Veteran Retreats: Immersion, Healing and Bonding in Community
Your source for science-based stress management information

COMBAT STRESS

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Combat Stress is a quarterly newsletter published in February, May, August and November with news and advertising designed with Service Members, Veterans and their families in mind. It appeals to all those interested in the myriad and complex interrelationships between combat stress because technical jargon is avoided and it is easy to understand. Combat Stress is archived online at stress.org. Information in this publication is carefully compiled to ensure accuracy.

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Cover photo credit: Mural, Warrior Family Retreat, 2012, courtesy of C.O’Hara
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Introduction to Military and Veterans Retreats

Christiane O’Hara PhD, FAIS
Issue Editor

Welcome to our 2 part series on Military and Veteran Retreats, a topic which has never been addressed in military and Veteran-related journals prior to this Spring 2017 issue of Combat Stress. We present not only descriptions of several retreat models, but research studies undertaken within these models. The research supports the power of these brief, immersive, integrative retreats in which Veteran and clinician leaders create safe, sacred spaces for Service Members and Veterans to reconnect, heal, bond, and move forward in re-claiming their places in our communities. In some of these models, primary support persons and families attend as well, allowing for connections between partners, within family units, and among partners, children, and families.

These retreat models have emerged in parallel over the past two decades. Military and Veteran Chaplains recognized the need for couples to reconnect over twenty years ago, responding with Strong Bonds Retreats that have been offered to more than 13,000 couples. Since then, civilian leaders impacted personally by international wars (Healing of Memories), and clinicians serving combat Veterans and Veterans of military sexual assault have identified the benefits of immersive safe space within a small community to begin or continue the path to healing from trauma-related military service.

These retreats serve as both an alternative and complement to Service Members and Veterans already involved in “traditional” treatment for military-related issues, and an initial step by others whom may have dropped out of treatment or never sought help after their military service. Some models serve Veterans from any era, reinforcing the inter-generational connections among Veterans (e.g. National Veterans Wellness and Healing Center/Angel Fire; Bridging the Gap Intensive Integrative Retreats), while others serve specific populations, including post 9/11 Veterans (e.g., Gratitude-America) or women Veterans (WVSJ). Retreat Models also differ in participants: some are designed for Veterans only (e.g., Walking with St. Francis), others include Veteran partners (Veterans plus spouse/partner/support person/buddy), and fewer include families (e.g., GratitudeAmerica, WVSJ). The rationale, selection process, staffing, program content, and outcomes are described within each model included in our 2 issue series described here.

Remarkably, there are several key programmatic elements and themes that are shared among all models, despite their having been developed with minimal or no contact among retreat directors and staff members. All programs:

• recognize the need for clinical staff trained in military issues, and incorporate Veterans in staffing
• screen applicants and hold the size to manage large, small, and individual/couple/family needs
• select retreat sites that enhance a quieting response and that can establish safe and nurturing spaces
incorporate metaphor and ritual in processing history, trauma, relationships, and military experiences (often through the expressive arts and warrior rituals)

acknowledge the impact of spiritual and moral injuries upon Veterans and their communities, and the magnitude of losses that war (and military sexual trauma, for those suffering from this additional loss) impose

include sessions that introduce participants to a variety of healing interventions, including quieting responses (breathing, meditation, yoga, etc.), education about brain/body/mind/heart wounds that affect warriors during and after military service, and healing of these wounds; skills building in self-awareness, behavioral patterns, and communication; equine therapy; expressive arts; etc.

rapidly build a small community, emphasizing that “you are not alone”

offer follow up, not just in assessment but in referrals, resources, and continuing opportunities for participants to remain connected within their retreat community groups

offer retreats at low or no cost to participants

Equally as remarkable is the fact that most of these retreats operate as nonprofits: working with small budgets, many volunteers, and financed for the most part through private donations and small grants from foundations. These limited resources compromise their capacity to conduct extensive quantitative and qualitative research within and across models; such data is imperative to demonstrate their efficacy to the Department of Defense and Veterans Administration to sign on for research and program expansion. Yet the retreat models included in these two issues of Combat Stress have undertaken research (of varying rigor, again limited by resources) while gradually increasing the number of retreats. We encourage these efforts, as well as commend the New Mexico Department of Behavioral Health for awarding a four year contract in 2014 to the National Veterans Wellness and Healing Center/Angel Fire to deliver retreats to its resident Veteran families. This precedent speaks to all civilian communities’ need to step up in partnering with Veteran nonprofits offering programs such as retreats that demonstrate positive outcome measures and strong positive responses from participant Veterans.

In this Spring Issue (May 2017), three Retreat Models and their research are presented: Closing the Gap Intensive Integrative Retreats (Bruner & Shoots), a four day model for dyads (Veteran and support person); Lone Survivor Foundation Intensive Integrative Retreats (Brown; Kip et al.), a three to five day model; and the National Veterans Wellness and Healing Center/Angel Fire Retreats (Ford), a seven day model. Voices from a clinician who has staffed a retreat for the first time after working with Veterans for 25 years (Mundt) and a couple who attended a retreat and are now peer leaders for retreats (Marcus & Theresa Coomer), are also included.
In our Summer issue (August 2017), we will continue our series with an overview and comparison of Military and Veteran Recreational Programs, Camps and Retreats (O’Hara & Vicars); and descriptions of several additional retreat models: Healing of Memories (Wold); Walking with St. Francis (MacLeish); and GratitudeAmerica (Hejmanowski & Brown). In addition, 2 participants, one (Jones) who participated in two WVSJ retreats for women, and another (Briggs) who participated with his children in a GratitudeAmerica family retreat, weigh in on the personal impact of attending retreats.

The descriptions of the retreat process, data, and outcomes bear witness to the impact of programs and the need to standardize, expand, and fund additional programs and research. The geographic locations and variations on intensive integrative retreat models allow for selection by applicants of programs that meet specific needs and accommodate financial constraints. But the demand outpaces available spaces, and expansion of retreat programs is needed.

We at Combat Stress could not include all of the retreat models currently available across the country, of which there are many more, nor can we endorse any one of them. We encourage clinicians to educate themselves and their Veterans/Veteran families about these opportunities and share this information with others, and we encourage Service Members and Veterans to select a “best match” before applying. We welcome feedback, the opportunity to hear from retreat models not included in these two issues, and encourage dialogue among retreat models to move this powerful intervention forward.

**About the Author**

Christiane O’Hara, PhD serves as a volunteer Psychologist through the Red Cross at the Functional Recovery Program, TBI Clinic, Dwight David Eisenhower Army Medical Center, Fort Gordon, as an Advisor and Retreat Leader for Gratitude America, a national nonprofit providing retreats for military and Veteran couples, and as an Advisor and Retreats Coordinator for Women Veteran Social Justice Network (WVSJ), a nonprofit network for women service members and Veterans. She has served as a Retreat leader for individual, couples, and family retreats through Fort Gordon Warrior Transition Battalion, Gratitude America, and WVSJ. She is co-author of Rehabilitation with Brain Injury Survivors: An Empowerment Approach (1991); “ArtReach Project America and other Innovative Civilian-Military Partnering” chapter in War Trauma and its Wake: Expanding the Circle of Healing (2012); and “Veterans and the Arts as Healing Interventions” (2014) and “Sleep Assessment and Interventions for Service Members and Veterans” (2017) in Combat Stress. She received her PhD in Clinical Psychology from the University of Georgia and completed postdoctoral training in Neuropsychology and Rehabilitation Medicine at the Atlanta Veterans Administration Medical Center and Emory University Center for Rehabilitation. She is a military daughter and mother of a Soldier.
GET INSIDE OUR HEAD

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We must create our own new models of healing which emphasize communalization of the trauma. Combat Veterans and American citizenry should meet together face to face in daylight, and listen, and watch, and weep, just as citizen-soldiers of ancient Athens did in the theater at the foot of the Acropolis. We need a modern equivalent of Athenian tragedy. Tragedy inclines us to prefer attachment to fragile mortals whom we love, like Odysseus returning from war to his aging wife, Penelope, and to refuse promised immortality. (Shay, 1994)

Introduction
This article is a follow-up to the Combat Stress issue on Veteran Retreats (Bruner, May, 2014). It describes the Bridging the Gap Integrative Intensive Retreat Model for Veterans, Spouses, and Support Persons that fills a significant gap in healing interventions for Service Members, Veterans and their partners/primary social supports. We are, as Jonathan Shay writes, creating a new model of healing which communalizes trauma. The model of the four day therapeutic Integrative Intensive Retreat once again brings to life the theater at the foot of the Acropolis; one in which a society shares responsibility for war recovery with its warriors.

Background
In 2004, a team based at Walter Reed Army Medical Center (of which I was a member) stood up the first three-week integrative intensive outpatient program for all active duty branches, called the Specialized Care Program. This was the clinical arm of the DoD Deployment Health Clinical Center (DHCC) which served all branches and NATO troops. The DHCC became the incubator and innovator for numerous progressive interventions in military medical care, psychological health and traumatic brain injury, and research. However, the program targeted only Service Members, treating their acute stress, post-traumatic stress, post combat adjustment and complex medical conditions related to war exposure. Routinely, participants would express
frustration that their significant others did not receive the same level of care, or no care whatsoever. Because of these requests, I designed a week-long Spouse/Significant Others Support Group (S/SOS) for the program graduates’ significant others that included education, self-management skills, and small and large group process.

After leaving the DHCC/DoD in 2014 and having led many retreats and consulted with Veteran retreat programs, I developed the Integrative Intensive Retreat Model and received funding from the Walter Reed Society for a “seed” grant to cultivate retreats regionally and research its efficacy.

The name “Bridging the Gap” retreat was chosen to reflect the need to “stand in the gap” with our Service Members/Veterans and their primary support persons to bring resources, augment existing services in the military and VA system, and construct a new identity that incorporates the warrior experience, significant others and communities.

The definition of “standing in the gap” is: “to expose one’s self for the protection of something; to make defense against any assailing danger; to take the place of a fallen defender or supporter” (Webster’s Revised Unabridged Dictionary, 1913). Community-based Integrative Intensive Retreats for Service Members/Veterans and their families were conceived to help our communities protect and restore our Veterans, “defend” against the danger of Veterans being lost and isolated, and to reconnect with partners and other warriors.

The 2014 Combat Stress article emphasized that there was a significant gap between those who had served post 9-11 and their communities. The burden of war appropriately lies with the entire nation. In the words of journalist Sebastian Junger (2013): “Warriors need a country that will share, rather than ignore, the moral burden of killing”. The next decade must be a decade of healing for all—Service Members, Veterans, families, and the communities that surround them.

Junger’s most recent book (2016) asserts that “the problem doesn’t seem to be trauma on the battlefield so much as re-entry into society” and “we are stronger when we come together”. Veteran retreat models encourage civilians, both individually and collectively, to support community-based retreats with volunteer time, donations, and partnerships that can sustain/expand programs and refer Veterans to attend.

In 2014, a grant was received to establish and support research for the “Bridging the Gap” integrative intensive therapeutic retreats in 4 national regions. With the completion of the grant, we are now seeking further funding.
Retreat Leadership, Staff and Planning
The lead facilitator is a clinician with extensive military/family treatment experience. Small group co-facilitators include military and Veteran clinicians and a chaplain. Assistant facilitators include peer mentors and leaders representing Veterans from all eras, graduate students, and interns. Combat Veterans serve as small group facilitators, dinner or lunch speakers, or as the “elder” Veteran for the entire group. We also include a Mind-Body Specialist, Peer support pair, and logistics staff. Other community providers provide lunch/dinner and mind-body interventions.

Retreat planners build community connections on many levels, including:
- The Departments of Defense and Veterans Affairs providers and leaders
- Veterans’ service organizations
- Not-for profit organizations
- The surrounding community, including volunteers, service organizations businesses, and public safety
- Academic institutions

Features of the retreat model:
- Trauma Informed Care, Empowerment, and Solution Focused
- Veteran and Support Person attend as dyad for 4 days
- Focus on supportive therapeutic interventions, not “therapy”
- Focus on gateway to treatment, augment to treatment and post treatment
- Referral by DoD/VA and other credentialled providers
- Staffed by licensed clinicians with Veteran/military expertise
- Screening for active psychosis, suicidal risk and significant cognitive impairment
- “Cost free” (transportation to retreat location only expense)
- Drug, alcohol, and weapon free
- Encourage help-seeking and how to use the help

Eligibility Requirements
- Open to any Veteran who served in combat or had trouble adjusting after a deployment regardless of discharge status
- Diagnosed with PTSD or displays symptoms of PTS/reintegration challenges that affect daily functioning and/or relationships
- Not actively addicted, suicidal, psychotic, actively violent or severely cognitively impaired

Retreat Demographics
Demographics of a sample of retreat participants include two thirds male/one third female; 50% discharged status; all branches and ranks; 88% reported PTSD; 73% reported sleep problems; 58% reported chronic pain; 49% reported TBI; 36% reported physical limitations; 34% reported weight gain; 26% reported hypertension; 26% reported breathing problems; 14% revealed a history of suicidal thoughts or attempts within past 6 months.

Treatment Status included 53% currently participating in VA hospital programs,
22% in Vet Center programs; 11% in DOD treatment programs; 15% receiving service from community provider; and 33% who were in no formal treatment. For one third of Veterans in this sample, then, the retreat was their portal to resources, healing, and hope. This alone suggests the need to expand retreat options in order to reach those whom have not sought, or whom have given up on, options accessed by their peers, as well as those who attend retreats as an adjunct to their ongoing treatment.

**Participant reasons for attending**

The application form for the retreat asks Veterans and significant others to describe their reasons for attending. Typically, a Veteran has been given an ultimatum by a spouse/partner that s/he must get help. Others are unable to find services, have hit a “stuck point” in therapy, may want to learn relaxation techniques, or miss collegial relationships with other Veterans. Some Veterans say their want their spouse to have support. In their own words:

### Why retreats?

“I get impacted most of the time because it’s part of him. He’s quicker to anger. We have to walk on eggshells. Excluded from VA appointments.”

“This is the last hope to save my marriage. She will leave me if I don’t come.”

“I have lost myself. I feel like life is passing me by and I’m in my own world stuck in a place where no one understands me.”

“I came back with PTSD. The PTSD led to my eventual medical retirement from the Army which was the only job I ever loved.”

“Destroyed my marriage as well as numerous other relationships after service. Can’t hold employment, can’t sleep, have become an alcoholic.”

“Hard to find services where we live.”

“My life has changed. I had ultimate goals of going to school, having a great job, and just being changed dramatically. I’ve changed colleges 5 times, had 15 different jobs, could never be in social gatherings.”

“I have a variety of medical conditions, both physical and mental, make daily life more difficult. Poor social skills and detached relationships with family and friends.”

“Photo credit: Walter Reed Society"
Key Components of Retreat Philosophy
From the inception of the Integrative Intensive Retreat Model, the principles of Trauma Informed Care have infused the retreat model: Safety, Trustworthiness and Transparency, Collaboration and Mutuality, Empowerment and Voice, and Choice. Principles of empowerment and focus on solutions and strengths are actively practiced.

These retreats strive to meet Veterans “where they are”. This requires, in addition to the above principles, an integrated program of interventions that, as Charles Hoge summarizes, “involves 5 core components: 1) narration, 2) cognitive restructuring, 3) in vivo exposure, 4) stress inoculation (e.g., relaxation) skills, and 5) psych education. Evidence indicates that if these components are applied, the method of ‘packaging’ them is less important.” (Hoge, 2011).

Through our retreat interventions, we incorporate and create narrative, the opportunity for connections with peers, family, community, and reconnections to self, teach skills for reducing Autonomic Nervous System Reactivity (ANSR) with daily practice of mind body skills, and emphasize strengths. The retreat model focuses upon building a social safety milieu, restoration of order, and resources for stability. “Social safety is defined as the sense of feeling safe with other people…there are so many traumatized people that there will never be enough individual therapists to treat them. We must begin to create naturally occurring healing environments that provide some of the corrective experiences that are vital for recovery” (Bloom, 2000).

The retreat reflects a dependable and accepting milieu to model a new order for one’s life. Guidelines are given in the beginning of the retreat which define “rules of engagement”, i.e., we respect and listen to one another’s experiences without attempting to change or convert them; we respect one another’s emotional and physical safety; no weapons/alcohol/illicit substances; we maintain confidentiality; we listen respectfully.

I cannot emphasize strongly enough the importance of creating a thematic goal of the retreat, which is delivered to participants prior to the retreat and during a thorough orientation at the retreat. Clearly defining goals, strengths, boundaries, informed care, staff roles and the philosophy of how retreats heal, is critical. It is central to military/Veteran retreat delivery that the warrior/military ethos/values be repeated and upheld.

Careful review of the schedule and explanation of the purpose of all interventions is essential to establishing safety and a dependable milieu. Participants’ stating their growth goals set the tone for their participation. Also, encouraging the creation of sanctuary, unplugging from phone and external media, and focusing on total wellness encourages the possibility of self-focus and refuge. The retreat environment is a metaphor for new choices, including practices such as seating participants and

The warrior ethos is a code of conduct, Pressfield writes, that embodies a life where integrity, loyalty, honor, and selflessness, and courage are one’s guide. Starting thousands of years ago with the hunters, these concepts evolved into the warrior societies where protection for the tribe was best achieved as a group working together. The rudimentary laws arising from the successful tribes evolved into the warrior ethos practiced by the Spartans and others where courage, cooperation, and acknowledging the strength of the group over that of the individual, enabled the tribe or the nation to survive. (Pressfield, 2012).
staff in a circle, establishing equality, and providing an atmosphere that is predictable and well-organized. Provision for a parallel staff orientation is crucial in mirroring the growth process. Every aspect of the milieu creates a metaphor for the retreat experience.

We involve, educate, and treat the primary social support system and link to community-based interventions. We use:

- Peer support and “soldiers saving soldiers”/“Battle Buddy” both for Veterans and support persons
- Engagement of the Veteran and primary social support together
- Support of significant others of Service Members who may experience serious challenges in supporting their loved ones, coping with their symptoms, and advocating for services. They also need information, encouragement, and connection with and support from others who are coping with similar challenges
- Incorporation of nature-based settings to enhance healing and recreation/rest
- Provision of follow-up community-based care
- Provision of resources, education, life skills and information on empirically supported interventions
- Blending of empirically supported modalities with Complementary and Alternative Medicine (CAM) modalities that have been reviewed for efficacy (Bruner, 2014).

Caregiver Needs

“Military Caregivers: Cornerstones for Support for our Nation’s Wounded Ill and Injured Veterans” first RAND Corporation report (Tanielian, et al., 2013) recommends empowering caregivers, creating caregiver friendly environments and filling gaps in programs and services. The RAND Corporation’s most recent report “Hidden Heroes: American Military Caregivers” (Ramchand, et al., 2014) identifies gaps in programs, policies, and initiatives to support military caregivers from a socioecological framework. The report identifies that there are overall 5.5 million military caregivers, of which 19.6% or 1.1 million are caring for a post 9/11 era Veteran. This population is younger and often not connected to a support network. Their identified caregiving tasks are primarily coping with stressful situations and emotional/behavioral challenges.

We propose that we follow the report’s recommendation to view caregivers as not just the spouse, but the entire social support system, which may include other family members and/or community supports/friends/peers. The first report recommends extension of services to family and friends or the caring community. Their identified caregiving tasks are primarily coping with stressful situations and emotional/behavioral challenges.

We propose that we follow the report’s recommendation to view caregivers as not just the spouse, but the entire social support system, which may include other family members and/or community supports/friends/peers. The first report recommends extension of services to family and friends or the caring community. Both emphasize the need for further research on effective models of caregiving support systems.

Caregiving is a heavy burden for caregivers, who encounter juggling family life and work, poorer health care outcomes and relationship satisfaction, and depression. The study found that most programs target care to the Veteran rather than the extended social support system. Further, the cost of caregiving extracts a significant toll on our nation due to caregivers lost income and mental health needs. The RAND report estimates a cost of $5.9 billion dollars lost to the economy.

Designated caregivers are actively encouraged to attend through the Military and Veterans Caregivers Network. https://milvetcaregivernetwork.org
Many of the tools and modalities used in this retreat model enhance participants’ connections with their own narratives and those of their retreat partner. Connective narrative opportunities include:

- An application form completed prior to the retreat
- Intake evaluation of coping, relationship adjustment and stress levels
- Display of an object, photo or symbol of war exposure
- Writing exercises on the past, present, and future
- Reading a written exercise about deployment experiences (“best and worst”)
- Large-group educational sessions (interactive and experiential)
- Small-group breakout discussions
- Expressive modalities, such as dance movement and group art

- Modeling of progress through the involvement of a “peer support pair” and peer-to-peer interaction
- A retreat manual with participation guidelines, schedule, work sheets, educational hand outs and resources.

The Integrative Intensive Retreat model is designed to foster connections among participants through several therapeutic and recreational activities, including:

- A welcoming/honoring ceremony with Veterans and community leaders
- Housing and eating meals together
- Recreational activities
- Large-and small-group discussions with solution focused approaches
- Opportunities for informal “sharing” among participants
- Communication skill building, intentional listening, team work, and equine therapy using Eagala model (Eagala, 2016)
- “Breakout group” focused on learning positive intention
- Closing ritual with sharing of intentional messages, letters participants have written to themselves (mailed one month after the retreat) and to one other participant, donated quilts for warriors, and a ritual honoring those who have been lost
- Community Forum

This retreat also provides training in several skills designed to reduce Autonomic Nervous System Reactivity (ANSR), including:

- Introductory training in stress-reduction and stress-management techniques to help participants choose, learn, and practice skills for reducing
and managing stress, and decide which therapeutic services that they want to access in their own communities

- Recreational activities
- Equine/canine therapy
- Fire circle/relaxation/live music/Native American performance
- Tai chi
- Yoga and I-REST
- Menu of CAM practices such as auricular acupuncture, Reiki, or Qigong
- Guided imagery, progressive muscle relaxation, deep diaphragmatic breathing, and QRS - Quick Resiliency Skill (grounding technique, Bruner 2007), Subjective Units of Distress scaling/monitoring (a scale of 0 to 10 for measuring the subjective intensity of disturbance or distress currently experienced by an individual)
- T2/VA Apps to support self-management (i.e., Breath to Relax, Tactical Breather, and Virtual Hope Box)

Large group experiential educational sessions curriculum


The Welcome, Overview and Community

The group is introduced to each other by the Leader’s reading aloud the strengths that participants listed on their applications. They are told that they have knowledge to help each other. In the welcome a well-known Veteran, Veteran elder, and the retreat peer pair welcomes them. We emphasize that we are all responsible for war as the nation who sent you to the tip of the spear. Participant introductions begin with staff sharing who they are. The peer couple then tells their story, and their experience of the retreat they previously attended. This sets the stage for participants to say as little or as much as they want about themselves. A safety brief and agreement for standards of participation are reviewed. The group is then divided into “Squads” or small groups for ice breaking exercises, naming their group, and choosing their motto and song. This is followed by an introduction to relaxation techniques by the mind-body specialist.

“Participant introductions vary. It can often be startling to have some Veterans open up quickly. One dual military couple, he Vietnam era and her post 9-11 deployed are an example. She came because she was still processing war exposures. He hadn’t talked about Vietnam even to her. He wept about his experiences for the first time.”

Overview

The Past is about surviving, The Present about awareness, adjusting and acceptance, and The Future about thriving and consolidating goals and changes. Handouts, self-reflection, metaphor, literature and relational enhancing exercises are utilized.
The Closing Ceremony
This is the ritual to acknowledge the group's growth, mutual support, significant relationships, and to honor them for their service. The ceremony welcomes the elder Veteran pair and the youngest Veteran pair, who begin by lighting candles in the center of the circle. There is an intentional writing task completed in silence for mutual encouragement. In silence, each small group comes to the center of the circle. Messages are shared, their respective group song is played, and their motto spoken. After this is completed, all participants return to the center and take a note from another group member. All staff then come forward and encircle the participants, presenting each with a quilt and words of encouragement to each set of partners. The quilts represent the "shelter of the community", having been prepared by a civilian non-profit group who wish to honor our Veterans and families. A brief statement is made to honor those who did not come home. Then one large circle is formed to speak closing messages of encouragement.

The groups are asked: What do you want your “other” to know that will help you most to improve communications? Comments are scribed on large newprint so responses will be anonymous and collective. A short educational session precedes the discussion and scribing, and introduces three communication skill sets: a) the 4 Parts of Assertive Statements, b) Skills for Listener/Talker, and c) Guidelines for Difficult Topics. Consistently, two things happen: The first is that Service members/Veterans have a lot to say that they have not been able to express. Often, they are the ones who run over or out of time, which surprises the significant others. Second, and more important, every group from every retreat has conveyed a statement of love as part of what they want their partner to know. The newprint is posted at the next morning large group, setting the stage for discussion of the Present. Participants can read posted responses for the remainder of the retreat, which remind them that they are loved as well as what they need to know to build communication.

Moral Injury Education
An important curriculum addition is the inclusion of a session on the concept of military moral injury. This is accomplished by showing a 2014 TEDx talk by Joshua Mantz titled "Overcoming Mor-
al Injury” https://www.youtube.com/watch?v=ORBf73HiJns, or by having a combat Veteran guest provide his/her story, followed by discussion. Many retreat participants suffer with survivor guilt and/or shame about their war experiences, haunted by those lost, and seeking to find meaning and purpose in their service. This session may assist them in: naming their source of despair and struggle with perceived acts of commission or omission; learning that one wrong decision does not define one’s entire life story; and transforming helplessness and despair into positive action.

**Small Group Curriculum**

For many retreat participants, living in isolation has kept them “stuck”, often for years. We say “isolation kills, community heals”. Small group sessions encourage verbal processing and a sense of acceptance that “I am not alone”. These sessions challenge “worldviews” created in war exposures and set the stage for reassessment of experiences and relationships. Group members feel accepted and validated by others in the small group process. The concept of a “new normal” emerges that incorporates the warrior identity with a new construction of the self, presenting the Veteran and significant other with opportunities to choose alternatives. Processing in small groups also promotes “communalization of the trauma or struggle”. Choosing alternatives helps decrease the intensity of emotional outbursts, including anxiety, guilt, anger and depression (Cooper & Lesser, 2005).

Throughout the small group process, strengths are emphasized, and the power of problem solving is seeded within the group. The process within the small group is solution-focused (Bannick, 2008). This leads to a shift from participants’ beliefs that things are impossible, to finding solutions or possibilities in a different manner.

**Small Group Vignette**

A Vietnam Veteran and his wife attended the small group with fear, apprehension and guilt over a 50-year-old traumatic event involving a submarine service related near death experience for he and a shipmate. It was apparent that the same terror he felt was then very much alive. After hearing several other vets tell of their ‘story’ and how they are progressing, he could verbalize this fears to his wife and the group. He found alternatives to his current way of thinking. He began to “attach” new words to the exposure that were more applicable to his current values. His perspective of himself and his choices changed. His self assessment led to viewing himself as successful in his life rather than a failure. His story and the supportive witnesses in the small group allowed him to see his changing beliefs about the incident. A new construct of his choices gradually emerged. He noted a change in his relationship with his wife happening. He felt more available to her and less shut down. As the session continued, he received validation from his wife, and other group members for this efforts. Instead of looking at the past being his “rudder”, he found a different appraisal of himself and way forward to manage the same feelings that had held on to for years.
Solution focused tools help participants to come up with alternatives to trauma based thinking.

Outcomes Research: Evaluating the Retreat Model
The research literature is sparse on Veteran therapeutic immersive retreats. Two peer reviewed articles on the Integrative Intensive Retreat Model (Monk, Ogolsky and Bruner, 2015) and the Bridging the Gap Model, its precursor (Monk et al., in press) include data collected at the beginning and end of the retreats, as well as at follow up. Measures include demographic variables, military history data, and scales measuring PTSD symptoms, posttraumatic growth, caregiver burden, and relationship satisfaction (for couple dyads). In these studies, measures were completed by all participants, including Veterans and their primary caregiver/support person. Empirical evidence of retreat outcomes provides staff, participants, and potential funders with information about the effectiveness of the Integrative Intensive Retreats Model. Pretest (day 1), post-test (day 4), and 3 month and 6-month follow-ups were carried out. The measures used were:

- PTSD Checklist (PCL-5; Weathers, 2013)
- Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996)
- Caregiver Strain Index (CSI; Robinson, 1983)
- Dyadic Adjustment Scale (DAS; Spanier, 1976)

The first study found a significant decrease in trauma symptoms among the Veterans, and a reduction in distress for their partners. There was also a significant increase in relational satisfaction. The limitations of the study included no waitlist control group or randomization, attrition at the 6-month follow-up, and no structured clinical interview. Despite these, we concluded that intensive retreat modalities for Service Members, Veterans and their significant others may be an efficient and effective intervention to reduce trauma symptoms and distress. Providing a safe, welcoming environment, improving communication and stress management skills, and rapidly building a small community of Veteran dyads may bridge the gap between service members and their partners. These promising findings led to a second study.

The second study focused specifically on data collected from the 4 day “Bridging the Gap” retreat model. Data was gathered from eight 4-day retreats held from June 2013 – April 2015. All participants completed a screening form and telephone interview prior to acceptance into the retreat. Participants were asked to complete a battery of pre-and post-test measures similar to the first study, in addition to post retreat program satisfaction evaluations. Veterans and Primary Support Persons (PSP) reported significantly reduced PCL (trauma symptom) scores from pretest to posttest, Veterans by 7 points and PSP by 9 points lower. Veterans and PSPs who were in a couple relationship also reported significantly improved DAS (Relationship Satisfaction) scores from pre-to post-test, moving from the dissatisfied range to satisfied range. On the posttraumatic growth measure, PSPs reported significant improvement in post-traumatic growth from pre-to post-test, while Veterans demonstrated a statistically insignificant increase. The need for further research is important for all the therapeutic retreat models. Funding of such research and linking with an academic institution are
two barriers to studies. Finding a control group for a randomized controlled study is difficult. One suggestion would be a waitlist control group. Isolating the healing ingredient also poses a challenge, as does consistency in the model. Additional research is critical, however, to continue to demonstrate that the Intensive Integrative Retreats Model is a viable referral option.

**What are the healing ingredients in the retreat model?**

“In all our searching the only thing we’ve found that makes the emptiness bearable is each other” (Sagan, 1997).

Veteran retreats provide opportunities for “communalization of trauma” and compassionate observation of self and others. Core military values of unit cohesion, leaving no one behind, self-sacrifice, considering the interests of the group before those of the individual, and shared culture may provide significant bonds for rapid community building. The inclusion of a peer couple as mentors also contributes to rapid sharing by participants, which strengthens group bonding.

We have found participants in prior retreat groups to be, for the most part, strong, resilient, loving, generous, supportive,
thoughtful, considerate, kind, respectful, inclusive, accepting, introspective, insightful, honest, eloquent, teachable, playful, creative, and humorous individuals. They have bonded together rapidly in these groups and in social and recreational activities outside the group process, despite differences in rank, socioeconomic status, age, experience, personality, and personal style. Follow up opportunities allow participants and peer mentors to have continued mutual support through online chat rooms after their return home; many have formed lasting friendships, and many have resolved to reach out to other military spouses/significant others in need of support and/or referral. Although this model can be credited with setting the stage for encouragement and development of these strengths, participants have brought these assets into the group process. Staff, volunteers, and visitors have expressed awe and gratitude at the strength and love of retreat participants, and gratitude for the opportunity to be part of their support. The retreat milieu becomes a sacred place of safety and growth.

We include representatives of the civilian community in our retreats who stand for and with the Service Members/Veterans and their partners as part of the communalization of war and to bridge the “military-civilian gap”. This bridging has been a central goal of the retreats. Participants are recognized for their sacrifices and strengths by those whom have not been at the tip of the spear.

Peter Kilner, an ethics instructor at West Point, states: “There is not a gap in values and moral ideals between the military and civilian society. There is a gap in values as standards of conduct between the military and civilian society. Shared ideals will pre-serve the proper civil-military relationship. Further, I claim that the gap in norms is justified by the demands of the profession” (Kilner, 2001).

Perhaps the retreat model gives the opportunity for military-civilian communalization of war that heals both groups.

Another healing factor is the provision of mind-body education and intensive skills for self-management and communication. These sessions demonstrate to participants that they are not weak or damaged, but rather in need of retraining the brain and body with calming skills. We have chosen Integrative Restoration (iREST) because it is a research-based transformative practice of deep relaxation and meditative training that is currently in use at VA hospitals, military bases, hospitals, and clinics. iRest combines positive intention, body awareness, breath training, and imagery to reset autonomic nervous system reactivity. Because sleep, pain and anxiety problems are consistently endorsed by participants in their retreat applications, mind-body interventions are practiced at the retreat and then taken home. Warriors at Ease http://warriorsatease.org/ has been a key collaborator with our retreat model since its inception. This national nonprofit instructs yoga and meditation teachers how to work with military and Veteran populations based on principles and practices that are 1) evidenced-based, 2) trauma sensitive, and 3) military culture informed.

Yet another contributing factor in the retreat model’s effectiveness is its intensity. Participants and staff work together in a 4 day short-term immersion experience that has no interruptions in time or therapist, both of which are typical of traditional
counseling and military and Veteran mental health settings. Stroller (1968) writes about accelerated interaction in the use of groups “for the purpose of personal change, which utilizes continuous group interaction over several days as its major source of impetus. Other ingredients of this new approach are time-limited contact, negation of the illness model, and the promotion of plans for the future”.

Finally, what are the roles of hope and post traumatic growth in these retreats? We know hope gives us the courage to persevere through suffering. Post traumatic growth is positive change that can come out of suffering through a major crisis or life transition. Does the combination of community building, hope, education, solution focused processing, an immersion experience, and hope/growth create the practical magic during, and positive outcomes following, these retreats? Hope cannot be underestimated as a force for healing. The Telehealth and Technology Center, or t2, a research and development arm of the Department of Defense and Veterans Administration, has developed a “Virtual Hope Box” phone app. This app helps with emotional regulation and coping with stress, through personalized supportive audio, video, pictures, games, mindfulness exercises, positive messages and activity planning, inspirational quotes, coping statements, and other tools. Perhaps what we see in the retreat model is a larger version, indeed a living hope box, that holds participants within a safe, intense, hopeful learning experience. The final element of follow up imparts to participants the message that “no person will be left behind”.

Feedback on the Integrated Intensive Retreats Model from a participating Clinical Psychologist

I am a Clinical Psychologist with more than 25 years’ experience in the treatment of Veterans for PTSD and other mental health problems. The vital importance of involving partners and families in the treatment process is now clear to anyone providing care to Veterans, yet it is an element of treatment that is frequently missing from standard hospital- or clinic-based approaches. I participated in the Chicago March 2016 IIR retreat as one of the facilitators, with this being my first experience of being involved in this kind of event. I was frankly blown away by the power of this approach to both engage the participants and to result in lasting growth and change in the relationship. Following the retreat, the bonds forged by those who participated have remained strong; they continue to offer outreach and support to each other through all kinds of crises. The structure and flow of these retreats has been carefully deliberated and painstakingly planned: the details are important, and nothing is left to chance. I truly wish that I had the opportunity to send more of my Veteran clients and their family members to a retreat like this; I enthusiastically support any efforts to ensure that this opportunity can be given to more and more Veterans.

John Mundt, Ph.D.
Licensed Clinical Psychologist
Marcus and Theresa fell in love, and love prevailed through the darkest of times of Marcus’ journey to health and reconciliation of his war experiences. In 2015 they were referred by a VA Caregiver Case Manager from Hines VAH to the first Chicago “Urban Retreat”. What follows is their story.

Marcus and Theresa Coomer attended a Bridging the Gap retreat in 2015. Marcus had served in the Army where he spent a tour in Samara, Iraq as a tank driver. He was medically retired from the military in 2006, having been determined as permanently disabled as the result of his military injuries. Theresa is a 7th grade Social Studies teacher. They are confronted daily with the realities of what being a wounded warrior means.

Prior to their attending an IIR retreat, Theresa had felt like an accessory to Marcus’s service. She felt that it was not appropriate for her to be in the Veteran community, even in the wider support community. She had not been around when he was in the service nor had she served in the military. This retreat opened a new avenue of community that she had not fully participated in previously.

At the retreat, they spent a good portion of their mornings in small groups, dissecting issues that they were dealing with in their day to day lives. They were amazed at how intimate and honest the group was. The connections made here are still strong to this day.

The resources provided in large group meetings were also instrumental in helping in the support of wounded warriors. They were given up to date information about conditions that Veterans deal with, including how the brain and body physiological react to combat. Although Marcus and Theresa had seen the reactions first-hand, it was beneficial to understand the science behind it. It also included a guest talk at the retreat about Moral Injury by retired Vietnam Veteran General James Mukoyama which helped them identify that in Marcus and move towards implementing new strategies to deal with this.

One of their most impactful sessions included the sharing of objects by Veterans. This was an opportunity for Veteran participants to tell the group about their war experiences. Marcus brought in a piece of shrapnel that had been given to him during his recovery from an IED blast that blew the treads off his tank, and consequently broke his back. The EOD team had told his

Retreat participants are invited to bring symbols, objects and photographs that represent their war exposures. The large group listens as they describe the meaning of it and encourage honoring of their experience.

Photo credit: Walter Reed Society

The impact on one couple: A life and a marriage saved
tank commander to make sure that he received that piece of shrapnel because they had determined that his quick thinking and action as a driver had saved the lives of all the soldiers in that tank. While these six inches of jagged metal symbolized his trauma sustained in Iraq, it also symbolized his sacrifice and strength in overcoming great obstacles.

The community built during this 4 day retreat is still a major factor in why Marcus is still here today. About six months after this retreat, he went through an extremely dark period; the support of his new brothers and sisters helped him through that time. The crippling isolation, which had been a shell around the couple previously, had been cracked and they now had outside support when they needed it. In their words: “The participants of the retreat reach out to each other and share resources amongst each other. It is their safe place to be connected and love one another. This was not a therapy weekend, but it was extremely therapeutic in nature. The staff at the retreat wanted desperately to support these Veterans who were dealing with so much turmoil. This retreat in Chicago opens so many doors of support to those that attend.”

Marcus and Theresa have graduated to take the role of Peer Couple at the IIR retreats. They attend retreats to give peer support to participants and help guide them through the weekend. They each attend small groups and act as intermediaries between participants and staff. They bring great insight and support to the participants, as they have also walked the path as participants.

In the retreat closing ceremony, Marcus and Theresa are wrapped in two quilts that are blended in recognition of their mutual sacrifice and as a welcoming back into their community. The quilts are donated by Jacob’s Hands to replicate the Native American ritual of community wrapping returning warriors and their families in acceptance and love. Marcus and Theresa have become peer outreach for retreat participants, establishing a secret Facebook page and coordinating retreat participant reunions.

Photo credit: Walter Reed Society
About the Authors
Victoria Bruner, LCSW-C, RN, BCETS
Ms. Bruner was a subject matter expert, researcher, and clinician in combat related PTSD, Post Deployment Adjustment, family and community services and programming for 14 years with the Department of Defense (DoD) Centers of Excellence (DCOE) for Psychological Health in Washington DC. She is now a consultant to several non-profits serving service members, their families and communities.

With DoD DCOE, she led the following initiatives: Clinical Communications and Outreach Director, Tri-service Integrative Intensive Outpatient PTSD Programs, Clinical Education and Training, Clinician/Traumatic Stress Specialist Specialized Care Program, Project De-Stress internet delivered treatment for military PTSD, military women with PTSD, and Trauma Therapist, Operation Solace at Pentagon after 9/11 attacks. Prior to her DOD service she worked as a trauma therapist in private practice, consultant, founder of a family therapy training institute, child therapist trainer, specialist in disaster and crisis mental health and adjunct professor at a medical school behavioral health department and graduate school for clinical social work. She was recently awarded a grant by the Walter Reed Society to provide intensive integrative healing retreats for Service Members, Veterans and their primary social support persons.

David Shoots, LCSW
David Shoots, LCSW, is a retired Army Veteran and has worked in the mental health field for the past 15 years. He earned his Bachelors of Social Work (BSW) and Masters of Social Work (MSW) from the University of Central Florida and is a Qualified Supervisor. He has worked in psychiatric hospitals, foster care, trauma services, substance abuse, and with returning Veterans and their families at a Vet Center in Florida. He has extensive experience working with trauma-based/focused care and working with couples and families. He is committed to providing individuals and families the highest quality of care using best practices and engagement strategies to impact those suffering from severe emotional issues, hopelessness, anxiety, depression, family/couples issues and isolation. Mr. Shoots has been an adjunct instructor at UCF, teaching social work practice courses. He is nationally trained in Cognitive Processing Therapy (CPT), Functional Family Therapy (FFT) and Integrative Behavioral Couples Therapy (IBCT).
References


Junger, S. (2013, May 24). Veterans need to share the moral burden of war.


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Lone Survivor Foundation Integrative Intensive Retreat (IIR) Model

Ann Brown, PsyD
LSF Program Director

The Lone Survivor Foundation was founded in 2010 by former Navy SEAL Marcus Luttrell with the mission to restore, empower, and renew hope for wounded service members and their families through health, wellness and therapeutic support. The Foundation seeks to encourage access to care and resources to Veterans and families dealing with the invisible injuries of war such as post-traumatic stress (PTS), mild traumatic brain injury (m-TBI), chronic pain, and military sexual trauma (MST) by offering five-day therapeutic retreats to Veterans, couples, families, and care givers.

Lone Survivor Foundation (LSF) retreats seek to be responsive to the needs of service members, Veterans, and their families to support and supplement care provided by the Department of Defense (DoD) and the Department of Veterans Affairs (VA), offering alternative modalities not typically provided by these agencies. These confidential retreats are fully funded by philanthropists and military supporters and are free to pre and post 9/11 active duty, retired military, and their families to introduce holistic, educational, experiential, supportive approaches to healing and wellness.

The modalities used at LSF retreats are empirically supported therapeutic techniques focusing on systemic wellness to assist service members, Veterans and families in the next step in their healing process. The central theme is to integrate mind, body, and spirit, empowering individuals toward wellness, resilience and recovery. LSF believes in the importance of families as an integral part of the healing process. Family is a primary support system, and PTS, m-TBI, Chronic Pain, and MST all affect marriage, family, and intimate relationships (Vasterling et al., 2015). Lone Survivor Foundation hopes to strengthen and assist these primary support systems by offering couples, family, and caregiver retreats. Couples and families learn new ways of understanding one another, coping mechanisms, and effective communication techniques to help create stronger relationships, as well as develop a support network of other Veterans and their families.

LSF uses best practices, including evidence based therapeutic methods for PTS, m-TBI, chronic pain, and MST, emphasizing connection and bonding with fellow comrades in arms and opportunities to learn more about self and others though laughter and shared experiences. Retreats incorporate group and individual educational sessions, problem-solving techniques, cognitive behavioral interventions, neurofeedback, creative arts activities, and Accelerated Resolution Therapy (ART), which has been shown to provide rapid effective treatment for symptoms of PTS including depression, anxiety, and trauma related guilt (Kip et al., 2013, Kip et al., 2017).

A key element of LSF retreats is the use of the Equine Assisted learning model of EAGALA (PRWEB, 2015) http://www.prweb.com/pdfdownload/12018780.pdf. This video link: https://www.youtube.com/watch?v=boVatiz-55g highlights why EAGALA fits our retreat model for each retreat type. The equine assisted growth and learning association (EAGALA) mod-
el involves nature, horses, and experien-
tial activities; it does not focus on horse-
manship skills or riding (Notgrass C. & Petti-
nelli, D., 2015). When in the arena, in-
dividuals learn about themselves and oth-
ers through working with an EAG-
ALA mental health therapist, an equine
specialist, and a team of horses and who
provide opportunities for self-reflection
and growth.

The five types of LSF retreats are led by li-
censed clinicians with extensive military
and family treatment expertise, and sup-
ported by a staff with a passion to give
back to service members and their fami-
lies. Retreats of 8-10 participants from a
nationwide pool of applicants are held at
LSF retreat facilities on the Texas coast,
Utah, and (soon to be added) North Caro-
linia.

LSF also incorporates Complementary and
Alternative Medicine (CAM) techniques
and tools such as mindfulness, yoga, and
i-Rest yoga Nidra, each of which contrib-
ute to psychological, physical, and spiritu-
al well-being through release of long-held
tensions, emotions, and beliefs. Certified
instructors from the Veterans Yoga Project
(http://www.Veteransyogaproject.org/)
work with participants to build resilien-
cy using breathing, meditation, mindful
movement, guided rest and gratitude.

Retreat participants are encouraged to
seek ongoing help and follow-up care
to integrate and consolidate methods
learned at retreats. LSF links service mem-
bers and Veterans to resources and provid-
ers in their home towns.

Following this brief overview and within
this issue of Combat Stress, you will find
a research article outlining our program
evaluation and outcome measures. We
invite you to read it.

To qualify for a retreat, interested individuals
can visit www.lonesurvivorfoundation.org
and fill out the “attend a retreat” applica-
tion. They will be connected to an LSF cli-
nician who will enable retreat scheduling.
LSF requires an individual service member
to attend a retreat prior to accompanying
his/her spouse and family at subsequent
retreats. LSF served over 350 individuals in
2016, and plans to serve 400 in 2017. Be-
cause of the small number of participants
attending each retreat and the large num-
ber of those in need, there is a probable
wait time for LSF retreats. Applying early
and having a completed application facili-
tates being scheduled in a timely manner.
LSF looks forward to becoming a part of
your healing journey.

About the Author
Ann Brown, PsyD, is honored to serve as
the Program Director at Lone Survivor
Foundation in Texas. She is the daughter of
a career Air Force couple who served during
the Cuban Crisis and Vietnam era. After 13
moves as an AF BRAT, Ann settled in the
Dallas Fort Worth where she finished her
bachelor’s degree, raised a family of three
boys, and completed her Master’s degree
and Licensure in Counseling. Ann has direct-
ed a Christian counseling center, provided
mental health for all branches of the DoD,
and moved to Houston to implement the
DoD directive of embedding mental health
professionals within all Air Force wings as
Director of Psychological Health for the Air
National Guard. With a love for learning,
Ann completed her Doctorate in Psychol-
ogy. She and her husband, whose father
was a career French Foreign Legionnaire,
enjoy snow skiing, travel, water sports, art,
horses, and many other activities. She
strongly believes that those serving and
sacrificing for their country deserve the very
best. Ann feels privileged to be a part of the
LSF team as the Lone Survivor Foundation
expands its services.
Introduction
The combat injuries of post-traumatic stress disorder (PTSD) and mild traumatic brain injury (mTBI) have been identified as the signature wounds of the US-led wars in Iraq and Afghanistan (Tanielian & Jaycox, 2008). These injuries can result in short-term resolution, or become progressive in nature and have devastating effects on those service members injured. Approximately 13% of Iraq or Afghanistan Veterans who have experienced combat have PTSD (Kok, Herrell, Thomas, & Hoge, 2012). In addition to PTSD, improvised explosive device (IED) blasts have resulted in a wide scope of injuries including TBI, shrapnel wounds, limb loss, and internal organ damage. Of note is the strong similarity in symptom presentation between these two signature injuries. PTSD typically manifests within four categories of symptoms consisting of: 1) avoidance of the reminders of the traumatic event; 2) re-experiencing the trauma; 3) increased emotional arousal; and 4) negative changes in cognitions and mood (American Psychiatric Association, 2013). These symptoms are often behaviorally demonstrated as episodes of anger, irritability, anxiety, and hypervigilance. In a similar realm, cognitive, emotional, behavioral and physical impairments are common sequelae of TBI (Defense and Veterans Brain Injury Center, 2015). Collectively, the similarities between combat-related PTSD and mTBI suggest consideration of similar, yet multifaceted treatment strategies.

Reasons for which Veterans do not seek treatment for PTSD, or drop out of treatment, are complex and include stigma, confidentiality concerns, time demands, perceived treatment inefficacy, and discomfort with the therapist (Hoge et al., 2014). When left untreated, the impact of the signature wounds of war (PTSD, mTBI) are often initially seen in disturbed interpersonal relationships, and then manifest as increased behavioral deficits that become evident in the workplace setting. It is at these junctures that many referrals for support begin to be initiated by either a spouse or the individual service member.

Traditional treatments offered in Behavioral Health clinics or the VA, which involve a predominant preference towards prolonged exposure (PE) therapy and/or cognitive processing therapy (CPT) (Forbes et al., 2010; Karlin & Cross, 2014; Karlin et al., 2010), yield a number of challenges to the service member or Veteran. First, both therapies are relatively lengthy (i.e. 12 treatment sessions and homework assignments), and the hours available for appointments are typically limited to week-
days between the hours of 9:00 am to 5:00 pm. Thus, individuals in need of an “after hours” appointment are usually not able to be accommodated. Second, some clinics and VA facilities have set appointment time frames of just 45-60 minutes. These limited appointment sessions restrict the ability to conduct some trauma-focused treatments. For example, eye movement desensitization reprocessing (EMDR), another first-line evidence-based treatment protocol (Shapiro, 2001), requests session time to be approximately 90 minutes in order to accommodate the time needed for adequate results within an individual session. Thus, EMDR, despite its empirical evidence base, is not routinely offered in many clinics and VA hospitals. Finally, a recent review of randomized controlled trials reported that approximately two-thirds of patients who receive PE or CPT retain their diagnosis post-treatment (Steenkamp, Litz, Hoge, & Marmar, 2015). Thus, there is an urgent need for innovative treatment strategies for PTSD and mTBI, whether trauma-focused or non-trauma-focused (Steenkamp et al., 2015).

In addition to seeking optimal treatment approaches for PTSD and mTBI, an often overlooked treatment component is psycho-education, as currently there are no mechanisms in place to offer structured education on the physiology of the injuries of PTSD and mTBI to those injured. The theoretical rationale for psycho-education is that when people (e.g. Veterans) are given information about what symptoms they may experience after trauma, they tend to normalize the symptoms and find them less disturbing (Wessely et al., 2008). Whereas direct, controlled empirical evidence for psycho-education as a primary treatment for combat-related PTSD and military is lacking, it is important to note that psycho-education is often a significant component of cognitive behavioral therapy (CBT).

On the basis of the above described treatment deficiencies and challenges, the United States Special Operations Command (SOCOM) initiated the development of a unique “retreat-based” multi-component intervention designed to address current treatment gaps and obstacles. In addition to consideration of a range of different treatment modalities (e.g. trauma-focused psychotherapies), this intervention included the provision of psycho-education on the physiology and coping strategies and treatments for PTSD, mTBI, and chronic pain. This initial effort was opened to spouses and subsequently to service members, and then evolved into development of a brief Therapeutic Retreat Program created in 2009, and now routinely implemented by the Lone Survivor Foundation (LSF). As an integral part of the LSF retreats, program evaluation data, including measures of symptomatology, are requested among all participants. The purpose of this paper is to describe the LSF therapeutic retreat model, and also to provide for the first time a summary of program evaluation results obtained through previously conducted retreats.

**Methods**

The stated mission of the LSF is to restore, empower, and renew hope for U.S. wounded service members and their families through health, wellness, and therapeutic support (Lone Survivor Foundation, 2015). The LSF Retreat program is typically three days in length and is conducted at different retreat locations across the U.S. and over the course of a weekend consisting of Friday, Saturday and Sunday. The 3-day
retreats are designed to allow participants to work progressively with individual components of the program (described below). Each day is designed to bring about increased insight, reduction of symptoms, and ideally extinguishment of traumas. The program has four main components consisting of: 1) a psycho-educational group; 2) a coping strategies practicum conducted with the use of the EAGALA form of equine-assisted learning; 3) an individual behavioral consultation session; and 4) receipt of one or more of the treatment modalities offered on site at the retreat.

**Component 1: Psycho-education.** This component targets an understanding of the physiology of the injuries sustained (physical and psychological), discussion of the myriad of coping strategies for various symptoms, and a discussion of treatment modalities available for specific injuries. In concept, this component lays a strong foundation for insight into one’s own symptoms, level of injury and desired outcomes with treatment. This is a didactic group activity that encourages participation of the Veterans attending.

**Component 2: Equine Learning.** This component uses the Equine Assisted Growth and Learning Association (EAGALA) model. In brief, the premise of equine-assisted learning is based on the bonding that occurs between the Veteran and horse. As prey animals, horses are hypervigilant until they learn they are not in danger, and thus, require the individual (Veteran) to gain their trust. By way of analogy, hypervigilance is a cardinal symptom of PTSD (America Psychiatric Association, 2013). In addition, horses are herd animals and look for a leader to follow. In gaining trust, the Veteran must be assertive without becoming aggressive, and show confidence to gain the respect of the horse and become the “herd” leader. A recent pilot study reported a significant reduction in symptoms of anxiety and PTSD among adults who received equine-assisted therapy (Earles, Vernon, & Yetz, 2015). Within the LSF model, use of EAGALA is designed to enhance coping strategies and more effective communication techniques.

**Component 3: Behavioral Consultation Session.** This component allows the participant to discuss his/her needs of support (e.g. sleep dysfunction, anxiety, nightmares, etc.) by learning about, and in some instances, being able to try out different support and treatment modalities. This flexibility enables the service member to experience or learn about a method that he/she may find to be effective, thus allowing him/her to make a preferred treatment choice. The modalities that participants learn about include, but are not limited to, the conventional treatments PE, CPT, EMDR, and CBT, in addition to emerging and alternative treatments consisting of neurofeedback (NF), acupuncture, hyperbaric oxygen therapy (HBOT), traumatic incident reduction (TIR), and accelerated resolution therapy (ART).

**Component 4: Trauma-Focused Treatment.** This component allows participants to experience (receive treatment) with NF, TIR, and/or ART. In brief, NF involves direct training of brain function by observing positive changes in brain wave activity through activities such as relaxation (Othmer & Othmer, 2009). TIR involves re-experiencing (mentally) past traumas in a safe environment that is free of distractions, judgments, or interpretations,
and is designed to examine the cognitive, emotional, perceptual, or other content of past incidents to reduce or eliminate emotional charge and symptoms. It is listed as an intervention in the National Registry of Evidence-Based Programs and Practices (NREPP) (National-Registry of Evidence-Based Programs and Practices, 2015b). ART is an emerging trauma focused therapy that uses the techniques of imaginal exposure and imagery rescripting, coupled with repeated set of lateral smooth pursuit eye movements (Kip, Shuman, Hernández, Diamond, & Rosenzweig, 2014). A randomized controlled trial of ART versus an attention control regimen among service members and Veterans showed large reductions in symptoms of PTSD in a mean of less than 4 treatment sessions (Kip et al., 2013), and ART is recognized by NREPP as an “effective” treatment for psychological trauma and depression (National-Registry of Evidence-Based Programs and Practices, 2015a). These treatment strategies aimed at reducing symptoms are unique in that they are designed to be complementary to the first two program components of psycho-education and equine-assisted learning. With all of the strategies, participants strive to strengthen their learning and reduce symptoms by working consistently with metaphors. For example, if a metaphor is developed during the EAGALA group session, the participant will be able to draw upon its image while performing the imagery rescripting component of the ART protocol.

Data Collection
As part of routine program evaluation, LSF retreat participants are requested to complete a battery of self-report instruments immediately before and after completion of the retreat. Each participant receives a unique ID number, and collection of the program evaluation data, which does not contain any identifying personal information, has been classified as exempt from formal human subject research by the Institutional Review Board (IRB) at the University of South Florida, Tampa FL. The data collection instruments used at each retreat include the 17-item DSM-IV PTSD Checklist (PCL-M) (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; F. Weathers, Litz, Herman, Huska, & Keane, 1993) and replaced by the more recent 20-item DSM-V PCL (F. W. Weathers et al., 2013) the 21-item State-Trait inventory for Cognitive and Somatic Anxiety (STICSA) (Dros, Antony, Simms, & McCabe, 2007), the 125-item Psychiatric Diagnostic Screening Questionnaire (PDSQ), a measure of global psychopathology (Zimmerman & Chelminski, 2006; Zimmerman & Mattia, 2001), and the Defense and Veterans Pain Rating scale which measures current pain on a 0 (no pain) to 10 (as bad as it could be) visual analog scale and 4 corresponding questions on biopsychosocial impact of pain (Defense & Veterans Center for Integrative Pain Management, 2015). In addition, selected demographic questions are completed along with the 3-item brief TBI screening tool (Schwab et al., 2006) at the beginning of the retreat.

Data Analysis
Demographic and clinical characteristics of LSF retreat participants were compared between those who provided post-retreat evaluation data (n=167) and those who did not (n=51) by use of student t-tests for continuous variables and chi-square tests for categorical variables. Similarly, for participants with pre- and post-retreat evaluation data, analysis of variance (ANOVA) and chi-square tests were used to
compare demographic and clinical characteristics by type of retreat attended, classified as Individual (n=93), Group (n=46), or Military Sexual Trauma (MST) (n=28). To examine the magnitude of acute clinical benefit reported by participants from attending the LSF retreat, paired t-tests were used for symptom measures of PTSD (PCL), global psychopathology (PDSQ), anxiety (STICSA), and pain inventory score. In addition, standardized effect sizes for each program outcome measure was calculated as: (mean score before retreat – mean score after retreat)/standard deviation of treatment difference score) (Morris & DeShon, 2002). Analyses were conducted overall and stratified by type of retreat attended. All of the LSF retreat program evaluation data were independently analyzed by faculty and staff at the University of South Florida, College of Nursing, Tampa, FL.

Results
Between the time period August 2012 to August 2015, a total of 218 participants attended one of 33 different LSF retreats classified as Individual (20), Group (7), or MST (6). Of these participants, 167 (76.6%) provided pre-retreat and post-retreat program outcome data (Table 1, Figure 1). Overall, 41% of LSF retreat participants were female and 67% were of white race. Symptomatology was high with 85% of participants screening positive for mTBI and the majority of participants screening positive on the PDSQ subscales for PTSD (90%), major depressive disorder (66%), generalized anxiety disorder (69%), somatization disorder (62%), social phobia (72%), and agoraphobia (75%). There were no statistically significant differences in the prevalence of demographic and clinical characteristics between participants with and without complete program evaluation data.

Lone Survivor Foundation (LSF) Retreats: 2012-2015

![Flowchart](image)

Figure 1. Flowchart of Lone Survivor Foundation (LSF) retreat participants by type of retreat attend and completion of program evaluation data.
Presenting Characteristics by Type of Retreat.

The Individual LSF retreats consisted primarily among male Veterans with previous combat-related exposure, whereas Group LSF retreats consisted of Veterans and their spouse/significant other, and MST LSF retreats consisted of female Veterans only (Table 2). Both Individual and Group retreat participants screened particularly high for mTBI, whereas nearly all of the Individual and MST participants screened positive for PTSD. Hence, mean PTSD scores on the PCL-M and global psychopathology scores on the PDSQ were significantly higher among Individual and MST retreat participants compared to Group retreat participants. None of the Group or MST retreat participants screened positive for drug

Table 1. Comparison of LSF Participant Presenting Characteristics by Completion of Program Evaluation Data

<table>
<thead>
<tr>
<th>Characteristic*</th>
<th>All (n=218)</th>
<th>Program Evaluation Data</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No (n=51)</td>
<td>Yes (n=167)</td>
</tr>
<tr>
<td>Female gender (%)</td>
<td>40.8</td>
<td>52.4</td>
<td>37.8</td>
</tr>
<tr>
<td>Race/ethnicity (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td>4.3</td>
<td>5.9</td>
<td>4.0</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>25.0</td>
<td>17.6</td>
<td>26.7</td>
</tr>
<tr>
<td>Native American</td>
<td>3.3</td>
<td>0.0</td>
<td>4.0</td>
</tr>
<tr>
<td>White</td>
<td>67.4</td>
<td>76.5</td>
<td>65.3</td>
</tr>
<tr>
<td>Screen positive for mTBI (%)</td>
<td>85.1</td>
<td>87.1</td>
<td>84.6</td>
</tr>
<tr>
<td>Screen positive on PDSQ subscale (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-traumatic stress disorder (PTSD)</td>
<td>89.7</td>
<td>90.5</td>
<td>89.5</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>66.2</td>
<td>71.4</td>
<td>64.8</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>69.1</td>
<td>71.4</td>
<td>68.5</td>
</tr>
<tr>
<td>Psychosis</td>
<td>40.7</td>
<td>42.9</td>
<td>40.1</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>22.6</td>
<td>19.1</td>
<td>23.5</td>
</tr>
<tr>
<td>Somatization disorder</td>
<td>62.1</td>
<td>73.8</td>
<td>59.0</td>
</tr>
<tr>
<td>Social phobia</td>
<td>71.9</td>
<td>78.6</td>
<td>70.2</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>22.2</td>
<td>23.4</td>
<td>21.6</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>74.6</td>
<td>78.1</td>
<td>73.8</td>
</tr>
<tr>
<td>Hypochondriasis</td>
<td>42.6</td>
<td>45.2</td>
<td>41.9</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>26.2</td>
<td>29.3</td>
<td>25.5</td>
</tr>
<tr>
<td>Drug abuse/dependence</td>
<td>8.5</td>
<td>17.1</td>
<td>6.3</td>
</tr>
<tr>
<td>PCL-M Score: DSM-IV (mean ± SD)**</td>
<td>58.3 (16.5)</td>
<td>58.8 (16.3)</td>
<td>58.2 (16.7)</td>
</tr>
<tr>
<td>PCL-M Score: DSM-V (mean ± SD)**</td>
<td>53.0 (15.5)</td>
<td>55.8 (15.8)</td>
<td>52.4 (15.5)</td>
</tr>
<tr>
<td>PDSQ total score (mean ± SD)</td>
<td>55.9 (21.8)</td>
<td>57.8 (21.2)</td>
<td>55.4 (21.9)</td>
</tr>
<tr>
<td>STICSA score (mean ± SD)</td>
<td>48.2 (14.5)</td>
<td>50.2 (13.1)</td>
<td>47.8 (14.8)</td>
</tr>
<tr>
<td>Pain inventory score (mean ± SD)</td>
<td>25.7 (9.9)</td>
<td>26.3 (9.2)</td>
<td>25.6 (10.0)</td>
</tr>
</tbody>
</table>

*Participants were not required to provide demographic information. Missing cases: gender (115); race/ethnicity (126); screening positive for mTBI (44); PDSQ subscale scores (14). mTBI: Mild traumatic brain injury. PDSQ: Psychiatric Diagnostic Screening Questionnaire. STICSA: State Trait Inventory of Cognitive and Somatic Anxiety. **Late in the program, evaluation of PTSD symptoms was switched from the PCL-M DSM-IV version (n=156) to the PCL-M DSM-V version (n=48).
abuse/dependence, whereas 26% of all participants screened positive for alcohol abuse.

**Program Evaluation Measures**

The majority of participants (76.0%) completed the 17-item DSM-IV PCL-M for assessment of PTSD symptomatology before the LSF program switched to the use of the 20-item DSM-V PCL instrument. Among all participants, mean score on the 17-item DSM-IV PCL-M dropped substantially from $58.2 \pm 16.7$ at the beginning of the retreat to $36.7 \pm 15.6$ (mean difference $= 21.5 \pm 15.7$; effect size $= 1.37$, 95% confidence interval: 1.13, 1.61, $p < 0.0001$) (Table 3). Similar substantial reductions were reported on the 20-item DSM-V PCL checklist for PTSD, as well as the PDSQ global measure of psychopathology ($p < 0.0001$). For all 167

<table>
<thead>
<tr>
<th>Characteristic*</th>
<th>All ($n=167$)</th>
<th>Type of Retreat</th>
<th>$p$-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Individual ($n=93$)</td>
<td>Group ($n=46$)</td>
</tr>
<tr>
<td>Female gender (%)</td>
<td>37.8</td>
<td>7.7</td>
<td>55.9</td>
</tr>
<tr>
<td>Race/ethnicity (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td>4.0</td>
<td>5.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>26.7</td>
<td>27.0</td>
<td>26.7</td>
</tr>
<tr>
<td>Native American</td>
<td>4.0</td>
<td>2.7</td>
<td>6.7</td>
</tr>
<tr>
<td>White</td>
<td>65.3</td>
<td>64.9</td>
<td>66.7</td>
</tr>
<tr>
<td>Screen positive for mTBI (%)</td>
<td>84.6</td>
<td>96.7</td>
<td>92.2</td>
</tr>
<tr>
<td>Screen positive on PDSQ subscale (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-traumatic stress disorder (PTSD)</td>
<td>89.7</td>
<td>97.7</td>
<td>71.7</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>66.2</td>
<td>73.0</td>
<td>47.8</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>69.1</td>
<td>70.8</td>
<td>58.7</td>
</tr>
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<td>Psychosis</td>
<td>40.7</td>
<td>51.7</td>
<td>19.6</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>22.6</td>
<td>27.0</td>
<td>13.0</td>
</tr>
<tr>
<td>Somatization disorder</td>
<td>62.1</td>
<td>62.9</td>
<td>48.9</td>
</tr>
<tr>
<td>Social phobia</td>
<td>71.9</td>
<td>72.7</td>
<td>67.4</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>22.2</td>
<td>19.1</td>
<td>21.7</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>74.6</td>
<td>82.9</td>
<td>54.3</td>
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<tr>
<td>Hypochondriasis</td>
<td>42.6</td>
<td>46.6</td>
<td>33.3</td>
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<tr>
<td>Alcohol abuse</td>
<td>26.2</td>
<td>29.6</td>
<td>17.4</td>
</tr>
<tr>
<td>Drug abuse/dependence</td>
<td>8.5</td>
<td>11.5</td>
<td>0.0</td>
</tr>
<tr>
<td>PCL-M Score: DSM-IV (mean $\pm$ SD)**</td>
<td>58.2 (16.7)</td>
<td>63.5 (12.7)</td>
<td>46.6 (19.3)</td>
</tr>
<tr>
<td>PCL Score: DSM-V (mean $\pm$ SD)**</td>
<td>54.3 (15.5)</td>
<td>53.2 (16.4)</td>
<td>48.3 (14.8)</td>
</tr>
<tr>
<td>PDSQ total score (mean $\pm$ SD)</td>
<td>55.4 (21.9)</td>
<td>59.5 (20.1)</td>
<td>46.0 (23.0)</td>
</tr>
<tr>
<td>STICSA score (mean $\pm$ SD)</td>
<td>47.8 (14.8)</td>
<td>50.4 (14.3)</td>
<td>42.2 (14.6)</td>
</tr>
<tr>
<td>Pain inventory score (mean $\pm$ SD)</td>
<td>25.6 (10.0)</td>
<td>26.0 (9.4)</td>
<td>22.3 (10.5)</td>
</tr>
</tbody>
</table>

*Participants were not required to provide demographic information. Missing cases: gender (85); race/ethnicity (92); screening positive for mTBI (24); PDSQ subscale scores (7). mTBI: Mild traumatic brain injury. PDSQ: Psychiatric Diagnostic Screening Questionnaire. STICSA: State Trait Inventory of Cognitive and Somatic Anxiety.

**Late in the program, evaluation of PTSD symptoms was switched from the PCL-M DSM-IV version ($n=127$) to the PCL-M DSM-V version ($n=40$).
Figure 2. Plot of change scores on the PTSD checklist (DSM-IV PCL-M or DSM-V PCL) before and at the end of attending a Lone Survivor Foundation retreat. Each vertical line represents the response of an individual retreat participant. The dashed horizontal line represents a clinically meaningful and reliable reduction of >10 points on the PTSD checklist.

Table 3. Effect Size Estimates for Evaluation Measures and by Type of Retreat Attended

<table>
<thead>
<tr>
<th>Evaluation Measure</th>
<th>All Participants</th>
<th>Pre-retreat Mean</th>
<th>Post-retreat Mean</th>
<th>Difference Mean</th>
<th>Effect size</th>
<th>95% C.I.</th>
<th>p-value</th>
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</thead>
<tbody>
<tr>
<td>PCL-M Score: DSM-IV (n=127)</td>
<td></td>
<td>58.2</td>
<td>16.7</td>
<td>36.7</td>
<td>15.6</td>
<td>21.5</td>
<td>15.7</td>
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<td>PCL Score: DSM-V (n=40)</td>
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<td>17.6</td>
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<td>PDSQ total score (n=159)</td>
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<td>22.0</td>
<td>25.1</td>
<td>19.4</td>
<td>30.4</td>
<td>24.1</td>
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<tr>
<td>STICSA score (n=121)</td>
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<td>47.8</td>
<td>14.8</td>
<td>37.4</td>
<td>12.9</td>
<td>10.4</td>
<td>12.6</td>
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<tr>
<td>Pain inventory score (n=101)</td>
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<td>26.6</td>
<td>9.6</td>
<td>18.9</td>
<td>9.4</td>
<td>7.7</td>
<td>9.0</td>
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<table>
<thead>
<tr>
<th>Individual Participants</th>
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<td>PCL-M Score: DSM-IV (n=71)</td>
</tr>
<tr>
<td>PCL Score: DSM-V (n=22)</td>
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<tr>
<td>PDSQ total score (n=88)</td>
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<tr>
<td>STICSA score (n=68)</td>
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<td>Pain inventory score (n=70)</td>
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<td>PCL Score: DSM-V (n=7)</td>
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<td>PDSQ total score (n=45)</td>
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<td>STICSA score (n=36)</td>
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<td>Pain inventory score (n=24)</td>
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<table>
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<tr>
<th>MST Participants</th>
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<tbody>
<tr>
<td>PCL-M Score: DSM-IV (n=17)</td>
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<tr>
<td>PCL Score: DSM-V (n=11)</td>
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<td>PDSQ total score (n=27)</td>
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<tr>
<td>STICSA score (n=17)</td>
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<tr>
<td>Pain inventory score (n=15)</td>
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</tbody>
</table>
participants with complete data, the mean reduction on the PTSD checklist (DSM-IV PCL-M/DSM-V PCL) was 24.1 ± 16.8 points, p<0.0001) (Figure 2). Overall, 77% of LSF retreat participants reported a reduction of >10 points on the PTSD checklist, a metric sometimes used to indicate statistically reliable and clinically meaningful change (Monson et al., 2008). Significant acute mean reductions in anxiety and pain were also reported among the LSF retreat participants.

In analyses stratified by type of LSF retreat, the mean reduction on the PTSD checklist was 30.7 ± 15.4 points for MST retreat participants, 25.4 ± 17.1 points for Individual retreat participants, and 17.5 ± 15.1 points for Group retreat participants (Table 3, Figure 2). The corresponded to rates of reliable and clinically meaningful change (>10 point reduction) of 92.9%, 80.6%, and 63.0%, respectively. Thus, the acute response for reduction in PTSD symptomatology was particularly strong for the 28 female Veterans who attended the MST retreats. As seen in Table 3, effect size estimates for reductions in global psychopathology (PDSQ), anxiety (STICSA), and pain were generally modest to large in magnitude across all types of retreat participants.

**Discussion**

As with the large number of U.S. not-for-profit foundations in existence with the primary mission of assisting Veterans, the LSF strives to restore, empower, and renew hope for U.S. wounded service members and their families through health, wellness, and therapeutic support. A principal activity of the LSF is the routine conduct of 3-day therapeutic retreats that include the core components of psycho-education, equine-assisted learning, behavioral consultation, and brief trauma-focused treatment. In addition to utilizing a holistic therapeutic approach, the LSF retreats are conducted over a brief 3-day period (weekend) and in remote locations believed to be conducive to emotional and physical healing. While not formally manualized or evidence-based, the LSF therapeutic retreat program responds, at least in part, to the sobering reality that a large percentage of Veterans enrolled in conventional treatment programs for PTSD (e.g. PE/CPT) do not complete a minimally acceptable number of treatment sessions to have a reasonable expectation of recovery (Harpaz-Rotem & Rosenheck, 2011; Lu, Duckart, O’Malley, & Dobscha, 2011; Spoont, Murdoch, Hodges, & Nugent, 2010).

In the present program evaluation analysis, the acute clinical response reported by retreat participants was substantial, with large statistically significant reductions reported for measures of PTSD, global psychopathology, anxiety, and pain. A particularly strong reduction in symptoms of PTSD was reported for the 28 female participants with a history of MST who attended LSF retreats, and with an emphasis on addressing this particularly virulent form of trauma. Whereas it is postulated that all four of the major components of the retreat (described above) conferred benefit to these participants, brief trauma-focused therapy with Accelerated Resolution Therapy (ART) has been shown to be effective among both female civilians and military personnel with a history of sexual trauma (Kip et al., 2015).
This initial program evaluation of the LSF therapeutic approach cannot conclude sustained clinical benefit to its retreat attendees, but does offer a potentially compelling alternative model to current mental health treatment available and provided to Veterans within conventional facilities. Specifically, conventional evidence-based treatments, including PE and CPT, are underutilized in both the civilian and Veteran service sectors (Becker, Zayfert, & Anderson, 2004; Shiner et al., 2013), and both PE and CPT have been promulgated as first line-therapies of choice for Veterans with PTSD treated within VA facilities (Karlin et al., 2010). Whereas PTSD patients consistently report a preference for the use of psychological intervention over psychopharmacology (Becker et al., 2009; Feeny, Zoellner, & Kahana, 2009), research also indicates that patient preference and choice in their specific type of mental health treatment is important and associated with less drop out and better clinical outcomes (Swift & Callahan, 2009). These findings call for greater accessibility of mental health treatment options for Veterans with PTSD. In this realm, it is notable that current proposed federal legislation, known as the Creating Options for Veterans’ Expedited Recovery (COVER) Act (U.S.Congress, 2015), aims to provide greater Veteran access to “alternative” therapies, including equine therapy and Accelerated Resolution Therapy (i.e. major components of the LSF retreats).

**Strengths and Limitations**

Strengths of this analysis include a large number of Veterans and family members evaluated using validated self-report measures of PTSD, global psychopathology, anxiety, and pain, and delivery of the 4 main components of the LSF therapeutic retreat model in a consistent manner. Limitations include outcome data collected as part of overall program evaluation and not as part of a formal research protocol, use of symptom scales (e.g. PCL-M) rather than formal diagnostic methods, lack of a control condition to compare the magnitude of results reported, assessment of acute response only, and 23% of retreat participants who did not provide post-retreat outcome evaluation data. Regarding the latter, comparison of participants with and without complete evaluation data did not identify a particular source of bias such as differential clinical presentation, yet cannot determine whether participants without complete data reported a similar level of overall benefit from retreat participation. In addition, the results do not permit examination of the effects of the individual components of LSF retreat program, such as provision of psycho-education versus the more active (therapeutic) elements of equine-assisted learning and Accelerated Resolution Therapy.

**Conclusions**

While preliminary, 4-year assessment of the 3-day LSF therapeutic retreat program indicates that Veterans and family members with significant psychological challenges and trauma experienced substantial acute benefits in reducing symptoms of PTSD, global psychopathology, anxiety, and pain. These data suggest formal research study of this model for Veterans with PTSD, in addition to examination of the effects of the individual components of the program.

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References


National Veterans Wellness and Healing Center
A Seven-Day Intensive Retreat Model for Veterans with Combat Stress and Their Families

Colonel Ron Ford, USAF (Ret)
Program Director

Background
Nestled in the beautiful mountains of Northern New Mexico, the National Veterans Wellness and Healing Center (The Center) in Angel Fire is responding to needs of Veterans with Post Traumatic Stress Disorder (PTSD) and their families with a unique retreat model (Veteranswellnessandhealing.org). In 2009, a group of Veterans and other citizens of Angel Fire led by Colonel Chuck Howe, USA (Ret), current President of The Center, worked with the New Mexico Department of Veterans Services, community businesses, and volunteers to establish an organization to help Veterans and their families. It was clear to them then, and it has become clearer since, that there is a great need for complementary and alternative services beyond those provided by the U.S. Department of Veteran Affairs (VA) and state and local agencies.

From the beginning, The Center’s founders recognized the potential benefit of an intensive, seven-day retreat format focused on Veteran couples (Veteran and a support person). While this model has continued, the content and process have evolved over time. In 2014, Mary Scott, Co-Program Director, and I were asked by The Center to work with the New Mexico Departments of Behavioral Health and Veteran Services to provide a program specifically directed at meeting the unmet needs of Veterans diagnosed with PTSD and their families. It was imperative that we have a clear understanding of what needs were not being met.

Unmet Needs
Relying on published research, particularly three extensive studies by the RAND Corporation (Tanielian et al., 2008; Watkins, et al., 2011; Kurz, 2015), we saw a pattern of behavioral health needs related to PTSD. We also had direct feedback from Veterans and their families whom had sought help from traditional sources. Not surprisingly, Veteran’s reports and research results were very similar. Identified needs included:

- Ability to get appointments and be seen on a consistent basis
- Consistency in timing of therapy sessions and assigned therapist
- Therapy for partners and family
- Alternatives to drugs
- Therapist with military experience and understanding of combat stress
- Consistent approaches to treatment by various providers
- Greater effectiveness and faster results from the therapeutic methods used
- Affordable, confidential, flexible and understandable alternative treatment approaches that do not involve the complexity and stigma of those available through traditional sources.
Focusing on these needs and using a seven-day intensive retreat model, we developed a couples-focused healing experience using diverse holistic modalities in a unique setting, while maintaining a balance of concentrated group and individual activities and time for contemplation, meditation, relaxation, and informal interaction with staff and other participants. We recognize that all or most of the Veteran participants are currently in or have been in Department of Defense (DOD), Veterans Administration (VA) or private treatment programs using traditional therapies and/or pharmacological treatment. Our strategy intentionally avoids duplication, and relies on these agencies for long-term continuing care. We embrace the use of alternative modalities and alternative staff with diverse skills, training, and backgrounds, including a component of staff with military combat experience.

In 2014, the Center won a competitively awarded four-year contract from the Department of Behavioral Health to deliver our retreats to Veteran families who live in New Mexico. We serve Veterans from other states, using donations from other sources. We have had land donated to build a permanent treatment facility in Angel Fire, and are currently raising funds for the facility as well as for future retreats.

The Seven-Day Intensive Retreat Model
A significant benefit of the National Veterans Wellness and Healing Center Model is its inclusion of over 50 hours of structured educational and therapeutic healing experiences addressing Mind, Heart, Body and Soul. Our model recognized that PTSD requires healing in all these areas. The “intensive” sessions in our retreats are balanced with time for relaxation, contemplation and communication between partners and among participants. We strongly encourage all to “unplug”, turning off all electronics. Comments include: “Being unplugged, we spent more time talking to each other than we have in years”, and “They told us this was a retreat, but all we did was charge forward”.

The program focuses on three main areas: Post Traumatic Stress (PTS), Moral Injury/Wounding, and Relationships. We drop the “D” from PTSD in our model, encouraging participants to shift their language and thinking from “something is wrong with me (him or her)” to “something happened to me (him or her)”. We have incorporated the concept of Moral Wounding during the last two years in recognition of the complex connections between Moral Wounding and PTS, and their impact on individual identity and the couple’s relationship. Also, we focus equally on partners as well as Veterans. Many partners arrive with their own symptoms of PTS (some with a diagnosis of PTS). Relationship building is integral to all aspects of our retreats, focusing not only on the couple’s relationship, but on extended relationships as well. At the end of one retreat, one couple stated: “This retreat was our last hope. We arrived on the verge of divorce, and left with a commitment to renew our vows”.

Beginning on day one of each retreat, we challenge the participants with three questions:

1. Are you living the life you want to live?
2. Do you have the relationships you want to have?
3. Are you being the person you want to be? *In spite of what has happened to you.*

We work with partners to create the desire and expectation to make changes neces-
necessary to answer yes to each of these questions. We use a carefully structured process to provide information, understanding, tools, and techniques to help prepare them for the journey toward “yes”.

The retreat offers a balance of group, couple and individual experiences. Early sessions provide opportunities for participants to develop into a community of trust, both among themselves and with the staff. We have had participants from all wars, ranging from WW II to Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). The dynamic interactions among older and younger participants are a powerful element of the healing process.

The first full retreat day captures the outdoor beauty and Native American heritage of New Mexico. It includes an equine experience that encourages participants to ride horses for the first time, ride again after many years, ride despite physical injuries, or simply interact with horses, including grooming them. This experience is followed by our initial Native American-based Welcoming Home gathering, along with a fireside ritual of setting an intention for themselves and for their week at the National Veterans Wellness and Healing Center.

As the week progresses, strong relationships of trust and friendship are developed. The staff uses this dynamic to facilitate sharing and learning among the participants. Morning and evening group sessions are conducted to develop a shared understanding of PTS and Moral Wounding among the Veterans and their partners, and to introduce techniques and tools to cope with these challenges.

Afternoon sessions target couples and individuals, including a mandatory one-hour counseling session for each couple with a counselor who works with them for the entire week. Participants attend alternative modalities sessions, such as yoga, massage, Reiki, and acupuncture, for two hours each day. One evening is dedicated to “Veterans only” and “partners only” group sessions. One session provides instruction in navigating the ins and outs of the VA. Couples are encouraged to use their free time for reflection, contemplation, and interaction with one other and other participants.

A key element of the model requires individual participants and each couple to strategize with staff to create and com-
mit to an action plan to put what they have learned at the retreat into practice at home. This brief but powerful document outlines specific agreed-on goals for each individual and for their relationship. It also allows participants to document their breakthroughs, while increasing insight into erroneous thinking and/or faulty behaviors that limit progress and growth.

Experiential Education (EE) sessions each day are devoted to group education, exercises, tools, and techniques to help identify, make and sustain behavior changes in four areas: mind, heart, body and soul. The objective is to teach participants how the brain and body respond to stress and trauma, and provide tools and techniques for reducing the impact of trauma symptoms. Sessions incorporate elements of Cognitive Processing Therapy, Energy Psychology, Guided Imagery and Relationship Building. This includes discovering and identifying perceptions and antecedents that contribute to undesirable behaviors and consequences. Existing perceptions are challenged and alternatives examined. Demonstrations and exercises to improve communications and deal with symptoms and triggers are included throughout the program. As tools and techniques are presented, participants are encouraged to choose and practice those which they feel will be most helpful going forward.

Evaluating Results – How Are We Doing?
Program evaluation is addressed in three areas: formal assessments using the Diagnostic and Statistical Manual of Mental Disorder V PTSD Checklist (PCL); comparing program results with the unmet needs identified above; and feedback from participants. Since 2009, The Center has conducted 23 healing retreats for a total of 293 couples. We use the PCL to assess each individual (Veteran and partner) within two weeks prior to the retreat, on the last retreat day, and approximately 6 and 12 months post-retreat.

Following 10 retreats conducted in 2011, research conducted by an independent organization analyzed the results of six retreats, including data on 149 Veteran couples (298 individuals). The results were published in The Journal of Science and Healing (Church, et al., 2014). All 149 Veterans had received a diagnosis of PTSD from the VA. Comparison of Veteran scores on beginning and end of program PCL-M showed 67% of the Veterans lowered their scores to below the diagnostic threshold of 49. Overall, Veterans showed a 32% decrease in PCL-M scores. This is based on average point reduction of 19.3. The VA National Center for PTSD’s guidance on the use of the PCL states “…a 10-20 point change is clinically meaningful” (Monson et al., 2008). Twenty-nine percent of the supporting partners met the clinical criteria for PTSD at the beginning of the program based on PCL-C results. Comparison of supporting partners’ scores on beginning and end of program PCL-C showed 83% of the partners that had initially met the criteria for PTSD lowered their scores to below the diagnostic threshold of 49. Overall, the supporting partners showed a 34% decrease in PCL-C scores. A six-month follow-up using the PCL for Veterans and their supporting partners showed that the Veterans had maintained the results achieved in the program, and the supporting partners had lowered their scores significantly.
As measured against the unmet needs listed above:

- We provide six counseling sessions and over 50 hours of structured healing in a seven day period. This is more than many Veterans get in two years from agency providers.
- Couples are assigned to one counselor for sessions throughout the week, providing desired consistency and continuity.
- Veterans and partners are included, and needs of each and of the relationship are addressed.
- A variety of alternatives to pharmacological treatment are introduced, allowing participants to select what works for them.
- Many of our staff have military experience, and all staff have experience with PTS.
- Working with the same staff each day who are working as a team provides desired consistency.
- Center empirical and anecdotal results indicate excellent effectiveness after one week retreat.
- Retreats are at no cost to participants except for travel to and from Angel Fire.
- The Center is committed to the highest level of confidentiality; all data collection is tracked by number only.
- We go to great lengths to educate and explain all aspects of our retreat process, avoiding “psychobabble” and stigma.

In addition to PCL measures, all participants complete a comprehensive end-of-program feedback form. This allows participants to identify the level of benefit received from various modalities, other aspects of the overall program that were particularly beneficial, and areas that might need changes or improvements. Examples of comments on the feedback form include:

- “I cannot fully describe how much this retreat has & will improve my/our lives.”
- “A great weight has been lifted. I have a new understanding of my partner.”
- “I was finally able to let go of all the guilt I was feeling about my trauma.”
- About a couple’s counselor: “What a knowledgeable man. Through his life experiences and active listening and invaluable feedback, my wife and I now have the tools to communicate & the awareness of each other’s feelings that had been lost over the years.”
- “… and all the staff that I had went out of their way to show me a better way of life, and plenty of tools to do so, and how I may be the person I want to be.”

Photo Credit: National Veterans Wellness and Healing Center, Angel Fire, New Mexico
• “… was able to connect and help me be honest with myself and be who I need to be. I greatly appreciated how he put emphasis on the needs of my spouse as well and made her feel human and better about herself.”
• “I received more benefit from this week than I have received in 10 years of VA counseling.”

Additional participant feedback indicates a higher level of comfort with and greater benefit from The Center model’s use of alternative modalities and our staff than with the traditional treatments provided by federal, state and local agencies/clinics. The National Veterans Wellness and Healing Center’s mission will continue to strive to provide state of the art healing interventions in an intensive retreat format that complements interventions by others, in order to meet the unmet needs of all our Veterans and partners.

**About the Author**

**Colonel Ronald D. Ford**

For the past 40 years, Ron Ford has been leading businesses, technical teams, organizations and individuals in accomplishing significant missions. His experience includes senior management positions with a Fortune 50 company, President and CEO of three high technology small businesses, and a distinguished 20-year career in the U.S. Air Force where he was a command pilot and attained the rank of Colonel. In the leadership roles he has held, he provided mentoring, guidance and coaching to individuals, helping them and their organizations make the changes necessary to overcome significant obstacles. Ron is a Vietnam combat Veteran serving multiple tours for a total of 22 months during which he flew over 200 combat missions. He holds a Master of Arts Degree in Psychology. Ron has served as a Program Director of the National Veterans Wellness and Healing Center’s retreats since 2012. Prior to and during his tenure as Program Director, he has served as counselor for approximately 100 participants.

**References**


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