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## FROM TRAUMA TO TRANSFORMATION: AN INTEGRATED MODEL OF SPORTS AND MUTUAL-AID GROUP PSYCHOTHERAPY FOR VETERAN REHABILITATION

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The ongoing war in Ukraine has created a generation of veterans facing profound psychological injuries, including Post-Traumatic Stress Disorder (PTSD), depression, and identity disruption. Current rehabilitation systems often provide fragmented care, addressing psychological, physical, and social needs in isolation. This siloed approach fails to address the complex, intertwined nature of combat-related trauma, leading to high rates of treatment dropout, chronic symptomatology, and poor social reintegration. There is a critical and urgent need for innovative, holistic, and sustainable models that can effectively address the multifaceted wounds of war and facilitate long-term recovery and successful reintegration into civilian life.

The objective of this study is to develop, implement, and evaluate the efficacy of an innovative, integrated Rehabilitation Center model for veterans. The primary goal is to test the hypothesis that the synergistic combination of neurobiologically-informed sports therapy, a peer-led mutual-aid group psychotherapy model («AA-Veteran»), and symbolic environment therapy will lead to significant, sustainable improvements in mental health, psychological resilience, and social functioning.

### 3. Methodology and Organization of the Research

3.1. Research Model: The project will employ a mixed-methods, longitudinal design over a 36-month period.

3.2. Participants: A cohort of 60-80 Ukrainian veterans with diagnosed PTSD or subclinical trauma symptoms will be recruited.

3.3. Integrated Intervention: The intervention is based on a three-pillar framework designed for synergy:

Pillar I: Sports therapy serves as the foundational pillar for physiological regulation and restoring a sense of agency. Evidence-based exercise protocols are designed to:

Modulate Neurochemistry: Regulate stress hormones (cortisol) and increase Brain-Derived Neurotrophic Factor (BDNF), supporting neural health and memory processing.

Re-establish Somatic Safety: Help veterans reconnect with their bodies not as a source of trauma, but as a source of strength and control.

Provide Mastery Experiences: Structured physical achievement rebuilds self-efficacy, a core component often shattered by trauma.

Pillar II: Mutual-Aid Group Psychotherapy («AA-Veteran» Model):

This is the emotional and social core of the model, adapting the proven principles of peer-led support to the specific trauma of combat and war horrors. It functions as a powerful canalizing mechanism, transforming traumatic energy through four key processes:

1. Universality and De-Isolation: Breaking the wall of solitary suffering by recognizing shared experience, reducing shame and social pain.

2. Altruistic Reciprocity: The act of helping a peer activates neural reward pathways (e.g., ventral striatum), fostering dopamine-driven motivation and oxytocin-mediated bonding. Giving support becomes a source of healing for the giver.

3. Emotional Containment: The group acts as a collective container, allowing for the safe expression and processing of painful emotions like grief, guilt, and rage within a context of empathic witness.

4. Identity Reconstruction: Through shared narrative and validation, identity shifts from «broken veteran» to «resilient peer-supporter», forging a new, positive social role.

The Canalization Process in the Group:

Stage 1 – Discharge: Chaotic traumatic affect is safely released within the group container.

Stage 2 – Symbolic Reorganization: Raw emotion is translated into shared language and narrative, creating meaning from chaos.

Stage 3 – Reinvestment: The energy bound in trauma is redirected into prosocial actions-mentorship, support for new members, and civic engagement

Pillar III: Symbolic Environment Therapy:

The intervention is conducted within a repurposed school bomb shelter. This environment is not a neutral space but an active therapeutic agent:

– The shelter itself operates as a tangible metaphor-embodiment of both threat (the reason for its original construction) and protection (the safety it now provides).

– By engaging in therapy within this space, veterans are able to renegotiate its meaning, transforming a site associated with danger into a sanctuary of recovery and mutual support. This transformative process mirrors the internal mastery of trauma.

– The school environment triggers a retrogression effect, allowing veterans to reconnect with earlier, more stable periods of their lives. This regression can positively influence personality reintegration and support a psychological «restart» following traumatic experiences of war.

– It also helps veterans bridge the stark contrast between the harsh realities of the frontline and the relatively safe, seemingly carefree lives of civilians in the rear. Encountering the ways civilians-and especially children-also endure wartime hardships provides a deeper understanding of shared suffering. This recognition may offer veterans an expanded sense of meaning in their sacrifice, reinforcing its significance and enhancing their self-esteem.

#### 3.4. Family Support Module

A parallel mutual-aid group for family members addresses secondary traumatic stress, educates on the recovery process, and repairs the familial bonds essential for long-term reintegration.

#### 3.5. Data Collection and Analysis:

Quantitative Methods: Standardized psychological assessments will be administered at pre-, mid-, and post-intervention points. Tools include:

PCL-5 (PTSD Checklist for DSM-5)

HADS (Hospital Anxiety and Depression Scale)

CD-RISC (Connor-Davidson Resilience Scale)

WHOQOL-BREF (Quality of Life)

Qualitative Methods: In-depth, semi-structured interviews will be conducted with a subset of participants to capture the lived experience of the recovery process, identity change, and social reintegration. Thematic analysis will be used to identify key patterns.

Expected quantitative results anticipate a statistically significant reduction (40-60%) in PTSD (PCL-5) and depression/anxiety (HADS) scores for approximately 80% of participants. We also expect a marked improvement ( $\geq 20\%$ ) in resilience (CD-RISC) and quality of life (WHOQOL-BREF) scores.

Expected qualitative results are predicted to provide rich evidence of successful family and community reintegration, a shift in self-identity from «broken veteran» to «resilient peer-supporter», and personal narratives that confirm the effectiveness of the «canalization» process – the redirection of traumatic energy into structured, prosocial pathways.

The proposed integrated rehabilitation model represents a significant paradigm shift. It moves beyond siloed treatment by simultaneously engaging the body, mind, and social self. The conclusions posit that the core mechanism of healing is the canalization of traumatic experience –

redirecting its disruptive energy through the structured, prosocial channels of physical discipline, altruistic community, and symbolic meaning-making. The model demonstrates strong potential for efficacy, offering a scalable, community-based, and sustainable framework to help Ukrainian veterans achieve not just recovery, but profound post-traumatic growth, transforming their identity from one defined by injury to one rooted in resilience and social contribution.

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