Transforming Trauma: Space for Growth and Meaning-Making after Adversity

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Transforming Trauma:
Space for Growth and Meaning-Making after Adversity

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Abstract

Traumatic experiences are not unique to war veterans, survivors of genocide, the wrongfully convicted, or those with visible disabilities. A better understanding of their experiences in overcoming these adversities – and growing from them – can help us all to create space for transformation in our lives, and the lives of others. The way we communicate, or talk about life experiences (including traumatic events), has a significant impact on the way they are experienced and responded to. This includes making meaning of traumatic events in the context of other life experiences, reconstructing/co-constructing a new worldview that takes into account permanent changes or expanded consciousness, and incorporating somatic or embodied experience in the transformation process. This paper will address the factors that may make positive change after adversity possible, and discuss some of the ways that supportive space, complex communication, and somatic awareness can help to make this happen on a broader scale.

Introduction

The purpose of this collaborative exploration is to examine the communication environment in which positive transformations have been experienced, and the roles that various conversational partners or processes have played in creating contextual space for positive transformation. The co-authors of this conference paper have worked with various populations who have experienced trauma, and have observed situations in which individuals have gone on to higher levels of awareness, functioning, and development following adversity. The communication environments to be explored here include the direct experience of the authors working with trauma-exposed populations in both research and practice. These include:

- Narrative experiences of survivors of terror attacks
- Communication strategies in healthcare for dealing with traumatized populations
- The impact of somatic practices and yoga on the self-efficacy of amputees
- Creation of coordinated mentoring communities for returning combat veterans in higher education

Healing Trauma Survivors: Stories Lived, Told, Heard, Retold … and Untold

Zieva Dauber Konvisser, Ph.D.

As a trauma researcher and oral historian, my passion is to listen to the voices of survivors of highly challenging life circumstances to learn from them about their experiences, their unique qualities and needs, and the strategies that have helped them cope with their situations. While this paper is informed by my work with three groups of trauma survivors, i.e. survivors of the Holocaust, terrorism, and wrongful conviction, it provides vivid examples from a narrative research study with one of these groups – survivors of the trauma of terror in Israel. As full disclosure, I come from a perspective of *resilience* or *recovery* – bouncing back after experiencing hardship and adversity and moving on with life as before – and *thriving* or *posttraumatic growth* – the ability to bounce forward and experience positive psychological change as a result of the struggle with highly challenging life circumstances.

What is trauma and the human impact of trauma? Traumatic events include natural disasters, serious diseases, or car accidents, as well as human-induced traumas, such as sexual assault or abuse, combat exposure, genocide, terrorism, and wrongful conviction. There are two factors which make an event traumatic: threat of death or serious injury to us or to another person; and a strong feeling of fear and helplessness. The traumatic event is usually unpredictable and uncontrollable. It may shatter our sense of security and leave us feeling vulnerable and agitated. Traumatic events may overwhelm the ordinary systems of care that give us a sense of control, connection, and meaning and overwhelm our ordinary human adaptations to life. Thus, trauma may result in feelings of intense fear, helplessness, loss of control, and threat of annihilation. In addition, trauma may produce profound and lasting changes in our ability to feel, think, and do and can shatter our fundamental assumptions about ourselves and our world.

However, the frightening and confusing aftermath of trauma also may be fertile ground for unexpected outcomes. "While survivors of trauma have learned that the world is evil and meaningless, that life is terminal and that people are unworthy, they have also experienced that there may be hope even in the worst of their experiences" (Janoff-Bulman, 1992). Typically, the struggle with the aftermath of trauma can produce a mixture of negative and positive experiences and continuing personal distress and growth often coexist.

What happens to the survivors of traumatic events? Will the physical and emotional scars overwhelm them? And/or can they transcend this experience to lead healthy lives? The manner in which each individual experiences the traumatic event, the meaning which each ascribes to the event, and the actions each takes result from his or her personal characteristics, past experiences, present context, and physiological state. Although there is no single factor or magical combination that ensures a positive – or a negative – outcome, certain factors are protective and enhance stress resilience and

growth, while others appear to be risk or vulnerability factors for poor adaptation; still others can either support resilience or undermine it depending on their quality or, in some cases, quantity. People who are resilient and grow share some common qualities – ones that can be cultivated to master any crisis. These include: positive emotions and optimism, self-confidence, humor, creativity, religion/spirituality, tendencies toward action, altruism, the capacity to recover from negative events, stress inoculation, as well as the ability to tell their stories.

What is the value of stories and storytelling? The cognitive processing of trauma into growth is enabled by storytelling or self-disclosure to supportive others, including friends, family, other traumatized people, professionals, society and culture (Tedeschi & Calhoun, 2006). Supportive others can aid by providing a way to craft narratives about the changes that have occurred and by offering perspectives that can be integrated into schema change (Tedeschi & Calhoun, 2004). Change in sense of identity may follow as people produce personal accounts of what happened to them (Tedeschi & Calhoun, 1998).

While some stories may remain untold, unheard, untellable, and unknown (Pearce, 1989, 2008) or unsaid, incommunicable, unbearable, and irretrievable (Greenspan, 2014) there is great value to being able to tell and listen to stories, especially the stories of trauma survivors, as we have learned from Holocaust survivors who have documented their life stories – the oral histories or testimonies – of their lived experiences.

Telling their stories can help most trauma survivors heal and move forward by gaining a better understanding of what has happened to them and discovering the meaning they take away from their experiences. While trauma survivors do not forget their traumatic experiences nor minimize their suffering, giving voice to their lived experiences can help them to integrate and own the painful emotions of their situation, make them part of their story, and live with them in a productive way. In struggling to make sense of the event, they are helped to realize a greater appreciation of what is really important and meaningful versus what is trivial.

Listening to their stories affords us historic memory and connection. Thus, these stories can help to personalize and contextualize historical events, humanize the people who have survived or perished, and establish real faces in the overwhelming sea of facts and statistics.

And in hearing their stories, supportive others, including families, friends, clinicians, counselors, employers, and communities, can gain valuable insights for helping the survivors through and after the recovery process.

In retelling their stories, we also build public awareness of the impact of such traumas and provide the empirical evidence for advocacy, reform and interventions that could not only mitigate the negative effects of these horrific traumatic events, but also help foster more positive, long-term adaptations for the survivors. And we also bear witness.

Why do survivors of traumatic events want to share their stories with interested and empathic listeners? Some answers to this question can be found in the stories of forty-eight otherwise ordinary people who experienced indiscriminate acts of terrorism in Israel during the Second Intifada – Jewish, Christian, Muslim, and Druze – the stories lived, told, heard, and retold of the survivors, their families, and the families of the bereaved, before, during, and after the attack (Konvisser, 2014). Like other trauma survivors, these survivors learned the value of telling their stories and asked me to share these lessons with you:

BD's psychologist told him that "The best form of therapy is just to sort of talk about it and keep talking about it and you demystify it, you sort of remove the poison from the fangs."

Ola is helped and energized by talking to people who understand, other people who were in an attack or lost something, and people from helping organizations. From them, she learned that "so many people they have much more difficulty … your trouble is not a problem."

Avi talks with other terror survivors, as well as non-Jewish Muslim and Christian audiences, "to encourage them. To show them that there is life after the terror act and that life is not finished."

How are they helped in the process? Stories provide order, structure, and meaning. Many of the participants previously have told their stories in interviews and as speakers. Narratives that had been told repeatedly are consistent, coherent, organized and significant. Stories and meanings were cognitively processed by thinking about and disclosing them to an interested and empathic listener in a safe environment.

For many, the tone of their narratives goes beyond acceptance and appreciation of life; hope and optimism replace despair: Shoshi hasn't given up anything. "Even walking I haven't given up. I still hope maybe the people of Christopher Reeve will find some cure."

They frequently use words like "positive," "I can do it," "I will do it" and "half full glass." Common expressions of their survival are "fortunate," "good luck" and "miracle." Isaac "can't afford to have that negative thing holding me down or weighing me down. I have to move forward. That's the way I look at life…. That's the way I stay positive."

How might this self-discovery change their self-identity and self-image? "Stories imitate life and present an inner reality to the outside world; at the same time, however, they shape and construct the narrator's personality and reality. The story is one's identity, a story created, told, revised, and retold throughout life. We know or discover ourselves, and reveal ourselves to others, by the stories we tell" (Lieblich, Tuval-Mashiach, & Zilber, 1989).

Thus, as these survivors of terrorism developed and retold their personal narratives, they came to understand and change their self-identity and self-image. They were able to reveal themselves to others and began to identify themselves as survivors, not as victims, and were no longer defined by victimization or by survivor's guilt. Shoshi realized that "in Israel, they call them survivors of the Holocaust. So why am I a victim? At that instant, I decided to regard myself as a survivor of terror, not as a victim."

Like the survivors of the Holocaust and other traumatic circumstances, these otherwise ordinary people – now survivors of terrorism – found the strength to share their remarkable journeys in remembrance of the past and as a responsibility to the future. Their powerful stories are testimony to their inner strength and determination – a victory of the human spirit. I hope these stories of triumph and struggle will help all of us to understand how tragedy and loss is endured, remembered, and retold. And I hope these stories will shed a little light on someone else's path through a dark period of life.

Suggestions for a Heuristic Turn in the Conversation on Posttraumatic Growth

Susan Parrish-Sprowl, PhD, LCSW
John Parrish-Sprowl, PhD

The increasing interest in posttraumatic growth (PTG) over the past two decades has been a welcome addition to the pathologizing focus of much of the trauma literature, which can largely be traced to the medicalization of mental health (S. Parrish-Sprowl, 2013). The interest in PTG is part of a more general movement known as "positive psychology" that promotes the scientific study of what makes people thrive, rather than simply how to treat mental illness. While this has been an important shift in the larger conversation about understanding trauma, we have concerns about the limitations of much of this work because it embraces the foundationalist epistemological and methodological assumptions of a traditional social science approach that fails to fully capture the systemic functioning of human experience. We will provide a brief elaboration of our concerns, followed by suggestions for a potentially heuristic turn in the conversation that might create space for more nuanced discussions of PTG both within and outside the therapy suite.

The importance of the limitations of a foundationalist perspective for capturing the process and flow of human experience is analogous to the move beyond Newtonian physics to the development of quantum mechanics. The latter has given us insight into the workings of atoms and subatomic particles that has led to our ability to have instantaneous voice, text, and email communication via our smartphones, as well as a multitude of inventions linked to quantum computers and lasers. This discovery did not make classical physics "wrong" (e.g. understanding how gravity works is still useful), but rather it is not sufficiently robust to account for phenomena that operate in a nonlinear process where something can be in multiple places at the same time, do not work within the rules of classical logic, and are changed by the measurement process itself (Buchanan, 2011). We not only agree with Buchanan's argument that humans think like

quarks, we suggest that all human interaction operates by similar principles and that our attempts to understand human experience should try to account for this. This is in contrast to a foundationalist approach to human experience that essentializes and reifies phenomena by treating them as "found" things "out there" (e.g. we need more and better research to find out what this "thing" called PTG "really" is and how it differs from other found things, like recovery and resilience). We typically find these "things" by having people check off the degree to which they agree with a series of statements that supposedly "measure" this thing, out of context at a moment in time divorced from the experience, and then assume the validity of their responses for the purposes of the study. We then discuss these findings as if we have really "found" them, i.e. these mathematical data points "become" not just indicative of the concept of PTG, but PTG itself. Research that relies on semi-structured interviews with individuals who have experienced growth following a traumatic experience often demonstrates a similar reductionistic approach.

There is a compelling face validity to such research because it appeals to a common underlying worldview grounded in a Newtonian way of understanding life that we rarely question. While we now regularly use the results of quantum thinking in our everyday lives, its impact on the assumptions we make about understanding human experience has lagged behind. We are surrounded by foundationalist thinking (e.g. "the 5 BEST ways" to do this and "the 3 ESSENTIAL features "of that). While the extant research on posttraumatic growth might offer some interesting ideas and a seductive simplicity, the general approach of the research does not sufficiently access the complexity of human experience. The mixed results of the research itself point to its limitations. In a recent review of the literature, Ramos and Leal (2013) discuss the myriad of contradictory, inconclusive, and mixed findings. As with most foundationalist research, recommendations across the literature suggest *more* investigation and *better* theory and measurement to address these issues. This assumes, of course, that even if we accomplished that goal such that the results were consistent, we would actually be measuring the phenomena in question.   What such research will not do, however, is address the problems inherent in the underlying meta-theoretical assumptions of the approach. Like classical physics, this type of research simply is not up to the task of capturing the ongoing flow of human interaction, and how stories of PTG emerge in the ongoing process of the multi-contexted lives we live. This would suggest potentially important distinctions between the story being told about the phenomena we refer to as PTG by theorists and researchers, and the stories actually lived by the millions of people who experience traumatic events everyday.

If we are to attempt a more quantum understanding of how we might facilitate PTG, we must start with a more process-oriented framework for thinking about traumatic experience in general. A necessary shift in taking a more dynamic perspective to understanding the lived experience of trauma is addressing the reified distinctions between self and other, mind and body, psychological and social, and other socially constructed notions based on a Newtonian understanding of experience. The heuristic shift we would like to propose is based on a more quantum view of how we might think about human functioning that sees movement "within the embodied self" and "between embodied selves" as a flow of energy and information in nonstop, simultaneous, dynamic

process that operates like quarks, defying the rules of logic and connecting people across time and space. We refer to this applied perspective as Communication Complex (ComComplex). It focuses on the notion that we live IN communication with others, rather than the more common simplistic view of communication as just a means of transmitting information between individuals, thus reifying the appearance of separation consistent with a Newtonian understanding of the world (J. Parrish-Sprowl, 2013, 2014). This perspective expands on developing thinking and research in neuroscience that suggests "cognition materializes in interpersonal space" (Hassan et al., 2012), and points to a reciprocal relationship between the mind, the brain and relationships thus highlighting the profoundly social nature of the brain (Porges, 2011; Siegel, 2012). It incorporates and extends the early systemic thinking of Reusch and Bateson (1951), the seminal work of Watzlawick, Beavin and Jackson (1967), as well as communication theorists such as Pearce and Cronen (1980), who recognized the limitations of reductionism and the dominant foundationalist research paradigm for the study of human behavior, and emphasized the importance and power of taking a more social view of individual experience.

From a ComComplex perspective, we are interested in a process view of human experience, patterns that constitute process, and the applied question of how we can perturb those patterns toward healthier functioning at multiple reflexively related systemic levels. We want to move away from the artificial categorical notions of health (i.e. people are healthy or sick) promulgated by the medical model and endemic in theory and foundationalist research designs. We embrace Siegel's more systemic notion of integration as the linkage of differentiated parts of a system as a useful working definition of health, and believe it is the basis of a more dynamic way of thinking of PTG. We take the perspective that as social beings, we are always living in conversation even when we are physically alone. Our internal conversations emerge from our constructions of past conversations as well as our projections into the future.   Who we "are" at any given moment is always in relation to conversations within and between, and across space and time. As part of these conversations, we story our world to manage meaning and coordinate our actions with others. We create many kinds of stories in this meaning-making process, including stories lived, unknown stories, untold stories, unheard stories, untellable stories, and stories told (Pearce, 2007). These stories are not just our own, but are social in nature and always reflect ourselves in relation. In other words, stories are emergent in ongoing interaction.

One way to think about a traumatic experience from a process perspective is to view the event as a particular conversational episode in a person's life, e.g. "the time I got trapped in my car for 4 days after a car accident." This gets increasingly complicated, of course, when there are multiple related traumatic episodes, e.g. war, ongoing childhood abuse, oppression, etc. We could further complicate the discussion by posing the important question of how an episode comes to "count" as traumatic. For our present purposes however, let's assume a single episode of what might be commonly agreed upon (from a social perspective) as being a traumatic experience. There will likely be many conversational episodes related to this event afterwards that will constitute the larger conversation about the traumatic event. This person will have had many other types of

conversational episodes in his life. In general, we can think of the multitude of episodes of ALL types (not just the trauma) that we live in over time as resources we use to act into other episodes. Our physiology as well as the stories we carry around about ourselves and our worlds are part of our resources as well. Resources guide our actions, or practices, which in turn reconstruct our resources. One way to think about traumatic experiences is that they put substantial resources at risk, potentially damaging or eradicating them. The resources that are put at risk for a given individual vary and are context dependent, but a shared feature is that there is some challenge to the integrity of how the person stories her world to some degree. It may be the story of I'm a strong person, the world is safe, I can handle things, I can't handle things, I'm safe in this moment, people don't intentionally crash planes into buildings, etc.

When the traumatic event occurs, we must story the new experience within the context of at-risk core stories that we rely on to make sense of our world so that we can safely navigate life. This storying takes place dynamically over time in conversations that we have with others and within ourselves. The process is always in relation to the larger systems within which the person lives. The conversations that constitute the storying are contexted by our stories of the past and the future as well as the stories of others, all of which are influenced by our storying of the current event. Clearly, storying is a complex process. We can live in different stories at the same time, e.g. "my friend Jane relates to the "new" me, but my dad talks to me like it didn't happen," and we may live in multiple stories that we do not even realize conflict with one another. How we story a traumatic episode can put other stories at-risk, so we may construct a narrative of the trauma so as to maintain other potentially at-risk core stories. It is also important to note that following a trauma, some of our internal conversations are the result of evolution, e.g. the activation of the sympathetic nervous system's fight or flight response or the parasympathetic freeze response to an appraisal of danger; they may be shaped by genetics or other influences on physiology, as well as neurally stored prior experiences. Integrative storying would include these physiological aspects. It is often through creating space for safe experiencing of these somatic representations of the trauma in the process of storying that there is potential for PTG.

Particularly relevant here is what we think of as unheard stories. We are referring to neural representations of traumatic experience that individuals live into every day and become part of the evolving stories of their lives, but they do not explicitly connect them to the trauma experience. This is the world of implicit memory fragments that have not been linguistically storied or are storied outside of the context of the trauma, but are a patterned neural re-experiencing that the person lives with over time. These may be somatic symptoms, emotional reactions, cognitions, or behaviors. When you ask a person about "the trauma," these aspects may not be accessed as part of the explicit memory and the story of the trauma. If there is an awareness of symptoms, they may have been storied as something other than a trauma symptom, such as part of another story (e.g. I'm fine emotionally, I'm just one of those people that has migraines), or they are contexted by fear, shame or guilt which inhibits access to explicit awareness, thus impeding integration even as the person may have constructed a "story told" of growth

after the trauma event. The protocols of most current research on PTG do not account for this important aspect of the trauma experience.

From a ComComplex perspective, there is potential for PTG, as reflected in the facilitation of integrative functioning, following most trauma experiences. For any given individual, a number of contextual considerations would be relevant: where "is" the person leading up to the trauma particularly regarding previous traumatic experiences and how they were storied (internally and in relation with others), what is the larger social context at multiple systemic levels in terms of ability to help shape meaning in the process of storying, and what are the available resources to facilitate integration, to name a few. In terms of the larger discussion on PTG, critical questions revolve around what kinds of resources we need to make sense of these experiences from a process perspective, how an event comes to be "counted" as "traumatic," how resources are put at-risk and how to identify them in a given situation, what resources might help us access unheard stories, what kinds of conversations constitute social support that could facilitate integration, what patterns of storying are more or less likely to lead to integration, what patterns (within and between) are indicative of integration or PTG, and how can we begin to create larger social conversations at all systemic levels that lead to the development of resources for integrative functioning even before a potential trauma occurs. Given the prevalence of trauma globally, we believe the conversational shift we propose is of particular importance. While bad things have always happened in the world, the stakes are higher today because more people than ever before have the capacity to destroy our planet in short order. If we accept neuroscientist Ramachandran's (2009) notion that the only thing that separates us is our skin, we must take seriously the goal of finding ways for all of us to thrive so that, as a planet, we have the chance to survive.

Somatics in Time and Space: A Transformative Process

Deedee Myers, PhD, MSC, MCC

In the past 10 years there has been an increased awareness of amputees and their stories. The return of wounded military from war and the loss of limb from improvised explosive devices, or IEDs, have been featured in print media, television, and online articles and videos. Bethany Hamilton, a young girl, lost her left arm from a shark attack while surfing; (The Telegraph, 2010). Tammy Duckworth, a Blackhawk pilot, the first female double amputee soldier to arrive at Walter Reed Hospital, is now a Congresswoman (Canzano, 2013). *Grey's Anatomy* (O & P Edge, 2013), an ABC television series, included a storyline about the amputation of a main character's leg and her emotional and physical journey through trauma and rehabilitation (Amputee Coalition™, 2012). The Boston Bombing, during the Boston Marathon on April 15, 2013, resulted in 20 to 25 amputees (Trotta, 2013). In the United States, there are 507 amputations per day and nearly 2 million people living with limb loss (Amputee Coalition™, 2011, Freeland & Psonak, 2007; Mackenzie, 2002) At the rate of 185,000 per year, this number is projected to double or triple by 2050 (Center for Disease Control, 2010).

Living with limb loss is a niche in the clinical field requiring ongoing education for the amputee and the caregivers and professionals alike. Even so-called "non–traumatic" amputations create trauma in the body and transform the sense of self that impacts sense of self. Amputation produces several changes in a person's life, well being, quality of life, and autonomy (Freeland & Psonak, 2007). Rehabilitation programs are structured to return persons to their own environment with the ability to perform activities of daily living, such as domestic chores, gainful work, and basic home and car maintenance (Zidarov, Swaine, and Gauthier-Gagnon, 2009). There is minimal research available regarding rehabilitation including practices for the amputee in managing self-perception, self-confidence, and stress and dignity of integrating and moving within a world of four-limbed people.

Post amputation life produces certain efficacy expectations that may or may not support a desired future healthy body and mind. Efficacy expectations are characterized by a certain volition and commitment of the amputee to expect success in realizing the desired change through behavior to produce a fit mind and body (Myers, 2014). As the amputee perceives the desired changes in his or her level of physical fitness, capacity and agility of self-efficacy increase contributing positively to coping strategies. The stronger the amputee's perceived self-efficacy, the more success the amputee has in facing obstacles and challenges.

Research (Myers, 2014) illustrates that an amputee's stigma (Goffman, 1963) is a deterrent to practicing in a yoga studio and yet, at the same time the amputee wants to be self-generative with the ability and capacity to feel strength from their bodies that transfer to resiliency in daily living (Myers, 2014). The ability and capacity to be self-generative (Strozzi-Heckler, 2014) is through change that emanates from, on, and through the body in intentional movement in support of a desired outcome.

Change in the body starts with an organizing principle for participants (Myers, 2014 & Strozzi-Heckler, 2014). An organizing principle is a conscious or unconscious embodied intention deeply embedded in the body (Myers, 2014). The foundational organizing principle theme in this research (Myers, 2014) was an embodied fear-based organizing principle —fear of being unfit, being judged, or being seen and watched. A common theme was fear of being unfit and unable to perform independent daily living with dignity and grace. Fear of an unhealthy body, increasing tension and distraction, and fear of being bound to a wheelchair compelled participants to seek options to counter the current trajectories of their bodies. Fear of rejection created hesitation and resistance for participants independently starting a yoga program. However, prior to the forward action of changing the trajectory of a less than desired healthy body and mind, participants experienced stigmatization as abnormal (Goffman, 1963). Living with the stigma produced a conscious detachment from the body. Active engagement to numb the body and isolate the self from the social environment further conditioned the body, in its present state, to minimize the felt sense of life in the soma.

The fear-based organizing principle led to a bifurcation point (Pearce, 2007) of choice. The present state of the body and the imaginative future state (Strozzi-Heckler, 2007, 2009) of the current trajectory of behavior were no longer acceptable to the participants. A defining moment or wakeup call presented a choice—transform or stay with the imagined future of the current body. Pursuant to the decision to create a new imagined future of their body, participants selected yoga as the vehicle of change.

A dual existence of fear was present: fear of current state in tension and fear of moving into the change. Participants wanted the change, yet another manifestation of fear burdened the change—the actual starting point of change, which required instigating a yoga practice. Fear of being seen and stigmatized as abnormal (Goffman, 1963) in the yoga studio, fear of being isolated as the only amputee, and fear of being asked to leave; fear of being called out as not belonging delayed and complicated the start of entering a yoga studio for the first time.

Research indicates change starts with a somatic sensibility of awareness (Myers, 2014, Nahai, 2012, Strozzi-Heckler, 2007, 2009, 2014). Awareness is a state of being in which one experiences "an internal felt sense of and connection to the body, mind, and spirit, and the external sense of connection with others and the world at large" (Nahai, 2012). Participants each described their own sense of awareness of their own body and sensations and their unique interpretations of these sensations. Awareness of sensations, which lead to somatic change and somatics in action off the mat, were distinguished in three spaces and times: pre-yoga, during yoga, and outside the yoga studio or room. Through evolved self-awareness, the ampyogi, moved to self-acceptance and self-accountability. Ampyogi is a yogi, a person who practices yoga, with one or more amputations (Myers, 2014).

The somatic distinction of choice is relevant to the fear-based organizing principle and awareness of the participant to shift their felt sense of life into and through their bodies. Participants wanted to be more alive somatically which requires deconstruction of the old self (Haines, 1999). This deconstruction (Haines, 1999), or somatic unlearning (Amann, 2003; Beaudoin, 1999), in the relevant context for each participant, was a precondition for reconstruction in order to be open to new possibilities to being more alive somatically. Participants wanted a different experience of their bodies that would create a shift from disconnection, detachment, and self-pity toward being self-generative and self-accountability.

Preceding the horizon of somatic choice is the thread of attention to an organizing principle and awareness. The essential theme of being in choice could not have happened without an organizing principle and increased awareness. Awareness has been described as "a state of being that is experienced and achieved through an internal felt sense of and connection to the body" (Nahai, 2012). I have extended this definition of awareness to include felt sense of the body in action. Through awareness, the participants increased their capacity to self-observe, recognize choice making, and understand the risks and rewards of choice. As an example, awareness of the fear associated with doing a first headstand, and increased connection to breath as a support mechanism for moving

through the fear of being inverted, allowed participants the space for choice to continue moving through the fear in the headstand. Following the headstand came the realization that the body can move through an uncomfortable state in order to achieve change. The moments of intentional choice, moving through the uncomfortable space of a new way of being in the body, and coming through the movement increased the self-efficacy expectations and enhanced the ongoing commitment to change

A dominant factor in being self-generative was feeling safe in relevant spaces such as the space on their yoga mat and how they located themselves in the yoga studio. As the feeling of safety evolved, ampyogis translated the felt sense of self *on the mat* to off the mat. Ampyogis took the action of yoga off the mat into daily living, to breathe through uncomfortable situations, to breathe when the body feels panic or anxiety, and to rest or pause in order to regain control of breath and movement.

Ampyogis started transformative change with a fear based organizing principle, increased somatic self-awareness and capacity for change with somatic sensibility and moved with effective action toward an efficacy expectation. Somatics in action, moving through, with and on the body, produces sustainable positive change.

Addressing Moral Injury: Rebuilding damaged communication structures to facilitate learning and growth

> Barton Buechner, PhD

For many veterans, the transition home from service can be a dangerous path, particularly if they walk it alone. This generation of veterans is not the first to face this perilous journey, and both classical literature and academic research provide keys to the navigation process. In a concurrent paper for this conference (Buechner, 2014), I present findings from an inquiry into the alternative approach of looking at communication and interpersonal mentor relationships within the context of higher education as a strategy to reduce risk to veterans in transition. These findings suggest a model for coordination between different types of mentor influences across temporal, disciplinary, and cultural boundaries to provide space for examining and resolving confounding experiences, including "moral injuries" (Wood, 2014) or conflicts with "moral code" (Pearce & Littlejohn, 2007). Such an approach draws on all of the assets in the higher education context as resources for repairing a shaken worldview, and discovery of future purpose in life through personal growth and development. In particular, taking a closer look at the communication phenomena that constitute "moral injury" as a separate and distinct phenomenon from Posttraumatic Stress Disorder (PTSD) offers insights as to how to create social systems that are both healing and growth-promoting.

Conclusions

Examining the phenomenon of personal growth and transformation after trauma from a communication and embodied perspective offers a fresh look at many of the longstanding debates in the field of trauma studies, and opens up new territory to explore what may be possible on a broader, systemic scale. These possibilities include alternatives to the widespread application of a "deficit-based" definition of posttraumatic stress disorder (PTSD) as a mental illness, and offer insights as to why posttraumatic growth (PTG) is possible, and what conditions and contexts may serve to facilitate it through increased awareness of transformative adult learning principles. These positively-focused "strength-based" alternatives may help to reduce stigmatizing impact on individuals through labeling them as disabled, damaged, or mentally impaired, which happens in many of our current clinical and social systems. Taken broadly, these principles from trauma studies may not just apply to certain groups of individuals, but to a common human experience that offers better pathways to growth and personal development for all.

References

Amann, T. (2003). Creating space for somatic ways of knowing within transformative learning theory. In C. A. Weissner, S. R. Meyer, N. L. Pfahl, & P. G. Neaman (Eds.), *Proceedings of the Fifth International Conference on Transformative Learning* (pp. 26-32). New York, NY: Teacher's College, Columbia University.

Amputee Coalition™. (2009). *Arms and legs are not a luxury*. Retrieved from http://www.amputee-coalition.org/armsandlegsarenotaluxury.

Beaudoin, C. (1999). Integrating somatic learning into everyday life. *Canadian Journal of Education/Revue Canadienne De l'Education, 24*(1), (Winter, 1999), 76-80. http://www.jstor.org/stable/1585773.

Buchanan, M. (2011). Quantum minds: Why we think like quarks. New Scientist Magazine, (2828). Retrieved from http://www.newscientist.com/article/mg21128285.900-quantum-minds-why-we-think-like-quarks.html?DCMP=NLC-nletter&nsref=mg21128285.900#.U9ZAeFYqDwc.

Buechner, B. (2014). Context and co-creation: coordinated mentoring in communicative space for cosmopolitan communication and personal growth. Concurrent Paper presented at the Transformative Learning Conference, Columbia University, New York.

Canzano, A. (2013, January 25). *Women in combat: Anna Canzano interview with double amputee Tammy Duckworth*. Retrieved from http://www.youtube.com/watch?v=xTYsNDW9KAg.

Center for Disease Control (2010). http://www.cdc.gov/media/pressrel/2010/r101022.html

Freeland, A., & Psonak, R. (2007). Traumatic below-elbow amputations. *Orthopedics, 30*(2), 120.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity.* New York, NY: Simon & Schuster.

Greenspan, H. (2014) Distinguishing the Unsaid, the Incommunicable, the Unbearable, and the Irretrievable. Presentation to International Oral History Conference: Looking at Then, Now. Jerusalem.

Hasson, U., Ghazanfar, A., Galantucci, B., Garrod, S., & Keysers, C. (2012). Brain-to-brain coupling: A mechanism for creating and sharing a social world. Trends in Cognitive Science, 16, 114-121.

Haines, S. (1999). *The survivor's guide to sex: How to have an empowered sex life after child sexual abuse.* San Francisco, CA: Cleis Press.

Janoff-Bulman, R. (1992) Shattered Assumptions: Towards a New Psychology of Trauma. New York: Free Press.

Konvisser, Z.D. (2014) Living Beyond Terrorism: Israeli Stories of Hope and Healing. Jerusalem, Israel: Gefen.

Lieblich, A., Tuval-Mashiach, R. & Zilber, T. (1989) Narrative research: Reading, analysis and interpretation (Vol. 47), (Thousand Oaks, Calif.: Sage, 7-9.

Merleau-Ponty, M. (2012). *Phenomenology of perception* (D. Landes, Trans.). New York, NY: Routledge. (Original work published 1945).

Nahai, A. E. (2012). *Trauma to dharma: The journey home, a phenomenological study of the practice of Kundalni yoga as taught by Yogi Bhajan.* (Doctoral dissertation, Fielding Graduate University). Retrieved from UMI Dissertations. (3513087).

National Limb Loss Information Center. (2008). *Amputation statistics by cause: Limb loss in the United States.* Retrieved from https://docs.google.com/viewer?url=http%3A%2F%2Fwww.amputee-coalition.org%2Ffact_sheets%2Famp_stats_cause.pdf

O &P Esge, The. (2013, March 21). *Prosthetist's work featured in* Grey's Anatomy. Retrieved from http://www.oandp.com/articles/news_2013-03-21_01.asp

Parrish-Sprowl, J. (2013). Communication complex: Achieving improved public health through greater coordination and collaboration. A world united against infectious diseases: Cross-

Sectoral solutions. Proceedings of the Prince Mahidol Awards Conference. Bangkok, Thailand 263-266, http://www.pmaconference.mahidol.ac.th/index.php?option=com_content&view=article&id=602&Itemid=195.

Parrish-Sprowl, J. (2014). Communication complex. In T.L. Thompson (Ed.), Encyclopedia of Health Communication (Vol. 1, pp. 210-212). Thousand Oaks, CA: SAGE publications.

Parrish-Sprowl, S. (2013). Locating mental health: Implications of our evolving understanding of the social nature of the brain. Paper presented at the National Communication Association annual convention, Washington, D.C.

Pearce, W. B. (1989). Communication and the Human Condition. Carbondale: Southern Illinois University Press

Pearce, W. B. (2007). Making social worlds: a communication perspective. Malden, MA: Blackwell Pub.

Pearce, W. B., & Cronen, V. E. (1980). Communication, action, and meaning: The creation of social realities. New York: Praeger.

Pearce, W.B. & Littlejohn, S. (1997) Moral Conflict: When Social Worlds Collide, 1st ed. San Francisco: Sage Publications.

Porges, S.W. (2011). The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication and self-regulation. New York. W.W. Norton.

Ramachandran, V. (2009, November). The neurons that shaped civilization. Retrieved from http://www.ted.com/talks/vs_ramachandran_the_neurons_that_shaped_civilization.html.

Ramos, C. & Leal, I. (2013). Posttraumatic growth in the aftermath of trauma: A literature review about related factors and application contexts. Psychology, Community & Health, Vol. 2(1), 43-54.

Ruesch, J. and Bateson, G. (1951). Communication: The social matrix of psychiatry. New York: W.W. Norton & Company.

Siegel, D. (2012). The developing mind: How relationships and the brain interact to shape who we are (2nd ed.). New York: Guilford.

Strozzi, R. (2007). *The leadership dojo: Build your foundation as an exemplary leader*. Berkeley, CA: Frog.

Strozzi-Heckler (2014) *The art of somatic coaching, embodying skillful action, wisdom, and compassion.* Berkeley, CA: North Atlantic Books.

Tedeschi, R. & Calhoun, L. (2006) Handbook of Posttraumatic Growth: Research and Practice. Mahwah, NJ: Lawrence Erlbaum Associates; 11-13.

Tedeschi, R. & Calhoun, L. (2004) "Posttraumatic growth: Conceptual foundations and empirical evidence," Psychological Inquiry, 15(1), 8.

Tedeschi, R. & Calhoun, L (Eds.) (1998) Posttraumatic growth: Positive changes in the aftermath of crisis. Mahwah, NJ: Lawrence Erlbaum, 227.

Trotta, D. (2013, April 30). *Boston marathon bomb amputees offered prosthetics free of cost*. Retrieved from http://www.reuters.com/article/2013/04/30/us-usa-explosions-boston-amputees-idUSBRE93T16320130430.

Watzlawick, P., (Beavin) Bavelas, & Jackson D. (1967/2011). Pragmatics of human communication: A study of interactional patterns, pathologies and paradoxes. New York: W.W. Norton & Company.

Wood, D. (2014) *Moral Injury: The Grunts*. *The Huffington Post*. Retrieved March 20, 2014, from http://projects.huffingtonpost.com/moral-injury/the-grunts

Zidarov, D., Swaine, B., & Gauthier-Gagnon, C. (2009). Life habits and prosthetic profile of persons with lower-limb amputation during rehabilitation and a 3-month follow-up. *Archives of Physical Medicine and Rehabilitation, 2009*(90), 1953-1959. doi: 10.1016/j.apmr.2009.06.011.