experience? | <input type="radio"/> |
| 5 | Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? | <input type="radio"/> |
| 6 | Avoiding memories, thoughts, or feelings related to the stressful experience? | <input type="radio"/> |
| 7 | Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? | <input type="radio"/> |
| 8 | Trouble remembering important parts of the stressful experience? | <input type="radio"/> |
| 9 | Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? | <input type="radio"/> |
| 10 | Blaming yourself or someone else for the stressful experience or what happened after it? | <input type="radio"/> |

[Next](#) (Page 1 of 4)



Follow-up Questionnaire

Thank you for completing this survey a second time as part of your time at Mighty Oaks Fight Club. This survey is part of a study we are conducting to improve our service to veterans and active duty service members and to enable us to reach out to even more people who are fighting Post Traumatic Stress.

In the past month, how much were you bothered by:

| | | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|----|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 11 | Having strong negative feelings such as fear, horror, anger, guilt, or shame? | <input type="radio"/> |
| 12 | Loss of interest in activities that you used to enjoy? | <input type="radio"/> |
| 13 | Feeling distant or cut off from other people? | <input type="radio"/> |
| 14 | Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? | <input type="radio"/> |
| 15 | Irritable behavior, angry outbursts, or acting aggressively? | <input type="radio"/> |
| 16 | Taking too many risks or doing things that could cause you harm? | <input type="radio"/> |
| 17 | Being "superalert" or watchful or on guard? | <input type="radio"/> |
| 18 | Feeling jumpy or easily startled? | <input type="radio"/> |
| 19 | Having difficulty concentrating? | <input type="radio"/> |
| 20 | Trouble falling or staying asleep? | <input type="radio"/> |

Next (Page 2 of 4)



Follow-up Questionnaire

Thank you for completing this survey a second time as part of your time at Mighty Oaks Fight Club. This survey is part of a study we are conducting to improve our service to veterans and active duty service members and to enable us to reach out to even more people who are fighting Post Traumatic Stress.

Please answer the following questions about religious faith using the scale below. Indicate the level of agreement (or disagreement) for each statement.

| | Strongly disagree | Disagree | Agree | Strongly agree |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 21 My religious faith is extremely important to me. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22 I pray daily. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23 I look to my faith as a source of inspiration. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24 I look to my faith as providing meaning and purpose in my life. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25 I consider myself active in my faith or church. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26 My faith is an important part of who I am as a person. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27 My relationship with God is extremely important to me. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28 I enjoy being around others who share my faith. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29 I look to my faith as a source of comfort. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30 My faith impacts many of my decisions. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Next (Page 3 of 4)



Follow-up Questionnaire

Thank you for completing this survey a second time as part of your time at MIGHTY Oaks Fight Club. This survey is part of a study we are conducting to improve our service to veterans and active duty service members and to enable us to reach out to even more people who are fighting Post Traumatic Stress.

Thank you again for re-taking this survey. You will should receive a \$10 Amazon ecard in your inbox within the next couple of days. If you can take a few minutes to answer these last few questions, it would be appreciated. Thank you.

Gender:

What is your age?

Ethnicity origin (or Race): Please specify your ethnicity.

What is your highest level of education completed?

What branch of the military did you serve in?

What military campaigns did you participate in (if any)?

- Operation Enduring Freedom
- Operation Iraqi Freedom
- Desert Storm
- Vietnam
- Other
- None

Finish

APPENDIX 6
APPLICATION VERIFICATION EMAIL

4/18/2019

Gmail - Online Application



Online Application

1 message



Fri, Sep 23, 2016 at 6:01 PM



Mighty Oaks Warrior Programs

September 23, 2016

Mighty Oaks Foundation
27919 Jefferson Ave. Suite 203
Temecula, CA 92590

Curtis Solomon
4085 Estrada Ave.
Atascadero, CA 93422

Dear Curtis Solomon,

Thank you for completing the online application. Someone from our team will be with you shortly to follow up.

Mighty Oaks Foundation
info@mightyoaksprograms.org

APPENDIX 7

FOLLOW-UP TO APPLICATION

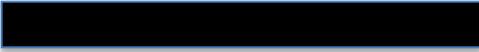
4/18/2019

Gmail - Mighty Oaks Warrior Programs



Mighty Oaks Warrior Programs

1 message



Tue, Nov 1, 2016 at 9:54 PM

Curtis,

Thank you for submitting your application. I would need a copy of your DD214 so that I may process your application and be able to place you into an upcoming session. This is only to verify your service. For security purposes I recommend blocking the first 5 of your SSN. To help me to get a better understanding of your situation could you please tell me a little of what is leading you to consider attending a Mighty Oaks Program.

Here is a template to help put your thoughts together.

Brief military bio regarding MOS, duty stations, units, combat deployments locations and count of how many times. Any major accomplishments, awards, accolades. Anything else you may feel is pertinent.

Any injuries sustained?

Struggles that you may deal with due to military service? I.e. Symptoms related to PTSD (Anger/irritability, depressive disorders, withdrawals suicide attempts?)

What lead you to the point to be interested in attending the Mighty Oaks Foundation Mighty Oaks Warrior Programs?

What do you hope to gain from attending the program and becoming one of the many successful alumni that have graduated?

I would also need to know if you have a specific timeframe that would work best for you to attend a program and if you are able to cover your transportation to

John Davis US Army 82nd Airborne Division [vet]
Applications Coordinator
Mighty Oaks Warrior Programs

APPENDIX 8

PREPARATION EMAIL

4/18/2019

Gmail - Mighty Oaks Warrior Programs May 8-13 Legacy Program



Mighty Oaks Warrior Programs May 8-13 Legacy Program

5 messages



Gentlemen,

Attached you will find a Welcome Letter with very important information regarding the upcoming week (May 8-13) of the Mighty Oaks Warrior Programs Legacy Program. I do apologize for the length of it but there is much information that is needed to be passed. In the letter, you will find information as to what's next, what to expect as well as what to bring and other pertinent info. Please open the attached file. Once you have read through the document please answer a few questions just confirm we are tracking everything. If you are flying, you should have received a copy of your flight itinerary. If you have not please look for an email sent by a member of the Mighty Oaks Team asking you to confirm your flight information. We understand that things happen and plans change so if you are unable to make the session, please let us know as soon as you can.

(when you reply please do not select all since you are all on the same email going out)

1. *That you are still attending. (If you can't. Is there another schedule session/timeframe that would work better?)*
2. *How you plan on attending. (driving yourself, using the shuttle van, flying)*
3. *Are there any updates regarding medications or medical issues or dietary concerns/allergies? *We need to pass to the kitchen staff any allergies asap so they may prepare for adjustments in advance. We need medications not to be nosey but in the event if there is a medical emergency we need to be able to pass this information along to the emergency staff.*

If there is something that was not covered in the letter that you have a question about, please feel free to contact me directly.

Below is a link to a private survey that is being conducted to better help with researching treatment and healing of PTSD as well as Traumas incurred. This survey is very like one or the many that you may have completed before. It is purely voluntary but highly encouraged!

<https://mail.google.com/mail/u/2?ik=4c7273839&view=pt&search=all&permthid=thread-f%3A1566356509292155488&siml=msg-f%3A1566356509292155488&...> 1/5

4/18/2019

Gmail - Mighty Oaks Warrior Programs May 8-13 Legacy Program

Please if you can take some time and complete it at your convenience.

<http://www.biblicalcounselingresearch.org/Survey.cshtml>

Please feel free to contact me if you have any questions or concerns. If you have any troubles contacting any of the people on the welcome letter, please contact me for assistance.

Branden Kunath USMC (ret)

National Programs Director

- Mighty Oaks Foundation

Mighty Oaks Warrior Programs

MightyOaksPrograms.org



Failure is not fatal, but the failure to change might be.

Hope for America's Warriors and Families

"From the Ashes to Mighty Oaks"

Isaiah 61

This message contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this e-mail. Please notify the sender immediately by e-mail if you have received this e-mail by mistake and delete this e-mail from your system. If you are not the intended recipient you are notified that disclosing, copying, distributing or taking any action in reliance on the contents of this information is strictly prohibited.

<https://mail.google.com/mail/u/2?ik=4cf7273839&view=pt&search=all&permthid=thread-f%3A1566356509292155488&simpl=msg-f%3A1566356509292155488&...> 2/5

APPENDIX 9
WELCOME LETTER

Greetings Gentlemen,

Welcome to the Fight Club for Men held at SkyRose Ranch, a Serving California Program.

We are finalizing the details for next session – December 6-12. I am confident this will be one of the most amazing and life changing weeks of your life. You only have to do one thing... show up, and do so with an open mind! I challenge you with this; if what you're doing in your life right now is not working, then why not try something different?

If you are driving you need to plan on arriving before 3pm on Sunday December the 6th so you can get settled in. We will get started at 5:00pm. When you enter SkyRose Ranch, follow the gravel road and signs that point you to the lodge on top of the hill. Please mind your speed as the roads are rough with wildlife and ranch animals present as well as other traffic. Please go to the lodge when you arrive and get your rooming assignment. Someone will be there to meet you. Driving instructions to SkyRose Ranch are included at the end of this email.

If you are flying in, we will be picking you up upon your arrival and will be dropping you off prior to your departure. Please arrive no less than two hours prior to your departure as we are on a tight schedule and missed flights will only cause delay in our program. We do understand that airlines are not always on schedule. We are prepared to make arrangements for pickup if this happens to you.

If you have any travel issues call **Mike Bryte at [REDACTED]**
home

Those of you that will be using the shuttle van leaving from Marine Corps Base Camp Pendleton must be at the Wounded Warrior Battalion Alpha Company quarter deck no later than 0730 on Sunday Dec 6th. The van will leave promptly at 0800. The trip will be approximately 5 hours of a drive. There are plans to make stops to eat along the way as well as pick up snacks or drinks during the drive. It is very important that we leave on time as it is a long drive and begin out program the same day Please be mindful of what you pack as there is limited room for luggage. If there are any issues please contact **Chris Carlisle at [REDACTED]**

SkyRose Ranch is a working ranch; cattle and various wild game roam freely. **However, we ask that you do not bring any firearms, weapons onto the property. An obvious but**

necessary rule is that no illegal drugs or alcohol of **any** kind are allowed on the property. The ranch is a high fire risk area, so all smokers must smoke in designated smoking areas only. (Small pocket knives are allowed.)

MEDICATIONS: Please be sure to bring all necessary medications. We cannot hand out any medications controlled or over the counter. There are some lengthy trips that will be made so its recommended to have some Dramamine on hand for motion sickness if riding in vehicles bothers you.

Most guests enjoy jogging or hiking in the early mornings, as well as using the hot tubs at night. If this is you, be sure to bring running shoes and swim trunks.

Bedding, towels, shower gel as well as a limited selection of shampoo and conditioners are provided. No over the counter medications will be available or dispensed by our staff. We are very remote. You need to pack all of your essential items. There are washers and dryers on site.

Pack accordingly for the week and for our recreational activities. We do go horseback riding so bring jeans and close-toed shoes. Additionally we go on a 4-wheeler ride. The roads at the Ranch are rather dry and dusty, bring clothes that you are willing to get dirty. A handkerchief of some sort of dust mask is a great idea as well. Our zip line tour is pretty low-key but you still need to bring close-toed shoes on that activity as well. You can expect temperatures to be around 70-80 degrees during the day but do drop in the evening. A light jacket or sweatshirt/hoodie is a good idea. We do a Martial Arts Demo of Brazilian jiu jitsu (grappling) so if you want to participate athletic clothes are a good idea. (shorts/tshirt) **This is not a requirement** Again there are WASHERS/DRYERS

If you have any dietary needs, please let us know immediately. We have an amazing kitchen staff and they are more than happy to accommodate any allergies or intolerances. So come with an appetite for food and for knowledge! Do not be shy or think this is an inconvenience as some of the staff as dietary issues.

Service animals are welcome, but must be ADA and California Code compliant. Personal animals or pets are not allowed at the ranch. This is private property and we must show the utmost respect for the owner's facilities. Rules and guidelines for service animals are provided at the end of this letter.

Below is a link (copy and paste into your browser) to a private survey that is being conducted in order to better help with researching treatment and healing of PTSD as well as Traumas incurred. This survey is very similar to one or the many that you may have completed before. It is purely voluntary but highly encouraged!

Please if you can take some time and complete it at your convenience.

<http://www.biblicalcounselingresearch.org/Survey.cshtml>

Please feel free to contact me if you have any questions or concerns. I am looking forward to meeting each one of you. Have a safe trip! My contact will be at the bottom of the email.

DIRECTIONS

Ranch Address:

69410 Deer Valley Ranch Rd

San Miguel Ca 93451

Traveling Interstate 5 North

Travel 5 North en route to the 46 West. You will travel on the 46 West until you reach the 101. The directions below from the **101** will help you for the rest of the way.

Traveling Interstate 5 South

Travel I5 South to the 580 West to lead you to the 101 South. Look for Mission St to San Miguel. Follow 101 Directions.

DIRECTIONS FROM 101 North/South

Take the exit into San Miguel onto Mission Street. When you see the sign to Parkfield turn East (Right) on River Road and drive until you cross the bridge over the Salinas River.

At the east end of the Bridge turn left, and then left again on Indian Valley RD, head up the hill on Cross Canyon Road.

At the next Y in the road go Right (Vineyard Canyon Road / Parkfield). From this Y you will travel approx. 4.1 miles to Cross Country Road which will be on your Left side. It's sort of hidden behind an Oak Tree. Landmarks are a series of mail boxes on your left side and white fences on Cross Country Road.

Turn Left onto Cross Country Road – it is paved for approx. 1 mile then becomes a dirt road for another 3.5 miles to the ranch gate, which will be on your right side. There is a large SkyRose Ranch sign at this gate but it is the only one on the road with large rock posts, brownish gate. You will notice an old airstrip near the road, too.

The Gate should be open. If not, drive past gate about 100 yards to top of hill for cell phone service and call Jonny or [REDACTED]. Go through the gate and continue down the road. Follow the sign to Ranch HQ and Lodge. Once you see the large silo with SkyRose Ranch on it, stay to the right of it. The road will turn to blacktop. Follow the blacktop all the way to the top of the hill and you will have arrived at the lodge.

SERVICE ANIMAL INFORMATION

Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

This definition does not affect or limit the broader definition of "assistance animal" under the Fair Housing Act or the broader definition of "service animal" under the Air Carrier Access Act.

Some State and local laws also define service animal more broadly than the ADA does. Information about such laws can be obtained from the State attorney general's office.

Under the ADA, service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

Under the ADA, State and local governments, businesses, and nonprofit organizations that serve the public generally must allow service animals to accompany people with disabilities in all areas of the facility where the public is normally allowed to go. For example, in a hospital it would be inappropriate to exclude a service animal from areas such as patient rooms, clinics, cafeterias, or examination

rooms. However, it may be appropriate to exclude a service animal from operating rooms or burn units where the animal's presence may compromise a sterile environment.

- At SkyRose Ranch, animals will not be allowed in the kitchen or be fed from the tables. Owners/handlers must feed the animal away from the kitchen or dining areas; preferably outside or at the yurts. The owner/handler is more than welcome into the kitchen, just not the service animal. Service animals can not be handed off to another participant as they or the ranch can not accept or be held accountable of the risk of the dog's actions in the absence of the owner for that period of time.

Additional Criteria:

1. The animal is well-behaved
2. The animal does not pose a public danger and is non-aggressive
3. You have control over your dog at all times while in public
4. The animal obeys your basic commands, such as sitting, heeling, waiting, down, summoning, both on-leash or (if the leash is dropped by accident) off-leash
5. The animal is comfortable in public spaces and environments and is relaxed in such places
6. The animal does not bark/make noise in public
7. The animal is house-trained
8. The animal remains under the table or lying down on a seat while in restaurants or sitting in commercial buildings
9. The owner must provide all food and care for the animal. The ranch and its staff will not be responsible for feeding/caring for the animal.
10. The animal must be well trained around other animals. The ranch does have other dogs and cattle; additionally we do recreation activities with horses and they do not allow animals during the ride.
11. The animal is not allowed on any furniture. This includes the beds and couches.
12. The owner/handler must provide all bedding, food, medications, treats and other comforts/needs for their animal.

In Conclusion:

- If the service animal does not meet the criteria above, we will ask that it be removed from the premises and the owner/handler will be more than welcome to return without the animal. The ranch/staff will not be responsible for boarding or caring for the animal if it needs to be removed.

APPENDIX 10

CONFIRMATION E-MAIL

4/18/2019

Gmail - Mighty Oaks Warrior Programs



Mighty Oaks Warrior Programs

2 messages



PM
iger

I am contacting you just to confirm that you are still a GO to attend the upcoming Mighty Oaks Warrior Men's Legacy Program in San Miguel California at SkyRose Ranch May 8-13 . I know plans change and things come up so if you are not able to attend any longer the sooner the better I know I have a better chance with filling that spot. We do still have a few spots open so if you know someone who would like to attend or that could benefit from the program please have them get their application in ASAP. Have them annotate that they are wishing to attend the session in California. Please send me their name as well so I can be on the lookout for it and make sure the application is in our database.

If you have any questions in the meantime, please contact me and I'd be happy to help anyway I can.

--
John Davis US Army 82nd Airborne Division [vet]
Retired Whittier Police Officer
Applications Coordinator
Mighty Oaks Warrior Programs



Thu, Apr 13, 2017 at 9:35 PM

John,

Thanks for touching base I am still a go for the May Legacy Program.

Sent from my iPhone
[Quoted text hidden]

APPENDIX 11

ALUMNI SURVEY INVITATION E-MAIL

SUBJECT: Mighty Oaks Wants Your Help

MESSAGE:

Mighty Oaks Alumni Survey

Mighty Oaks is conducting a survey of alumni and we would greatly appreciate your participation.

Thank you in advance for participating.

The first 100 participants to complete this survey will receive a \$20 Amazon gift card.

The results of this survey will be used to help improve the Mighty Oaks Warrior Program as they continue to serve our nation's warriors. Your participation in this survey is strictly voluntary and the results will be kept confidential.

The survey will take approximately 10-15 minutes to complete.

Thank you for your participation in the survey and thank you for your service.

[Begin Survey](#)

APPENDIX 12
ALUMNI SURVEY

Mighty Oaks Alumni Survey

Welcome to the Mighty Oaks Warrior Program Alumni Survey

Thank you for participating in this survey.

The first 100 participants to complete this survey will receive a \$20 Amazon gift card.

The results of this survey will be used to help improve the Mighty Oaks Warrior Program as they continue to serve our nation's warriors. Your participation in this survey is strictly voluntary and the results will be kept confidential.

The survey will take approximately 10-15 minutes to complete.

Thank you for your participation in the survey and thank you for your service.

Mighty Oaks Alumni Survey

1. What is your gender?

- Female
- Male

2. What is your age?

- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 or older

3. What is your ethnicity? (Please select all that apply.)

- American Indian or Alaskan Native
- Asian or Pacific Islander
- Black or African American
- Hispanic or Latino
- White / Caucasian
- Prefer not to answer
- Other (please specify)

4. What is the highest level of school you have completed or the highest degree you have received?

- Less than high school degree
- High school degree or equivalent (e.g., GED)
- Some college but no degree
- Associate degree
- Bachelor degree
- Graduate degree

5. In which branch (or branches) of the United States military have you served? (Check all that apply)

- Army
- Marine Corps
- Navy
- Air Force
- Coast Guard
- None

6. What military campaigns did you participate in (if any)? (Check all that apply)

- Operation Enduring Freedom
- Operation Iraqi Freedom
- Desert Shield/Storm
- Viet Nam
- None
- Other (please specify)

Mighty Oaks Alumni Survey

*** 7. Date of first Legacy Program (formerly Fight Club):**

Date / Time

*** 8. Location of Fight Club attended:**

- Sky Rose Ranch-Paso Robles, California
- Blaylock Ranch-Junction, Texas
- Bull Run Warrior Retreat Center-Haymarket, Virginia
- The Wilds-Columbus, Ohio
- Other (please specify)

9. Date of any Subsequent Legacy Programs (if applicable):

Date / Time

10. Please select any of the following Mighty Oaks Warrior Programs you have participated in:

- Marriage advance
- Legacy Program
- Fight Club Instructor Training
- Mentorship Program

*** 11. What led you to attend Mighty Oaks?**

Mighty Oaks Alumni Survey

*** 12. Did you ever make a suicide attempt prior to participating in the Legacy Program (formerly Fight Club)?**

- Yes
- No

13. Were you ever hospitalized for suicidal thoughts?

- Yes
- No

Mighty Oaks Alumni Survey

*** 14. Using the following scale, how would you rate your progress in the following areas after attending Legacy Program (formerly Fight Club)? Select "N/A" if you have never had indicated symptoms.**

| | Major worsening | Slight worsening | Remained the same | Slight improvement | Major improvement | N/A |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Having repeated, disturbing and unwanted memories | <input type="radio"/> |
| Experiencing repeated, disturbing dreams | <input type="radio"/> |
| Suddenly feeling or acting as if the stressful experiences were actually happening again (as if you were actually back there reliving it) | <input type="radio"/> |
| Having strong physical reactions when something reminded you of the stressful experience (for example: heart pounding, trouble breathing, sweating) | <input type="radio"/> |
| Blaming yourself for the stressful experiences in your life or what happened after them | <input type="radio"/> |
| Having strong negative feelings such as fear, horror, anger, guilt or shame | <input type="radio"/> |

Mighty Oaks Alumni Survey

*** 15. Using the following scale, how would you rate your progress in the following areas after attending Legacy Program (formerly Fight Club)? Select "N/A" if you have never had indicated symptoms.**

| | Major worsening | Slight worsening | Remained the same | Slight improvement | Major improvement | N/A |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Loss of interest in activities you used to enjoy | <input type="radio"/> |
| Feeling distant or cut off from other people | <input type="radio"/> |
| Trouble experiencing positive feelings | <input type="radio"/> |
| Irritable behavior, angry outbursts or acting aggressively | <input type="radio"/> |
| Being "superalert" or watchful or on guard | <input type="radio"/> |
| Feeling jumpy or easily startled | <input type="radio"/> |
| Having difficulty concentrating | <input type="radio"/> |
| Trouble falling or staying asleep | <input type="radio"/> |

Mighty Oaks Alumni Survey

*** 16. On a scale of 1-5 (1 being not important at all 5 being extremely important) how important were the following elements of the Legacy Program (formerly Fight Club) to helping you improve? Select N/A if you don't remember.**

| | 1. Not important at all | 2. | 3. | 4. | 5. Extremely important | N/A |
|---|-------------------------|-----------------------|-----------------------|-----------------------|------------------------|-----------------------|
| The fact it was held in a non-clinical setting: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Teaching on the physiological aspects of PTS: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Comradery developed with fellow Fight Club attendees: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Comradery with the instructor cadre: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Testimony of Heather Cangemi: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Mighty Oaks Alumni Survey

Empty response area for the survey.

*** 17. On a scale of 1-5 (1 being not important at all 5 being extremely important) how important were the following elements of the Legacy Program (formerly Fight Club) to helping you improve? Select N/A if you don't remember.**

| | 1. Not important at all | 2. | 3. | 4. | 5. Extremely important | N/A |
|-----------------------------------|-------------------------|-----------------------|-----------------------|-----------------------|------------------------|-----------------------|
| Round 1, "Why Men Need to Fight": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 2, "Character": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 3, "Discipline": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 4, "Brotherhood": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 5, "Purity": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 6, "The Truth About PTS": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 7, "Money and Possessions": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 8, "Margin": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 9, "Our Common Enemy": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 10, "Legacy": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 11, "Marriage": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Round 12, "Forgiveness": | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Mighty Oaks Alumni Survey

*** 18. On a scale of 1-5 (1 being not important at all 5 being extremely important) how important were the following elements of the Legacy Program (formerly Fight Club) to helping you improve? Select N/A if you don't remember.**

| | 1. Not important at all | 2. | 3. | 4. | 5. Extremely important | N/A |
|--|-------------------------|-----------------------|-----------------------|-----------------------|------------------------|-----------------------|
| Fight Plans: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Personal Testimonies: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| "Why the Bible?" | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Reflection Walks: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Team Breakouts: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Daily Challenges: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Presentation of the Gospel: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Recreational elements: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Distraction-free environment: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Having instructors who had personally experienced PTS: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Mighty Oaks Alumni Survey

19. On a scale of 1-5 how well have you kept up with the following after attending the Legacy Program (formerly Fight Club)?

| | 1. Not at all | 2. Barely at all | 3. Somewhat | 4. Regularly | 5. All the time | N/A |
|---------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Use of Fight Plans | <input type="radio"/> |
| Use of "Corner Men" | <input type="radio"/> |
| Daily Bible reading | <input type="radio"/> |
| Church attendance | <input type="radio"/> |

Mighty Oaks Alumni Survey

20. What other elements of the Legacy Program (formerly Fight Club) were most beneficial to you?

21. What has been the most significant life change you have experienced since attending Legacy Program (formerly Fight Club)?

22. How did the Legacy Program influence that significant change?

Mighty Oaks Alumni Survey

23. Would you say you were a Christian before attending the Legacy Program (formerly Fight Club)?

- Yes
- No
- Unsure

Mighty Oaks Alumni Survey

24. How was your faith influenced by your experience at the Legacy Program?

| | | | | | |
|-----------------------|-------------------------|-------------------------------|---------------------------|----------------------------|-----------------------|
| 1. I left my faith | 2. My faith grew weaker | 3. My faith remained the same | 4. My faith grew slightly | 5. My faith grew extremely | N/A |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Mighty Oaks Alumni Survey

25. Did you make a profession of faith in Jesus Christ at the Legacy Program or after the Legacy Program?

- Yes
- No

Mighty Oaks Alumni Survey

26. How has your decision to trust in Jesus Christ changed your struggle with PTS?

Mighty Oaks Alumni Survey

*** 27. What other PTSD treatment programs did you attend prior to attending the Legacy Program (formerly Fight Club)?**

- None
- One-on-one psychotherapy at the VA
- Non-VA individual therapy
- Group therapy at the VA
- Non-VA group therapy
- Inpatient treatment at VA hospital or clinic
- PTSD Clinical Team (CPT)
- Substance Use PTSD Team (SUPT)
- PTSD Residential Rehabilitation Treatment Program (PTSD RRTP)
- PTSD Domiciliary Program (PTSD DOM)
- Counseling with a pastor
- Counseling with a biblical counselor
- Specialized Inpatient PTSD Units (SIPUs)
- Other (please specify)

Mighty Oaks Alumni Survey

*** 28. On a scale of 1-5 (1 being completely ineffective and 5 being extremely effective) how would you rank this program in helping you change?**

| | 1. Completely ineffective | 2. | 3. | 4. | 5. Extremely effective | N/A |
|---|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| One-on-one psychotherapy at the VA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Group therapy at the VA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Inpatient treatment at a VA hospital or clinic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PTSD Clinical Team (CPT) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Substance Use PTSD Team (SUPT) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PTSD Residential Rehabilitation Treatment Program (PTSD RRTP) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PTSD Domiciliary Program (PTSD DOM) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specialized Inpatient PTSD Unit (SIPUs) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Mighty Oaks Alumni Survey

*** 29. What other PTSD treatment programs did you attend since attending the Legacy Program (formerly Fight Club)?**

- None
- One-on-one psychotherapy at the VA
- Group therapy at the VA
- Inpatient treatment at VA hospital or clinic
- PTSD Clinical Team (CPT)
- Substance Use PTSD Team (SUPT)
- PTSD Residential Rehabilitation Treatment Program (PTSD RRTP)
- PTSD Domiciliary Program (PTSD DOM)
- Specialized Inpatient PTSD Units (SIPUs)
- Other (please specify)

Mighty Oaks Alumni Survey

*** 30. On a scale of 1-5 (1 being completely ineffective and 5 being extremely effective) how would you rank this program in helping you change?**

| | 1. Completely ineffective | 2. | 3. | 4. | 5. Extremely effective | N/A |
|---|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| One-on-one psychotherapy at the VA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Group therapy at the VA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Inpatient treatment at a VA hospital or clinic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PTSD Clinical Team (CPT) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Substance Use PTSD Team (SUPT) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PTSD Residential Rehabilitation Treatment Program (PTSD RRTP) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PTSD Domiciliary Program (PTSD DOM) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specialized Inpatient PTSD Unit (SIPUs) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Mighty Oaks Alumni Survey

31. Please provide us with any question you wish we would have asked that we did not.

32. If you have any other thoughts you would like to add please share them here.

33. Please enter your e-mail so we can send you a gift card if you are one of the first 100 respondents.

APPENDIX 13

LEGACY PROGRAM SCHEDULE

| MONDAY | TASK |
|------------------|------------------------------------|
| 1500 | Instructor Meeting |
| 1630 | Introduction |
| 1645 | Admin/Logistic/Ranch Rules |
| 1730 | Welcome to Legacy Program |
| 1800 | Dinner |
| 1900 | Rules and Promises |
| 1930 | Testimony "Fighting for Your Life" |
| 2000 | Ice Breaker |
| 2030 | I am Second Video/Team Intro |
| TUESDAY | TASK |
| 0700 | MORNING COLORS / BREAKFAST |
| 0750 | Daily Challenge |
| 0800 | Round 1 / Why Men Need to Fight |
| 0830 | Depart for Work Ranch |
| 0900 | Trail Ride |
| 1130 | LUNCH |
| 1230 | Return to SkyRose Lodge |
| 1400 | Round 2 / Character |
| 1500 | Team Breakouts |
| 1600 | Round 4 / Brotherhood |
| 1700 | Rec Activity |
| 1800 | DINNER |
| 1900 | Team Breakouts |
| 1930 | Personal Testimony |
| 2000 | Team Breakouts |
| WEDNESDAY | TASK |
| 0700 | MORNING COLORS / BREAKFAST |
| 0730 | Daily Challenge |
| 0745 | Round 9/ Our Common Enemy |
| 0850 | Team Breakouts |
| 0930 | Round 3 / Discipline |
| 1030 | Team Breakouts |
| 1100 | Round 6 / The Truth About PTSD |
| 1130 | Team Breakouts |
| 1200 | Lunch |
| 1245 | Round 12/Forgiveness |
| 1345 | Team Breakouts |
| 1430 | Intro Fight Plans |
| 1500 | Quad 4 Wheeler Trail Ride |
| *1500-1755* | Fight Plans/Team Time |
| 1800 | Dinner |
| 1900 | Round 10 / Legacy |
| 2000 | Team Breakouts |

| THURSDAY | TASK |
|-----------------|-------------------------------------|
| 0700 | MORNING COLORS / BREAKFAST |
| 0750 | Daily Challenge |
| 0800 | Team Time |
| 0900 | Round 8/ Margin |
| 1000 | Team Breakouts |
| 1030 | Round 7/Money & Possessions |
| 1130 | Team Breakouts |
| 1200 | LUNCH |
| 1300 | Round 5/Purity |
| 1400 | Team Breakouts |
| 1500 | Student Personal Testimony |
| 1800 | DINNER |
| 1900 | Movie |
| FRIDAY | TASK |
| 0700 | MORNING COLORS/BREAKFAST |
| 0800 | Team Time |
| 0800 | Baptism and Devotional (How to?) |
| 0900 | Team Leader Meeting |
| 1000 | Round 11 / Marriage |
| 1100 | Reflection Walk |
| 1155 | Reflection Walk Completion |
| 1200 | LUNCH |
| 1300 | Why The Bible |
| 1330 | Whats Next? |
| 1500 | Student Critiques |
| 1530 | Baptisms |
| 1530 | Clean/Pack/Personal Time |
| 1730 | Dinner |
| 1830 | Graduation Rehearsal/ Setup |
| 1900 | Graduation Ceremony/Final Challenge |
| 2000 | Session Complete |
| SATURDAY | ALL DEPART |
| 0800 | Breakfast and Departure |

APPENDIX 14

MIGHTY OAKS STATEMENT OF FAITH

We believe the Bible to be the inspired, the only infallible, authoritative Word of God.

We believe that the Bible is sufficient for all matters pertaining to a life of righteousness and Godliness. It is our primary source for teaching, reproof, correcting, and training.

We believe that there is one God, eternally existent in three persons: Father, Son and Holy Spirit.

We believe in the deity of our Lord Jesus Christ, in His virgin birth, in His sinless life, in His miracles, in His vicarious and atoning death through His shed blood, in His bodily resurrection, in His ascension to the right hand of the Father, and in His personal return to power and glory.

We believe that salvation is a gift of grace to be received and not something that can be earned by the works of man.

We believe that salvation (the forgiveness of sins) and new life comes to a person who acknowledges that:

They are sinful before a Holy God.
They cannot do anything to earn, merit or deserve salvation.
Jesus Christ is fully God.
He paid the price for sin in His sacrificial death on the cross.
He rose again victorious.
And that believing these things put their faith in Him alone.

We believe that a regenerate person will bear spiritual fruit in his life as a result of the indwelling of the Holy Spirit.

We believe in the resurrection of the saved unto the resurrection of life.

We believe in the present ministry of the Holy Spirit by whose indwelling the Christian is enabled to live a godly victorious life.

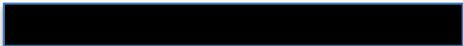
We believe in the spiritual unity of believers in our Lord Jesus Christ.

APPENDIX 15

AFTERCARE COMMUNICATIONS

4/18/2019

Gmail - Attitude and morale check



Attitude and morale check

1 message

Tue, May 16, 2017 at 6:40 AM

Gents

I just wanted to reach out to you and see how you're doing. While in church on Sunday our pastor taught on Faith. It was a great message, but a song we sang before he spoke as "Still my soul Be Still" by Keith and Kristyn Getty. It's a beautiful song, and a reminder of where our hope is and Who our Faith is in. He controls all, and He not only gives me Faith, but he renews it daily, He protects it. Don't let emotions dictate the state of your faith, rely on the Promises of God.

Still My Soul Be Still Lyrics

*Still my soul be still
And do not fear
Though winds of change may rage tomorrow
God is at your side
No longer dread
The fires of unexpected sorrow*

*God You are my God
And I will trust in You and not be shaken
Lord of peace renew
A steadfast spirit within me
To rest in You alone*

*Still my soul be still
Do not be moved
By lesser lights and fleeting shadows
Hold onto His ways
With shield of faith
Against temptations flaming arrows*

*Still my soul be still
Do not forsake
The Truth you learned in the beginning
Wait upon the Lord
And hope will rise As stars appear when day is dimming*

Your brother
John

--
**Semper fi,
John Foldberg
805-610-8102
Director, Aftercare Programs
Mighty Oaks Foundation
Mighty Oaks Warrior Programs**

<http://www.mightyoaksprograms.org/>



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<https://mail.google.com/mail/u/2?ik=4cf7273839&view=pt&search=all&permthid=thread-f%3A1567549040743525345&simpl=msg-f%3A1567549040743525345> 1/2

APPENDIX 16

LEADERSHIP INVITATION

4/18/2019

Biblical Counseling Coalition Mail - Mighty Oaks Leadership



Mighty Oaks Leadership

1 message



Wed, May 24, 2017 at 4:24 PM

Gents

I'd like to congratulate you for being recommended by your team leaders for potential leadership within Mighty Oaks. If you are interested please let me know and fill out the attached questionnaire. Feel free to call me if you have any questions about the process. When you send in your questionnaire I'll give you a call and we'll go over it. Once again, congratulations and I hope to speak with you soon.

--

***Semper fi,
John Foldberg
805-610-8102
Director, Aftercare Programs
Mighty Oaks Foundation
Mighty Oaks Warrior Programs***

<http://www.mightyoaksprograms.org/>



Hope for America's Warriors and Families
"From the Ashes to Mighty Oaks"
Isaiah 61

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APPENDIX 17

BIBLICAL DEFENSE OF EMPIRICAL RESEARCH

For those outside the biblical counseling community, it may seem odd that an academic dissertation would include a defense of empirical research. But for those within the movement this is a legitimate question. The need for this section is demonstrated by the fact that the founder of the modern biblical counseling movement, Jay Adams, dismisses the use of empirical validation. Adams argues that Nouthetic Counseling does not need empirical validation. He takes his argument to the degree that anyone who would dare to utilize statistics, to support their counseling, undermines its very nature as Christian.¹ While I greatly respect Adams and am certainly indebted to him as a biblical counselor, I cannot agree with his assessment. My contention with Adams encompasses two main points. First, I disagree that there is absolutely no way to measure the effectiveness of biblical counseling and, second, that there is no value in empirical research.

Before I offer a defense of empirical research it is important to define the term. Related to knowledge, empirical is defined as, “That pursues knowledge by means of direct observation, investigation, or experiment (as distinct from deductive reasoning, abstract theorizing, or speculation); that relates to or derives from this method of pursuing knowledge.”²

Empirical is distinct from the philosophical position of empiricism which

¹ Jay E. Adams, “Empirical Evidence?,” *Institute for Nouthetic Studies* (blog), October 25, 2011, <http://www.nouthetic.org/blog/?p=3877>.

² “Empirical,” in *OED Online* (Oxford University Press), accessed January 16, 2020, <https://www.oed.com/view/Entry/61341>.

argues that human knowledge is limited to that which can be observed or tested.³ Empirical research is the field of study dedicated to gaining knowledge through sensory experience; “Empirical research is based on observed and measured phenomena and derives knowledge from actual experience rather than from theory or belief.”⁴ This is why empirical research is often used as a synonym for scientific research. It attempts to uncover knowledge through repeatable, measurable observations. This differs from other forms of knowledge seeking such as reason/logic (knowledge gained through rational thought) or divine revelation (knowledge gained when God communicates truth to people).⁵ People gain knowledge empirically or make empirical observations on a regular basis. For instance: That tree is taller than that man. My wife must have baked something delicious based on the smell that fills my nostrils, as I enter my home. And the speed of light is 186,000 miles per second. Utilizing empirical research or gaining knowledge empirically does not make one an empiricist.

Adams articulates a number of questions which he intends to validate his point that it is impossible to empirically verify biblical counseling. Since the primary goal of biblical counseling is to glorify God, he questions whether or not we can evaluate the achievement of that goal. He questions whether anyone can test if God is glorified or honored in a person’s life. He also questions how someone can test the involvement of the Holy Spirit in bringing about change in a person’s life. Without ever engaging any of his questions, Adams jumps to this conclusion: “...there is no way to obtain empirical evidence. Since it is biblical attainments that are under consideration, it is impossible to get statistical evidence for the spiritual changes that the biblical counselor seeks to bring

³ “Empiricism,” in *Dictionary of the Social Sciences*, Craig J. Calhoun, ed., (New York: Oxford University Press, 2002).

⁴ Ellysa Cahoy, “Library Guides: Empirical Research in the Social Sciences and Education: What Is Empirical Research?,” accessed November 13, 2019, //guides.libraries.psu.edu/emp/whatis.

⁵ Robert Audi, *Epistemology: A Contemporary Introduction to the Theory of Knowledge*, 3rd ed, Routledge Contemporary Introductions to Philosophy (New York: Routledge, 2011), 113–14.

about.”⁶ Adams’ claims are intended to appear self-evident and beyond refutation but thankfully they are not. I would agree with Adams’ claim that we will not be able to put someone’s soul in a test tube, shake it up, and see if it turns blue, but does that mean we can never observe the work of God in someone’s life?

On a number of occasions, Scripture uses empirical evidence to verify the work of God. All three Synoptic Gospels include the account of Jesus healing a paralytic who is brought before Him by his friends. The reason Jesus gives for healing this man is “so that you may know that the Son of Man has authority on earth to forgive sins” (Matt 9:6; Mark 2:10; Luke 5:24). Jesus points to the verification of an internal, spiritual work manifested in outward physical healing. Peter declares to his hearers on Pentecost that Jesus was “a man attested to you by God with miracles and wonders and signs which God performed through Him in your midst” (Acts 2:22). Repeatedly the book of Acts demonstrates how God used miracles to attest to His work in the lives of His messengers (4:30; 5:12; 6:8; 8:6; 14:3; 15:12).

Certainly some will argue that the miracles performed cannot be used to justify the use of empirical study on biblical counseling because of the unusual nature of the divine intervention. I will concede the point that, in and of themselves, the miracle accounts are not a direct analogy to empirical research. However, the point still remains that the work of the Holy Spirit can often be seen in objective, empirically verifiable, physical realities. It is not just the miraculous accounts of Scripture that demonstrate God working in observable ways.

As a young captive in pagan Babylon, Daniel finds himself faced with a challenge to his faith. Daniel is given food that he cannot eat without being defiled. He appeals to the man charged with his care to allow him to eat only vegetables and drink only water. The commander is hesitant to comply with Daniel’s request. Daniel does not

⁶ Jay E. Adams, “Empirical Evidence?”

attempt to reason with the man from Scripture. Daniel does not articulate his religious convictions to the commander. Instead, he proposes a test. He gives the test parameters and a timeline, then promises observable results. The commander agrees and at the end of the ten-day trial period the observable results are astounding. Daniel and his friends eat a very restricted diet yet are “fatter” than their counterparts who gorge themselves on the king’s choice meats and wine (Dan 1:15).

Daniel proposes and conducts something akin to an empirical study. It is subject to peer review (the commander), uses a control group (those who ate the king’s food), and has measurable parameters (observed appearance). I do not claim that this text is intended to justify empirical research, but it does demonstrate the fact that observable, measurable realities in human life can point to the effectiveness of following after God.

Growth towards Christlikeness is also measurable through observing the actions and words of a counselee. Counselors may not be able to directly examine a counselee’s heart, as God can, but they are able to assess what is going on inside a person by observing her behaviors and listening to her words. Adams makes the point that human counselors are only able to observe behaviors and listen to the words of their counsees. His point is that we cannot actually measure the human spirit. While we “cannot put someone’s soul in a test tube,”⁷ God has told us to examine the words and actions of people, so as to peer into their hearts. Jesus makes it abundantly clear that what comes out of people’s mouths is what ultimately flows out of their hearts (Matt 12:34; 15:18). The words someone uses, especially when describing their desires, fears, goals, etc., help us to see what is truly going on inside of them.⁸

Scripture also attests to the fact that a man’s behaviors are an indication of

⁷ Jay E. Adams, “Empirical Evidence?”

⁸ Jeremy Pierre, *The Dynamic Heart in Daily Life: Connecting Christ to Human Experience* (Greensboro, NC: New Growth Press, 2016), 180–91.

where his heart lies. Galatians 5:16-26 describes a stark contrast between those who “live by the flesh” and those who “live by the Spirit.” Paul uses behaviors to describe what characterizes the lives of those on each side of the contrast. One should be able to examine his own life, or the life of another, and see a life characterized by “deeds of the flesh” or “fruit of the Spirit.” These deeds and fruit manifest in behavioral ways but are indications of internal spiritual reality. Jesus uses the analogy of fruit to describe the same principle. He warns His followers to beware of false prophets and tells them to identify these false teachers by examining the fruit of their lives (Matt 7:15-20). Fruit manifested through obedience to God’s commandments is evidence of a love for Christ and proof that those who manifest such fruit are His disciples (John 15:8-10). Contrary to what Adams asserts, it appears that one can take a measurement of the status of a person’s soul by examining both words and actions.

Biblical counselors evaluate success in counseling all the time. We do this by observing whether or not the counselee is changing the way he acts and speaks. In practice all biblical counselors takes measurements of progress, or lack of progress, in their counseling. Each of us performs some type of assessment at the beginning of counseling. Through data gathering on intake forms, like a Personal Data Inventory (PDI) and during our initial counseling sessions, we try to determine whether or not someone is a follower of Christ. We also attempt to discover particular problems with which the counselee is struggling. These struggles are far deeper than external behavior. Adams even encourages counselors to move beyond the “presentation problem” to uncover “performance problems” and “pre-conditioning problems.”⁹ Our goal is to move past the behavioral manifestations of sin, to uncover the heart idolatry that is taking place, within the inner man.¹⁰ Not only do we attempt to measure the state of a person’s soul but we

⁹ Jay E. Adams, *Competent to Counsel: Introduction to Nouthetic Counseling*, (Grand Rapids: Ministry Resources Library, 1986) 148-151.

¹⁰ Timothy S. Lane, *How People Change*, 2nd ed (Greensboro: New Growth Press, 2008)

also endeavor to measure spiritual growth and change. We bring our counseling cases to an end at some point, but we do so after assessing that the counselee is either growing in godliness or that he is refusing to cooperate with counsel. We examine his words and behavior (fruit) and determine whether he has grown (i.e., whether there has been measurable success in counseling).

Empirical research can be a valuable tool to help advance the biblical counseling movement. Adams states that empirical evidence is not necessary to validate biblical counseling and he is absolutely correct. Biblical counselors have never been motivated by pragmatism. We counsel biblically because God has called us to minister to His people through His Word. However, it would be an illogical leap to say that just because something is not necessary, then it is wrong to utilize it. I am extremely thankful for the ministry of Adams and completely understand why he did not focus his efforts on empirical study considering the context of the world and culture at the time of his initial writing. He was trying to awaken the church to its ignorance of and disengagement from the world of soul care. Of the utmost importance was reminding Christians of their call to care for the needs of the Body of Christ through the inspired Word of God. While there is still much ground to be gained in that battle, thankfully there has been great advancement.

Heath Lambert outlines the advancements that have been made and calls for further advancement, in the movement, in his seminal work *The Biblical Counseling Movement After Adams*. One key area of advancement he calls for is in the academic community. “If the biblical counseling movement is to expand, it will be necessary for those in the movement called to the academy to make—as part of their calling—the effort to engage with those who hold different views on counseling.”¹¹ In order to engage the

162ff.

¹¹ Heath Lambert, *The Biblical Counseling Movement after Adams* (Wheaton: Crossway

academic community, the biblical counseling movement will need to demonstrate the effectiveness of its counseling model. While Adams began the fight where it was most needed, in our churches, the battle has advanced beyond that arena. Advancements into academia have already begun and there has been great success. For years very few academic institutions have been teaching biblical counseling but in the last decade that number has grown immensely. There are now numerous seminaries, Bible colleges, and universities that have biblical counseling programs. These institutions are able to influence and prepare many pastors and other ministry workers who will go back to their churches and further advance the biblical counseling movement and the Kingdom of God. Adding empirical research to help demonstrate the effectiveness of biblical counseling as well as evaluate our practice is one more tool we can utilize to enhance and advance biblical counseling.

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ABSTRACT

EVALUATING THE LEGACY PROGRAM OF THE MIGHTY OAKS FOUNDATION: A MIXED METHOD STUDY

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Post-Traumatic Stress Disorder is a serious diagnosis that plagues many men and women who have served in the United States military. With high veteran suicide rates, an overwhelmed VA system, and a host of treatments that are often ineffective; it is important to find affordable and effective alternative treatment options. Additionally, there is a growing recognition that spirituality plays a key role struggle of PTSD and therefore must play a role in its treatment. The Mighty Oaks Foundation has developed multiple programs that are designed to help men and women struggling with PTSD as well as their spouses and families. The flagship program of Mighty Oaks is the Legacy Program, a week-long residential, peer-to-peer, faith-based treatment program. This dissertation employs a variety of research methods in order to assess the effectiveness of the Legacy Program for men.

Chapter 1 describes the purpose for the current study, lists research questions that will be addressed by the research. This chapter also offers delimitations to the research and provides a procedural overview of the research that was conducted.

Chapter 2 reviews the precedent literature relating to Post Traumatic Stress Disorder. This provides an overview of the history of PTSD, various treatments available for PTSD and studies to determine their effectiveness. This chapter also offers insights from biblical counseling literature on the topic of PTSD.

Chapter 3 gives an overview of the Mighty Oaks Foundation. It recounts the

history of the ministry, describes its philosophy, and reviews the content of the Legacy Program for Men.

Chapter 4 outlines the methodology of the research undertaken in this dissertation. It includes a restatement of research questions and how each will be addressed in the research. Information on the population studied, instrumentation, and research procedures used are also covered in this chapter.

Chapter 5 provides an analysis of the findings. The quantitative pre/post-test study demonstrated that attendance at the Legacy Program reduces one's PTSD symptoms and results in an increase in one's faith. The correlation between these two changes was not demonstrated to a clinically significant degree by the data. The retrospective alumni survey also provided insights into what components were seen as beneficial by participants.

Chapter 6 offers conclusions drawn from the data gathered in the research. Recommendations for implementing this type of program are made and areas for further research are also proposed.

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