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Veteran Couples Integrative Intensive Retreat Model: An Intervention for Military Veterans and Their Relational Partners

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ABSTRACT

Military veterans are among those most affected by posttraumatic stress disorder (PTSD) due to combat-related experiences and are often reluctant to seek long-term services. Trauma is commonly associated with distress for veterans as well as their partners, which makes it important for both individuals within a couple to receive mental health care. There are few brief programs, however, that provide these needed services for both active military and veteran couples who may still suffer from the effects of trauma. The authors provide a description and evaluation of a brief couples retreat model program aimed at reducing distress for veterans and their partners. A total of 149 couples (298 individuals) participated in weeklong retreat-style interventions. Results showed that trauma symptoms were significantly reduced for veterans, and partners reported a decrease in distress after the intervention. Although the magnitude of this effect diminished over time, there was evidence of long-term treatment effects at a 6-month follow-up. Results support the efficacy of this program, but the authors call for further research to provide additional evidence of treatment outcomes in this population.

KEYWORDS

Traumatic stress; military couples; health and well-being; integrating creative, experiential approaches to couples therapy; multi-couple group treatment

Introduction

The lifetime risk for posttraumatic stress disorder (PTSD) is approximately 8.7% in the United States (American Psychiatric Association, 2013). Veterans and those who have experienced military deployments into combat specifically are among the populations at the greatest risk for developing PTSD (American Psychiatric Association, 2013), and there is a marked increase in rates of PTSD, anxiety, and depression symptoms in soldiers after deployment (see Hoge et al., 2004). Scholars estimate that the prevalence of PTSD for Vietnam veterans ranges from 18% to 54% (see Stretch, 1986; see also Zatzick et al., 1997) and about 16% to 30% for veterans of the recent

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conflicts in Iraq and Afghanistan (see Miller et al., 2013; see also Vaughan, Schell, Tanielian, Jaycox, & Marshall, 2014) depending on the sample. PTSD is alarming due to the fact that symptoms can include involuntary and intrusive memories of traumatic events, negative recurrent nightmares, persistent negative beliefs and emotional state, self-destructive behavior, prolonged distress, feeling detached or emotionally numb, sleeping difficulties, hypervigilance, outburst of anger, and concentration difficulties (American Psychiatric Association, 2013).

Combat exposure is the most commonly endorsed trauma from military service (Miller et al., 2013), and these combat experiences are associated not only with negative mental health outcomes but also with relational difficulties (see Monson, Taft, & Fredman, 2009; Nelson Goff, Crow, Reisbig, & Hamilton, 2007, 2009). Few services, however, focus on the interpersonal and systemic effects of trauma, and although there are mental health services for active duty personnel, as well as services through the Department of Veterans Affairs (VA) for military veterans, some individuals are reluctant to seek extended services once they have left the military (Kehle et al., 2010). In addition to the reluctance to seek services, veterans also have a high rate of dropout in longer treatments (Imel, Laska, Jakupcak, & Simpson, 2013; see also Hoge, 2011). To mitigate these problems, we sought to evaluate a brief retreat model that focused on veterans and their partners with a goal of reducing distress.

From a systems perspective, if the family and social support systems are not considered when intervening, a treatment may not be as effective for individual clients as they return to their home environment after intervention (see Ford & Saltzman, 2009). This need for systemic integration is present in recent prevention and treatment recommendations from the Institute of Medicine (IOM) for the Department of Defense (DoD; see IOM, 2013, 2014). In their report, the IOM (2013) argues that a more systematic and coordinated approach is needed to support programs for military veterans *and* their partners across the life-span as many veteran couples do not get the help they need. In addition, many military personnel report that they would be more interested in treatment if the interventions were family focused (Khaylis, Polusny, Erbes, Gewirtz, & Rath, 2011) and this inclusion of family, such as intimate partners, can provide support for veterans (see Sautter, Armelie, Glynn, & Wielt, 2011). Although strides have been made (e.g., the initiative to increase access to marriage and family therapists at Veterans Health Administration treatment centers; see Department of Veterans Affairs, 2010; see also Karlin & Cross, 2014), it seems that this systems philosophy has not been fully integrated into practice (see MacDermid Wadsworth et al., 2013). Therefore, the present clinical model incorporates the partner as a primary support in an effort to address some of the systemic, interpersonal issues commonly faced by military families.

Interpersonal Effects of Trauma for Veteran Spouses or Caregivers

In addition to family or couple interventions making veterans more comfortable seeking treatment, systemic treatment (see Nelson Goff & Smith, 2005) should be

considered when assessing and treating those who may experience symptoms associated with traumatic stress, even if clients were not directly exposed to their partner's traumatic combat event. In fact, vicarious, indirect exposure and subsequent acquisition of secondary trauma symptoms are a realistic possibility for partners of service members (Figley, 1995; see also Nelson Goff et al., 2007, 2009). Vicarious traumatization or secondary trauma refers to a condition where traumatic stress symptoms are transmitted to a partner or another person from interaction with the traumatized individual (Salston & Figley, 2003). Further, according to new criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013), individuals who learn "that the traumatic event(s) occurred to a close family member" or experience "repeated or extreme exposure to aversive details of the traumatic event(s)" (p. 271) may be at risk for developing PTSD themselves. It can be difficult for those with secondary trauma symptoms (or traumatic stress themselves) to cope with their own stressors, as they have taken on the distress of the traumatized individual (Figley, 1995; Salston & Figley, 2003).

Renshaw and colleagues (2011) suggest, however, that most distress felt by partners of service members may be due to general psychological distress, instead of developing secondary traumatic stress directly from a partner's PTSD. In fact, less than 20% of spouses attributed their distress completely or directly to their service members' military experience (Renshaw et al.). Although distress felt by the partners of service members with trauma may not always be due to secondary trauma, trauma symptoms can create distressing interaction or impairments in relationship quality (e.g., Nelson Goff et al., 2007, 2009). This interaction can include, for example, a felt experience of living with a partner's trauma reactions (e.g., being startled by a spouse's angry outburst; see Renshaw et al.) or projective identification and conflict (see Nelson Goff & Smith, 2005). Thus, for the purposes of this report, we use the more general term "distress" when including the reactions of partners who may not have been directly exposed to traumatic events.

The interpersonal impairments that accompany PTSD can lead to further distress (see Monson et al., 2009) and can influence the course of recovery for veterans and partners. In a recent meta-analysis, Taft, Watkins, Stafford, Street, and Monson (2011) found a significant association between PTSD and intimate relationship problems (i.e., relationship discord, partner physical or psychological aggression) for this population across 31 studies, and this association was stronger in military than in civilian samples. In fact, PTSD symptoms including persistent and exaggerated negative beliefs or expectations about oneself or others, detachment or estrangement from others, persistent inability to experience positive emotions (e.g., loving), problems with concentration, irritable behavior, and angry outbursts can all interfere with relational functioning (see American Psychiatric Association, 2013).Thus, there is a critical need for treatment models that account for these difficulties associated with PTSD symptomatology (Taft et al., 2011) and address systemic concerns by including relational partners in treatment (see also Riggs, 2000).

Although distress associated with trauma as well as relationship difficulties are treated in individual work, if one member of the dyad does not attend therapy, his or her distress may go unaltered even if meaningful change is implemented by the member who did attend therapy (see MacDermid Wadsworth et al., 2013, for more information on advantages of systems care and existing systems approaches in military contexts). From a systems perspective, partners can also unknowingly interfere with trauma recovery. This interference, for example, can occur in the form of change back messages (i.e., feedback loops) from partners as they react to the veterans' symptoms during the change process of therapy (see Blount et al., 2014; Ford & Saltzman, 2009; Nelson Goff & Smith, 2005; see also Knobloch & Theiss, 2011, for a discussion about interference from partners in military couples). For many of these couples, interpersonal difficulties are common presenting issues and motivators for seeking services (Interian, Kline, Callahan, & Losonczy, 2012), and these difficulties can be strongly tied to trauma symptoms (see Monson et al., 2009). Therefore, the present treatment model specifically incorporates partners into the intervention to provide them with psychoeducation and therapeutic resources, and to assess their distress in addition to veterans' trauma symptoms. This research is of critical importance as few studies have evaluated veteran couple interventions (see Monson & Feldman, 2012; Sautter, Glynn, Thompson, Franklin, & Han, 2009, for examples of a few of the notable exceptions) and there is a dearth of research assessing both partners through interventions. For example, most veteran couple treatments only assess the PTSD-identified partners' symptoms and, thus, partner-reports are of the veteran's symptoms (e.g., Monson et al., 2011; Sautter et al., 2009; see also Monson, Schnurr, Stevens, & Gutherie, 2004).

Existing Retreat and Couple/Family Focused Programs for Service Members

Although there is a need for more services that are systemic in military contexts (MacDermid Wadsworth et al., 2013), there are some existing initiatives that work with military personnel and their support systems. Existing brief, retreat-style programs that focus on reducing trauma or reintegration distress for military couples and families (e.g., Families Over-Coming Under Stress [FOCUS; Lester et al., 2011; Saltzman et al., 2011], Coming Home Project [Bobrow, Cook, Knowles, & Vieten, 2013], and Operation Restoration [Davis et al., 2012]), however, seem primarily aimed at active duty or recently deployed service members who are currently affiliated with the military and their families. Thus, veterans and their partners who are no longer affiliated with the military may go untreated.

In addition to typically being delivered to current service members, many other programs provided to couples often focus on reducing relationship difficulties. For example, the Prevention and Relationship Enhancement Program (PREP) for Strong Bonds (Stanley, Allen, Markman, Rhoades, & Prentice, 2010; see also Stanley et al., 2005) is an initiative intended to strengthen the relationships of service members and their partners and offers retreat or group model relationship education

services for military couples. Although they have curricula that address reintegration after deployment, these programs primarily target relationship processes in current military-affiliated couples and do not have a core focus on providing information about trauma or PTSD. In fact, there are very few evaluations of programs aimed at helping reduce distress in veteran couples, with the exception of a few couple therapy interventions (e.g., Doss et al., 2012; Schumm, Fredman, Monson, & Chard, 2013). In addition to a focus on veterans and their partners, service providers have called for further investigation into brief workshop or retreat style treatments for service members and their support systems to assess whether benefits are clinically significant (Bobrow et al., 2013). We assess one such brief, retreat style treatment in the present study.

The Veteran Couples Integrative Intensive Retreat (VCIIR) Model: A Community-Based Holistic Approach to PTSD

Due to the fact that few other models focus on traumatic stress reduction in both active military and retired veteran couples, we sought to evaluate a specific, inclusive treatment for those who served and may still suffer from trauma, and their partners. The current intervention model, the VCIIR model, was aimed at supporting veterans (both currently military affiliated and not currently affiliated) who had a previous diagnosis of PTSD and their partners by providing a structure that promotes ongoing peer support. The model uses a holistic treatment approach including traditional therapeutic couple sessions and group psychoeducation, as well as yoga, massage, and other recreational wellness activities to promote relaxation when participants are not engaging in direct services.

These relaxation activities were integrated not only because of their mainstream popularity and the fact that they have been implemented in other military family treatments (i.e., yoga; Bobrow et al., 2013) but also because of the emerging documentation of their benefits in treating mental health concerns. For example, there is preliminary evidence of the benefits of yoga as an augmentation to therapy in reducing scores on measures of depression for young adults (see Woolery, Myers, Sternlieb, & Zeltzer, 2004), as well as benefits of yoga for other disturbances in those with a formally diagnosed disorder or who report symptoms in the general population (see Balasubramaniam, Telles, & Doraiswamy, 2013). Similarly, recreational activities such as hiking may also have mental health benefits as walking in nature compared with urban environments was found to decrease anxiety, as well as improve mood and cognitive functioning in adults without psychiatric disorders (Bratman, Daily, Levy, & Gross, 2015).

The VCIIR Model Development

The VCIIR model was designed to assist service members, veterans, and their families affected by distress and trauma. These retreats were modeled after the 3-week intensive Specialized Care Program at the Deployment Health Clinical Center within the U.S. DOD (see Bruner, 2015; Nelson Goff & Johannes, 2011). The

present retreat model uses a community-based integrative approach that seeks to motivate and educate participants. The 3-week program was adapted into a brief 1-week retreat for veteran couples. An initial retreat model was developed by Michael Wagner, a psychologist and retired Army colonel, that serves as the foundation for the present study and these types of retreats have been adapted and implemented elsewhere (see Bruner, 2014; Nelson Goff & Johannes, 2011).

These retreat programs use a strengths-based, psychoeducational and skill training approach aimed at reducing stigma associated with seeking services, empowering participants, and providing healthy ways to cope with stress effects associated with past deployment experiences. As part of the VCIIR model, facilitators attempt to help build a sense of community to combat feelings of isolation. Facilitators also seek to help couples understand the physiology of war-zone stress (see Bruner & Woll, 2011) and how this stress can affect emotional reactions. To promote resilience, the programs also underscore the importance of finding balance in the system even in the presence of chronic stress (Bruner, 2014, 2015; see also Bruner & Woll, 2011, for a discussion on the foundation of resilience for veterans). The VCIIR model moves beyond a deficit-based pathology model, which may reinforce a sense of being abnormal or defective and potentially increase the reluctance to acknowledge symptoms and to seek services (see Imel et al., 2013). (For more information on the VCIIR model see Bruner, 2014, 2015; see also Nelson Goff & Johannes, 2011, for another application and description of the retreat model).

The Present Study

We sought to evaluate the VCIIR intervention focused on reducing distress for veteran couples. According to the systemic community-based model, interactions with professionals, other participants, and other partners were intended to provide validation and normalization of experiences. Specifically, integration of partners, along with the implementation of the community systems focus, may alleviate distress for veterans and their partners by reducing feelings of isolation as well as providing information about trauma and distress management so both partners are aware of symptoms and ways of coping. Accounting for the dependence between partners and including all time points in one model, we hypothesize that veterans will have a downward trajectory in trauma symptoms. Similarly, we also hypothesize that there will be a significant decrease in partner distress over time.

Method

Sample and Procedure

Data and information about data collection procedures were acquired from the National Veterans Wellness and Healing Center. In 2011, 149 veteran couples (N = 298 individuals) participated in eight, 7-day retreats conducted by the National

Veterans Wellness and Healing Center in New Mexico. The majority of the participants were white (54%), followed by Hispanic or Latino (40%), Native American (5%), and African American (1%). Veterans who provided ages ranged from 25 to 84 years old ($M = 55.52$, $SD = 12.87$). Similarly, their partners ranged from 23 to 83 years old ($M = 52.96$, $SD = 12.53$). Many participants indicated that they were deployed once (62%) or twice (29%), with the remaining indicating they had been deployed more than twice. The majority of participants served during the Vietnam era (63%), followed by the Operation Iraqi Freedom/Operation Enduring Freedom (25%), Desert Storm, Gulf War, or Kosovo (10%), Korean war (2%), and World War II (1%) eras. The participants were from a variety of demographic regions across the United States, representing 17 different states. The majority (83%) of participants were married couples, and 17% were unmarried dyads. The majority of veterans were men and the majority of partners were women (only two dyads were dual military veterans).

The program was open to any military veteran who served during a war era, including Active Component, Reserve, and National Guard Service members. In order to be eligible for the present study, participants were required to have either a prediagnosis of PTSD (e.g., from a VA primary provider) or a referral from a provider for displaying symptoms of PTSD. Those without a formal diagnosis of PTSD, however, were admitted on a case-by-case basis if they were still living with the symptoms and reactivity from their war experiences. All participating veterans were required to have a current partner who was also willing to participate in the retreat because the VCIIR model treats the partners together as a single unit. Applicants were asked to complete a brief questionnaire and application to gain acceptance into the retreat program. Data were collected over the course of 12 months in 2011–2012, including eight retreats and one reunion event. Participants completed the surveys at the beginning of the 7-day retreat, at the end, and some participants ($n = 46$ veterans; $n = 48$ partners) completed the survey at the 6-month follow-up reunion. Because data were collected previously by the National Veterans Wellness and Healing Center, we received permission and were sent the data for analysis. Due to the fact that we were not involved in data collection and there was no identifying information connected with these secondary data, the university institutional review board did not require approval for the present study.

The Intervention: Core Principles Incorporated in the VCIIR Model

Preparation and Follow-Up Care

The VCIIR model is provided by a team of multidisciplinary facilitators. These facilitators provide support and resources to participants before, during, and after the retreat. For example, each veteran couple is assigned a licensed behavioral health provider who conducts their initial screening and intake assessment, monitors their needs during the retreat, and connects the couple to services within the community after the retreats. The team also facilitates periodic alumni reunions, continued

peer recovery support (e.g., connecting participants through online modalities such as social networking sites), as well as continual mentoring relationships between participants. These resources are intended to provide ongoing connection between participants to support continued improvement in distress.

Intergenerational Interaction and Ongoing Peer Support

The current model intentionally combines veterans from a variety of generations or combat eras to facilitate interaction between younger and elder veterans. As part of the retreats, formal and informal interactions between veterans are encouraged through incorporated break-out sessions. Interpersonal exchanges in the context of support have been found to be important in the process of healing in other populations (e.g., survivors of intense political and intergroup violence; Staub, Pearlman, Gubin, & Hagengimana, 2005). Although these interactions are about experiences with distress symptoms associated with the military combat context, partners may also find benefits from hearing experiences from past and recent veterans and their partners.

The model also encourages this interaction and intergenerational support through facilitated peer discussions. It is a goal of the model for elder veterans (e.g., deployed in Vietnam), who may have learned coping and symptom management techniques, to provide wisdom and encouragement to veterans who returned from more recent deployments (e.g., Afghanistan). This interaction can not only provide a connection to combat feelings of detachment or estrangement from others, which are often associated with PTSD (American Psychiatric Association, 2013), but also provide a sense of normalization by showing the younger veterans that they are not alone in these struggles.

Likewise, the current model assumes that elder veterans may find intergenerational interaction beneficial as it can provide a "new mission" by assisting the younger generation, thus providing empowerment and a sense of generativity. Even elder veterans who have overcome certain symptoms or have learned to cope with PTSD may experience additional benefits through peer support and through the process of healing.

Focus on the Veteran and Partner or Caregiver as a Single Unit

Tension during deployment and reintegration, as well as dealing with the effects of trauma years later, can itself be distressing for family systems (see Nelson Goff & Smith, 2005). During the retreat, partners are encouraged to participate in activities to combat some of these systemic effects and to encourage the co-construction of narratives about the lived experiences of both partners. Facilitators of group discussions work to ensure that the partners' experiences do not go unheard during interactions. Therefore, another core assumption of this retreat model is that treating the couple system as a unit will promote supportive success in the partners.

Community Involvement

Recommendations have been made for incorporating linkages between community and military soldier reintegration (IOM, 2013). To address this need, another principle of the model is to ensure that these community-based retreats are connected to the cultural contexts in which they are embedded so that local veterans feel that they are a part of the community. In addition to building a sense of community within the retreats, for example, facilitators incorporate cultural components of the region where the retreats are located and provide veterans a sense of community support. Retreat facilitators (i.e., educators, clinicians, and other health providers associated with the program) provide workshops to the local community and engage in dialogue with local veteran organizations, service providers, and faith-based communities. Local behavioral health providers are also embedded with the participants as clinicians or facilitators.

To be successful and to promote continuity, VCIIR staff work to ensure that local communities support the program because it is important that the veterans feel a sense of stability and acceptance in their respective communities (see Bobrow et al., 2013). This community support occurs in very tangible ways as the community nurtures the retreat with in-kind services, meals, and by hosting recreational functions (see Bruner, 2014, 2015). The goal of this community involvement initiative is to promote community buy-in so that participants have seamless support from the retreat back into their homes. The retreat facilitators attempt to provide awareness on behalf of all service members, veterans, and their families who reside in the community. This community support initiative demonstrates concern and appreciation for veterans, attempts to provide a sense of welcoming to veterans, and attempts to promote community action to support veterans.

The "Soldiers Saving Soldiers" or "Battle Buddies" Concept

In line with support group formats (see Cox, Davies, Burlingame, Campbell, Layne, & Katzenbach, 2007; Jarero, Artigas, & Hartung, 2006), another core assumption of the model is that the interaction with those who have the shared, lived experience of deployment is an important mechanism for recovery. Similar to the principle of intergenerational interaction, veterans are encouraged to relate and share techniques to combat a sense of isolation. Although formal discussions are mediated by a trained facilitator, veteran-to-veteran interactions and camaraderie are important components of the VCIIR model for the treatment of trauma symptoms and distress. Similarly, partner-to-partner interactions may also serve to normalize experiences. It is assumed in the VCIIR model that this interaction provides a validation of experience in addition to the facilitation of bonding to cope with stress. Research has found it is important for those who have experienced stress, especially due to violence, to be able to engage in these kinds of interpersonal exchanges (Staub et al., 2005). (See Nelson Goff & Johannes, 2011; see also Bruner, 2014, 2015, for addition information on the core principles of the VCIIR Model.)

The Intervention: The Retreat Modalities and Treatment Procedure

The VCIIR intervention was administered over a 7-day period. Modalities of treatment included (a) group psychoeducation, (b) therapeutic conjoint/couples' sessions, and (c) relaxation and therapeutic recreation. (A more detailed daily schedule sample is available from the third author.)

Group psychoeducation provided an opportunity for participants to hear from others with similar experiences to promote a sense of validation and to normalize the experiences shared. At these types of retreats, participants receive daily group sessions. Interaction and community building is encouraged to counteract the feelings of isolation associated with trauma. The groups were facilitated by trained staff who provided some psychoeducation about the physiological and interpersonal neurobiological effects of trauma, but participants were encouraged to engage in active discussion with each other to establish connections with others.

Couple assessment and counseling sessions were also available daily as part of the retreat schedule. Conjoint sessions typically contained elements of solution-focused and narrative approaches for couples to feel empowered to construct their own narratives about their experiences (e.g., deployment, reintegration, and continued living with the impact of trauma) and to process these experiences openly. The couples then co-constructed a unique outcome narrative to provide a sense of empowerment and understanding that change is possible for the system. Other intervention techniques that were integrated came from work on couple relationship skills and physiological reactions (e.g., Gottman, 1999) and cognitive-behavioral therapy (CBT) for couples.

When not in formal therapy or group work, veterans and their partners were encouraged to participate in a variety of relaxation and engagement activities. These activities include yoga, equine-assisted therapeutic experiences, massage, spiritual healing activities for those looking for a sense of faith, and retreats also included the use of nature and outdoor experiences including hiking and swimming. (See Bruner, 2014, 2015, or contact the third author for additional details about the course of treatment and modalities used in the VCIIR program.)

Measures

The PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) was used as a measure of distress in participants. Veterans completed the military version of the PCL (PCL-M) and their partners completed a slightly modified civilian version (PCL-C). The PCL is a self-report rating scale for assessing the DSM-IV symptoms of PTSD. Participants are asked to rate the degree to which they feel bothered by symptoms on a 1 (*not at all*) to 5 (*extremely*) scale (range = 17–85). The PCL was found to correspond well with DSM-IV symptoms, had excellent test-retest reliability over a short time period, and internal consistency was high for the 17-item scale ($\alpha = .97$ in similar populations; see Jakupcak et al., 2007). The PCL also correlates strongly with other measures of PTSD, including the Clinician Administered PTSD

Scale (CAPS; see Blanchard, Jones-Alexander, Buckley, & Forneris, 1996), as well as the Mississippi Scale for PTSD (MS-C) and the Symptom Checklist 90-Revised (SCL-90-R; see Ruggiero, Del Ben, Scotti, & Rabalais, 2003) with the PCL-C. Due to the fact that it was unclear if partners experienced a trauma, their PCL scores are referred to as being indicative of "distress" and veterans' scores are referred to as "trauma symptoms" in the present study due to their potential exposure to combat-related traumas.

Previous research on screening classifications in a veteran population used a global cut-off score of 50 for the threshold for potential PTSD and scores ranging from 35 to 49 were classified as the subthreshold (see Forbes, Creamer, & Biddle, 2001; Jakupcak et al., 2007). A cutoff score of greater than 50 for putative diagnoses of PTSD has also been suggested for the PCL-C (see Andrykowski, Cordova, Studts, & Miller, 1998). Further, researchers recommend a 5-point improvement in score as a minimum cut-off for determining if an individual responds to treatment and a 10-point improvement is potentially indicative of a change being clinically meaningful (see Monson et al., 2008, 2012). Due to the fact that these suggested threshold values are general and approximate, we present the cut-off scores as descriptive points of reference and for comparison across the intervention for veterans and partners, not as definitive clinical diagnoses.

Results

Preliminary descriptive analyses were conducted using SPSS 22, and missing data were handled by listwise deletion. One partner was dropped from the analysis due to a missing posttest PCL score and two couples did not complete posttest surveys resulting in a final sample of 147 veterans and 146 partners. According to a missing value analysis (MVA), 1.3% of data were missing for veterans and 2.0% for partners at posttest. At the 6-month follow-up, 68.5% of data were missing for veterans ($n = 46$) and 67.1% for partners ($n = 48$). Although there was a large amount of attrition at the 6-month follow up, there were no significant differences between those who returned and those who did not on the posttest measure of distress ($t[145] = -0.89$, $p = .37$; $t[144] = -1.55$, $p = .12$, for veterans and partners, respectively).

Descriptive Statistics

Paired-samples *t*-tests were conducted to provide preliminary, descriptive information about mean differences in trauma symptomology in veterans and distress for their partners. For veterans, there was a significant decrease in trauma symptoms from pretest ($M = 60.71$, $SD = 12.55$) to posttest ($M = 42.04$, $SD = 12.98$; $t[146] = 17.55$, $p < .001$). Nearly 81% of veterans were above the cut-off for potential PTSD at pretest (scores > 50; see Forbes et al., 2001), whereas only 31% remained above the cut-off at posttest. There was a slight decrease in trauma symptoms for those who participated in the 6-month follow-up ($M = 43.46$, $SD = 13.99$ posttest; $M = 42.44$, $SD = 13.03$, follow-up); however, this decrease was not significantly different from

the veterans' posttest scores ($t[45] = 0.61, p = .54$). This indicates, on average, veterans had no additional reduction in trauma symptoms, but intervention effects were maintained (i.e., veterans did not revert to preintervention scores on the measure of trauma symptoms at the follow-up).

Partners also had a significant decrease in symptoms of distress from pretest ($M = 42.55$, $SD = 15.72$) to posttest ($M = 29.06$, $SD = 10.73$; $t[145] = 13.04$, $p < .001$). At pretest, 28% of partners were above the cut-off for potential PTSD with scores greater than 50 on the PCL, compared with only 5% of partners at posttest. On average, partners went from the subthreshold for potential PTSD (scores from 35 to 49; see Jakupcak et al., 2007) to below the cut-off, thus being classified as non-PTSD (scores < 35). At the 6-month follow-up, partners not only sustained treatment effects, but showed a further reduction in distress ($M = 31.02$, $SD = 10.87$ and $M = 26.98$, $SD = 10.19$ for posttest and follow-up, respectively; $t[47] = 3.39$, $p < .001$).

Longitudinal Dyadic Results

To estimate the degree of dependence between partners, we calculated a partial correlation between veterans' and partners' outcomes scores. The results of the partial correlation showed a modest but significant association within couples for posttest scores of distress, controlling for the pretest scores ($r = 0.24$, $p < .01$). Thus, we used hierarchical linear and nonlinear modeling (HLM 7; Raudenbush, Bryk, & Congdon, 2010) to account for the nonindependence between partner scores, and missing data were handled using the restricted maximum likelihood algorithm. Given the pattern of results from the paired-samples *t*-tests, we tested a dyadic growth model with both linear and quadratic effects using the two-intercept approach, which simultaneously estimated a unique parameter for veterans and partners while controlling for the interdependence within couples (Raudenbush, Brennan, & Barnett, 1995; see Table 1). The equation for the mixed effects model was as follows:

$$\begin{aligned}\mathrm{PCL_{ij}} = {} & \gamma 10(\text{Veteran Intercept}) + \gamma_{20}(\text{Partner Intercept}) + \gamma_{30}(\text{Veteran Time}) \\ & + \gamma_{40}(\text{Partner Time}) + \gamma_{50}(\text{Veteran Time}^2) + \gamma_{60}(\text{Partner Time}^2) + \mathrm{u_{0j}} + \mathrm{r_{ij}}\end{aligned}$$

Partners reported less distress at baseline than veterans. Both veterans and partners showed a significant reduction in distress from pretest to posttest, but the

Table 1. Multilevel growth model with linear and quadratic effects.

Trauma Symptoms	Unstandardized Coefficient	*SE*	*t*-ratio
Veteran baseline, γ_{10}	60.62	1.03	59.18***
Partner baseline, γ_{20}	42.66	1.89	22.57***
Veteran time, γ_{30}	− 27.43	1.42	–19.31***
Partner time, γ_{40}	− 18.58	2.30	–8.08***
Veteran quadratic time, γ_{50}	8.81	1.01	8.70***
Partner quadratic time, γ_{60}	4.94	1.16	4.26***

Note. ***$p < .001$.

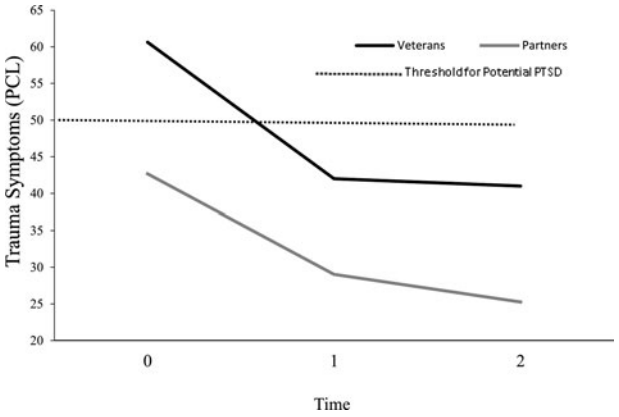

Figure 1. Curvilinear effect of time on trauma symptoms for veterans and partners.

reduction was larger for veterans than for partners. Although this reduction effect diminished over time, there was also a reduction in distress from posttest to follow-up that was more pronounced for partners than for veterans (Figure 1).

Discussion

These results provide initial evidence that the retreat model is associated with a decrease in trauma symptoms for veterans and a reduction in distress for their partners. We found longitudinal support for both hypotheses as evidenced by reports of significantly fewer trauma symptoms from veterans and a significant decrease in distress for partners after the intervention. In other words, veterans and partners had significant decreases in distress across all three time points, although these decreases tapered over time.

Our findings provide initial support for the VCIIR model, which has not been empirically evaluated previously. Although these retreats are intensive, there was favorable feedback on retreat evaluations from veterans and their partners. Participants reported enjoyment of group interaction and having a support system in their feedback of the retreats. According to the assumptions of our model, these interactions are integral in combating the feelings of distress and isolation associated with PTSD.

From a systemic perspective, allowing partners to attend with veterans for support, system distress management, and greater awareness of the effects of trauma for both partners (see Nelson Goff & Smith, 2005) may be beneficial for this population. The long-term effects, therefore, could potentially be due to changes made in the system as a whole, in addition to the ongoing supports and resources provided by the retreats. In other words, partner integration into treatment and subsequent awareness may provide additional support that helps to maintain progress; however, this was not directly evaluated in the present study and should be evaluated in future research. In addition to maintaining effects for veterans and partners, this couple-focused treatment is particularly important due to the negative interpersonal effects

of trauma on others in a system (see Monson et al., 2009; Nelson Goff et al., 2007). Although future research should address partner support and relationship functioning directly, this systemic approach is reinforced by previous researchers who report the benefits of incorporating partners or family members, as well as adapting a family systems perspective into treatments for military populations (e.g., MacDermid Wadsworth et al., 2013).

Clinical Implications

This brief couple retreat model intervention has a holistic focus that incorporates many modalities intended to provide a relaxing and healing experience. We found significant decreases in the levels of perceived distress among veterans and their partners. Not only did veterans drop below the threshold for potential PTSD from baseline to postretreat intervention, but their partners also dropped below the subthreshold, which indicates potential clinical significance of the treatment. With this initial pilot study, we argue for further exploration of this type of intensive and integrative retreat model as a potential, viable intervention, especially to augment traditional therapies. Improvement in access and utilization of services is critical in caring for posttraumatic stress in active duty personnel, as well as retired veterans. Due to the fact that most programs target recently deployed military personnel, the present model provides an opportunity for those personnel, as well as elder veterans who continue to suffer from trauma, to heal. Clinicians and policy makers, however, can take steps to remedy the neglect of this population by providing services specialized for veterans (and their partners) and can take steps to attract veteran couples to mental health services. More specifically, veterans may be likely to attend and benefit from brief treatments that include someone from their support system, given that there is a high rate of attrition in long-term services (Imel et al., 2013) and there is a strong preference for family-focused intervention (Khaylis et al., 2011).

Practitioners working with military and veteran clients may be encouraged to include partners in treatment depending on the severity and circumstances of treatment. We also advocate for further research on veteran couple retreats to gather more evidence to assess whether these retreat interventions are effective at improving other outcomes, such as relationship quality and depression. Research in this area is of paramount importance due to the high rates of distress and apprehension associated with seeking long-term, individual services, as well as the strong association between distress and relationship difficulties for military-affiliated populations (see Monson et al., 2009). Therefore, expanded clinical services for current military and veteran populations and making more policy changes (see IOM, 2013) that allow for brief, systemically integrative treatments within a military context, will not only allow for further research but also may benefit veterans' families. In addition to partner support, many of the retreat principles focus on group and community interaction to reduce isolation. Although this was not directly assessed as an outcome, the group format of the retreats may provide validation, normalization, and

serve to reduce the stigma associated with mental illness and seeking services. This social support should be assessed directly in future research.

Limitations and Future Research

As with any study, our results should be viewed within the context of their limitations. There was no waitlist control group or randomization as all voluntary participants were placed in a weeklong retreat. Future research would benefit from implementing a randomized controlled trial to test for treatment effects more explicitly. Another limitation of the study is that there was attrition at the 6-month follow-up, which could represent a self-selection bias at the third time point.

Our reliance on secondary data analysis had a variety of weaknesses as the amount of information collected, including demographics, was limited. A key limitation of the collected data, for example, is that we only had one measure of trauma symptoms and other measures, like relationship improvement and caregiver stress, were not included. Similarly, there was no structured clinical interview provided as part of the intervention to determine changes in PTSD diagnoses. Despite a clinical diagnosis being required for referral to the intervention, no structured clinical interview was provided as part of the intervention data to determine change in clinical diagnosis of PTSD. Having one measure of distress over three time points only provides modest information about treatment outcomes.

Additional measures of PTSD and other mental health concerns, as well as a structured clinical interview, would provide additional nuance to our understanding of the mechanisms that improve mental health in this population and if the improvement is clinically meaningful. Having measures of relationship functioning would also help us gain insight into processes that improve relationships and could help us assess the supportive, maintenance efforts partners may provide. Satisfaction with the program and assessments of specific retreat modalities were also not directly assessed. Future research should investigate the modalities and core principles of the retreat model, as well as participant satisfaction with treatment to provide further information about the efficacy of the intervention.

Conclusions

Integrative, intensive retreat modalities for service members, veterans, and their partners may be an efficient way to reduce trauma symptoms and distress. The benefits of connectedness with partners, other veterans, and communities of support are core to the VCIIR model treatment. In addition, providing insight and a safe, welcoming environment, improving skills like communication, bridging the gap between the service members and their partners, and management of symptoms are also emphasized in the model and all likely contribute to reducing distress for participants. Although replication is needed due to the limitations of this initial pilot study, the retreat model shows promise as a brief intervention to decrease trauma symptoms among veterans and to reduce distress in their support systems.

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