University of South Carolina
Scholar Commons

Senior Theses | Honors College

Fall 2021

The Road Home Program: An Efficient Model of PTSD Treatment in Veterans

Alexandra J. Fischer
University of South Carolina - Columbia

Brian J. Klassen
Rush University

Rhea A. Merck
University of South Carolina - Columbia

Follow this and additional works at: https://scholarcommons.sc.edu/senior_theses

Part of the Clinical Psychology Commons

Recommended Citation

Fischer, Alexandra J.; Klassen, Brian J.; and Merck, Rhea A., "The Road Home Program: An Efficient Model of PTSD Treatment in Veterans" (2021). *Senior Theses*. 477.
https://scholarcommons.sc.edu/senior_theses/477

This Thesis is brought to you by the Honors College at Scholar Commons. It has been accepted for inclusion in Senior Theses by an authorized administrator of Scholar Commons. For more information, please contact dillarda@mailbox.sc.edu.

THE ROAD HOME PROGRAM: AN EFFICIENT MODEL OF PTSD TREATMENT IN VETERANS

By

Alexandra Fischer

Submitted in Partial Fulfillment
of the Requirements for
Graduation with Honors from the
South Carolina Honors College

December 2021

Approved:

Rhea A. Merck, PhD
Director of Thesis

Brian J. Klassen, PhD
Second Reader

Steve Lynn, Dean
For South Carolina Honors College

Summary

This thesis details my experiences at Rush University's Road Home Program during the summer of 2021. The Road Home Program is an intensive treatment program for veterans suffering from PTSD. It is unique from conventional PTSD treatments in that it provides the equivalent of six months of treatment in just two weeks. The Road Home Program approaches PTSD in a comprehensive way by implementing a variety of therapies and supplemental treatments to veterans. These therapies include Cognitive Processing Therapy (CPT), Mindfulness Based Resiliency Training (MBRT), Dialectical Behavioral Therapy (DBT), and Art Therapy. The supplemental treatments include cognitive seminars, acupuncture, and individual consultations with clinicians.

During the summer of 2021 I watched the drastic change that occurred in veterans as they journeyed through the Road Home Program. At the end of two weeks, veterans experienced less intense PTSD symptoms as well as symptoms of comorbidities such as anxiety, depression, and suicidal ideation. Some of these veterans no longer met the diagnostic criteria for PTSD upon treatment completion. In addition, there has been research, done by the Road Home Program, that supports that these effects are retained up to a year after treatment (Held et al., 2020). I was inspired by the Road Home Program and how drastically it changed veterans' lives in such a short amount of time. Moreover, my goal in writing this thesis is to share with others the hope and potential that exists for veterans at The Road Home Program. I argue that greater consideration and research be allocated towards intensive treatment programs such as the Road Home Program. Most veterans who attend the Road Home Program attest that it saved their lives and as such, this program merits greater consideration from the PTSD treating community in America.

Table of Contents

Summary…………………………………………………………………………………….2

Introduction………………………………………………………………………………….4

Post Traumatic Stress Disorder……………………………………………………………...5

PTSD Symptoms in Veterans………………………………………………………………..7

Social Implications of PTSD………………………………………………………………...9

Barriers to Treatment for Veterans…………………………………………………………10

Cognitive Processing Therapy – Biological Foundations……………………………………11

Cognitive Processing Therapy – Design and Effectiveness…………………………………..13

CPT for Veterans…………………………………………………………………………...16

The Road Home Program…………………………………………………………………..17

Motivations for Treatment………………………………………………………………….18

Therapies and Experiences at Road Home…………………………………………………20

Mindfulness Based Resiliency Training……………………………………………………21

Dialectical Behavioral Therapy…………………………………………………………….23

Art Therapy…………………………………………………………………………………28

Cognitive Seminars, Acupuncture, and Individual Consults……………………………….32

Road Home Program – A Comprehensive Model of Treatment…………………………...33

Road Home Program – An Efficient Model of Treatment…………………………………34

Conclusion………..…………………………………………………………………………...38

References…………………………………………………………………………………..41

Appendix……………………………………………………………………………………...47

Introduction

A visit to the United States Veterans Affairs (VA) website reveals a red button at the top right corner of the screen (U.S. Dept. of Veterans Affairs, n.d.). It says, "Talk to the Veterans Crisis Line now". This bright red button is a public acknowledgement of the increased need for psychological assistance among U.S. veterans. One of the most common mental dysfunctions among veterans is Post Traumatic Stress Disorder (PTSD) (U.S. Dept. of Veterans Affairs, 2018).

During the summer of 2021, I was fortunate enough to intern at the Road Home Program at Rush University Medical Center in Chicago. This program is an intensive two week treatment given to veterans suffering from combat PTSD or military sexual trauma (MST) PTSD (The Road Home Program, n.d.). The experiences I had at the Road Home Program motivated me to write this thesis about the life-changing treatment offered there. My thesis will detail what PTSD is and what it looks like from both a biological and a sociological perspective, as well as highlight the difficulties specific to veterans in pursuing PTSD treatment. Additionally, I will discuss the most effective form of PTSD treatment therapy offered through the Road Home Program, Cognitive Processing Therapy (CPT). I will also identify what makes the Road Home Program unique from other widely accepted forms of treatment. It is my goal to have this thesis disseminated among psychologists and clinicians who may consider the Road Home Program's treatment model as an effective alternative to more common PTSD treatments for veterans.

In this thesis, real life examples are used from veterans who I met with at the Road Home Program. For some readers, the content discussed may be disturbing and potentially triggering, especially if one has PTSD. It is important to note that the stories and ideas reflected in this paper have been altered to preserve and maintain the confidentiality of each individual who

participated in the Road Home Program. No identifiable information is included in this paper. Further, any comments made by veterans have been de-identified so that they may not be traced back to any one specific participant. As expected with this subject matter, maintaining the integrity and privacy of these individuals is of utmost importance while still being able to convey, in a general manner, the tremendously real suffering that comes with PTSD and the extraordinary results currently being achieved following treatment at the Road Home Program.

Post Traumatic Stress Disorder

The Veterans Affairs' website provides insightful information regarding the prevalence of PTSD in America. Every year, approximately 4.5% of the general population in the United States is diagnosed with PTSD. The number of veterans diagnosed with PTSD every year is far greater than the number of civilians diagnosed with PTSD every year. It is estimated that approximately 11 to 20% of veterans who served in Operations Iraqi Freedom (OIF) or Operations Enduring Freedom (OEF) are diagnosed with PTSD in a given year. In addition, approximately 12% of veterans who served in the Gulf War (Desert Storm) are diagnosed with PTSD in a given year. Further, it is estimated that approximately 30% of veterans who served during the Vietnam War were diagnosed with PTSD. It is likely that these percentages underestimate the prevalence of PTSD in veterans given that many never seek a diagnosis or treatment. Despite this, there is still a clear disparity between PTSD prevalence in the general population and PTSD prevalence in the veteran population. In the three war eras mentioned above, the prevalence rate of PTSD among veterans may be anywhere from approximately 3 to 6 times greater than that of the general population in a given year.

It is no coincidence that The National Center for PTSD is the VA (Veterans Affairs) (U.S. Dept. of Veterans Affairs, 2018). According to the Diagnostic and Statistical Manual of

Mental Disorders, Fifth Edition (DSM-5)(American Psychiatric Association [APA], 2013), there are three main groups of individuals who experience the highest incidence of PTSD. These three groups are: (i) military members that have experienced combative trauma, (ii) individuals that have experienced sexual trauma, and (iii) individuals that have experienced either ethnically or politically motivated internment or genocide. Naturally, veterans have a high potential for being part of any of these high incidence groups, making them some of the most at-risk individuals for PTSD. Therefore, it is only fitting that the National Center for PTSD, the VA, be directly accessible to veterans. While there are current treatments and programs available to veterans through the VA, there is still much work to be done. To best understand how to treat PTSD, one must first look to the DSM-5 for a clinical definition and description of common symptoms.

According to the DSM-5, PTSD can result from a traumatic event that occurs to an individual or to someone whom that individual deeply cares about. The DSM-5 outlines some common traumatic events that may lead to PTSD such as:

> ...exposure to war as a combatant or civilian, threatened or actual physical assault (e.g., physical attack, robbery, mugging, childhood physical abuse), threatened or actual sexual violence (e.g., forced sexual penetration, alcohol/drug-facilitated sexual penetration, abusive sexual contact, noncontact sexual abuse, sexual trafficking), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war, natural or human-made disasters, and severe motor vehicle accidents. (p.274)

During a traumatic event, the body elicits the fight, flight, or freeze response which triggers physiological and psychological responses so that your body may address the present threat (stress response mechanism) (Wiltsey Stirman FAST Lab, 2019). This can include elevated levels of epinephrine (adrenaline) throughout the brain, feelings of intense fear or

anxiety, profuse sweating, shortness of breath, racing heartbeat, or in some cases an inability to react or escape the immediate danger (freeze response). For individuals with PTSD, this stress response mechanism is rendered dysfunctional by their trauma. It is often elicited by stimuli that are not threatening but that remind individuals of their traumatic event. Further, the bulk of PTSD symptoms result from a broken stress response mechanism.

The most common symptoms of PTSD include flashbacks and recurring nightmares about the traumatic event (APA, 2013). Flashbacks occur when an individual thinks they are reliving their traumatic experience again. This often results from someone or something that triggers their distressing memories of that event. They often lose consciousness of where they are and they may be lost in this episode anywhere from approximately a few minutes to a few days. Recurring nightmares about their trauma are also common, making it difficult for veterans to maintain good sleep habits. Moreover, veterans with PTSD often avoid sleep and anything that puts them at risk for a flashback or other distressing memories. Sights, smells, sounds, people, places, and things that an individual associates with their trauma are called triggers because they "trigger" (elicit) the stress response mechanism, causing them to physically and psychologically respond as if they were in danger (Wiltsey Stirman FAST Lab, 2019).

PTSD Symptoms in Veterans

At the Road Home Program one veteran described how he experienced a flashback after accidentally knocking over a box of old war items. He said that as the box fell, he caught a smell of the contents inside and was instantly taken back to his traumatic event. Everything smelled, tasted, and looked just as it did when he had experienced it a decade earlier. He perceived that he was in the middle of the battlefield frantically searching for his friend who he lost that day 10 years prior. He searched and searched believing he had a chance at saving him. Approximately

15 minutes later, he realized what he had just experienced was a memory and not real life. It was distressing and heartbreaking to say the least. Moreover, he left the box and its contents scattered across the ground. As he feared experiencing that moment over again if he smelled or touched the contents of the box.

Another veteran described how he would often lie in bed awake, afraid to close his eyes and attempt to sleep. He said every time he did close his eyes, the memories of his triggering event would all come flooding back to him. He could see his friend and the attack being made on him. Even worse, every time he replayed the scenario in his mind, he could never manage to save his friend. As a result, he felt immense guilt and shame over his friend's death and erroneously took on all of the responsibility for this tragedy by himself, despite the fact that there was nothing he could have done to save him. His friend was gone forever, and he believed that he would always feel responsible for the death of one of his brothers.

Another veteran described a trip to Disney where he became distressed by the large crowds present at the theme park. His traumatic event took place in a crowd making the busy theme park a trigger for him. As people accidentally bumped into him while moving through the park, he screamed and yelled, embarrassing himself and his wife and kids. He knew they were uncomfortable, yet, he could not reconcile what he had experienced years ago in the marines with what was happening in that moment.. He had been trained to watch all the sets of eyes and hands around him during his time in the service. Given the large number of people in the park, this was an impossible task for him to do. This specific aspect of being at the theme park was familiar to what he experienced during his traumatic event, which took place in a crowd. The last time he felt like this, unprecedented chaos erupted leading to many injuries and deaths. Further, he perceived the crowds at Disney to be threatening, making the trip distressing for not only him

but for those close to him as well.

Social Implications of PTSD

Distressing experiences from triggers can make it difficult for veterans to go to work, interact appropriately with others, and to be functional in society (Anxiety and Depression Association of America, n.d.). For a veteran, something as regular as an ambulance siren can change the trajectory of a conversation. One moment they are fine and then after hearing the siren they are angry, defensive, and irritable. Their stress response has been elicited, but the people around them don't know that. Those around the individual may become uncomfortable or start to have negative feelings towards this individual given their unprecedented mood swing. It is quite common for individuals with PTSD to struggle with emotional regulation and maintaining healthy relationships (Anxiety and Depression Association of America, n.d.). From an outsider's perspective, one may interpret individuals with PTSD as impatient and easily agitated or angered individuals (APA, 2013). They have an unregulated stress response which is easily set off by non-threatening stimuli, making them more susceptible to lashing out and inappropriately responding to everyday challenges (Wiltsey Stirman FAST Lab, 2019).

It is common for individuals with PTSD to isolate themselves from anyone or anything that reminds them of their trauma (Wiltsey Stirman FAST Lab, 2019). This is the key difference between individuals that have PTSD and individuals that experience traumatic events and never end up having PTSD. Avoidance works in the short term as it prevents the individual from having the intense and uncomfortable physiological and psychological responses elicited by triggers. However, in the long term, this becomes even more debilitating to the individual on their recovery journey. As they isolate themselves from others, they tend to develop negative beliefs and ideals about themselves, their families, and the world in general that are harmful to

their well-being. They can even develop other disorders such as anxiety, depression, or suicidal ideation (Reisman, 2016). While it is clear they need help, only half of veterans with PTSD seek treatment (Hart, 2015).

Barriers to Treatment for Veterans

According to veterans at the Road Home Program, in military culture, there is a large presence of stigma around receiving mental health treatment. While in the service, receiving any sort of mental health care while on base is viewed as weak and one is likely to be labeled as crazy for doing so. Further, very few individuals actually seek out mental health treatment while serving. A veteran at the Road Home Program stated that he never wanted to be ostracized as some of the other men were when they pursued mental health treatment. Further, he suppressed the distressing emotions he felt while in the service and did not pursue treatment for years after coming home. He, like many other veterans, did not want to be labeled (Stecker et al., 2013). In addition, he thought his symptoms would eventually go away in time.

When veterans return home, they have various places where they can pursue treatment. The VA offers free mental health services, however, many of the veterans I met stated they would never seek treatment there. There is a common distrust of the VA given prior negative experiences while in the service (Stecker et al., 2013). Treatments for PTSD are available outside of the VA, however, these can be extremely expensive for veterans given that many struggle financially (Elbogen et al., 2012). Financial struggles are another significant barrier to treatment. This can be due to many different reasons, a 2012 study conducted by the U.S. Department of Human and Health Services (HHS) stated, veterans suffering from PTSD, depressive disorder, or a traumatic brain injury may experience greater financial struggles than the average person. This is due in part to their disorder making it more difficult for them to hold a job. They also estimate

that up to 41% of the homeless population in America is veterans. Finding a provider that the veteran will trust and be able to afford are huge barriers to treatment (Stecker et al., 2013; Elbogen et al., 2012).

Even with trustworthy and affordable therapists, veterans often dropout of treatment programs before they have been completed (Held et al., 2019). This may be due to many different reasons. For one, they may have difficulty attending therapy in the midst of other familial and work obligations. This is especially apparent in younger veterans who are starting families or raising children. In addition, most improvements seen with therapy take anywhere from months to years to achieve. Given the slow progression of treatment, individuals are likely to drop out early on. It is distressing for veterans to go to therapy and to have to face their traumas head on. They are used to avoiding thoughts and feelings associated with them. Further, if positive results are not achieved and maintained in a timely fashion, it is likely that many veterans will drop out as they feel like they are continuing to suffer with no improvement in return. Avoidance can be one of the largest deterrents to treatment completion.

Cognitive Processing Therapy -- Biological Foundations

The Road Home Program's treatment model is heavily based in a form of Cognitive Behavioral Therapy (CBT) called, Cognitive Processing Therapy (CPT) (Zalta et al., 2018). Patricia A. Resick, a former University of South Carolina Gamecock professor, developed CPT after witnessing the unique distress experienced by female rape victims (Resick, Monson, & Chard, 2017). She noted that their symptoms, although similar, were not characteristic of generalized anxiety disorder or depressive disorder. The women she worked with did not feel fear after their trauma, rather, they experienced feelings of betrayal and patterns of avoidance.

It was not until 1980, that the DSM-III listed PTSD as its own specific anxiety disorder

(Resick, Monson, & Chard, 2017). Given that the cognitive effects of PTSD are very different from those of anxiety disorders, a new model of treatment was needed. Resick, Monson, and Chard developed CPT with avoidance tendencies in mind. This therapy required individuals to face their traumas head on by returning to old thoughts and emotions associated with them. This was in stark contrast to more common anxiety treatments which required individuals to focus on thoughts and feelings in the present. Returning to buried thoughts and emotions posed a daunting task for individuals with PTSD, given their tendency to avoid thoughts and feelings associated with their triggering event. To understand why CPT works so well for individuals with PTSD, one must first understand the biological underpinnings of the fight or flight mechanism. The prefrontal cortex and the amygdala are involved in the fight or flight response of the brain. The amygdala regulates emotions such as fear and aggression. The prefrontal cortex functions in decision-making and cognition. These two brain areas share a reciprocal relationship during the fight or flight response. When there is a perceived threat, the amygdala emits messages of fear to the rest of the brain. As a result, the prefrontal cortex and its functioning are dampened. This effectively lowers one's ability to think logically and make decisions. This is why many people panic when in danger and often do not make the best choices in a distressing situation. When the threat is gone, the amygdala stops firing, the feelings of fear evade, and the prefrontal cortex is activated again. Decision-making and logical thinking is now occurring again while fearful emotions are no longer existent.

For individuals with PTSD, this reciprocal relationship is damaged (Resick, Monson, & Chard, 2017). That is, the amygdala is more easily stimulated than is the prefrontal cortex. It has been found that individuals with PTSD have a more active amygdala and smaller sized prefrontal cortexes than the general population. Therefore, it requires more effort to stimulate the prefrontal

cortex of an individual with PTSD than it does for the average individual. Likewise, it is difficult to dampen the messages of the amygdala given this characteristic. This is the biological explanation for why it is difficult for individuals with PTSD to regulate their emotions and distressing feelings. These brain regions in the fight or flight mechanism therefore, must be targeted and trained in order to repair the reciprocal relationship.

Cognitive Processing Therapy - Design and Effectiveness

Cognitive Processing Therapy takes a unique approach to treatment in order to help repair the broken fight or flight mechanism in the brain (Resick, Monson, & Chard, 2017). Research done by Hariri and colleagues in the 2000s found that exercises involving the verbal or written use of language to describe emotional faces or dangerous objects stimulated the prefrontal cortex (Hariri, Bookheimer, & Mazziotta, 2000; Hariri et al., 2003). Resick, Monson, and Chard extrapolated on this finding, when she created CPT (Resick, Monson, & Chard, 2017). She did this by incorporating written accounts of trauma into therapy, effectively stimulating the prefrontal cortex. This helped individuals to logically work through their trauma and to not get bogged down in strong emotions. This is in stark contrast to other common therapies such as prolonged exposure therapy (PE), which involves subjecting individuals to sounds and visual stimuli that excite the amygdala. This method prevents the stimulation of the prefrontal cortex, making it more distressing for individuals with PTSD to work through trauma.

While both CPT and PE are efficient at improving PTSD symptoms, CPT yields significantly less feelings of guilt, hopelessness, and suicidal ideation among patients (Resick et al., 2002; Gallagher & Resick, 2012; Gradus et al., 2013). In fact, the significant loss of these feelings and the lessening of PTSD symptoms as a whole was found to still exist at both five and ten years after treatment completion (Resick, et al., 2012). CPT is likely more successful at

reducing negative feelings than PE because the prefrontal cortex, and likewise, rational thinking are stimulated during activities involving language (writing/speaking about the trauma) (Resick, Monson, & Chard, 2017). When the prefrontal cortex is stimulated, the amygdala is dampened. Thus, the individual has a better chance of logically working through their trauma under these conditions, as they are less likely to experience uncontrollable emotions while engaging in activities having to do with language (stimulating the prefrontal cortex). The end goal of the writing exercises is, in part, to practice activating the prefrontal cortex, making avoidance less characteristic to normal functioning.

CPT with writing has been found to yield the largest effect sizes in two meta-analyses completed in 2013 and 2015 (Hageen et al., 2015; Watts et al., 2013). The 2013 analysis found CPT to have the largest effect size when compared with other common treatments for PTSD such as exposure therapy and eye movement desensitization and reprocessing (Watts et al., 2013). CPT also had an effect size approximately two times greater than that of the most effective medication, paroxetine. The results from the 2013 analysis indicated that veterans had lower effect sizes than did non-veterans in every form of therapy and medication studied. The results of the 2015 meta-analysis indicated that CPT had the greatest overall effect size in veteran populations when compared to exposure therapy, stress management training (SMT) and eye movement desensitization and reprocessing (EMDR), three other common therapies for PTSD (Hageen et al., 2015). It also found that the combination of individual and group therapies yielded the greatest effect sizes in veterans, when compared with just individual therapy and just group therapy approaches to PTSD treatment.

Resick relied heavily on McCann and Pearlman's *Constructivist Self-Development Theory* while developing CPT (Resick, Monson, & Chard, 2017). The theory supports that

humans actively create their own personal realities. That is, what they experience is interpreted to fit their own individual perspectives and beliefs rather than objective reality. CPT is designed to improve one's cognitive flexibility, that is, one's ability to see their event from a more objective perspective. Many veterans with PTSD will blame themselves for events that they never could have prevented and that they had little to no control over. For example, a veteran may blame himself for not preventing an ambush. He may experience thoughts like, "It is my fault the ambush killed 20 of my brothers. I should have stopped it, I should have known we would be attacked." Resick calls this kind of thought a stuck point because it prevents an individual from moving forward in treatment.

Stuck points are not based in fact. In the example above, the stuck point is clearly erroneous given that an ambush by definition is a surprise attack, and therefore, there is no way the individual could be held responsible for it happening (Resick, Monson, & Chard, 2017). Yet, the individual firmly believes it because this is the reality he or she has perceived on their own. In CPT, the therapist points out to the individual the flaws in their stuck point. In this example, they would make clear to the individual that objectively speaking, there is nothing anyone can do to prevent an ambush. It is not something that can be predicted given its surprising nature. Working through stuck points allows for the individual to cultivate a healthier way of thinking that is based in logic rather than subjective truth or emotion. This exercise is the bulk of CPT.

While in practice this process can become more complicated, one does not need to be a licensed psychologist to effectively deliver CPT (Bass et al., 2013). A study conducted in the Congo provides great evidence for the potential good that can be achieved through the deliverance of CPT by less educated groups. Among the women who received CPT from therapists only holding a high school diploma, only 9% of these participants still had PTSD after

a 6 month follow up. This is significantly different from the 42% of individuals who still had PTSD after having been given supportive therapy by individuals only holding a high school diploma. These results are promising given that these women came from communities experiencing high daily rates of crime and violence, increasing their risk for trauma. If it can be successfully delivered by high school graduates in the Congo, it should be able to be delivered just about anywhere.

CPT for Veterans

The first study of CPT in veterans with PTSD was conducted in 2006 (Monson et al., 2006). When compared to prolonged exposure (PE), veterans receiving CPT with writing exhibited greater success in treatment. This was seen in improvements not only in the PTSD symptoms but also in other comorbidities they had been suffering from (i.e. anxiety and depression). At the one month treatment follow-up, 40% of veterans who received CPT with writing were found to have no further symptoms of their PTSD. This study highlights that this is an effective method of therapy not only for civilians with PTSD but also for veterans.

In 2011 CPT was studied among male veterans in both a telemedicine and face to face format (Morland et al., 2011). No significant differences were found between these two conditions. Both resulted in significant reductions in PTSD symptoms that were maintained at follow-up. This suggests that veterans receiving CPT via telemedicine should experience outcomes comparable to veterans receiving CPT in person. Another study, conducted by the same group compared CPT outcomes for female veterans and female civilians (Morland et al., 2015). While both telemedicine and face to face therapy were effective, civilian women had better outcomes than did the veteran women. This suggests that veterans may require a different approach to CPT than do civilians in order to achieve similar outcomes.

Another telemedicine study was conducted on Iraq and Afghanistan war veterans (Maieritsch et al., 2016). The treatment was found to be just as effective as in person therapy, however, the dropout rate was found to be higher amongst these individuals. This group was much younger than those tested previously in 2011 and 2015, further, it is hypothesized that these individuals were more likely to drop out given they may need to allocate more time to relationships, jobs, and children, than do older individuals. The study suggested that further research be done on commitment and completion of treatment.

The Road Home Program

The Road Home Program is a two week, intensive treatment program for veterans with PTSD (The Road Home Program, n.d.). They serve veterans suffering from military sexual trauma (MST) PTSD as well as veterans suffering from combat PTSD. This program is unique from many others given that it provides the equivalent of six months worth of treatment in just two weeks. Veterans are at the treatment center from Monday through Friday, 7am to 5:30pm. They are provided housing in the Illinois Medical District. All expenses such as housing, meals, travel, and treatment, are paid for by the Road Home Program. They are funded by generous donors such as The Wounded Warrior Project, Robert R. McCormick Foundation, The Chicago Bears, Welcome Back Veterans, and Bank of America to name a few. They are also one of four Warrior Care Network treatment centers for PTSD. As such, veterans from all over the country have come to the Road Home Program for PTSD treatment.

At the Road Home Program, veterans receive both individual and group therapy along with psychoeducational services and Mindfulness meditation practices (Zalta et al., 2018). The bulk of treatment is given in twice daily, individualized sessions of CPT with writing. The writing assignments are completed as homework outside of the actual treatment session. These

involve written accounts of trauma as well as stuck point worksheets. Further, treatment takes place both during and after the program everyday. Many veterans who have been to the Road Home Program will tell you that while it was one of the most intense experiences of their life, they would do it again to be where they are today.

During the summer of 2021, I had the privilege and the honor of interning at the Road Home Program. I witnessed vulnerability and brokenness like I had never seen before. It was not until this experience that I really understood just how discarded veterans feel when they leave the service. Many arrived at the Road Home Program, feeling isolated, avoided, fearful, depressed, irritable, suicidal, left for dead, and undeserving of the help and care they so desperately needed. By as early as day three of treatment, many had started to find light that they never believed would exist for them again.

Although this thesis is incomparable to what was actually seen and heard at the Road Home Program, my hope is that I may inspire others with the stories and experiences described here. It is my desire that the Road Home Program's model of treatment be more heavily funded and expanded throughout the United States. For now, I hope that this thesis will spark an interest in further research on intensive treatment programs. I hope to convey that they are a very promising avenue of treatment for veterans with PTSD (Zalta et al., 2018).

Motivations for Treatment

The first day of treatment was nothing short of intense and intimidating. Each veteran was asked three questions. First, had they attended any sort of treatment program prior to attending the Road Home Program. Second, what is their biggest reason(s) or motivator for coming to the Road Home Program. Third, what would they most like to change about themselves. The veterans gave similar answers to each of these three questions.

Every single veteran had attended psychological treatment prior to attending the Road Home Program. For the majority of them, prior treatment was pursued on and off ranging anywhere from a few years to a few decades. Many noted that they had started and stopped different types of therapy over the course of that time. Some described that they would feel better while attending treatment and then when it was completed, or when they prematurely stopped attending, they would eventually fall back into their PTSD symptoms as well as any symptoms relating to comorbidities they had (anxiety, depression, suicidal ideation, etc.).

The biggest motivator for veterans in getting better was their families. Everyone noted the toll their PTSD and comorbidities took on their relationships with spouses as well as their children. The men and women expressed not wanting to "f*** up their children" and not wanting to separate or divorce from their spouses. Many also noted that it was their spouses who had pushed them to pursue more treatment, despite that their prior experiences had been unsuccessful. Their lives were typically spent in isolation from others or in constant arguing with those closest to them. Further, these veterans claimed they sought treatment for their family's sake rather than their own. Many, if not all of them, stated they did not deserve to get better, they did not deserve to be happy again, and they did not believe they could. They acknowledged without hesitation that their spouses and children most certainly deserved better. Family, therefore, was the biggest motivator for these veterans.

When asked what they would most like to change about themselves, their answers covered a variety of problems. Depression, anxiety, and suicidal ideation were mentioned by every veteran. They desired to rid themselves of the darkness and sadness that comes with these debilitating diagnoses. Many also acknowledged substance abuse as an unhealthy coping mechanism that they commonly used. They noted, they never really felt better under the

influence, rather, they felt nothing which was better than feeling depressed or anxious. Moreover, they wished to have better control of their emotions and to experience more positive emotions. All of these struggles exacerbated their PTSD as well as their damaged relationships with their families. While the Road Home Program centers itself on PTSD treatment, there have been cited improvements in other comorbid diagnoses at the end of the treatment program. Given that multiple different forms of therapy are offered, many diagnoses are able to be tackled during the two weeks. This ultimately leads to better results and better retention of results after treatment completion.

Therapies and Experiences at Road Home

The Road Home Program tackles PTSD and its comorbidities so well because they approach the diagnoses from multiple perspectives. Individual and group therapy is used every day, multiple times a day, over the course of the two weeks. Many veterans noted that the use of both types of therapy was helpful for them on their journey. They were able to receive individualized treatment sessions, specifically in CPT or individualized consults with therapists. In addition, they spent the two weeks with other men and women who experienced similar traumas and environments. One chief complaint among veterans with PTSD is that most people cannot understand what has happened to them and how they feel on a daily basis. Group therapy, therefore, was cathartic for these individuals. They found reassurance and comfort in each other, knowing they were going through similar struggles and enduring a most difficult journey back to health together.

There are three main group therapies at the Road Home Program, including: Mindfulness Based Resiliency Training (MBRT), Dialectical Behavioral Therapy (DBT), and Art Therapy. In between individualized CPT sessions, veterans would attend these three therapies. They were

each given ninety minutes at a time. MBRT was given every day of the treatment. DBT was given twice a week and Art Therapy was given once the first week and three times the second week. These therapies work together with each other and CPT to elicit the best results possible from the intensive treatment program. Each is evidence based and need not rely on the other therapies to be successful.

Mindfulness Based Resiliency Training

Mindfulness Based Resiliency Training (MBRT), or Mindfulness, is the practice of noticing thoughts, sensations, and emotions in the present moment, without judgment and without trying to change them (Schure et al., 2018). It is a non-trauma focused therapy that has been proven to reduce “emotional numbing, avoidance behaviors, and hyperarousal” in veteran populations suffering from PTSD. MBRT has been proven to help veterans to improve their ability to stay in the moment, to accept adversity, and to reconcile negative memories and emotions of the past.

Based on my experience at Road Home, PTSD sufferers often judge themselves for having many negative emotions and thoughts. They do their best to avoid distressing thoughts and memories as much as possible. However, in avoiding these thoughts and feelings, they prevent themselves from getting better. They never find peace with themselves or with what has happened to them because they never allow themselves to work through their pain. In MBRT, veterans practice allowing whatever thoughts, sensations, and emotions they have to exist (Schure et al., 2018). They are to notice them, without judging or changing them. The idea is that with practice, Mindfulness will become a more natural practice for them in everyday situations, ultimately helping them to better acknowledge and cope with negative emotions and feelings they may have.

Mindfulness practice involves both meditation and mindful movement (yoga). During the session, individuals may choose to sit, stand, or lie down in whatever position is most comfortable for them. At the Road Home Program, an instructor guided the meditation, providing directions for the veterans to follow if they so desired. They had the freedom to focus on any thoughts, sensations, or emotions they were experiencing, whether the instructor mentioned them or not. An example of a direction is, “Focus on your feet, how they feel on the ground, in your shoes, what sensations you are able to detect. Are they clammy or cold? Are they tight in your shoes or loose? What sensations can you feel in your toes? What thoughts and emotions are you experiencing at this moment?”. This type of practice would be done for anywhere between five and fifteen minutes at a time. The practice would either be done in complete stillness (mindful meditation) or in controlled movements (mindful movement - yoga).

While being mindful may sound simple and maybe even relaxing, many of the veterans at the Road Home Program experienced great difficulty with this at the beginning of treatment. They had habitually avoided allowing their minds to be complacent up until this point. They avoided negative thoughts, sensations, and emotions that came with sitting in silence, without some other distraction around. During the first few days of MBRT they struggled with thoughts and emotions that revolved around their traumas. In addition, some individuals struggled with injuries which affected their ability to move and to find a comfortable position during mindful movement. This was an exercise which sought to reverse one’s tendency to avoid negative thoughts, sensations, and emotions by practicing facing them head on.

Veterans, in addition to practicing MBRT, discuss topics relating to MBRT. For instance, they discuss instances in their life when they have difficulty regulating how they respond and how they can best implement mindfulness in those scenarios. They also discuss practicing self-

care such as exercising, reading a book, or talking with a friend when they feel down. The topic of resilience is heavily discussed, specifically, what it means to be resilient. That is, being able to adapt to stress both in the present and to stress that we have carried with us from previous events. Self-compassion is another big theme, given that many veterans feel they are undeserving of compassion from others, let alone themselves. The impact of MBRT is multi-faceted in that it touches multiple aspects of recovery all in the same practice of stopping, sensing, and noticing one's thoughts and emotions.

Towards the second week of treatment, many veterans expressed that they looked forward to mindfulness and yoga everyday. They stated that it was a nice way to sit without judgment and to just be with themselves, to take note of what thoughts, feelings, and emotions they had and to just notice them. The mindfulness training was not nearly as intense as the CPT and as such, it was a nice sort of break between their two CPT sessions during the day. It provided them with a place and a practice of just being in the moment, just noticing, not judging.

While none of the veterans were experts in Mindfulness when they left the Road Home Program, many noted that they continued to practice Mindfulness when they returned home from treatment. In this sense, the Road Home Program not only treated these individuals while they were there, but it continues to treat them from hundreds of miles away while they are at home.

Dialectical Behavioral Therapy

Dialectical Behavioral Therapy (DBT) is an evidence-based practice which has been shown to improve emotional dysregulation as well as lessen suicidal ideation in veterans (Landes et al., 2016). At the Road Home Program, DBT introduces a variety of emotion and communication skills to veterans. Veterans built on the skills being learned in other therapies at Road Home during DBT sessions. For instance, Mindfulness provided the practice of noticing

one's emotions whereas DBT provided the practice of communicating and regulating those emotions. In the same vein, CPT provided a space for identifying stuck points whereas DBT provided a space for working through stuck points in a group setting. Moreover, DBT allowed for the application and practice of the tools and topics being offered in other therapies at the Road Home Program.

Many veterans benefit from improving their emotional regulation skills (Landes et al., 2016). When asked about how they experienced emotions in the military, many veterans stated they were not allowed to have them. In short, how they felt about a situation never mattered when looking at the end goal of surviving with their fellow troops. If anything, emotions detracted from one's ability to work efficiently and to prevent unnecessary death. It wasn't feasible for them to feel everything they were experiencing. If they became too bogged down in their emotions, they were likely to never make it through their mission. As a result, veterans become excellent at completely suppressing emotions. In doing so, they lost their ability to effectively regulate and communicate their emotions to others. DBT is necessary to improve one's ability to experience, regulate, and communicate their emotions effectively.

During DBT, therapists detailed different skills that veterans could use in a variety of situations. The skills centered around regulating one's emotions in a distressing situation. One of the skills given was called the STOP skill. That is, Stop, Take a step back, Observe, and Proceed mindfully. This skill encourages veterans to notice how their environment impacts their emotions. Further, rather than just reacting instinctually, they should remove themselves from the situation and take note of what is happening inside them as well as around them. Then, when they are ready, they should return to the situation with an action that will help them to achieve whatever their goal is in that specific scenario (something that will make the situation better).

Another distress tolerance skill is TIP. That is, Tip your temperature, Intense exercise, Paced breathing and Paired muscle relaxation. These are all different actions that can affect the physical symptoms of distress. Splashing your face with cold water, going for a run, taking deep breaths, and practicing paired muscle relaxation are all effective ways of lowering the stress response of your body. This skill involves physical actions that can help one take control of a stressful situation. At times, it may be easier to go and workout your feelings of stress or anger than to stop and take deep breaths. The best method for stress regulation is different for each person and may also differ for varying scenarios.

In the Road Home Program therapies, emotional regulation skills like STOP and TIP were practiced and discussed in a group setting. Therapists would pose hypothetical situations in which different skills could be applied. Then, as a group, individuals would talk through each step of the skill and what that would look like in real life. These hypothetical situations were accompanied with group discussions about emotions. Many veterans struggled to name positive reasons for having emotions, but one veteran gave a very meaningful answer, stating, "greatness cannot be achieved without emotions". If one was to be completely logical all the time, nothing would ever mean anything. One would never feel any sort of connection to others and would never be able to accomplish or service anyone or anything beyond themself. Further, emotions allow for greatness because they sometimes defy logic.

For instance, it is not logical to run back into an ambush to save your friend who has been deeply wounded. He is unlikely to survive given the severe injury to his chest. Yet, by deciding to run in, you risk your own life for the slight chance that you will save his. This is illogical for you to do due to the increased likelihood and risk of being killed yourself. Yet, emotionally, you cannot resist trying to save your friend. Greatness, by this veteran's definition, is the ability to go

above and beyond what is asked of you and to defy what is logical when necessary. Emotions are what prevent us from existing monotonously. A life without emotion would feel meaningless, boring, and without deep connection. A life without emotion is far from greatness.

While this example may have been triggering to some of the other veterans in the room, it was a convincing argument for emotions. The point is, emotions carry great weight and value in our day-to-day lives and we would not be better off without them. In fact, much of who we are would be missing without emotions. Further, with emotional regulation practices, the goal is not to suppress emotions and to never allow ourselves to feel them. Rather, emotional regulation helps one to experience emotions in a healthy way. If one can regulate their response to distressing circumstances no matter how small or large they are, they are better able to face life's many challenges.

Based on the DBT instruction given at Road Home, emotional regulation is a stepping stone to improving communication. The foundation lies in recognizing one's emotions and applying the necessary skills to experience them in a healthy way. In order to resolve conflict or whatever is causing distressing emotions, it is imperative to be able to effectively communicate. People need to be able to explain to others in a constructive and acceptable way how they feel in a certain situation. This also means learning to listen in a more effective way to better respond to what someone else may need or feel. For veterans, effective communication skills are extremely important given that how they experience communication now may be starkly different from the type of communication experienced in the service.

When asked about communication norms in the military, all veterans stated they were starkly different from what they now experienced at home. Members in the military are told what to do, how to do it, and when to do it. Orders are given and there are no options for questions or

comments. While this is effective in the military and in getting individuals to follow your authority, outside of the military, this often drives people away. At home they noted their family members did not take well to this kind of communication style. Oftentimes, it caused a divide between them and their spouses as well as strained relationships between them and their children. Coworkers found them to be dominating and arrogant. Generally, most people avoided interacting with them because of how they communicated with others. Further, effective communication methods were necessary to lessen much of the distress they experienced in everyday interactions with others.

A significant amount of DBT was dedicated toward learning how to establish boundaries in relationships, referred to here as, interpersonal effectiveness. According to therapists at Road Home, the goal of establishing healthy boundaries is to be able to effectively communicate what you want or need from others. As a result, individuals are better able to build strong and healthy relationships and to eliminate destructive ones. During the session, stuck points related to interpersonal effectiveness were addressed as a group. Individuals checked off whatever statements they believed to be true for them from a handout given in class (see Appendix A). The most commonly shared stuck points were then discussed among the group. Then, a new skill, DEAR MAN, was introduced as a way of effectively setting boundaries with others. DEAR MAN stands for the following: Describe the current situation, Express your feelings and opinions about the situation, Assert yourself by asking for what you want or clearly stating what you do not want, Reinforce the person ahead of time by explaining positive effects of getting what you want or negative effects of not getting what you want, be Mindful and focus on your own goals, Appear confident, and be willing to Negotiate. Hypothetical situations were worked through as a group, implementing this new skill.

The third component of DBT involved working through stuck points as a group. While no veteran revealed any of his personal stuck points, hypotheticals were given to work through together as a group so that each individual would have more opportunities to practice dealing with stuck points. Following the group practice sessions, it became easier for the veterans to correctly work through stuck points on their own. In class, individuals would complete an ABC Worksheet while working through stuck points (see Appendix B). They would first describe the event that elicited the stuck point (A - activating event), then they would describe the stuck point (B - belief/stuck point), and finally they would describe the consequence of this stuck point (C - consequence/how they feel). After identifying these three things, the group would discuss whether the stuck point was realistic or helpful to the individual. Then, they would come up with thoughts they could use in the future to replace the stuck point with when it came up.

DBT ultimately provided a safe and controlled environment in which different skills such as Mindfulness could be built upon and where new skills such as STOP, TIP, and DEAR MAN could be introduced. It served as a cooperative therapy with CPT as well in that it provided more practice on working through stuck points. It was collaborative in that it was group therapy where individuals could share what they struggled with and even learn from their peers in how to better utilize skills and work through stuck points. DBT provided the tools and practice necessary to foster strong emotional regulation and communication skills. These skills learned here would be useful for the rest of their life, as they provided instruction and guidance on how to re-acclimate to a civilian lifestyle.

Art Therapy

It can sometimes be difficult for veterans to verbalize to others the emotions connected to a specific trauma, as well as during the journey that follows (American Art Therapy Association,

2010). This can arise from being surrounded by civilians who have no military experience or any idea what military life is like. It can also arise from simply not having words to describe the intense feelings of pain and suffering that they have endured and even continue to endure on a daily basis. Understanding this, the Road Home Program implements Art Therapy which requires no words, just expression. The goal of Art Therapy is not to create an amazing looking product, but rather, to overcome obstacles that come with creating the product. Art involves areas of the brain not necessarily having to do with language, and as such, Art Therapy helps to reorganize thoughts and feelings that may not be easily verbalized. This is a more holistic approach to negative thoughts, given they might not always be words. Many individuals experience traumatic images and as such, this sort of symbolic expression of trauma helps individuals to visually face these thoughts, ridding themselves of more avoidance tendencies.

Most of the veterans I met at the Road Home Program had previous hobbies in art or music prior to their traumatic event. After their event occurred, they stopped pursuing the hobby given they found little enjoyment in it anymore. Many argued they didn't believe that they deserved to enjoy things anymore and never picked up the hobby again because of it. For many, Art Therapy was the first time in decades that they had returned to some form of art since their traumatic event.

At the first Art Therapy session, veterans were given a white paper mask to do with whatever they wanted. The front of the mask would represent what they showed to the world. That is, how they thought the world saw them. The inside of the mask would be what they hid from the world. That is, how they felt about themselves. They were not restricted to taking the piece in this direction, however, this is the framework that was presented to them to help them start. Art Therapy provided a space where the veterans could really bond with and get to know

one another. It was a lowkey environment where individuals were able to process their thoughts and emotions in a more symbolic manner. They talked to each other as friends and bonded over many things, especially the difficult journey they were enduring together at the Road Home Program.

The last day of therapy revealed how close the veterans had become to one another during the intensive therapy sessions. Each veteran presented their artwork to the rest of the group and described what the inside and outside represented. Veterans did this on their own account with the understanding that they did not have to share anything that they did not want to share. Everyone gave a short description of their art and what it revealed about them. The group members supported each other when struggles were shared and discussed. Not only that, some of the veterans said they had never felt more understood by someone else. They could relate to each other on a level that was not possible with others who had (i) not been diagnosed with PTSD and (ii) who had never endured military culture and norms.

While each mask was beautiful and meaningful, I have limited myself to only speaking about a general theme that was portrayed amongst multiple masks during my time at the Road Home Program. This is to help maintain the privacy of all the veterans who participated. Given that multiple people created similar masks, it only makes sense to use the following description so as to prevent the identity of any particular individual as being easily recognizable.

A number of individuals painted their mask to look like the Joker, from Batman. I was astounded by the number of veterans who cited this character as someone they strongly related to because of his darkness, bitterness, his dark humor, and the smile he carved into his face. Be assured that none of them wished for mass destruction as the character portrayed in the movie. Rather, they related to his struggle with mental health more than anything. These veterans, like

the Joker, have been beaten and bruised physically and psychologically. Eventually, their hearts became darkened by the terrible things that happened to them. Like the Joker, they felt as if they were incapable of climbing out of the hole of despair in which they were so deeply entrenched.

The veterans highlighted a few quotes from the Joker as descriptive of how they felt about themselves and the world around them. They felt dark and alone and like no one could understand them. They believed they were unworthy and undeserving of anything good. The smile they showed the world was far from sincere, it was a mask they used to avoid burdening others with the darkness they carried around inside of them. They were ashamed of this darkness and they believed it would never leave them. Below are some of the quotes they cited when presenting their masks:

> Smile because it's easier than explaining what's killing you on the inside.
>
> Why so serious?
>
> Let's put a smile on that face.
>
> They need you right now, but when they don't, they'll cast you out like a leper.
>
> The worst part of having a mental illness is people expect you to behave as if you don't.
>
> All I have are negative thoughts.
>
> I'm only laughing on the outside. My smile is just skin deep. If you could see inside, I'm really crying, you might join me for a weep.
>
> No matter the situation, always wear a smile. (Sager, 2021)

For these men and women, their masks represented how they felt before coming to the Road Home Program. They felt better on the last day of treatment than they had in years. Many noted that for the first time in years, they had stopped experiencing suicidal thoughts. Others said they were nervous about the transition back home, but were hopeful for their future. They were

still learning to have compassion toward themselves and were by no means in perfect condition when they left the Road Home Program. They did, however, possess new skills and tools necessary to maintain and even improve how they felt when they returned home.

Cognitive Seminars, Acupuncture, and Individual Consults

Two cognitive seminars are given at the Road Home Program centering on sleep hygiene and cognitive health. Both of these were given in order to help veterans better understand how to improve sleep habits as well as memory among other cognitive abilities . This was important to them given that many veterans experience insomnia or irregular sleep cycles as well as memory issues (APA, 2013). This may be a result of their trauma and the symptoms associated with PTSD that affect sleep and memory: flashbacks, recurring nightmares, and avoidance of thoughts associated with the trauma. These difficulties may also be associated with traumatic brain injuries acquired during their time in the military. Veterans were instructed about how to improve one's sleep habits and cognitive abilities. This was not therapy, rather, it was education on how to sleep better and work better upon returning home.

In addition to cognitive seminars, other non-therapy services were offered to veterans. During the last hour of the day, veterans could choose to pursue acupuncture or individual consultations with psychologists about skills or areas where they felt they needed more help. If they did not wish to pursue acupuncture or individual consults, they had this extra time to work on writing assignments given to them during CPT. Many opted for acupuncture which is heavily supported in literature as being effective in lowering the symptoms of PTSD. A 2020 meta analysis of acupuncture for PTSD treatment asserts, "...acupuncture can affect the autonomic nervous system, and the prefrontal as well as limbic brain structures, making it able to relieve the symptoms of PTSD." (Ding, Li, Song, Huang, & Zhang, 2020). Moreover, the Road Home

Program offered more than just a therapeutic approach to PTSD treatment. The problem was approached from multiple angles. It was all encompassing in that it provided education and other well supported forms of medicine to provide these veterans with the best chance at overcoming their PTSD.

Road Home Program - A Comprehensive Model of Treatment

The Road Home Program is unique in that it combines multiple types of therapies and supplemental approaches in treating its patients. This allows for a more holistic treatment of each individual. This multi-faceted approach goes above and beyond what is expected when delivering Cognitive Processing Therapy to clients by providing them with various skills, practice, and discussion about what they are learning at the Road Home Program. This is a likely contributor to the high efficacy therapy achieved by the Road Home Program, even after patients have left the treatment center. While every component of the Road Home Program is able to stand well on its own, when combined into a comprehensive model of treatment, individuals seem to have a much greater chance at overcoming their PTSD symptoms (Zalta et al., 2018; Held et al., 2019).

The practice of Mindfulness allows for individuals to learn how to identify and notice how they are feeling (Schure et al., 2018). This is extremely important for veterans given that many of them have suppressed their emotions and feelings since their time in the military. They must relearn how to identify what emotion they are experiencing and even more so, they must learn how to accept negative thoughts and feelings that they will inevitably experience. Mindfulness lays the groundwork for Dialectical Behavioral Therapy in that it provides the foundation to emotional regulation and communication skills. Once the individual has identified what they are feeling, they must learn how to manage their feelings in an appropriate and healthy

way. This means practicing skills like STOP and TIP as well as learning how to effectively communicate how they feel to others.

Art Therapy provides a different approach to PTSD treatment in that it allows for the individual to work through their trauma without having to use words. This therapy fills in the holes that Mindfulness and DBT cannot account for in doing so. Many veterans experience negative images or memories that they may have difficulty expressing through language. Art Therapy is like Mindfulness in that it is teaching the individual to accept the thoughts and feelings they are having and to work through them (like in DBT).

The cognitive seminars, acupuncture, and individual consults all serve as supplemental to the other therapies offered at the Road Home Program. They provide an education on how to improve memory and sleep (cognitive seminars) which are both necessary to working through emotions and regulating emotions well. They also offer acupuncture which is a supported practice for the treatment of PTSD. In addition, the individual consults are always available for any individual looking to gain more practice on skills or guidance on anything they are struggling with.

All of these therapies and supplemental treatments complement the bulk of the treatment at the Road Home Program which is Cognitive Processing Therapy. The ultimate goal of this treatment is to improve cognitive flexibility and to help activate the logical area of the brain (Prefrontal Cortex). One can argue that treatments such as Mindfulness, DBT, and Art Therapy are rewiring the brain similarly to how CPT does. Moreover, they are group therapies that allow for the practice and discussion of what is being done during CPT sessions, creating a very comprehensive and strong model of treatment.

Road Home Program - An Efficient Model of Treatment

Current intensive treatment programs, such as the Road Home Program, have been able to lower dropout rates, maintain large effect sizes and high retention rates seen with CPT in a shorter amount of time, and obtain high patient satisfaction rates (Zalta et al., 2018; Held et al., 2019). The Road Home Program has also been successful in removing any financial responsibility from participants as well as in providing easier access to the treatment program in doing so (The Road Home Program, n.d.). In short, intensive treatment programs like The Road Home Program posit an evidence based model to improving treatment of PTSD in veterans (Zalta et al., 2018; Held et al., 2019).

According to the 2015 meta-analysis done by Fernandez, Salem, Swift, and Ramtahal, dropout from CBT treatment is more common among (i) individuals suffering from depression, (ii) individuals attending outpatient programs rather than inpatient programs, and (iii) individuals who have completed less sessions of CBT than those who have completed more. This meta-analysis was done on traditional and non-traditional approaches to Cognitive Behavioral Therapy. For the purposes of this thesis, traditional delivery of Cognitive Behavioral Therapy will be in reference to outpatient programs where treatment is delivered once or twice a week for a number of weeks or months. Non-traditional delivery of CBT will be in reference to intensive outpatient programs, whether it be Road Home specifically or other programs delivered similarly to Road Home.

Traditional CBT can look differently given different practitioners and individuals undergoing therapy (Held et al., 2019). It is common for individuals to attend traditional CBT therapy sessions once a week for about an hour. Treatment may take anywhere from weeks to months before yielding significant improvements in symptoms. Depending on where the individual is going for treatment, traditional CBT can be given in an individual setting, a group

setting, or both. In addition, traditional CBT does not necessarily include the supplemental therapies like those that are offered at Road Home (MBRT, DBT, Art Therapy, Cognitive Seminars, Acupuncture). Moreover, individuals attending traditional CBT therapy do not stay at the treatment center for a prolonged period of time. This is all in stark contrast to the Road Home Program as it is an intensive outpatient program where individuals receive all of their treatment in two weeks and they do not leave the program until they are finished.

According to researchers at Road Home, although The Road Home Program is much shorter (two weeks) than traditional CBT treatment (10-12 weeks), it yields comparable effect sizes to traditional CBT treatment (Zalta et al., 2018). Moreover, compared to outpatient settings, where therapy is often delivered once a week for multiple weeks or months, intensive treatment programs, like Road Home, have lower dropout rates (Zalta et al., 2018; Held et al., 2019). Approximately 8% of veterans dropped out of the Road Home Program in 2018. This is well above the average dropout rate of approximately 40% of veterans in traditional PTSD outpatient programs such as traditional CBT (Zalta et al., 2018).

There are numerous reasons why veterans stop treatment before completion (Held et al., 2019). For example, with traditional CBT, individuals may have difficulty scheduling therapy with work and family needs in combination with the ability of their provider. In addition, it is understood that individuals with PTSD struggle with avoidance and may not pursue therapy every week. Given that in traditional CBT, therapy sessions are only given once or twice a week, the results of treatment are slowly revealed over longer periods of time, increasing the likelihood of dropout. Conversely, intensive treatments, like Road Home, are able to alleviate the difficulties associated with scheduling therapy every week by delivering the entire program over the course of two weeks. In addition, avoidance tendencies are better managed given that the

individual resides at the intensive for a two week time period and that the individual experiences results in a shorter amount of time.

It has been demonstrated that great success is achieved through the Road Home Program (Zalta et al., 2018). Road Home has reported large reductions in PTSD symptoms and retention of these effects for up to one year after treatment (Held et al., 2020). At the three month follow-up veterans have noted a slight increase in their PTSD symptoms, however, researchers at Road Home hypothesize that this is due to difficulties that come with re-acclimating to home life after treatment. Despite this, individuals seemingly return to the level of symptoms experienced upon leaving the treatment center at both the six month and twelve month follow ups. The Road Home Program also reports a great reduction in suicidal ideation among veterans despite the fact that suicidal ideation is never directly targeted during the program (Post et al., 2021). In their 2018 effectiveness study, the Road Home Program noted that symptom reduction never plateaus during the intensive (Zalta et al., 2018). Further, they hypothesize that a longer intensive treatment program may be even more beneficial, yet less feasible for veterans in reducing symptoms of PTSD and depression (Zalta et al., 2018).

The Road Home Program takes a multi-faceted approach to PTSD treatment and in doing so, makes it difficult to determine the most necessary and beneficial components of the program (Zalta et al., 2018). They note that CPT directly targets negative cognitions and as such is an integral component to the program. Nonetheless, it is not necessary to understand the exact benefit of every therapy or psychoeducational service offered at the Road Home Program to recognize that it is a promising program, especially given its brevity. Approximately 53% of individuals who attended the intensive no longer met the criteria necessary to be diagnosed with PTSD.

Research supports that Road Home is a promising avenue of treatment for veterans with PTSD yielding lower dropout rates, and high patient satisfaction and retention (Zalta et al., 2018; Held et al., 2019).The Road Home Program also eliminates the common barrier of cost of treatment completely (The Road Home Program, n.d.). While large scale studies are scarce among intensive outpatient programs, the results of small scale studies on the Road Home Program and other intensive outpatient programs speak clearly about the benefits and success of choosing to give a shorter and faster version of treatment (Zalta et al., 2018; Held et al., 2019). Further attention should be given to the idea of intensive treatment programs for veterans suffering from PTSD as the Road Home Program has changed the lives of many.

Conclusion

Before the Road Home Program, these many veterans had been tremendously suffering from PTSD. They isolated themselves from the world, ashamed of what they had experienced or witnessed. Distressing circumstances followed them everywhere. They had no escape from the darkness that had been created inside their minds. Suicide often seemed like the easiest answer. Their families and loved ones suffered alongside them, watching them struggle and enduring their never-ending irritability and then grief. They were in need of rescuing; they were falling hard and fast down a bottomless pit.

Many different therapies and medications were used. For the majority, they worked as well as a silk parachute. A sound and outdated idea that in practice lacked the characteristics necessary to ensure a safe landing. Silk parachutes are easily tangled and warped out of shape by winds, something that is inevitable when falling from the sky. The fabric itself is lacking in elasticity. It requires idyllic conditions to perform appropriately, and there is not much give and take there. In addition, mildew easily embeds itself in the minute fibers, making it impossible to

remove the weight it adds to the fabric, rendering the process ineffective. The therapies and medications pursued by veterans prior to the Road Home Program were not made to withstand heavy winds, to bend and adapt under difficult conditions, and to prevent the festering of mold that is anxiety, depression, and suicidal ideation.

The veterans I met arrived at the Road Home Program with outdated, torn, and moldy parachutes in their hands. Throughout the intensive treatment therapy, these men and women stitched and sewed together a new PTSD parachute made from nylon. This fabric is common in newer parachute models and has been successful for others in recent years. It can withstand even the heaviest of winds, as it is equipped with the tools necessary to do so (Mindfulness, DBT). The fabric possessed more elasticity than did the silk, allowing for adaptation given different elements and conditions (CPT - Stuck Points). Best of all, it was water resistant, preventing the buildup of mildew so that nothing could weigh them down (improvement of comorbidities alongside PTSD). Many participants would go on to say their nylon parachute was the best thing they had ever made. It was their lifeline, and it helped them to land safely on their feet. It grounded them during their time at the Road Home Program and it continued to ground them upon their return home.

The Road Home Program offers a life changing treatment for veterans suffering from PTSD. The impact this treatment can have on them and their families cannot be understated. Multiple veterans claim the Road Home Program to be what saved them from suicide. They have called it the light they never thought they would see again. Every individual who I met agreed that they had never experienced mental health care like what they experienced at the Road Home Program. Many participants started to feel better by day three and continued to get better and better every day thereafter. Not only that, they maintained their progress after treatment as well.

I hope this thesis reaches the hands of someone very important who has the ability to make the Road Home Program more widely accessible across the country. This means more resources, more treatment centers, more psychologists and clinicians, and more lives saved from PTSD. The goal of those treating veterans should be to remove the bright red button from the top right corner of the VA's website. The goal should be to alleviate the psychological needs of veterans so efficiently that psychological dysfunction is no longer so prevalent among them as to merit a crisis line front and center on the Veterans Affairs page. The red button screams of the injustice done to our fellow brothers and sisters, it screams of the many men and women that have been left behind by the United States military, despite the oath taken by every member to never leave a fallen comrade behind. The battlefield is not limited to the confines of a warzone. For many who suffer from PTSD and comorbidities such as anxiety, depression, and suicidal ideation, the battlefield continues into civilian life.

References

American Art Therapy Association. (2010). Use of Art Therapy in the Treatment of Veterans. *American Art Therapy Association*. www.arttherapy.org

American Psychiatric Association. (2013). PTSD. *Diagnostic and Statistical Manual of Mental Disorders 5th Edition. 271-280*. https://doi.org/10.1176/appi.books.9780890425596

Anxiety and Depression Association of America. n.d. Understanding PTSD. *ADAA*.https://adaa.org/understanding-anxiety/posttraumatic-stress-disorder-ptsd

Bass, J.K., Annan, J., McIvor Murray, S., Kaysen, D., Griffiths, S., Cetinoglu, T., Wachter, K., Murray, L.K., Bolton, P.A. (2013). Controlled trial of psychotherapy for Congolese survivors of sexual violence. *New England Journal of Medicine*, *368(23), 2182-2191.*

Ding, N., Li, L., Song, K., Huang, A., & Zhang, H. (2020). Efficacy and safety of acupuncture in treating post-traumatic stress disorder: A protocol for systematic review and meta-analysis. *Medicine*, *99*(*26*). https://doi.org/10.1097/MD.0000000000020700

Elbogen, E. B., Johnson, S. C., Wagner, H. R., Newton, V. M., & Beckham, J. C. (2012). Financial well-being and postdeployment adjustment among Iraq and Afghanistan war veterans. *Military medicine, 177*(6), 669–675. https://doi.org/10.7205/milmed-d-11-00388

Fernandez, E., Salem, D., Swift, JK., Ramtahal, N. (2015). Meta-analysis of dropout from cognitive behavioral therapy: Magnitude, timing, and moderators. *Journal of Consulting and Clinical Psychology Dec;83(6):1108-22*. doi: 10.1037/ccp0000044. PMID: 26302248.

Gallagher, M., & Resick, P.A. (2012). Mechanisms of change in cognitive processing therapy and prolonged exposure therapy for posttraumatic stress disorder: Preliminary evidence

for the differential effects of hopelessness and habituation. *Cognitive Therapy and Research*, *36(6), 750-755*.

Gradus, J.L., Suvak, M.K., Wisco, B.E., Marx, B.P., & Resick, P.A. (2013). Treatment of posttraumatic stress disorder reduces suicidal ideation. *Depression and Anxiety, 30, 1046-1053.*

Haagen, J.F.G., Smid, G.E., Knipscheer, J.W., & Kleber, R.J. (2015). The efficacy of recommended treatments for veterans with PTSD: A metaregression analysis. *Clinical Psychology Review, 40, 184-194*.

Hariri, A.R., Bookheimer, S.y., & Mazziotta, J.C. (2000). Modulating emotional responses: Effects of a neocortical network on the limbic system. *NeuroReport, 11(1), 43-48.*

Hariri, A.R., Mattay, V.S., Tessitore, A., Fera, F., & Weinberger D.R. (2003). Neocortical modulation of the amygdala response to fearful stimuli. *Biological Psychiatry, 53(6), 494-501*

Hart, N. (2015). Veterans Battling PTSD: Know the Triggers Recognize the Symptoms. *North Carolina Medical Journal*. https://www.ncmedicaljournal.com/content/76/5/308.short

Held, P., Bagely, J., Klassen, B.J., & Pollack, M.H. (2019). Intensively Delivered Cognitive Behavioral Therapies: An Overview of a Promising Treatment Delivery Format for PTSD and Other Mental Health Disorders. *Journal of Occupational and Environmental Medicine*. https://doi.org/10.1080/20008198.2020.1789324

Held, P., Klassen, B. J., Boley, R. A., Wiltsey Stirman, S., Smith, D. L., Brennan, M. B., Van Horn, R., Pollack, M. H., Karnik, N. S., & Zalta, A. K. (2020). Feasibility of a 3-week intensive treatment program for service members and veterans with PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy, 12(4), 422-430.*

https://doi.org/10.1037/tra0000485

Held, P., Zalta, A.K., Smith, D.L., Bagley, J.M., Steigerwald, V.L., Boley, R.A., Miller, M., Brennan, M.B., Van Horn, R., & Pollack, M.H. (2020). Maintenance of treatment gains up to 12-months following a three-week cognitive processing therapy-based intensive PTSD treatment programme for veterans. *European Journal of Psychotraumatology, 11(1),* doi: 10.1080/20008198.2020.1789324

Landes, S.J. PhD, Matthieu, M.M. PhD, LCSW, Smith, B.N. BA, Trent, L.R. PhD, Rodriguez, A.L. BA, Kemp, J. PhD, RN, Thompson, C. PhD. (2016). Dialectical Behavior Therapy Training and Desired Resources for Implementation: Results From a National Program Evaluation in the Veterans Health Administration. *Military Medicine. Volume 181, Issue 8, 747–752*. https://doi.org/10.7205/MILMED-D-15-00267

Maieritsch, K.P., Smith, T.L., Hessinger, J.D., Ahearn, E.P., Eickhoff, J.C., & Zhao, Q. (2016). Randomized controlled equivalence trial comparing videoconference and in person delivery of cognitive processing therapy for PTSD. *Journal of Telemedicine and Telecare, 22(4), 238-243.*

Monson, C.M., Schnurr, P.P., Resick, P.A., Friedman, M.J., Young-Xu, Y., & Stevens, S.P. (2006). Cognitive processing therapy for veterans with military related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 74(5), 898-907.*

Morland, L.A., Hynes, A.K., Mackintosh, M., Resick, P.A., & Chard, K.M. (2011). Group cognitive processing therapy delivered to veterans via telehealth: A pilot cohort. *Journal of Traumatic Stress, 24(4), 465-469.*

Morland, L.A., Mackintosh, M.A., Rosen, C.S., Willis, E., Resick, P.A., Chard, K.M., & Frueh, B.C. (2015). Telemedicine versus in-person delivery of cognitive processing therapy for

women with posttraumatic stress disorder: A randomized noninferiority trial. *Depression and Anxiety, 32(11), 811-820.*

Post, L. M., Held, P., Smith, D. L., Black, K., Van Horn, R., Pollack, M. H., Rothbaum, B. O., & Rauch, S. A. M. (2021). Impact of intensive treatment programs for posttraumatic stress disorder on suicidal ideation in veterans and service members. *Psychological Services. 18(4), 671–678.* https://doi.org/10.1037/ser0000518

Reisman M. (2016). PTSD Treatment for Veterans: What's Working, What's New, and What's Next. *P & T : a peer-reviewed journal for formulary management, 41(10), 623–634*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047000/

Resick, P.A., Monson, C.M., Chard, K.M. (2017). Cognitive Processing Therapy for PTSD: A Comprehensive Manual. *The Guilford Press. 1-19, 33, 102-105.*

Resick, P.A., Nishith, P., Weaver, T.L., Astin, M.C., & Feuer, C.A. (2002). A comparison of cognitive processing therapy, prolonged exposure and a waiting condition for the treatment of posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology, 70(4), 867-879.*

Resick, P.A., Williams, L.F., Suvak, M.K., Monson, C.M., & Gradus, J.L. (2012). Long-term outcomes of cognitive-behavioral treatments for posttraumatic stress disorder among female rape survivors. *Journal of Consulting and Clinical Psychology, 80(2), 201-210.*

Sager, J. (2021). 150 Joker Quotes To Make You Appreciate The Madness and Put a Smile on That Face. *Parade.* https://parade.com/1231125/jessicasager/joker-quotes/

Schure, M. B., Simpson, T. L., Martinez, M., Sayre, G., & Kearney, D. J. (2018). Mindfulness-Based Processes of Healing for Veterans with Post-Traumatic Stress Disorder. *Journal of alternative and complementary medicine (New York, N.Y.), 24(11), 1063–1068.*

https://doi.org/10.1089/acm.2017.0404

Stecker T, Shiner B, Watts BV, Jones M, Conner KR. (2013). Treatment-seeking barriers for veterans of the Iraq and Afghanistan conflicts who screen positive for PTSD. *Psychiatr Serv.1;64(3):280-3.* doi: 10.1176/appi.ps.001372012

The Road Home Program. (n.d.). Intensive Outpatient Program. *Road Home Program*.https://roadhomeprogram.org/intensive-outpatient-program/

The Road Home Program. (n.d.) Our Corporate Partners. *Road Home Program.* https://roadhomeprogram.org/corporate-donations/

The Road Home Program. n.d. Welcome To The Road Home Program. *The National Center Of Excellence For Veterans And Their Families At Rush*. https://roadhomeprogram.org/

U.S. Department of Veterans Affairs. n.d. Access and manage your VA benefits and healthcare. *VA Benefits and Healthcare*. https://www.va.gov/

U.S. Department of Veterans Affairs. (2018, September). How Common is PTSD in Veterans?. *PTSD:National Center for PTSD*. https://www.ptsd.va.gov/understand/common/common_veterans.asp

Watts, B.V., Schurr, P.P., Mayo, L., Young-Xu, Y., Weeks, W.B., & Friedman, M.J. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *Journal of Clinical Psychiatry, 74, 541-550.*

Wiltsey Stirman FAST Lab. (2019, December 19). Recovery and Fight or Flight [Video]. *Youtube*. https://www.youtube.com/watch?v=7IEqnlnDSAE

Zalta, A.K., Held, P., Smith, D.L., Klassen, B.J., Lofgreen, A.M., Normand, P.S., Brennan, M.B., Rydberg, T.S., Boley, R.A., Pollack, M.H., Karnik, N.S. (2018). Evaluating patterns and predictors of symptom change during a three-week intensive outpatient

treatment for veterans with PTSD. *BMC Psychiatry 18*, 242.

https://doi.org/10.1186/s12888-018-1816-6

Appendix

A

INTERPERSONAL EFFECTIVENESS HANDOUT 2

Stuck Points Related to Interpersonal Effectiveness

- ☐ 1. I don't deserve to get what I want or need.
- ☐ 2. If I make a request, this will show that I am a very weak person.
- ☐ 3. I have to know whether a person is going to say yes before I make a request.
- ☐ 4. If I ask for something or say no, I can't stand it if someone gets upset with me.
- ☐ 5. If they say no, it will kill me.
- ☐ 6. Making requests is a really pushy (bad, self-centered, selfish, etc.) thing to do.
- ☐ 7. Saying no to a request is always a selfish thing to do.
- ☐ 8. I should be willing to sacrifice my own needs for others.
- ☐ 9. I must be really inadequate if I can't fix this myself.
- ☐ 10. I shouldn't have to ask (say no); they should know what I want (and do it).
- ☐ 11. They should have known that their behavior would hurt my feelings; I shouldn't have to tell them.
- ☐ 12. I shouldn't have to negotiate or work at getting what I want.
- ☐ 13. Other people should be willing to do more for my needs.
- ☐ 14. Other people should like, approve of, and support me.
- ☐ 15. They don't deserve my being skillful or treating them well.
- ☐ 16. Getting what I want when I want it is most important.
- ☐ 17. I shouldn't be fair, kind, courteous, or respectful if others are not so toward me.
- ☐ 18. Revenge will feel so good; it will be worth any negative consequences.
- ☐ 19. Only wimps have values.
- ☐ 20. Everybody lies.
- ☐ 21. Getting what I want is more important than how I get it.

From *DBT Skills Training Handouts and Worksheets, Second Edition*, by Marsha M. Linehan. Copyright 2015 by Marsha M. Linehan. Permission to photocopy or download and print this handout is granted to purchasers of this book for personal use or for use with clients.

B

HANDOUT 6.3

ABC Worksheet

Date: ____________ Client: ____________

Activating Event **A** *"Something happens"*	**Belief/Stuck Point** **B** *"I tell myself something"*	**Consequence** **C** *"I feel something"*

Are my thoughts above in column B realistic or helpful? ____________

What can I tell myself on such occasions in the future? ____________

From *Cognitive Processing Therapy for PTSD: A Comprehensive Manual* by Patricia A. Resick, Candice M. Monson, and Kathleen M. Chard. Copyright © 2017 The Guilford Press. Permission to photocopy this handout is granted to purchasers of this book for personal use or for use with individual clients (see copyright page for details).