
Comprehensive Soldier Fitness

Building Resilience in a Challenging Institutional Context

Rhonda Cornum
Michael D. Matthews
Martin E. P. Seligman

Headquarters, Department of the Army
United States Military Academy at West Point
University of Pennsylvania

The Comprehensive Soldier Fitness (CSF) program is designed to increase psychological strength and positive performance and to reduce the incidence of maladaptive responses of the entire U.S. Army. Based on the principles of positive psychology, CSF is a historically unique approach to behavioral health in a large (1.1 million members) organization. There are four program elements: (a) the assessment of emotional, social, family, and spiritual fitness; (b) individualized learning modules to improve fitness in these domains; (c) formal resilience training; and (d) training of Army master resilience trainers (MRTs) to instill better thinking skills and resilience in their subordinates. In contrast to traditional approaches, CSF is proactive; rather than waiting to see who has a negative outcome following stress, it provides ways of improving resilience for all members of the Army. CSF aims to move the full spectrum of responses to trauma and adversity—ranging from stress-related disorders to ordinary resilience—toward personal growth. This program may provide a model for implementing similar interventions in other very large institutions.

Keywords: assessment, fitness, resilience, training

As General Casey (2011) underscores in the opening article in this special issue of the *American Psychologist*, the U.S. Army faces historic challenges. It must select, train, and maintain a force that is capable of successfully achieving mission success in two extremely challenging operations in two separate theaters. Our soldiers are now engaged in extended operations of an indefinite duration and unprecedented complexity. Modern warfare is characterized by demanding missions, extreme climates, sleep deprivation, cultural dissonance, physical fatigue, prolonged separation from family, and the ever-present threat of serious bodily injury or death (Mastroianni, Mabry, Benedek, & Ursano, 2008). Up to 70% of our soldiers are exposed to traumatic incidents in Operation Iraqi Freedom and in Operation Enduring Freedom in Afghanistan (Tanielian & Jaycox, 2008). It is not surprising, under these cumulative stressors, that soldiers experience high rates of posttraumatic stress symptoms (Hoge et al., 2004), and suicide rates of Army soldiers have reached a 28-year high (Kuehn, 2009).

The Traditional Response

Approximately 1.64 million military personnel have served in either Iraq or Afghanistan (or both) since 2001 (Brenner, Vanderploeg, & Terrio, 2009). Moreover, most of these service members have personally experienced traumatic incidents (taking a life, being shot at, seeing/handling corpses, having a colleague killed or seriously wounded) that may be associated with posttraumatic stress disorder (PTSD) and related disorders (Hoge et al., 2004). If even 10% of these soldiers subsequently develop a pathological response, this represents nearly 150,000 new cases that must be addressed by the health care system, either through the Department of Defense (DoD), the Department of Veterans Affairs (VA), or other providers. Those who remain on active duty may be impaired enough that their effectiveness is compromised.

Psychology's "business as usual" (Peterson, 2006, p. 5) response to the massive influx of active duty soldiers and veterans experiencing combat-stress-related symptoms is treatment: Develop improved screening for psychopathology and, once detected, increase the therapeutic services available. The DoD and the VA have implemented screening protocols designed to detect physical and mental health problems among military personnel (Brenner et al., 2009). The DoD currently employs the Post-Deployment Health Assessment and the Post-Deployment Health Reassessment programs. These detect physical and psychological problems in soldiers immediately upon returning from combat or several months following deployment. Similarly, as described by Brenner et al. (2009), the VA has focused on screening veterans for "PTSD, depression, alcohol abuse, infectious diseases, and chronic symptoms" (p. 240).

Rhonda Cornum, Comprehensive Soldier Fitness, Headquarters, Department of the Army, Arlington, Virginia; Michael D. Matthews, Department of Behavioral Sciences & Leadership, United States Military Academy at West Point; Martin E. P. Seligman, Department of Psychology, University of Pennsylvania.

We thank Gretchen Bain Matthews for her assistance in the technical editing of this manuscript and for her help in the preparation of this special issue.

Correspondence concerning this article should be addressed to Michael D. Matthews, Department of Behavioral Sciences & Leadership, Building 601, Room 281, Cullum Road, United States Military Academy, West Point, NY 10096. E-mail: mike.matthews@usma.edu



**Rhonda
Cornum**

Improved screening and expansion of mental health services for active duty soldiers and veterans are important components of the Army's response to rapidly increasing rates of combat-stress-related disorders. This approach is reactive, however, and focuses on treatment instead of prevention. For an institution the size of the Army, focusing on prevention may yield greater returns than the traditional diagnosis/treatment-oriented model. Even a modest reduction of PTSD, for example, would result in larger numbers of soldiers being fully capable and would lessen the burden on an already overtaxed health care system.

An Alternative Approach

Waiting for illness or injury to occur is not the way commanders in the U.S. Army approach high-risk actions; and it is not the way we should approach high psychological risk activities. In any other area—whether it is risk of a mosquito-borne illness or risk of injury from an IED (improvised explosive device) exploding—commanders follow three basic steps: assess risk, mitigate risk at the unit level, then mitigate risk at the individual level. This proactive approach is illustrated by the Army's strategy for reducing malaria among its soldiers. Historically, malaria exacted a major toll on the combat effectiveness of units deployed in areas affected by malaria. The Union Army reportedly suffered 1.3 million cases of malaria during the Civil War, with 10,000 deaths (Rocco, 2003). In the early 20th century, Colonel William Crawford Gorgas was detailed to Panama to deal with the massive malaria infections among workers building the Panama Canal. Employing an aggressive preventive strategy, "Gorgas . . . reduced the incidence of malaria from 800 cases per 1,000 workers to 16" (Ockenhouse, Magill, Smith, & Milhous, 2005, p. 13). This proactive, preventive-based approach to malaria

was many magnitudes more successful than a reactive, treatment-focused approach.

Parallel to the Army's approach to reducing malaria, positive psychology provides the conceptual model for an alternative approach to the high incidence rates of PTSD and other combat-stress-related disorders. Positive psychology (e.g., Peterson, 2006; Seligman & Csikszentmihalyi, 2000) emphasizes human strengths and potential. Areas of focus include positive emotion, positive traits, positive institutions, and positive social relationships. In contrast to traditional psychology, which emphasizes the repair of pathology, positive psychology is the science of understanding and promoting behavioral, cognitive, and emotional health. Health is not simply the absence of pathology: It is flourishing and excellence in all aspects of the human condition.

The military may provide a natural home for positive psychology. The Army, for instance, is composed of relatively young soldiers (70% are under age 40). The Army is a highly selective institution. Standards for enlistment include excellent health and physical condition, completion of high school or the equivalent, acceptable performance on standardized tests, and a clean criminal record. Indeed, only 25% of Americans (17–24 years old) meet the Army's standards for enlistment (Christeson, Taggart, & Messner-Zidell, 2009). Once in the Army, soldiers must complete challenging training courses, maintain high physical fitness standards, and adhere to a strict code of conduct compared with their civilian counterparts. The Army doctrine explicitly recognizes the importance of positive traits among its soldiers (U.S. Department of the Army, 2006). For instance, the Army's seven core values (loyalty, duty, respect, selfless service, honor, integrity, and personal courage) correspond to character strengths postulated by Peterson and Seligman (2004). Finally, the Army is a positive institution as defined by Seligman and Csikszentmihalyi (2000) in the sense that it actively promotes the overall welfare of its soldiers through extensive formalized programs aimed at improving and enriching their lives and those of their families.

There is a growing body of evidence that positive traits predict success in challenging military contexts. Duckworth, Peterson, Matthews, and Kelly (2007) found that a measure of passionate pursuit of long-term goals—"grit"—was a strong predictor of the successful completion of Cadet Basic Training among new West Point cadets. Preliminary data also show grit to be an important predictor of the successful completion of Army Special Forces selection (Duckworth, Matthews, & Beal, 2009). The character strengths of courage, teamwork, optimism, honesty, persistence, leadership, and self-regulation seem to be important mediators of success in situations characterized by significant cognitive, emotional, and physical challenges (Matthews, 2008).

There is also evidence that positive-psychology-based interventions are effective in improving affect. Seligman, Steen, Park, and Peterson (2005) found that three positive-psychology-based exercises significantly improved affect and diminished depression among a sample of 577 adults.



Michael D. Matthews

For example, completing the “three blessings exercise” (in which individuals are asked to reflect daily on what went well that day and why it went well) for seven days was associated with increased happiness and decreased depression for up to six months. Other research has linked character strengths to positive adjustment among people who had experienced a significant physical or psychological illness (Peterson, Park, & Seligman, 2006) and to general life satisfaction (Peterson, Ruch, Beermann, Park, & Seligman, 2007).

The Comprehensive Soldier Fitness Program

The Comprehensive Soldier Fitness (CSF) program was developed through a series of discussions with the Chief of Staff of the Army and his senior advisers. The program is not meant to replace existing efforts to diagnose and treat mental health problems. Rather, it is proactive, providing soldiers the skills needed to be more resilient in the face of adversity. The program is universal, is being implemented Army wide, and as of late 2010 includes the families of soldiers and Army civilians. The goal of the program is to shift the normal psychological performance “curve” of the soldier population to the right, that is, to increase the number of soldiers who derive meaning and personal growth from their combat experience (the rightmost part of the curve), to increase the number of soldiers who complete combat tours without pathology, and to decrease the number of soldiers who develop stress pathologies. Importantly, the program is evidence based, and because its results are measured online it is subject to rapid trajectory corrections to ensure that it achieves its objectives.

Background

CSF aims to create an Army that is just as psychologically fit as it is physically fit. In response to the observed need, in 2008 the Army established the Directorate of Comprehensive Soldier Fitness to begin to apply the same resources to ensuring psychological fitness as had historically been applied to physical fitness and technical excellence. The Army established the CSF program to increase the resilience and performance of all soldiers and their families. It involves testing and training specific mental and physical resilience skills and increasing physical, emotional, social, spiritual, and family strengths through continuous self-development. Its four-pillared approach, modeled after the Army’s approach to physical fitness and technical proficiency, consists of the following components:

1. **Assessment:** In combination with physiological measures, a Global Assessment Tool (GAT) measuring psychological fitness will be administered when recruits enter the Army. Reassessment will occur at appropriate intervals and follow soldiers through their entire careers; the GAT will thus track the psychological fitness of the entire Army.
2. **Universal resilience training:** Progressive training on techniques to improve resilience in self and subordinates, beginning at initial entry (for both officers and enlisted soldiers), will build resilience at every level of the Army.
3. **Individualized training:** On the basis of their performance on the GAT, training in different aspects of resilience (emotional, social, family, or spiritual) will be available to soldiers.
4. **Trained master resilience trainers (MRTs):** Soldiers with advanced training in building the mental, emotional, and physical skills for maintaining and enhancing resilience will become the teachers of resilience throughout the Army.

CSF is a long-term strategy. This integrative program will span the career of Army personnel, beginning with an initial assessment and resilience training, followed by periodic reassessments of resilience and tailored training interventions as needed. Just as physical fitness is not achieved by a single visit to the gym, psychological strength is not achieved by a single class or lecture. It is achieved by learning, practicing what one has learned, seeing the results, and then learning more. An intended outcome is for psychological health to become as ingrained into the soldier ethos as is the critical importance of physical fitness to effective performance.

Program Components

Assessment. The physical component of fitness is relatively easy to measure. Although it provides only a partial indicator of overall physical well-being, the Army requires all soldiers to complete the Army Physical Fitness Test (APFT) twice a year. The APFT consists of three events: a two-mile run, sit-ups, and push-ups. Soldiers must



Martin E. P. Seligman

perform to a minimum standard, and failing one component results in failure of the overall APFT. Standards for run times and numbers of sit-ups and push-ups are age and gender adjusted, and the scores on the individual components yield an overall APFT score, which ranges from a minimum passing score of 180 points (soldiers must score at least 60 points in each event) to a total of over 300 points. The APFT, combined with other common measures of health (percentage of body fat, blood pressure, blood lipids and glucose, and VO_2 max), provides a metric for physical fitness that can be used to set goals for improvement and to recognize high levels of fitness.

An early challenge for the CSF program was developing metrics for the psychosocial components of fitness. Toward that end, a group of leading military and civilian psychologists met to identify the key components of psychological resilience and to develop a psychometrically valid assessment tool that could be used to assess soldier psychosocial fitness. A guiding principle was that it should incorporate existing assessment tools of known validity.

Over the group's ensuing meetings, five areas of fitness were identified as critical to the overall physical and psychological fitness of soldiers. These are physical, emotional, social, family, and spiritual fitness. The group focused on identifying measures of the latter four domains, since robust measures of physical fitness already exist. The result of this cooperative effort is the Global Assessment Tool (GAT). Details of the GAT are covered in this special issue by Peterson, Park, and Castro (2011). The GAT, administered online, is a time-efficient way of measuring an individual's fitness in the four dimensions of psychological fitness. Current plans call for individual soldiers to complete a GAT reassessment not less than every two years throughout their careers in order to allow time for measur-

able growth, maturity, and learning. The importance of this timetable is clear: Each soldier will be able to monitor his or her personal improvement over time. To enhance the likelihood of honesty, no one besides the individual taking the GAT will have access to the individual's personal score, although scores will be de-identified and aggregated to provide feedback to senior Army leadership. The GAT is *not* used as a selection tool for promotion, command, or schooling. Rather, the GAT provides feedback to individual soldiers, along with empirically based guidance for self-development. By integrating the results of the GAT with other personnel databases, the Army may be able to see the psychological effects of some human resource policies as well as the impact of resilience training (as described below).

Universal resilience training. Also beginning at initial entry into the Army, soldiers are receiving instruction on specific mental and physical skills to enhance performance when facing challenges, whether those challenges are in their personal or professional lives, in garrison, or in combat. Small unit leaders will be taught how to instill these qualities in their subordinates as a normal part of leadership training. There will be continuous, progressive, and sequential sustained resilience training of both enlisted soldiers and officers, given at every level of professional military development.

Working groups were formed to identify the attributes, knowledge, skills, and behaviors needed for the emotional, social, family, and spiritual components of resilience. These groups were composed of leading academic and military experts in each respective area. Each group was tasked with developing educational modules for their specific area of expertise and evaluating existing products for evidence-based interventions and applicability to military populations. Detailed descriptions of the outcomes of the working groups for emotional fitness (Algoe & Fredrickson, 2011), social fitness (Cacioppo, Reis, & Zautra, 2011), family fitness (Gottman, Gottman, & Atkins, 2011), and spiritual fitness (Pargament & Sweeney, 2011) follow in this issue.

Individual training. Depending on their relative psychological strengths identified on the GAT assessment, soldiers are offered a menu of appropriate self-development opportunities. Each soldier is afforded the opportunity to improve on each of the dimensions regardless of the level at which he or she begins. These interventions are based on input from the working groups described above. Again, a strict evidence-based approach is followed, and the outcomes of the courses are continuously monitored so that adjustments may be made to improve them. Both live and virtual training protocols will soon be available, and all training will be documented within the Army's Digital Training Management System (DTMS). When integrated with the GAT and other data sources, this documentation will help the Army decide which programs should be sustained, expanded, or eliminated.

Master resilience trainers. The fourth and last pillar of the CSF program is the training of master

resilience trainers (MRTs) for the delivery of resiliency training within their units. These MRTs are primarily non-commissioned Officers (NCOs), who will have direct daily contact with soldiers. Long considered the backbone of day-to-day leadership in the Army, trained NCOs are our teachers—men and women perfectly situated within platoons and companies to administer and monitor resilience training.

Initial MRT training at the University of Pennsylvania, described in this issue by Karen Reivich and Martin Seligman (2011), has been given to over 2,200 senior NCOs to date. This training is based on the Penn Resiliency Program (Gillham, Hamilton, Freres, Patton, & Gallop, 2006), with input from the Walter Reed Army Institute of Research and the strong sports psychology program at the United States Military Academy. The basic Penn Resiliency Training has been integrated and adjusted to reflect the vocabulary and the needs of soldiers and Army culture. Beginning in late 2010, MRTs were placed at the installation level to teach family members and Army civilians.

Additional Considerations

Discussion in the media and research within psychology have focused on the adverse effects of combat exposure, especially PTSD. A PsycINFO search with the keywords of *posttraumatic stress disorder* and *military* yielded 1,186 results for the past five years alone. This is a 54% increase compared to the five-year period prior to September 11, 2001, when a search using the same terms yielded 771 results.

This nearly exclusive focus on combat-related psychopathology shapes expectations among soldiers about what they believe will happen to them following combat. Matthews (2009) asked West Point cadets enrolled in a senior seminar in psychology to survey 100 of their classmates about their knowledge of PTSD and also of another sequel to combat exposure, posttraumatic growth (PTG; see Tedeschi & McNally, 2011, this issue). Among these cadets, all of whom were juniors and seniors at West Point with considerable education and training about military issues, 80% were confident that they understood PTSD well. In stark contrast, 78% had never even heard of PTG, and of those who had, only 2% were confident in their understanding of it. Moreover, 85% indicated they had received explicit training on PTSD since arriving at West Point, compared with just 18% claiming some degree of training about PTG. Perhaps most alarming, only 22% of these highly educated and motivated future officers believed they “would not” or “most likely would not” develop PTSD following a future combat deployment. Just as with other depressive and anxiety disorders, such expectations can be self-fulfilling.

Findings of this sort highlight the need to teach soldiers a complete account of the psychological consequences of combat exposure. Psychology has not adequately answered the call for a balanced and comprehensive account of combat effects. A PsycINFO search over the past five years using the keywords of *posttrau-*

matic growth and *military* yielded only 20 results. Compared with the 1,186 studies on PTSD reported in the same period, this number underscores the paucity of research on this important aspect of the psychological impact of war. A continuing narrative of PTSD for combat exposure may kindle self-fulfilling prophecies and actually contribute to an increase in cases. Thus, understanding the predictors and correlates of PTG in the same degree of detail in which PTSD is understood is a vital component of the CSF program.

Once the CSF program was applied to soldiers, it was modified and made available to family members of soldiers. The families themselves face significant challenges when their soldier family members are deployed. The goal here is also proactive: to improve support and psychological services for spouses and children of deployed soldiers. This goal is an exemplar of the Army as a positive institution in that it formally recognizes the vital importance of the family to its active duty members and uses an evidence-based approach to improve families’ quality of life while their soldiers are deployed.

Conclusions

The CSF program is unique and historically significant for several reasons. First, it represents the first psychology-based approach to improving the psychological fitness of all members of an organization with over 1.1 million members (including active and reserve components). Perhaps no other major institution could initiate, plan, and execute an intervention on this scale. Second, the Army’s embracing of psychology as the best approach to deal with this problem highlights the relevance of contemporary psychological science to social issues at the macro level. The Army, despite its traditional focus on materiel and arms, recognizes the fundamental importance of the human component in successful military operations in the 21st century. Just as chemistry played a key role in winning World War I and physics played a key role in winning World War II, we believe that psychology and related disciplines will prove instrumental to success in 21st-century warfare and 21st-century peacekeeping (Scales, 2009).

Finally, CSF as it has been conceived and executed would not have been possible 20 years ago. The advent of positive psychology, with its emphasis on positive states, traits, institutions, and social relationships, provides a novel scientifically based approach well suited to the Army’s concerns. Traditional psychology addresses the issue of how to treat pathology, but it has little to offer with respect to how to improve the performance of large numbers of people. This confluence of need (high PTSD, suicide rates, and divorce), the emerging paradigm of positive psychology, and the Army’s holistic view of soldier fitness has created a unique opportunity to demonstrate how psychology can effect significant positive change in large organizations. We believe that the CSF program may ultimately be a model for psychological fitness in other large organizations.

REFERENCES

- Algoe, S. B., & Fredrickson, B. L. (2011). Emotional fitness and the movement of affective science from lab to field. *American Psychologist*, *66*, 35–42. doi:10.1037/a0021720
- Brenner, L. A., Vanderploeg, R. D., & Terrio, H. (2009). Assessment and diagnosis of mild traumatic brain injury, posttraumatic stress disorder, and other polytrauma conditions: Burden of adversity hypothesis. *Rehabilitation Psychology*, *54*, 239–246. doi:10.1037/a0016908
- Cacioppo, J. T., Reis, H. T., & Zautra, A. J. (2011). Social resilience: The value of social fitness with an application to the military. *American Psychologist*, *66*, 43–51. doi:10.1037/a0021419
- Casey, G. W., Jr. (2011). Comprehensive Soldier Fitness: A vision for resilience in the United States Army. *American Psychologist*, *66*, xxx–xxx. doi:10.1037/a0021930
- Christeson, W., Taggart, A. D., & Messner-Zidell, S. (2009). *Ready, willing and unable to serve: 75 percent of young adults cannot join the military*. Washington, DC: Mission: Readiness, Military Leaders for Kids. Retrieved from <http://cdn.missionreadiness.org/NATEE1109.pdf>
- Duckworth, A. L., Matthews, M. D., & Beal, S. (2009). [The relationship between Grit and completion of Army special forces selection]. Unpublished raw data, United States Military Academy, West Point, NY.
- Duckworth, A. L., Peterson, C., Matthews, M. D., & Kelly, D. R. (2007). Grit: Perseverance and passion for long-term goals. *Journal of Personality and Social Psychology*, *92*, 1087–1101. doi:10.1037/0022-3514.92.6.1087
- Gillham, J. E., Hamilton, J., Freres, D. R., Patton, K., & Gallop, R. (2006). Preventing depression among early adolescents in the primary care setting: A randomized controlled study of the Penn Resiliency Program. *Journal of Abnormal Child Psychology*, *34*, 195–211. doi:10.1007/s10802-005-9014-7
- Gottman, J. M., Gottman, J. S., & Atkins, C. L. (2011). The Comprehensive Soldier Fitness program: Family skills component. *American Psychologist*, *66*, 52–57. doi:10.1037/a0021706
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, *351*, 13–22. doi:10.1056/NEJMoa040603
- Kuehn, B. H. (2009). Soldier suicide rates continue to rise: Military, scientists work to stem the tide. *Journal of the American Medical Association*, *301*, 1111–1113. doi:10.1001/jama.2009.342
- Mastroianni, G. R., Mabry, T. R., Benedek, D. M., & Ursano, R. J. (2008). The stresses of modern war. In B. J. Lukey & V. Tape (Eds.), *Biobehavioral resilience to stress* (pp. 43–55). Boca Raton, FL: CRC Press.
- Matthews, M. D. (2008). Positive psychology: Adaptation, leadership, and performance in exceptional circumstances. In P. A. Hancock & J. L. Szalma (Eds.), *Performance under stress* (pp. 163–180). Aldershot, England: Ashgate.
- Matthews, M. D. (2009). [Self-reported knowledge of posttraumatic stress disorder and posttraumatic growth among West Point cadets]. Unpublished raw data, United States Military Academy, West Point, NY.
- Ockenhouse, C. F., Magill, A., Smith, D., & Milhous, W. (2005). History of U.S. military contributions to the study of malaria. *Military Medicine*, *170*, 12–16. Retrieved from <http://www.afids.org/AFIDS%20Milit%20Med%20Suppl%203-Malaria.pdf>
- Pargament, K. I., & Sweeney, P. J. (2011). Building spiritual fitness in the Army: An innovative approach to a vital aspect of human development. *American Psychologist*, *66*, 58–64. doi:10.1037/a0021657
- Peterson, C. (2006). *A primer in positive psychology*. New York, NY: Oxford University Press.
- Peterson, C., Park, N., & Castro, C. A. (2011). Assessment for the U.S. Army Comprehensive Soldier Fitness program: The Global Assessment Tool. *American Psychologist*, *66*, 10–18. doi:10.1037/a0021658
- Peterson, C., Park, N., & Seligman, M. E. P. (2006). Greater strengths of character and recovery from illness. *Journal of Positive Psychology*, *1*, 17–26. doi:10.1080/17439760500372739
- Peterson, C., Ruch, W., Beermann, W., Park, N., & Seligman, M. E. P. (2007). Strengths of character, orientation to happiness, and life satisfaction. *Journal of Positive Psychology*, *2*, 149–156. doi:10.1080/17439760701228938
- Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. New York, NY: Oxford University Press.
- Reivich, K. J., Seligman, M. E. P., & McBride, S. (2011). Master resilience training in the U.S. Army. *American Psychologist*, *66*, 25–34. doi:10.1037/a0021897
- Rocco, F. (2003). *The miraculous fever-tree*. New York, NY: Harper Collins.
- Scales, R. H. (2009). Clausewitz and World War IV. *Military Psychology*, *21*(Suppl. 1), S23–S35. doi:10.1080/08995600802554573
- Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, *55*, 5–14. doi:10.1037/0003-066X.55.1.5
- Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology: Empirical validations of interventions. *American Psychologist*, *60*, 410–421. doi:10.1037/0003-066X.60.5.410
- Tanielian, T., & Jaycox, L. H. (Eds.). (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: RAND Corporation. Retrieved from http://www.rand.org/pubs/monographs/2008/RAND_MG720.pdf
- Tedeschi, R. G., & McNally, R. J. (2011). Can we facilitate posttraumatic growth in combat veterans? *American Psychologist*, *66*, 19–24. doi:10.1037/a0021896
- U.S. Department of the Army. (2006). *Army leadership: Competent, confident, agile* (Field Manual No. 6–22). Washington, DC: Headquarters, Department of the Army. Retrieved from http://usacac.army.mil/CAC2/repository/materials/FM6_22.pdf