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Coming All the Way Home: Integrative Community Care for Those Who Serve

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This project describes the programming and evaluation of Coming Home Project (CHP) retreats that address the mental, emotional, spiritual, and relationship challenges experienced by those affected by military service and deployments. Three types of retreats held for veterans, service members and their families, as well as professional service providers, were evaluated. Original program-evaluation measures were administered to elicit feedback from participants and facilitators to optimize the intervention, and to evaluate whether the experimental and learning objectives of retreat components were achieved. Data analyses reveal statistically significant reductions in stress and isolation, as well as improvements in relaxation and hope, for all retreat participants. Implications for the success of this type of innovative, resilience-based, community programming are discussed. Future directions are suggested for further research, replicability of these services in other locations, and the incorporation of CHP retreats into existing government programs and services.

Keywords: veterans, military families, transition assistance, resilience, community-based program

The wars in Iraq and Afghanistan have created significant stressors for military-service members, veterans, and their families. Since October 2001, more than 2 million U.S. troops have been deployed and have faced the challenges of reintegrating into civilian life (SIAD, 2011). Evidence suggests that psychological wounds of prolonged combat exposure are more common than physical injuries (Tanielian, 2008). In addition to clinical diagnoses of post-traumatic stress disorder (PTSD) or depression, many service members experience subclinical psychological problems that affect mood, thoughts, and behaviors.

Mental-health disorders are now the top cause of hospitalizations among U.S. military personnel (replacing pregnancies), with numbers of mental-health-related hospitalizations having grown more than 50% since 2006 (Thompson, 2011). Yet notably, it is often more than a year after return from combat before psychological or behavioral-health symptoms appear and appropriate diagnoses are made. Some success has been achieved through the integration of mental-health screenings into primary-care visits, yet the evaluation of such programs is in early stages (Barber, Franstve, Capelli, & Sanders, 2011). Of specific concern for veterans is that the 2011 U.S. Federal Court of Appeals found the Department of Veterans Affairs (VA) unprepared for the flood of psychologically troubled troops returning from the recent conflicts, and warned of a high risk of

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inadequate behavioral-health services at veterans' clinics (Fung, 2011).

As service members struggle to readjust to civilian life after deployment, so too do family members struggle to adjust to changes in their service member or veteran. Multiple deployments often strain family relationships, as spouses and children respond to prolonged absence, the ever-present threat of death or injury, and the significant changes in psychological and emotional well-being of the returning service member (Cozza, Chun, & Polo, 2005).

Government help with the transition to civilian life offers a set of relatively disconnected programs that exist in separate silos, often duplicating one another and competing for personnel, funding, and participants. Despite recent efforts of these organizations, seeking care is still often perceived as stigmatizing and potentially jeopardizing. A recent RAND study of New York found that 46% of veterans with mental-health disorders preferred to obtain treatment outside the VA system. (Schell & Tanielian, 2011).

Recommendations from the U.S. Department of Defense Centers of Excellence (DCOE) to improve total force fitness (TFF) include, in part, the application of a more holistic approach to reintegration programs (DCOE, 2012). Fortunately, military organizations are mobilizing around these guidelines to provide integrative services for service members and their families to strengthen their resilience skills, loosely grouped as transition-assistance programs (Bowles & Bates, 2010). Generally, the concept of military-family resiliency reflects a service member's ability to effectively adapt to adverse stress and maintain physical and mental well-being. Aspects of resilience exist along several dimensions: individual, family, unit, and community (Meredith et al., 2011).

According to one model, higher levels of resilience were associated with more personal growth, less distrust in others and the world, and less avoidance of negative emotion (Schok, Kleber, & Lensvelt-Mulders, 2010). Furthermore, this model also associated personal resources with resilience, namely, self-esteem, optimism, and perceived control, and might be enhanced or reinforced through psychoeducation or training. The strength of family relationships and processes also plays an important role in developing military-family resiliency (Riggs & Riggs, 2011). A recent evaluation of a family-based resiliency program demonstrated that the collaborative military- and community-led program was effective in helping participants manage interpersonal conflicts and create a low-stress family environment (Sherman, Fischer, Sorocco, & McFarlane, 2011).

In an effort to add to this growing field of holistic resilience-based programming and to assess the effectiveness of strengths-based interventions, the present paper describes the components of CHP retreats and evaluates the impact of participation in them on the lives of service members, veterans, and those who care for them.

The Coming Home Project

Retreats and Programming

The CHP has been recognized as a model postdeployment reintegration program (DCOE, 2012) and provides retreats to veterans, service members, their families, and professional care providers that are unique in several respects. Developed as a holistic alternative to existing programming, they are not meant to provide psychotherapy but rather to be therapeutic; retreat activities are nonstigmatizing and emphasize community building and resilience rather than symptom-targeted treatment. Activities are presented in a variety of formats, including large group meetings and instruction, small peer-based support and discussion groups, and free individual and family time. Retreats offer psychoeducational training in wellness practices, such as mindfulness meditation and relaxation techniques, as well as family life skills, such as parent education and couples communication. This psychoeducation is further enhanced through activities that cultivate the mind–body connection, such as *qigong*, expressive arts, and recreational programs. As retreats end, participants are provided with resources that connect them to services in their home regions, as well as opportunities for them to engage in public service. Additionally, participants are made aware of an array of follow-up services through the CHP, including free psychological assessment and treatment through a local network of volunteer providers. Table 1 T1 describes the six core activities of retreat pro-

Table 1
Core Activities of Retreat Programming

Goal	Core activity
1	Share experiences and stories, struggles and breakthroughs, in an atmosphere of mutual support, safety, and trust, in small supportive "affinity" groups with peers who share their particular situation (i.e. veterans with other veterans).
2	Connect with the community of retreat participants and staff in a spirit of mutual understanding and shared goals.
3	Practice resilience skills (e.g., mindfulness, qigong, and yoga) to reduce stress and dysregulation and to enhance wellbeing and recovery.
4	Express what cannot be spoken through expressive arts such as journaling, drawing, music, dance, and movement.
5	Enjoy invigorating outdoor recreational activities in scenic, peaceful settings.
6	Heal unseen wounds during secular ritual that recognizes, honors, and helps integrate experiences.

gramming to achieve the overall goals of connection, learning, and healing.

The CHP offers several different types of retreats, each of which is evaluated in the present data analysis. Military-family retreats are offered for veterans, service members, and their families. In order to address the unique challenges associated with being a woman in the military, female-only retreats are offered for these veterans and active-duty service members. Veteran- and service-member-only retreats are four days long; when families are invited, retreats last five days. Service-provider retreats were developed to address the distinctive mental, emotional, spiritual, and relationship challenges facing professionals who care for veterans and their families. These retreats emphasize self-care and resilience practices to alleviate compassion fatigue, vicarious trauma and burnout, and provide a space to tend and transform the invisible injuries of caring for warriors and their families. Service-provider retreats last four days.

Participation in retreats is voluntary, confidential, and free to all attendees, including veterans, active-duty service members, National Guard members, and reservists. Recruitment for veteran, service-member, and family retreats begins when a retreat is posted on the CHP website and an email blast is sent to its mailing list. Participants may also learn about upcoming retreats from local referral sources, including VA therapists, Army Family Readiness Group coordinators, other counselors or advocates, fellow veterans or service members, unit commanders, and peers who have attended past retreats. In addition to website posting of retreat dates, service providers are also specifically contacted through VA hospitals, military treatment facilities, military units, and community nonprofit organizations.

Applicants are screened by CHP staff to assure eligibility status as veteran, service member, or family member, and for an appropriate level of need, motivation, and ability to make use of the program. Participants are asked to demonstrate need, such as reporting feeling isolated or suffering emotionally; those who report wanting to attend for other reasons, such as wanting a vacation away from family, are excluded. Service-provider eligibility includes all who directly treat or counsel post-9/11 veterans, service members, or their families for at least 50% of their caseloads. All levels of professional personnel are eligible, including chaplains, social workers, therapists/counselors, nurses, physicians, and hospice workers. Retreats are facilitated by group leaders who are experienced with trauma management and are knowledgeable about the unique challenges faced by those connected to military service, including psychotherapists, chaplains, some veterans and family members, and interfaith leaders.

Method

Participants

This evaluation included data from a total of 347 participants who attended one of three types of CHP retreats: military family, female only, and service provider. Participants' retreats were recruited through the CHP website, local military installations, and by word of mouth.

A combined total of 175 participants, including veterans and active-duty service members of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) and their adult family members, attended one of four military-family retreats in May, June, July, and August of 2010 in Washington DC, San Diego, CA, Santa Rosa, CA, and San Antonio, TX, respectively. Forty-two percent of the participants were men and the majority of participants were between 25 and 35 years old. Participants were diverse in ethnicity: White (34%), Latino (17%), African American (12%), Asian/Pacific Islander (9%), and other/mixed (11%). Participants on active duty were deployed in the Army (56%), Navy (16%), Air Force (13%), and Marines (17%). Of both active-duty and veteran participants, about half had been deployed once (51%) and another 24% had been deployed twice. Thirty-two percent of the participants were married and 78% had at least one child.

Forty-six participants attended a female-only retreat in February, 2011 in Oceanside, CA. Family members were not invited to this retreat and participation was limited to women who had been deployed to OIF or OEF, including current veterans and those on active duty. Participants ranged in age from 23 to 56. Records of participant ethnicity were not obtained. Of both the active duty and veteran participants, branches of service included Army (22%), Army Reserves (22%), Navy (22%), Navy Reserves (2%), Air Force (4%), Air Force Reserves (2%), National Guard (11%), and Marines (17%), with two participants serving in both the Army Reserves and the National Guard.

A combined total of 126 service providers attended one of two service-provider retreats in October, 2010 and April, 2011, both in Burlingame, CA. Family members were not invited to these retreats and participation was limited to professional service providers who were currently providing care to veterans, military-service members, and/or their families. Seventy-eight percent of the participants were women and participant ages ranged from 28 to 65 years old. The majority of participants were White (60%), followed by Latino (20%), African American (10%), and other/mixed (10%). Service-provider job titles included nurses (44%), mental-health professionals (34%), social workers/case managers (16%), and physicians (6%).

Measures

Participants were asked to complete surveys to evaluate how successful the retreats were in achieving their goals. Although several established assessment instruments relevant to post-traumatic stress disorder, depression, anxiety, and perceived stress were identified, it became clear that these measures designed for clinical populations were not appropriate for a general population of service members, veterans, and families. Focused too closely on specific and severe clinical symptoms, these measures failed to capture the spectrum of subjective changes indicated in qualitative reports by participants of early retreats, which included both reductions in subclinical indicators of distress and less well-characterized constructs such as feelings of aloneness or emotional numbness, and positive outcomes such as meaning and hope. Therefore, in order to more appropriately characterize and evaluate the changes observed by participants, investigator-developed evaluation instruments were utilized.

As is appropriate in the initial stages of intervention development, the purpose of these assessments was to establish feasibility and promise of the intervention, to elicit feedback from participants and facilitators with respect to the learning objectives of each component of the intervention with the aim of optimizing it. Item selection was informed by a team process of reviewing each of the intervention components and their intended objectives, and developing items that precisely captured those objectives. Resulting items were intended to be face valid and were reviewed by retreat facilitators and former participants for relevance and understandability. Since no subscales were used in favor of examining items individually, the survey was not psychometrically validated (e.g., there were no factor analyses or reliability estimates). Because family members, service providers, and military-service members experience similar types of challenges (e.g., stress, isolation), though not for the same reasons, the resilience and stress-reduction goals of the three types of retreats were similar, and the same program-evaluation instruments were used for each. Copies of the assessment instruments are available upon request to the corresponding author.

Entry and exit surveys. The entry survey was administered to all participants upon arrival at all retreats. Participants were asked to rate how often over the past 1–2 weeks prior to the retreat they experienced each of 15 items. Items include negative states such as "exhausted" and "isolated," as well as positive states such as "connected "and "able to calm myself after a stressful day." Responses were given on a Likert-type scale, ranging from 1, *not at all* to 5, *almost daily*. The exit survey (identical to the entry survey) was administered to all participants at the close of all retreats, as well as 30–60 days following select retreats.

Program evaluation. The program evaluation was administered to all participants at the close of the retreats. Participants indicated which activities they attended by circling from a list of all offered activities., and were asked to identify which specific elements of the retreat were most meaningful, offer suggestions for retreat improvement, and provide general comments about the retreat experience. Participants were also asked to indicate agreement on a Likert-type scale ranging from 1, *disagree* to 5, *agree,* with 25 statements representing the specific goals of the retreat. Example items include "I felt I could better manage my emotions" and "I learned new ways to take care of my physical and emotional well-being." All items on the program evaluation were worded positively; higher scores indicated greater achievement of program goals.

Hypotheses and Data Analysis

It was hypothesized that participants would experience reduction in negative states and improvement in positive prosocial states after retreat participation. Furthermore, for the military-family retreats, it was hypothesized that these results would remain significant at follow-up. Two-tailed paired-samples *t* tests with alpha set to .05 were used to compare means of individual items 2–4 weeks prior to attending the retreats, the day of arrival, the day of departure, and 4–8 weeks following the retreats. Because difference scores were generally normally distributed and the response sets were interval level (rather than nominal), our research indicated that paired *t* tests were acceptable, providing similar power and protection against Type I error to nonparametric tests (De Winter & Dodou, 2010). Effect sizes were calculated to estimate the magnitude of results, and rather than correcting for multiple comparisons, are displayed to mitigate risks of inflated *p* values.

In addition, it was hypothesized that participants would report achievement of retreat goals. Responses were evaluated qualitatively through analysis of the free-response comments in Part 2 and quantitatively through descriptive statistics of participant ratings of the items in Part 3.

Data analyses and program evaluation were conducted on each type of retreat separately by independent research consultants not affiliated with the CHP.

Results

Military-Family Retreats

Results for the military-family retreats are presented in Table 2. Participants reported significant changes in the predicted direction from retreat entry to exit for all survey items. Ratings of positively worded items such as "energized" and "supported" significantly increased over the course of the retreat, whereas ratings of negatively worded items such as "stressed" and "emotionally numb" significantly decreased over the course of the retreat. T2

Analysis of the follow-up survey administered 4–8 weeks after the retreat demonstrated that participants continued to report significant positive changes from the retreat with the exception of two of the survey items. All but two of the 15-item follow-up exit-survey items remained significantly improved. As seen in Table 2, the items "Able to care for self" and "Hopeless" did not maintain significant improvement from baseline between retreat exit and follow-up.

Participant mean ratings of achievement of retreat goals were high (see Table 3), with an overall mean of 4.57 ($SD = 0.29$) on a scale of 1 to 5, and ranging from 3.61 to 4.95. The most highly rated responses were "I realized I am not alone in my struggles" ($M = 4.95$, $SD = 0.22$) and "I felt gratitude for community support" ($M = 4.86$, $SD = 0.42$). The least highly rated response was "I felt my physical pain ease" ($M = 3.61$, $SD = 1.15$). T3

Additional insight was gained through a review of the qualitative results from Part 2 of the program evaluation. Although some comments

Table 2
Military-Family Retreat Hypothesis 1 Results

Response item	Entry survey	Exit survey	Follow-up survey				Entry to follow-up		
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	*t* statistic (*df*)	Entry to exit Cohen's *d*	*p* value	*t* statistic (*df*)	Cohen's *d*	*p* value
Stressed (−)	3.68 (1.17)	1.99 (1.00)	2.84 (1.15)	16.16 (162)	1.27	>0.001	5.59 (98)	.565	>0.001
Exhausted (−)	3.46 (1.21)	2.12 (1.13)	2.65 (1.14)	11.92 (162)	.936	>0.001	6.27 (98)	.633	>0.001
Happy (+)	3.40 (0.96)	4.27 (0.82)	3.83 (1.02)	−10.55 (166)	−.819	>0.001	−3.715 (100)	−.372	>0.001
Relaxed (+)	2.53 (1.04)	4.01 (1.01)	3.42 (1.08)	−15.54 (164)	−1.21	>0.001	−7.15 (100)	−.715	>0.001
Able to care for myself as well as I care for others (+)	3.80 (0.99)	4.29 (1.10)	3.95 (0.96)	−5.19 (167)	−.402	>0.001	−.702 (101)	−.070	=0.478
Burned out (−)	3.22 (1.26)	1.95 (1.12)	2.26 (1.13)	10.82 (163)	.847	>0.001	6.86 (97)	.697	>0.001
Anxious (−)	3.30 (1.18)	2.22 (1.13)	2.54 (1.15)	10.05 (165)	.782	>0.001	6.82 (100)	.682	>0.001
Isolated (−)	2.40 (1.26)	1.57 (0.88)	1.91 (1.03)	7.66 (163)	.600	>0.001	2.837 (98)	.287	>0.001
Hopeless (−)	1.85 (1.02)	1.39 (0.77)	1.62 (0.84)	5.06 (165)	.394	>0.001	.852 (99)	.086	=0.401
Energized (+)	2.73 (1.07)	3.94 (0.98)	3.35 (1.00)	−13.21 (164)	−1.03	>0.001	−4.74 (99)	−.476	>0.001
Connected (+)	3.02 (1.06)	4.25 (0.81)	3.70 (1.04)	−13.53 (163)	−1.06	>0.001	−5.74 (100)	−.574	>0.001
Supported (+)	3.49 (1.09)	4.46 (0.70)	3.85 (1.00)	−11.18 (166)	−.868	>0.001	−3.51 (101)	−.349	>0.001
Hopeful (+)	3.59 (0.90)	4.40 (0.86)	3.98 (0.95)	−10.96 (160)	−.866	>0.001	−3.13 (100)	−.313	>0.001
Emotionally numb (−)	2.44 (1.24)	1.54 (0.90)	1.82 (0.95)	9.52 (163)	.746	>0.001	4.92 (99)	.494	>0.001
Able to calm myself after a stressful day (+)	3.29 (1.06)	3.96 (0.96)	3.77 (0.91)	−6.94 (167)	−.537	>0.001	−3.60 (101)	−.358	>0.001

Note. Positively or negatively worded items are marked with a (+) or (−) for clear interpretability; degrees of freedom differ based on the number of missing responses for each item.

Table 3
Military-Family, Female-Only, and Service-Provider Retreat Hypothesis 2 Results

Response item	Military family *M* (*SD*)	Female only *M* (*SD*)	Service provider *M* (*SD*)
I found meaning in the difficult experiences I've had.	4.43 (0.80)	3.89 (1.19)	4.15 (1.09)
I felt more hopeful about the future.	4.54 (0.56)	4.30 (0.76)	4.26 (1.03)
I felt a renewed sense of purpose in my life.	4.43 (0.69)	4.29 (0.84)	4.12 (1.05)
I felt I had more control over my life and the power to change certain things.	4.41 (0.64)	4.33 (0.79)	4.02 (1.04)
I felt a sense of relief.	4.59 (0.55)	4.47 (0.63)	4.15 (1.04)
I felt that I could better manage my emotions.	4.19 (0.81)	4.15 (0.84)	3.81 (1.14)
I felt more aware of the things I need to work on in my life.	4.65 (0.59)	4.39 (0.71)	4.30 (0.88)
I would be open to getting help with reintegration challenges.	4.51 (0.77)	4.37 (0.83)	4.07 (1.07)
I felt more calm and whole.	4.68 (0.58)	4.50 (0.62)	4.26 (0.99)
I felt my physical pain ease	3.61 (1.15)	3.68 (1.03)	3.62 (1.23)
It felt good to let go of the feelings I had bottled up inside.	4.51 (0.69)	4.46 (0.72)	4.11 (1.08)
I learned new ways to take care of my physical and emotional well-being.	4.38 (0.76)	4.26 (0.93)	4.19 (1.07)
I feel less isolated now.	4.14 (1.06)	4.30 (0.79)	3.94 (1.21)
I felt supported by my peers.	4.76 (0.55)	4.61 (0.65)	4.38 (0.89)
I learned from others' experiences.	4.81 (0.40)	4.70 (0.63)	4.48 (0.89)
I felt a sense of belonging, like being part of a community.	4.84 (0.44)	4.67 (0.60)	4.37 (0.95)
I felt accepted for who I am.	4.81 (0.46)	4.67 (0.60)	4.37 (0.95)
I realized I am not alone in my struggles.	4.95 (0.23)	4.67 (0.56)	4.51 (0.82)
It was helpful to be with others who were coping with the same issues as me.	4.78 (0.48)	4.59 (0.72)	4.48 (0.86)
I felt more comfortable at this retreat than I have for a long time.	4.57 (0.69)	4.52 (0.69)	3.81 (1.29)
I learned that there are others I can trust.	4.68 (0.53)	4.48 (0.72)	4.02 (1.11)
I learned to trust myself more.	4.57 (0.65)	4.30 (0.76)	4.09 (1.08)
I felt safe with this group.	4.84 (0.37)	4.61 (0.65)	4.37 (1.00)
I felt gratitude for community support.	4.86 (0.42)	4.70 (0.63)	4.50 (0.88)
I learned about programs available to service members and their families and would consider seeking assistance.	4.70 (0.52)	4.27 (1.03)	3.88 (1.22)

indicated areas for improvement, the majority of comments were positive. Representative positive comments include:

> I would recommend this retreat to every OEF/OIF veteran or service member.

> This is the type of community-building experience we need. This has changed my life!

> The CHP is a great 'boot camp' for the rest of my life. It has truly been a life-changing experience for me and my family.

Some negative comments highlighted suggestions for changes to the retreat program to increase small-group interactions, for example:

> Add couples-group time to discuss our specific problems and reconnect with my spouse.

> I would like to see time added for at least one small-group break out, for example, family members with veterans together in one group and family members with active duty in another.

Female-Only Retreats

Results for the female-only retreats are presented in Table 4. Paired-samples *t* tests were used to test the significance of differences between the means from entry to exit. Participants reported significant changes in the predicted direction from retreat entry to exit for all survey items. For example, the experience of positively worded items such as "energized" and "supported" significantly increased over the course of the retreat, and the experience of negatively worded items such as "stressed" and "emotion-

Table 4
Female-Only Retreat Hypothesis 1 Results

Response item	Entry survey *M* (*SD*)	Exit survey *M* (*SD*)	*t* statistic (*df*)	Cohen's *d*	*p* value
Stressed (−)	3.93 (1.01)	2.22 (1.17)	8.56 (45)	1.276	>0.001
Exhausted (−)	3.85 (1.21)	2.17 (1.14)	7.33 (45)	1.093	>0.001
Happy (+)	3.24 (1.05)	4.16 (0.77)	−5.00 (44)	−0.754	>0.001
Relaxed (+)	2.11 (0.99)	4.09 (0.81)	−10.26 (45)	−1.529	>0.001
Able to care for myself as well as I care for others (+)	3.50 (1.33)	4.20 (0.83)	−3.30 (45)	−0.492	>0.001
Burned out (−)	3.50 (1.39)	1.77 (0.94)	6.57 (43)	1.002	>0.001
Anxious (−)	3.46 (1.24)	2.28 (1.20)	5.08 (45)	0.757	>0.001
Isolated (−)	2.93 (1.27)	1.93 (1.08)	4.46 (45)	0.665	>0.001
Hopeless (−)	1.96 (1.19)	1.42 (0.81)	2.94 (44)	0.443	=0.012
Energized (+)	2.37 (0.99)	3.93 (0.90)	−9.94 (45)	−1.482	>0.001
Connected (+)	2.54 (0.84)	4.09 (0.76)	−9.11 (45)	−1.358	>0.001
Supported (+)	2.96 (1.03)	4.35 (0.60)	−7.31 (45)	−1.090	>0.001
Hopeful (+)	3.33 (1.02)	4.33 (0.64)	−6.06 (44)	−0.914	>0.001
Emotionally numb (−)	2.85 (1.38)	1.74 (0.91)	4.72 (45)	0.704	>0.001
Able to calm myself after a stressful day (+)	2.98 (1.04)	3.83 (0.88)	−4.37 (45)	−0.651	>0.001

Note. Positively or negatively worded items are marked with a (+) or (−) for clear interpretability; degrees of freedom differ based on the number of missing responses for each item.

ally numb" significantly decreased over the course of the retreat. Follow-up measures were not administered for these retreats.

Participant mean ratings of achievement of retreat goals were high (See Table 3), with an overall mean of 4.41 ($SD = 0.25$) on a scale of 1 to 5, and ranging from 3.68 to 4.70. The most highly rated responses were "I felt gratitude for community support" ($M = 4.70$, $SD = 0.63$) and "I learned from others' experience" ($M = 4.70$, $SD = 0.63$). The least highly rated responses were "I felt my physical pain ease" ($M = 3.68$, $SD = 1.03$) and "I found meaning in the difficult experiences I've had" ($M = 3.89$, $SD = 1.19$).

Additional insight was gained through a review of the qualitative results from Part 2 of the program evaluation. Although some comments indicate areas for improvement, the majority of comments were positive. Two representative positive comments include:

> I'd never had the chance to share with other combat vets since I left the Army shortly after I returned from deployment. Thank you for the opportunity to share my experiences in a safe and accepting environment.

> Thank you for taking the time to show compassion and empathy for what military women experience. Thank you for honoring our service.

Some negative comments highlighted differences in the needs of participants in engaging in elements of the retreat program, for example:

> Please ensure the staff ask the participants of their limitations/profiles prior to the physical exercises—my injury prevented me from fully participating and I didn't like feeling left out.

> I think it is important to separate veterans from wounded warriors sometimes because not all veterans have had traumatic experiences in the service.

Together these findings indicate that the female-veteran retreats provided services that resulted in expected outcomes for participants.

Service-Provider Retreats

Results for the service-provider retreats are presented in Table 5. Paired-samples *t* tests were used to test the significance of differences between the means from entry to exit, and follow-up measures were not obtained for these retreats. Participants reported significant positive changes in the predicted directions from entry to exit for all but one survey item. The item "Hopeless" did not significantly decline between entry and exit, possibly because participants reported already low levels of hopelessness at the beginning of the retreat ($M = 1.59$,

Table 5
Service-Provider Retreat Hypothesis 1 Results

Response item	Entry survey *M* (*SD*)	Exit survey *M* (*SD*)	*t* statistic (*df*)	Cohen's *d*	*p* value
Stressed (−)	3.91 (0.92)	1.82 (0.95)	17.22 (124)	1.546	>0.001
Exhausted (−)	3.82 (1.00)	1.93 (1.04)	14.85 (123)	1.339	>0.001
Happy (+)	3.63 (0.99)	3.94 (1.06)	−2.64 (122)	−0.239	=0.011
Relaxed (+)	2.50 (0.86)	3.78 (1.19)	−9.27 (120)	−0.846	>0.001
Able to care for myself as well as I care for others (+)	2.97 (1.15)	3.79 (1.19)	−5.80 (123)	−0.523	>0.001
Burned out (−)	2.98 (1.27)	1.72 (0.82)	9.09 (122)	0.823	>0.001
Anxious (−)	3.14 (1.20)	1.87 (0.90)	9.48 (123)	0.855	>0.001
Isolated (−)	2.34 (1.31)	1.77 (1.13)	3.66 (123)	0.330	>0.001
Hopeless (−)	1.59 (0.90)	1.39 (0.90)	1.78 (122)	0.161	=0.082
Energized (+)	2.83 (0.94)	3.71 (1.21)	−6.39 (122)	−0.579	>0.001
Connected (+)	3.09 (1.13)	3.88 (1.11)	−5.64 (120)	−0.515	>0.001
Supported (+)	3.08 (1.14)	3.99 (1.09)	−6.71 (122)	−0.607	>0.001
Hopeful (+)	3.56 (0.85)	4.14 (1.11)	−4.61 (123)	−0.416	>0.001
Emotionally numb (−)	2.43 (1.24)	1.58 (1.05)	5.89 (122)	0.533	>0.001
Able to calm myself after a stressful day (+)	3.19 (0.93)	3.91 (1.10)	−5.06 (123)	−0.456	>0.001

Note. Positively or negatively worded items are marked with a (+) or (−) for clear interpretability; degrees of freedom differ based on the number of missing responses for each item.

SD = 0.90). For all other items, the experience of positively worded items such as "energized" and "supported" significantly increased over the course of the retreat, and the experience of negatively worded items such as "stressed" and "emotionally numb" significantly decreased over the course of the retreat.

Participant mean ratings of achievement of retreat goals were high (See Table 3), with an overall mean of 4.17 (*SD* = 0.24) on a scale of 1 to 5, and ranging from 3.62 to 4.51. The most highly rated responses were "I realized I am not alone in my struggles" (*M* = 4.51, *SD* = 0.82) and "I felt gratitude for community support." (*M* = 4.50, *SD* = 0.88). The least highly rated response was "I felt my physical pain ease" (*M* = 3.62, *SD* = 1.23).

Additional insight was gained through a review of the qualitative results from Part 2 of the program evaluation. Although some comments indicate areas for improvement, the majority of comments were positive. Two representative positive comments include:

> Talking with participants was important because I have felt alone and isolated over the last year; to see so many together that share the similar feelings and experiences was positive for me.

> Really, all activities were important. But the small group discussions "gelled" everything for me emotionally. I made valuable contacts with people who understand me and my issues even though we have very different jobs. The meditation sessions were also important in that they helped me come back inside.

Some negative comments highlighted suggestions for changes to the retreat program to make it more relevant to the service provider experience, for example:

> I truly enjoyed the retreat. But not so much talking though, we talk all the time. We like quiet time.

> I wish we had one evening out in the host city to sightsee and spend time together, in a way different from talking/meditating. Also, I would have liked purposeful connection with others from my profession.

Consistency Across Retreats

Although data for each of the individual retreats are not presented in this report, it is important to note that the strength and pattern of improvements were highly consistent across all of the retreats. In all retreats, across type, ALL variables changed in the expected directions, and a similar pattern of significant improvements were observed. This pattern indicates that the CHP as a whole is reliably providing services that result in intended outcomes for military service-member and family-member partic-

ipants across the retreats in different regions of the country.

Discussion

CHP retreats are designed to address the emotional, spiritual, and relationship problems experienced by those who serve in the military, their families, and their providers. The main goal of the retreats is to contribute to the well being and healing of participants. Results of program evaluation for each of the three types of CHP retreats offer support that retreat programming reliably meets these goals of diverse, nonclinical populations in different geographic areas. Overall, the results provide evidence that CHP retreats consistently provide effective services to target populations. All three types of retreats appear to be effective in decreasing negative thoughts and emotions, and similarly effective in increasing positive prosocial thoughts and emotions, such as feeling connected or supported. For those who attended military family retreats, these improvements were sustained over time.

The program evaluations also provide important evidence of the achievement of specific retreat goals. Qualitative analysis of the free-response comments demonstrates that even among participants who offered suggestions for programming changes or gave critical feedback, CHP retreats were a valuable experience that most would recommend to their friends, colleagues, and fellow service members and veterans.

Although it is impossible from the current data to determine which specific aspects of the retreats contributed most significantly to their success, it is theorized that three key elements of CHP-retreat programming were critical variables in alleviating the psychological wounds of war: the creation of a safe communal environment, the provision of self-care skills, and the reduction of stigma to seek further resources of support.

The comments of participants attest that the quality and range of measured changes were enabled by the intentional creation of a safe communal environment. Supported by research on family networks (Riggs & Riggs, 2011), CHP retreats may have fostered a resilience-building environment through reconnection within the self, with family members, with the peer group, and the wider community. Serving participants as a "reverse bootcamp," the retreat experience seamlessly joins relational strategies with training and education to reduce stress and isolation and to enhance feelings of hope and new energies.

In addition, it has been demonstrated that the enhancement of personal resources such as self-esteem and optimism are vital to the processing of deployment stress and subsequent resiliency (Meredith et al., 2011; Schok et al., 2010). CHP retreats provide a range of genuinely engaging self-care activities known to promote health and well-being. Participants reported that the teaching of self-care skills such as meditation allowed them to reconnect with themselves.

Finally, reducing stigma is an essential component of successful resilience interventions (Meredith et al., 2011). The structure of CHP retreats likely decreased perceived stigma in several ways: attendance at the retreats was voluntary, required no psychiatric diagnoses, and was intended to be therapeutic but not psychotherapy. Perhaps in part due to reduction of stigma, participants reported being more open to accessing psychological and other resources to continue on their journeys toward reconnecting with self, their peers, their families, and communities.

Limitations and Future Directions

Several limitations of the present program evaluation should be considered. First, Although the data presented from CHP retreats provide evidence of short-term benefits of the program in promoting wellness and stress relief, little is known about the long-term effects of participation. Future retreats should incorporate longitudinal follow-up data collection for all participants to investigate the sustainability of changes over more extended periods of time.

Another point for consideration is that although study hypotheses were affirmed by statistically significant differences between means on the entry and exit surveys, large effect sizes, and generally positive feedback on retreat participation, it is unclear whether the magnitude of change from pre- to postretreat could be considered clinically meaningful. Free-response comments suggest that the positive gains experienced during the retreats were indeed important. Validation of these surveys on larger pop-

ulations of veterans, service members, their family members, and service providers will be important for developing normative levels of these variables for various populations.

In addition, it may be important to conduct future program evaluations with a control-group design in order to investigate the benefits associated with retreat participation, comparing retreat participants with others who did not participate. Future program evaluations may also focus on specific subgroups, such as retreats for veterans with clinical diagnoses or for spouses only. Other research questions could include: "Is a similar pattern of results obtained by participants experiencing clinical levels of distress, such as those undergoing treatment at a Veterans Hospital?" "As compared with peers who have not attended retreats, how successfully have participants managed the challenges of personal efficacy, economic viability, family stability, and meaningful participatory reconnection with civilian life?" And, "In light of such information, how might this retreat experience be shaped to improve outcomes?"

Finally, it is important to note that the evaluation instrument used in this research was investigator-developed and was not evaluated for validity and reliability. The use of these instruments makes it difficult to determine whether the interventions will be appropriate for clinically disordered populations, or whether they might have an effect on psychological disorders present in military populations. Future studies might evaluate the efficacy of the interventions in randomized controlled trials with clinical populations using validated and reliable measures of PTSD, depression, and family cohesion. Planning for this trial is currently underway by the authors.

Conclusions

This paper reports evaluation results of CHP retreats for veterans, their families, active-duty military, and professional caregivers. Across different populations, geographical regions, and times, participants reported positive personal changes through the creation of a safe communal environment, the provision of tools of self-care, and the reduction of stigma. CHP retreats, with their integrative therapeutic approaches at multiple levels, do not replace existing medical and psychological programs. In fact, they aim to reduce the resistance to accessing these programs when the need becomes salient. This research suggests that the CHP may be a replicable prototype of reintegration programming to serve all returning troops, National Guard members and reservists, veterans and their families, and providers.

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