Posttraumatic Growth Themes: An Analysis of Oral Histories of OIF Service Members and Veterans

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Abstract

There is an ongoing growth of literature that examines the negative effects of war among service members and veterans of Operation Iraqi Freedom (OIF). For example, there have been unprecedented occurrences of posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) among those who have served in OIF. While these studies identify the deleterious effects of deployment in war zones, consideration of the possibilities of posttraumatic growth (PTG) related to war zone deployment may be beneficial. This study analyzes collections of oral histories for themes of PTG among veterans and military service members who served in OIF. An analytical template based on six themes taken from an abbreviated version of the Post-Traumatic Growth Inventory (PTGI) originally developed by Tedeschi and Calhoun (1996) is used. Using the PTGI model, this study contributes further data to the growing body of research that is attempting to address the possibility of positive effects of struggling with traumatic war zone experiences.

The war of Operation Iraqi Freedom (OIF) is one of the longest combat operations since Vietnam (U.S. Department of Veterans Affairs 2011). The OIF war was one of the first wars fought with an all-volunteer military force; most have served multiple deployments in combat (Hosek, Kavanagh, and Miller 2006). More than 1.64 million soldiers have served in the OIF war (Tanielian and Jaycox 2008). The effects of war on fighting forces have included psychological and neurological injuries associated with posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and other psychiatric disorders have developed post deployment (Hoge et al. 2004). The general mental health conditions commonly associated with the deployment have left an overflow of veterans and service members of the OIF struggling when searching for mental health care (Seal et al. 2010). These invisible wounds and conflicts of mental health care accessibility have been the focus of recent and increasing literature (Seal et al. 2010). These invisible wounds and conflicts of mental health care accessibility have been the focus of recent and increasing literature (Seal et al. 2010). These invisible wounds and conflicts of mental health care accessibility have been the focus of recent and increasing literature (Seal et al. 2010). These invisible wounds and conflicts of mental health care accessibility have been the focus of recent and increasing literature (Seal et al. 2010).

Efforts have been made in treating those who served in OIF and return with mental health conditions. In an attempt to address these unprecedented mental health needs, the Veteran Affairs (VA) agency has added 4,330 mental health enhancement positions and lightened clinicians’ caseloads (Voss Horelle et al. 2011). In addition, the Department of Defense (DoD) implemented mandatory PTSD screenings that are completed upon return from combat and 3-6 months post deployment (Milliken, Auchterlonie, and Hoge 2007). The DoD implemented reassessment because clinicians have found that mental health issues may not surface until several months after the veteran’s return (Hoge, Auchterlonie, and Milliken 2006). Although there has been unprecedented attention and resources focused on addressing mental illness conditions (Defense Centers of Excellence 2007), more work needs to be done. Soldiers are not responding or accessing services due to barriers to care: access and stigmatization (Hoge et al. 2004).

Researchers have found that among the military service members who have returned from OIF and reported symptoms of mental illnesses, only a few more than half have sought treatment (Tanielian and Jaycox 2008). Even when soldiers decide to seek help, they are hindered by a lack of access. According to an assessment of the soldiers who served in the OIF war, National Guards and Reserve soldiers seemed to score higher in reported mental health problems than Active duty soldiers (Milliken, Auchterlonie, and Hoge 2007). This is concerning when one considers that approximately 40% of US OIF troops are Guard or Reserve service members (Milliken, Auchterlonie, and Hoge 2007). Active duty soldiers have ongoing access to health care, while reservist standard health insurance benefits (DoD) expire six months after return to civilian life (Milliken, Auchterlonie, and Hoge 2007). The National Guard and Reserve soldiers are mostly affected by the barrier of access; securing ongoing health care may be a more prevailing concern because of limited care (Hoge et al. 2004).

Stigma is another barrier that suppresses all military service members (Hoge et al. 2004). Over half of surveyed soldiers who tested positive for mental illnesses thought they would be perceived as weak, treated differently, or blamed for their illnesses if they sought help (Hoge et al. 2004); the soldiers thought seeking help would cause them to feel ashamed and embarrassed. Military culture and careers have been reported as a reason not to seek help. Some mental health treatments under present military policies trigger automatic involvement of a soldier’s commander, which can lead to negative career ramifications if the soldier fails to comply (Milliken, Auchterlonie, and Hoge 2007). Service members believe that seeking care will change others’ perceptions of themselves, threaten career advancement and security clearances, and cause possible removal from their unit (US DoD Task Force on Mental Health 2007).

There has been a large amount of research focusing on the negative effects of war, but recent research suggests that all effects of war do not have to result in permanent negative changes (Tedeschi and Calhoun 1996). There has
been a growing interest in studying the possibility of positive psychological changes after trauma. The term posttraumatic growth (PTG) refers to positive psychological change experienced as a result of the struggle of highly challenging life circumstances (Tedeschi and Calhoun 2004). Examples of PTG include a new appreciation of life, change in priorities, increased confidence, relating to others, and new positive spirituality (Tedeschi et al. 1998). In fact, there have also been studies exploring OIF service members’ experiences of PTG (Benetato 2011; Pietrzak et al. 2010). Such studies have utilized surveys and mental illness assessments rather than interviews with U.S. troops. This study intends to build on the PTG body of knowledge by adding an investigation of oral histories.

Recently there have been books published of oral histories shared by troops who served in OIF. For example, What Was Asked of Us: An Oral History of the Soldiers that Fought in it by Trish Wood (2006) provides a collection shared by service members who had deployed to OIF. Analysis of oral histories of U.S. service men and women opens up a new way to identify themes of PTG that may emerge from experiences of war. Content analysis of narratives enables the researcher to identify emerging themes from the personally recounted stories of OIF service members. This research project analyzes a collection of oral histories from Wood’s (2006), What Was Asked of Us: An Oral History of the Soldiers that Fought in it for themes of posttraumatic growth among veterans and military service members who have served in OIF. Through this analysis, the researcher addresses the following question: Is it possible for soldiers and veterans who served in the OIF war to have experienced posttraumatic growth when overcoming post traumatic experiences of war and combat zone deployments?

**Literature Review**

Though studies are slowly increasing in the area of positive growth after trauma, the deleterious effects of war trauma most definitely remain. Therefore, to fully understand PTG it is necessary to identify the types of traumas which create opportunities for posttraumatic growth among OIF service members. The following literature review includes a brief discussion of psychological wounds of war, barriers to care, background of PTG and PTG among combat service members.

**Psychological Wounds**

Studies of recent military operations in OIF have found that deployment stressors and exposure to combat result in considerable risks to mental health. The primary psychological wounds of war are posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), substance abuse, major depression, suicidal thoughts and anxiety (Hoge et al., 2004). For example, mental health issues can be estimated to range between 16% to 49% for anyone who has been deployed (Tanielian and Jaycox 2008). PTSD, in particular is thought to affect 11% - 20% (U.S. Department of Veterans Affairs 2011). PTSD can occur after exposure to a traumatic event like combat, assault, or disaster. While stress and anxiety are typical reactions to trauma, more severe and unrelenting symptoms can result in a diagnosis of PTSD (U.S. Department of Veterans Affairs 2011). Symptoms of PTSD vary from person to person, but essential features include re-experiencing trauma, avoidance, and hyperarousal (National Council on Disability 2009). Re-experiencing trauma is the most disruptive of the symptoms of PTSD, and it involves flashbacks, nightmares, and intrusive memories of the disturbing event. A noise, an image, certain words, or a smell can trigger a memory of the original traumatic event. Avoidance refers to evasion of thoughts or activities that could remind them of the traumatic event. In addition, they may lose their ability to experience pleasure and they can become nonresponsive. Hyperarousal is the experience of being constantly in danger. Experiencing increased arousal may disrupt sleep, to irritability and anger, and impair concentration. Most recent estimates of PTSD among those who served in OIF indicate that 11% - 20% may be suffering from PTSD (U.S. Department of Veterans Affairs 2011).

TBI is the signature injury of the OIF war, with blast related brain injury as the most common (Elder and Cristian 2009). Improvised explosive devices (IEDs) have proven to be the major cause of blast injuries in OIF and have been estimated to be responsible for approximately 40% of coalition deaths and TBIs in returning soldiers (Elder and Cristian 2009). TBI can cause changes in a person’s ability to think, control emotions, walk, or speak, and can affect sense of sight or hearing (Cernak et al. 2001). The full extent of the TBI among soldiers is not fully known but it is estimated that approximately 22% of wounded service members of the OIF wars have experienced TBI (Bowling and Sherman 2008).

Other psychiatric injuries found among OIF soldiers and veterans include anxiety, depression (Bowling and Sherman 2008) substance abuse, and suicidal thoughts (Voss Horrell et al. 2011). A study of 1,700 Army and Marine personnel who had served in OIF found that 15% - 17% met criteria for major depression and anxiety disorder (Hoge et al. 2004). There have also been a percentage of service members that have experienced high levels of anxiety post deployment. This has been seen as a result of their need to be on guard and alert during combat (Bowling and Sherman 2008). Depression often emerges, during the process of reintegrating into civilian life (Bowling and Sherman 2008). Common depressive symptoms often include fatigue, failure to concentrate, sleep disturbance, social withdrawal and suicidal thoughts (Hoge et al. 2004).

Substance abuse (alcohol and illegal drugs) often emerges post deployment as negative coping mechanisms (Hoge et al. 2004). In a study of 88, 235 US soldiers returning from OIF, 56,350 active duty soldiers were assessed for substance abuse, and 6,669 reported alcohol abuse (Milliken, Aukerlonie, and Hoge 2007). Out of these 6,669 soldiers, 134 were referred to treatment, and only 29...
actually followed through with an alcohol abuse treatment program (Milliken, Auchterlonie, and Hoge 2007). One prominent reason for lack of follow up with referrals is the lack of confidentiality under military policies (Milliken, Auchterlonie, and Hoge 2007). Suicidal thoughts and suicidality have emerged as a significant problem among those who have been deployed to OIF (Hoge, Auchterlonie, and Milliken 2006). While it is difficult to measure the number of veterans who have suicidal thoughts, a recent study found a substantial number of suicides among OIF Army service members (Bowling and Sherman 2008).

Barriers to Care

Service members (Active, Guard, and Reserve) have a variety of health care coverage including Civilian insurance (Medicare, Medicaid, or private insurance), VA, DoD, or they may be uninsured (Hoge et al. 2004). Even though service members have access to care, each health care system has fallen short in delivery of care (National Council on Disability 2009). A large percentage of OIF veterans rely on civilian insurance because a large amount of the soldiers are Reservist or National Guard and their care eventually expires (National Council on Disability 2009). As a result, many providers treating these service members are not part of the military or VA system, and may not be familiar with the unique needs of the military population (National Council on Disability 2009). Relative to Active duty service members, members of the National Guard and Reserves have limited access to military health services (US DoD Task Force on Mental Health 2007) because their military health services benefits expire once they return to civilian status. Civilian insurance is the final option after military benefits expire and due to lack of military treatment competency among civilian providers, this may not guarantee access to quality mental health services (National Council on Disability 2009).

The VA operates the nation’s largest integrated health care system with over 210,000 employees and has given care to millions of veterans at 157 VA Medical Centers and 875 community based outpatient clinics nationwide (National Council on Disability 2009). However, there is a concern that the VA is not geographically accessible to all veterans. According to the VA, over 92% of enrollees reside within one hour of VA facility, and 98.5% are within 90 minutes, which offers very limited or no mental health care services (National Council on Disability 2009). In addition, Guards’ and Reservists’ access to VA services is limited for only 24 months after they return from deployment. Active duty service members have ongoing health care for deployment related problems (Milliken, Auchterlonie, and Hoge 2007).

The DoD provides health care to over 8 million service members. The DoD medical health system ensures service members “readiness” for deployment and provides medical “benefits” and support to service members (National Council on Disability 2007, 39). The Standard DoD health insurance benefits for Guards and Reservists include 180 days of premium-free coverage (Milliken, Auchterlonie, and Hoge 2007). While Active duty soldiers receive ongoing care, once Guards’ and Reservists’ benefits expire they must pay for additional coverage (National Council on Disability 2007). In addition, there is also a concern with DoD’s shortages of mental health care providers because they are spread about military bases and deployment missions (National Council on Disability 2007). Some service members may have to wait weeks or months for available appointments (National Council on Disability 2007).

Mental illness despite centuries of research is still perceived as an indulgence, a sign of weakness (Byrne 2012). Self-stigmatization has been described, and there are numerous personal accounts of psychiatric illness, where shame overrides even the most extreme symptoms and prevents those who suffer from receiving treatment (Byrne 2012). The stigma of mental illness also affects many soldiers, preventing them from accessing mental health care. Often experienced as a sense of shame or discredit, stigma often results in marginalization from one’s peers (Byrne 2012). While mental illness has long been stigmatized in society, military members carry an additional burden as it relates to stigma and psychological wounds.

The additional potential for such stigma is found in the significant training that service members receive that steadfastly grounds them in their branch’s military core values. For example, the core values of the Marines are Honor, Courage, and Commitment and are considered to be the foundation of each Marine’s character (U.S. Marine Corps 2012). Honor requires that each Marine live life according to the highest standards of moral and ethical conduct (U.S. Marine Corps 2012). Courage is the moral, mental and physical strength that is ingrained in each Marine. The guardian of all other values, Courage drives the Marine to hold the highest of personal standards and to act under great stress (U.S. Marine Corps 2012). Commitment is the spirit of determination found in every Marine and compels them to never accept defeat (U.S. Marine Corps 2012). The core values of Marines and other military branches are honorable and provide the foundation to act under the stress and pressures of war, but these same values may also hinder service members from seeking help (National Council on Disability 2007). For instance, an Army survey of soldiers who served in OIF, found that male soldiers who met the screening for mental disorders express concern that they would be seen as weak and 40% believed that their commanders would blame them for the problem (US Army Surgeon General 2008). Reducing the perception of stigma and barriers to care among military should be a priority for the military, health care systems and clinicians who are involved in providing care for those who have been in war zones.
Posttraumatic Growth and the PTG Model

The notion that people can grow psychologically in the aftermath of trauma is not new. Some studies have explored the phenomenon known as posttraumatic growth (PTG) (Tedeschi and Calhoun 1996) but others have used different terms. The present research uses the term PTG (Tedeschi and Calhoun 1996) as the ability to increase one level of positive change following traumatic experiences. PTG has been observed in various trauma-experienced populations, including survivors of medical illnesses (cancer and HIV/AIDS), rape, disasters (Tedeschi and Calhoun 1996), and military service members (Benetato 2011). Trauma can be experienced by all and can be a catalyst for personal and social transformation (Tedeschi and Calhoun 1996). Studies that are more recent have developed a model to measure PTG. The Posttraumatic Growth Inventory (PTGI) (Tedeschi and Calhoun 1996) assesses the positive changes reported by people who experienced traumatic events. The PTGI model points to five categories of growth: new appreciation of life, change in priorities, increased confidence, better acceptance of how things play out, and new positive spirituality. Tedeschi and Calhoun (2004) argue that PTG is more than moving beyond the ability to resist and not be damaged by traumatic experiences: it is personal and psychological growth that moves the individual past pre-trauma levels. According to Tedeschi (1999), survivors of trauma often self-report positive changes in identity, philosophy, and goals. Through Tedeschi (1999) examining survivors’ narratives, he concluded that trauma survivors report skills of wisdom and empathy; however, in contrast, he stated that individuals who do not grow from trauma develop the damaging effects from anxiety, depression and PTSD.

Posttraumatic Growth of Combat Service Members of OIF Wars

Researchers have been interested in comprehending PTG among survivors of traumatic combat experiences. One of these examined PTG among soldiers who deployed to combat in the Operation Enduring Freedom (OEF) and OIF (Pietrzak et al. 2010). The authors surveyed 272 combat veterans and used the PTGI to analyze data. Findings indicate that 72% of study participants showed significant PTG in at least one of the six dimensions of PTG. The most common areas of growth were found in the PTG dimensions of changing priorities about the important areas of life (52.2%), appreciating each day (51.01%), and ability to cope with difficult situations (48.5%). Results of hierarchical regression analysis revealed that younger age and increased feelings of being supported were significantly associated with PTG (Pietrzak et al. 2010). Another survey based on OEF-OIF veterans focused on soldiers with amputations (Benetato 2011). The focal point of the survey was on the amputees’ social support received and self-reflection of their traumatic experiences (Benetato 2011). The strongest correlation was between PTG and self-reflection; the veterans showed PTG through a way of responding to and comprehending their distresses (Benetato 2011). Benetato (2011) found that the relationship between social support and PTG was particularly small. These studies suggest that the support soldiers receive from their unit members or in other social relationships helps in the development of positive growth.

The concept of PTG is being researched among a diversity of traumatic events from divorce and death to natural disasters and terrorist attacks (Haidt 2006). More recent studies have begun to identify the PTG effect among OEF-OIF service members. Many of these studies either interviewed or surveyed OEF-OIF veterans as the method of data collection (Benetato 2010; Pietrzak et al. 2010). No published studies, however, have examined PTG in OIF soldiers and service members’ analysis of oral histories of their traumatic experiences. Is it possible for soldiers and veterans who served in the OIF war to have experienced posttraumatic growth when overcoming posttraumatic experiences of war and combat zone deployments? This study addresses this research question.

Research Design

This study, an exploratory research project, is best conducted using a qualitative research design. The qualitative design is best suited for this project because so little is known about posttraumatic growth in general and specifically among soldiers and veterans who have been deployed to combat. In addition, and perhaps most significantly, this researcher wishes to give voice to the subjective experiences of these military service persons and the qualitative method allows for this process.

Methodology

This is a research project that used qualitative methodology to examine the research question. This researcher chose to analyze entries in the oral histories published in the book What Was Asked of Us: An Oral History of the Iraq War (Wood 2006) because the book consists of the personal stories written by soldiers of the OIF war. What Was Asked of Us: An Oral History of the Iraq War is a collection of oral histories that captures various personal narratives told by men and women who served in the OIF war. This study analyzes eight randomly selected oral histories from this collection. A qualitative research method is used to explore these oral histories for themes of PTG. Specifically content analysis of the stories is used to identify themes of PTG.

To examine the oral histories of OIF service members, the method of qualitative content analysis is used. The narratives are analyzed for themes of posttraumatic growth. Qualitative content analysis is a research method that involves analyzing and interpreting qualitative data such as interviews and written accounts in order to discover emergent meaningful patterns descriptive of a particular phenomenon (Auerbach and Silverstein 2003).
Sample
In the present study, eight oral histories of OIF service members were used. These oral histories were selected from the text, *What Was Asked of Us: An Oral History of the Iraq War* (Wood 2006). The text contains forty-one oral histories that reflect experiences which occurred between the dates of March 2003 through April 2006. Due to the limitations of this study, it was not possible to analyze all of the oral histories in the book. The researcher identified the sample of eight oral histories by randomly selecting eight narratives from *What Was Asked of Us: An Oral History of the Iraq War* using Mads Haahr’s (1998) *Dice Roller*. The *Dice Roller* is a form of rolling dice virtually. For every chapter in the book the researcher virtually rolled dice. The number of dice that would be rolled was determined by the number of personal narratives in each of the 4 chapters in the book. For example, in chapter one there were only five narratives, so only one die was rolled. The researcher virtually rolled one die for chapter one and it landed on two indicating that the second narrative in that chapter was to be selected for analysis. The same process was repeated to select the remainder of the sample of oral histories.

Assessment Instrument
To analyze the collection of oral histories for themes of PTG this researcher used the main thematic dimensions of the Posttraumatic Growth Inventory (PTGI) (Tedeschi and Calhoun 1996). There are five main thematic dimensions in the PTGI model that this study used as the template for identifying PTG themes within the personal narratives (Tedeschi and Calhoun 1996). The five dimensions of PTG are New Possibilities, Relating to Others, Personal Strength, Appreciation of Life, and Spiritual Change. The thematic dimension, New Possibilities, represented the process of engaging in positive change and making meaning of trauma. For example, discovering positive aspects of oneself that they did not realize before the trauma is a new possibility. Relating to Others is defined as being positively affected by personal evaluations of competence after a traumatic experience. The category Appreciation of Life is demonstrated by making a change in personal value of life and appreciation of everyday. Lastly, Spiritual Change is represented by the ability to struggle and make sense of trauma, which can lead to a strengthening of personal beliefs.

Data Analysis
The process of content analysis as developed by Auerbach and Silverstein (2003) in their text, *Qualitative Data* was used to analyze each of the eight oral histories. The researcher developed a template consisting of the five main thematic categories of the PTGI. Each oral history was analyzed for any content that related to any of these PTG dimensions. In addition, the oral histories were analyzed for any themes of posttraumatic growth that may or may not fit one of the PTGI dimensions. Following the procedure of Auerbach and Silverstein (2003), themes were identified through the process of data coding and grounded theory, which were derived from and grounded in, service members’ personal narrative understandings. Data coding is a procedure of first organizing the relevant text of the oral histories, and discovering patterns of themes within the relevant text. It was through the coding process that the researcher found recurring themes that represented PTG amongst the service members’ narratives.

The process of data coding as outlined by Auerbach and Silverstein (2003) is depicted in Figure 1. Figure 1 shows the process of how the researcher analyzed the data by using the coding procedure. After the oral histories (raw text) were selected by the *Dice Roller* method (Haahr 1998), each narrative was then read through and analyzed for relevant text that reflected PTG. Once the relevant text information was identified, it was then analyzed for repeating ideas that were emergent in the relevant texts. The researcher found that the service members had similar themes of PTG emerging from their narratives. These similar themes reflected the dimensions of Tedeschi and Calhoun’s (1996) five thematic dimensions. The final step was to identify the thematic dimensions that represented PTG amongst OIF service member’s experiences.

Figure 1
Process of Data Coding

Findings
The findings of this research are contextualized along with repeating ideas and themes found within the eight raw texts of oral histories sampled from *What Was Asked of Us: An Oral History of the Iraq War* (Wood 2006). The main purpose
of this study was to address the research question: Is it possible for soldiers and veterans who served in the OIF war to have experienced posttraumatic growth when overcoming traumatic experiences of war and combat zone deployments? The content analysis of the eight oral histories revealed that themes of PTG emerged. Using the template of the Tedeschi and Calhoun (1996) dimension of PTG, the analysis found PTG themes reflecting four of the five dimensions. In addition, another dimension emerged. The researcher will discuss the themes that emerged from analyzing the narratives and explain the significance of the posttraumatic growth from the soldiers’ combat experiences.

Discussion

New Possibilities

The first thematic dimension of Tedeschi and Calhoun’s (1996) themes of PTG was new possibilities. PTG can be seen though individual identification of new possibilities. A new possibility theme that emerged from the data was that of understanding an enemy. The OIF service members were putting into perspective their own feelings of their enemy during their traumatic experiences. The personal narratives expressed their frustration of being in Iraq but they also expressed that they had to really put themselves in the enemy combatants’ and the Iraqi peoples’ situations. The narratives expressed that they coped with some traumatic experiences by allowing themselves to observe the situation from the perspectives of the enemy and the Iraqis who were being invaded by Americans. For example, Justin LeHew (Marine) expressed “When we assaulted Kuwait, we were pushing Iraqi forces out of a country they had invaded. But now we are invading their country, and so if somebody’s coming into my backyard, why should I surrender?” (Wood 2006, 17). Being able to make an effort to understand why a traumatic event is in progress is a sign of PTG. Establishing personal interpretations of a traumatic experience can keep service members safe. The service members expressed traumatic events where they risked their lives to keep the Iraqi people safe. Tania Quinones (Army National Guard) was a part of the team that operated a diner exchange where people traded their money because it was not safe. Tania’s open-minded emotion of what the Iraqi people were experiencing reflects self-reflection needed in developing PTG. The personal narratives expressed efforts in understanding the enemy will in the end keep them safe because once they comprehend they will be able to better protect themselves from traumatic experiences and harm. A new possibility like understanding an enemy is a PTG coping strategy to help manage distress and doubts of why the service members were even fighting in the war.

Appreciation of Life

The second thematic dimension captured the idea that appreciating life coexists with positive thinking. Service members expressed positive thinking and living in the moment. An increased appreciation of life is a personal change in what is important when someone has experienced a traumatic event. Daniel B. Connoir wrote about his experience of witnessing Marines that were blown up in their vehicles. He expressed that “It’s just a matter of luck that you are not that guy. No one wants to be that guy, so you beat around in your head how lucky you are” (Wood 2006, 220). It is not uncommon to have a feeling of being lucky. Seth Moulton (Marine) expressed that “there is a part of it, because of the adrenaline rush and excitement, that you can even enjoy. So you don’t commiserate about your predicament, you make light of it. You can joke about the most terrible thing…Gee, its great to be alive; I’m one lucky son of a bitch with a grin on your face” (Wood 2006, 128). Even the smallest things increase the service member’s value in their appreciation of life. Witnessing and participating in actions of war zones can create a positive outlook and joy in life. Gregory Lutkus expressed he “always liked riding in the turret just because I thought it was the wildest to be in this country that most people have never seen before, and you’ve got the blast of this sweltering heat in your face…I just thought it was so cool that we were getting to be here” (Wood 2006, 82). Turning traumatic experiences into positive experiences by focusing on controllable experiences rather than uncontrollable situations is a key factor in PTG. Lutkus expressed in his narrative about uncontrollable traumatic experiences and coped with it by having a more positive outlook. He said “…I’m glad that we all got him out of there. And that’s going to have to be – it’s got to be good enough for me to go on with my life. Otherwise, I’ll spend the rest of my time analyzing it and I just try to get past it” (Wood 2006, 87).

Personal Strength

A general sense of individual resilience or recognition of possessing strengths is a theme of PTG that emerged from the personal narratives. The service members were faced with traumatic experiences and showed resilience when under pressure. Tania Quinones and her partner were being surrounded by sharp concertina wire and a huge group of angry civilians advancing towards them. She found strength within herself and said “You bet your ass I’m going to fight my way out” (Wood 2006, 68), even though it was insane and they nearly got trampled. Another expressed the same feeling of resilience “I would say that was one of my proudest moments of my entire career. That in that kind of a hellish situation, we got everybody, and we turned north to go up Ambush Alley” (Wood 2006, 25). Another common theme of personal strength among the service members was the ability to accept the way things worked out. The service members had strong mentality that “Right now there’s this cold and calculated side of war that just accepts tragedy for what it is, and
Pride represents a positive attachment toward one's own or another's choices and actions, or toward a whole group of people. For example, in the Marines, Mortuary Affairs is tasked to recover the bodies of all fallen soldiers. Daniel B. Cotnoir (Marine of Mortuary Affairs) expressed “The Marines always get their guys off the battlefield; we always remove those that are killed” (Wood 2006, 111). Another Marine, Justin LeHew was on site of an AAV tank accident to help with triage. Triage is the process of sorting victims. During the process of triage LeHew went to pull a Marine out and his upper torso separated from his bottom half. LeHew did not hesitate and reacted by saying “Put this in the back of the Humvee because Marines don’t leave our dead and wounded on the battlefield; everybody comes home. Even if it’s a piece of you, I have responsibility to your mom and dad to bring everything back” (Wood 2006, 22). The service members expressed great pride in being in the military because they saw their caring acts as just doing their part as a Marine.

Other personal narratives expressed pride in their branch through positive sense of attachment: their duty to care and be able to depend on others (military peers). Themes of pride emerged in their narratives as the ability to depend on others in time of danger. Gregory Lutkus (Connecticut Army National Guard) was on a battle field and taking care of an injured soldier. He was surrounded by gun fire and suddenly Marines and Army arrived and secured where he and the soldier were located. Lutkus expressed that he “remember[ed] looking up and seeing all these people were here to help this one soldier. And they didn’t know the soldier; they didn’t know anything about him. But they were all here to help us. It kind of got me a little choked up because they’re putting their lives on the line now” (Wood 2006, 85).

**Conclusion**

Methodological limitations of this study include a small sample size which limits generalizability of the findings. More research using a larger sample which includes oral histories of OEF and Afghanistan is needed to further explore the themes of PTG. Despite these limitations, this study is among the first to analyze OIF oral histories for PTG. This study was exploratory in nature and the results support the experiences of posttraumatic growth. All of the thematic dimensions that emerged from this study bring to light the different experiences and perceptions of PTG. However, the presence of growth does not necessarily signal an end to psychological wounds accompanied by traumatic experiences. It is important to know that service members facing devastating tragedies do experience positive growth arising from their struggles. Research on preventative treatment could enhance PTG and influence positive outcomes, such as resilience to traumatic stress in the military. Additional research is needed to examine some pre-trauma characteristics in order to further the development of PTG among military members who experience combat.
References


Beyond the Slots: Exploring Cultural Narratives within California Indian Casinos

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**Abstract**

Some tribal communities have begun to use their gaming facilities as venues for cultural exhibits, a phenomenon that dovetails with two pieces of federal legislation. Passage of the Indian Gaming and Regulatory Act (IGRA) provides federally-recognized tribes with the opportunity to establish casinos; while the Native American Graves Protection and Repatriation Act (NAGPRA) enables them to reclaim objects of cultural patrimony held by museums. Some gaming tribes, like the Mashantucket Pequot, have used a portion of their gaming revenues to embark upon sophisticated projects of cultural self-representation. This research explores the extent to which similar projects exist in California Indian casinos and can be understood to serve as tribal alternatives or intermediaries to actual museums. The researcher conducted fieldwork at twelve North-Central California casinos and created a typology of representational forms to aid in analysis. Findings demonstrate that tribal gaming facilities instantiate one site of contemporary California Indian cultural production.

The history of California Indian conquest is unique in comparison to the rest of the United States, mostly because the United States government never ratified the treaties it made with California Indian groups (Phillips 1996). This meant that the land originally delineated in the treaties for these California Indian groups was never granted despite having signed these treaties. However, a major victory occurred for California Indians with the U.S. Supreme Court decision supporting the Cabazon Band of Mission Indians in *California v. Cabazon Band of Mission Indians* (Darian-Smith 2004; Lane 1995). This ruling opened the door for California Indians to have a means to promote economic growth and create revenue through the creation and use of gaming facilities. IGRA in 1988 followed suit and allowed for the creation of American Indian casinos (Darian-Smith 2004; Lane 1995). Gaming was seen as a way to hopefully improve the impoverished conditions that indigenous people had endured within their communities for centuries (Goldberg and Champagne 2002). These facilities have been used as a means to establish economic independence (Darian-Smith 2004). Despite the fact that not all tribes are recognized by the federal government (and...