Evaluating the Use of Poetry to Reduce the Signs of Depression, Anxiety, and Stress in Veterans

Misty Pearl Ely

Liberty University

A Dissertation Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Education

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Abstract

A veteran is anyone who has served on active duty in one of the five branches of the military, regardless of peacetime or combat exposure. Currently, veterans make up 2.2 million of our nation's population and the rates of mental health concerns are continually on the rise due to the prolonged nature of Operations Enduring Freedom, Iraqi Freedom, and New Dawn. With the drawdown of forces, the military is smaller than usual and yet must maintain the safety and security of the world at the same standard. Therefore, these service members are recycled over and over to deployments abroad and their invisible wounds of war are becoming more recognized in society as a whole. The Department of Veterans Affairs cannot keep up with the mental health needs of these veterans. New innovative treatment approaches need to be developed and integrated into mainstream society, creating different avenues in order for veterans to receive care. Poetry in therapy has been used in several studies to reduce the symptoms of depression and anxiety with traumatized clients. It is proposed that the use of poetry therapy in a group setting with veterans could reduce traumatic symptomology, such as depression and anxiety.

Keywords: veterans, poetry therapy, trauma, anxiety, depression

Dedication

Dedicated to the men and women of our armed forces and the talented humans that hear their stories, guide their recovery, and inspire hope. Thank you for your service, sacrifice, and the selfless love you have for our nation.

Acknowledgments

This dissertation would not be possible without the inspiration of my fellow veterans, my incredible family, those born of blood and those born of my beloved Corps.

My spectacular children, Felicity, and Julian. You are my world, my universe, and the reason I survived. I hope I have made you proud.

Thank you, family, and friends, for the countless hours of listening to me ramble, cry, scream, and find the resolve to keep going. I love you all more than air, even water, but not more than books.

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List of Abbreviations

Cognitive Processing Therapy (CPT)

Department of Veterans Affairs (VA)

Depression Anxiety Stress Scale 42 (DASS-42)

Eye Movement Desensitization Reprocessing (EMDR)

Military Sexual Trauma (MST)

Operation Enduring Freedom (OEF)

Operation Iraqi Freedom (OIF)

Operation New Dawn (OND)

Posttraumatic Stress Disorder (PTSD)

Prolonged Exposure (PE)

Traumatic Brain Injury (TBI)

Veterans' Health Administration (VHA)

Chapter One: Introduction

Overview

The wars in Iraq and Afghanistan are now the longest-running wars in United States history having commenced October 7, 2001 (Rubin et al., 2013). As veterans return home and reintegrate into society after years of war, we must ensure resources are allocated to meet their medical and mental health needs (Cohen et al., 2009). Alternative treatment approaches are needed at this crucial time due to the number of veterans in need of access to care from Veterans Affairs (VA). Goetter et al. (2015) explained that novel interventions are needed to mitigate the problem of dropout, such as treatment with shorter time frames, motivational components, or social connection enhancements. Poetry in a group therapy setting could provide significant motivation and healing for this vulnerable population (Ben-Tovin, 2017).

Background

Research indicates that the key mental health issues affecting the approximately 2.4 million veterans of our wars are traumatic brain injury, posttraumatic stress disorder, substance use, depression, anxiety, and marital discord, and oftentimes these disorders overlap (Li et al., 2018; Rubin et al., 2013). Several challenges affect a veteran's access to mental health care including insufficient mental health workforce capacity and competency in evidence-based practice, inadequate systems to support care, and the veteran's reluctance to seek care (Burnam et al., 2009). Additionally, homelessness disproportionality affects veterans, and it is estimated that 23% of the homeless population in the United States are veterans (Russell, 2009). Within the homeless veteran population itself, "45% suffer from mental illness and half have substance abuse problems" (Russell, 2009, pg. 359). If a veteran is struggling with homelessness, seeking mental health counseling is often not a top priority for them.

Wait times for appointments, lack of bed space, and distance from VA facilities have been additional challenges to care (Burnam et al., 2009). Research has indicated that approximately 61% of all separated Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) veterans used Veterans Health Administration (VHA) services between October 2001 and 2014, making the VHA the single largest health care provider for these veterans (Ramsey et al., 2017). However, not all veterans are entitled to VHA services. This entitlement is based on several factors, including type of discharge characterization, combat deployment, length of service, or reason for discharge. There are currently five types of discharges from the Armed Forces, including Honorable, General Under Honorable, Other Than Honorable, Bad Conduct, and Dishonorable (Brooks et al., 2017).

The first two types of discharges allow ready access to VHA care and services such as educational benefits. However, the last three types do not allow access to services easily. For example, if a veteran received an Other Than Honorable discharge and wanted to receive mental health care at the VHA they would need to apply for a discharge upgrade, acquire the assistance of a Veterans Service Officer to navigate the paperwork process, and wait on a determination from the higher authorities to gain access (Brooks et al., 2017). Between Vietnam and the current conflicts, over 200,000 veterans left the military with discharges of Other Than Honorable conditions. Therefore, most of these veterans do not have mental or medical health care, homeless programing, educational benefits, or any of the other benefits bestowed upon veterans (Brooks et al., 2017).

Depression and post-traumatic stress disorder (PTSD) are widespread within the veteran population and are associated with impairments across a number of areas, including decreased social functioning, poor overall health, and poor quality of life (Painter et al., 2016). It has been

suggested that traumatic memories are assigned to active memory storage and repeat their content until processing has been completed and the memory is integrated (Scott, 2020). Palmer et al. (2017) reported that PTSD and depression prevalence rates of 80% and 73%, respectively, had been observed among veterans in their research.

Post-traumatic stress disorder has afflicted service members for many years; however, it was previously referred to as shell shock, battle fatigue, soldier's heart, nostalgia, 1000-yard stare, and other descriptive names (Walker et al., 2016). According to the VA, PTSD was not added to the Diagnostic and Statistical Manual of Mental Disorders until the third edition in 1980 (Rubin et al., 2013). The incidence of mental illness among veterans spans all ages and periods of conflict (Russell, 2009). Schnurr et al. (2009) explained that advances in military medicine increased the rate of survival from combat wounds and that blast injuries have caused a high rate of traumatic brain injury. Therefore, many service members return home to cope with serious physical impairments along with the psychological consequences of trauma exposure (Ramsey et al., 2017; Schnurr et al., 2009). Roadside bombs improvised explosive devices (IEDs), suicide bombers, the handling of human remains, and human violence are all extreme stressors in the combat environment (Burnam et al., 2009).

Personal growth, long term economic benefits, a better job, and pathways to education are some of the reasons why people join the military. Some leave troubled homes, others join for patriotism, and some choose to follow in family members' footsteps who served. Veterans often describe ingrained military values and traditions that influence their present-day beliefs and behaviors (Wray et al., 2016).

PTSD is often comorbid with other psychological disorders as well as physical health conditions. Vietnam veterans with persistent PTSD symptoms (over 14 years) were found to

have worse family relationships, less life satisfaction and happiness, more mental health use, and more non-specific health complaints than those without PTSD (Li et al., 2018). However, Wray et al. (2016) discussed how the perceived impact of symptoms on the veteran's life or family influences the decision to seek care. Family members themselves are often in need of therapeutic services, as well.

Increasing access to mental health treatment and decreasing stigma about seeking treatment are two important barriers to treatment (Kashdan et al., 2010; Wray et al., 2016). Competence, confidence, and stoicism in the military may make negative mental health beliefs an especially salient barrier to care for veterans (Vogt et al., 2014). An attitude of openness and nonjudgment toward one's experiences may be a crucial mechanism of promoting change within this population (Thompson & Waltz, 2010; Vogt et al., 2014). Russell (2009) discussed the Department of Defense Task Force on Mental Health's findings that the current system of care for physiological health is "insufficient" in meeting the needs of service members and their families. According to Deshpande (2010) one of the ways to help clients recover from trauma is to restore their sense of power and control. Most agree that trauma recovery happens in stages: stabilization, remembering, and reconnection (Deshpande, 2010; Szto et al., 2005; Wachen et al., 2016). Poetry could be a potential bridge to provide the much-needed treatment for these veterans, while also creating an environment free of stigma with an all-veteran group.

Creative arts therapy is a term used to describe therapeutic modalities including visual arts, drama, creative music, and dance (van Westrhenen et al., 2017). Accordingly, bibliotherapy, journal therapy, narrative therapy, and poetry also fall within the creative arts therapies (Chilton et al., 2015; Collins et al., 2006; Mazza & Hayton, 2013). Poetry, like narratives, tells stories and evoke powerful feelings, although not always in a linear fashion (Furman, 2004; Malekoff,

2007). Poetry typically uses figurative language (metaphors), imagery, rhythm, and sound (Hilse et al., 2007; Witney, 2012). Language and experience can feel woven together with the words we use to articulate our emotions (Carroll, 2005; Dorman, 2017). Nevinski (2013) expanded on the value of self-expressive writing for veterans and family members in reporting that those who had engaged in writing made fewer physician visits for illnesses in the months following the intervention. Expressive writing can also be used to confront and reframe traumatic events (Deshpande, 2010).

King et al. (2013) discussed poetry therapy as the longest established writing therapy in the United States that has the creative virtue of encouraging creative play with imagery and the practical virtue of brevity. Vietnam war poet Bruce Weigl wrote in his memoir about the connection between death, poetry, and the irony, as well: "The war took away my life and gave me poetry in return" (2001, p. 5–6). Ben-Tovim (2017) explained how poetry can help veterans find the words to discuss their trauma, whereas in traditional psychotherapies the veteran is at a loss for words relating to not only the event, but the emotion evoked. According to Nevinski (2013), "Poetry provides a safe environment in which clients can explore feelings previously buried; it creates a holding environment in which clients can experience and re-experience feelings which were previously inaccessible" (p. 213). Additionally, poetry can help people understand the reality of war from a perspective rarely seen or acknowledged (Van Devanter & Furey, 1991).

Systems theories emphasize reciprocal relationships among the elements that constitute a whole, including individuals, groups, organizations, or communities and mutually influencing factors in the environment. By employing a systems theory approach, we can look at the veteran population as its own group and culture, with separate rules, ethics, and moral underpinnings.

Systems theory can be used to develop a holistic view of an individual within their social environment, and it best applied to situations where several systems are inextricably connected and influence each other (Tan, 2011). We can begin to examine the problem/issue through the lens of a veteran as they see their world, learning to survive and navigate anew.

The model for this study was poetry therapy utilizing a strengths-based perspective. The theory behind strength-based therapy is that through trauma or hardships, people discover their inner strengths (Tan, 2011). This focus sets up a positive mindset that helps build on best qualities, find strengths, improve resilience, and change their worldview to be more positive (Tan, 2011). These approaches are used together often and examine not only the individual, but also the multiple system environments a veteran will have in their lives. According to Deshpande (2010), working in a group setting is a definite advantage for veterans to help them break through their isolation and rebuild the trust that has eroded over the years. Goodwin et al. (2018) explained how the combination of backgrounds and unique perspectives of the group members can enhance creativity and problem-solving.

Problem Statement

Research indicates that veterans experience significant perceived barriers to engaging in treatment and many do not benefit from treatment (Palmer et al., 2017). Goetter et al. (2015) noted, in their review of treatment outcome studies of veterans with PTSD, the average dropout rate was 23%. Worthen (2011) posited that a better understanding of the relationships among traumatic experiences, PTSD symptoms, and anger problems, would assist mental health professionals in creating more targeted therapy for those affected veterans. The research problem explored in this dissertation is whether using poetry in a group therapy setting decreases the symptoms of depression, anxiety, and stress in veterans.

There is a significant amount of research concerning veterans' mental health and the types of traditional treatments available. There is also an expansive collection of expressive and creative arts therapies that have been utilized throughout history to provide treatment for anxiety and depression. According to Albright (2015), the use of poetry and other artistic therapies with veterans and their families has been relatively unexplored. Poetry can articulate the complexities of the inner world and experiences of the writer (Bolton, 1999; Jones, 2011). The gap in the literature, however, is a systematic investigation of the use of poetry in therapy to assist veterans suffering with anxiety and depression, due to traumatic experiences, in a group environment. To date, this specific topic utilizing this method, has not been researched and further inquiry could potentially produce new approaches to help the many veterans in need.

Purpose Statement

The purpose of this quantitative research was to examine whether using poetry in group counseling influences veterans' levels of depression, anxiety, and stress as measured by the Depression Anxiety Stress Scale (DASS-42). The independent variable in this study was participation in poetry group counseling across a seven-week period. The treatment group participated in seven group counseling sessions in which the counselor implemented at least one poetry technique per session (e.g., preexisting poems, completing blank spaces in a poem, or collaborative poetry writing). The poetry and technique used in each session was chosen by the author based on the needs of the group. The control group participated in seven traditional group counseling sessions utilizing CPT techniques. The three dependent variables in this study were depression, anxiety, and stress levels. Each variable was measured using the DASS-42 (Parkitny & McAuley, 2010); the DASS-42 was also administered as a part of the presurvey and used as a covariate in the experimental, pretest-posttest randomized control group design.

Participants were military veterans, at least 18 years of age, willing to participate in a poetry therapy group, with no foreseeable barriers to group treatment (seven weeks). Any veteran presenting mental health diagnoses such as psychotic disorders or substance use disorders precluded the individuals from participating in the study. Individuals with circumstances preventing any consistent treatment over the seven-week period were also excluded, as assessed in the presurvey. Veterans were recruited with the use of a recruitment flyer (Appendix A). All participants completed the Recruitment Survey questionnaire consisting of demographic and experience questions (Appendix B). Informed consent paperwork (Appendix C) and the DASS-42 (Appendix E) were sent to each participant after they were selected to participate.

Individuals in the treatment group participated in seven 90-minute group poetry counseling sessions and at least one poetry technique per session. The poetry techniques included the reading of preexisting poems, completing blank spaces in a poem, and collaborative poetry writing. Appendix D lists all poetry chosen for the research. The participants in the control group also participated in seven 90-minute group counseling sessions across a seven-week period. Both treatment and control group sessions began with a short check-in and an introduction to and discussion of the theme for the week. Poetry for this study was chosen using the isoprinciple which holds that the most helpful poems are those that are close in feeling and tone to that of the patient (Reiter, 2004). Upon completion of either the treatment or control groups, all participants completed the DASS-42 as a postsurvey. Data were analyzed using three Mann-Whitney U tests to determine if there were differences in the DASS-42 subscales of the depression, anxiety, and stress postsurvey scores between the control and treatment groups.

Significance of the Study

Fawson (2019) explained that often veterans can make the long journey home and struggle to understand that the person who went to war is not the same person as the one that came home. Evidence-based practices (EBPs) have been used in the community to help treat veterans, including cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), and eye movement desensitization reprocessing (EMDR). Additionally, many providers have also reported engaging in solution-focused treatment aimed at symptom management and goal attainment (Matarazzo et al., 2016).

Research emphasizes the need to train providers specifically on veteran-related issues such as traumatic brain injury (TBI), co-occurring disorders, military culture and structure, and local/ available resources (Matarazzo et al., 2016). Scotland-Coogan (2019) explained that the trust veterans have built with military comrades does not carry over to civilians and this understanding of military culture is central to working with veterans. Furthermore, Lehavot et al. (2018) emphasized that although men and women experience PTSD similarly, the literature indicates that women are more likely to report co-occurring internalizing disorders like anxiety and depression and men are more likely to report externalizing disorders, such as substance use (Kintzle et al., 2018).

When stressors exceed personal coping skills or social support resources, the veteran will seek assistance (Wray et al., 2016). Veterans can be exposed to non-deployment stress-related events that occur while on active duty such as training accidents, assault, sexual assault, and body recovery (Forbes et al., 2012). There are substantial concerns for veterans when mental health issues are left untreated or self-medicated. Mental illness that is untreated can result in relationship difficulties, job performance issues, and "self-medication" with drugs and alcohol

(Blosnich et al., 2016; Kirchner et al., 2011). Self-medication with drugs or alcohol is substantial within the military culture (Rubin et al., 2013). Reiter (2004) explained how it is important for addicts to reach into the world of their feelings because using has numbed their inner life. The attendance and participation in a group as described in this study could help veterans process their traumatic experiences in the comfort of their peers, while relying on poetry to help them find their words.

Fitzpatrick (2017) reported on the findings of an analysis of two veteran cohorts, those who had served in either Iraq or Afghanistan, that found there was a 41% to 61% higher risk of suicide compared to that of the United States general population. The veteran suicide rate reported in 2017 (Tanielian et al.) was between 20-22 a day, with 33 per day attempting suicide 2017). Traumatic experiences increase the risk for PTSD, substance use, relationship problems, and anger issues, as well as suicidality (Forbes et al., 2012).

In a study published in January 2020, Steenkamp et al. explained that the high nonresponse and dropout rates for veterans utilizing Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) suggest a mismatch between the complex clinical reality of managing military-related PTSD and one-size-fits-all treatment approaches rolled out in VA and Department of Defense (DoD) health care systems. The Veterans Writing Project (2020) emphasizes that writing is therapeutic and returning warriors have known for centuries the healing power of words. They hold seminars and workshops to help veterans develop new skills to write songs, poetry, and even nonfiction for therapeutic recovery (Veterans Writing Project, 2020). Levy et al (2018) explained: “Organizations such as Americans for the Arts and the National Endowment for the Arts have specifically recognized the benefits of arts and creative therapies for service members and their families across all stages of the military continuum” (p.

20). Deshpande (2010) described a program called Recon Mission which "introduced veterans to the concept of using writing and poetry for healing and focusing on those writings as a means of exploring the internal landscape of war" (p. 240). Use of the creative arts therapies to treat veterans is not a new idea. Dr. Hirsch Lazaar Silverman, a psychologist, was using poetry therapy in the military in the 1940s (Reiter, 2004). For example, music therapy first became recognized as a profession due to the work of musicians with veterans of World Wars I and II (Levy et al, 2018).

This type of research is necessary based on several factors, with the most significant reason being there are simply not enough practitioners to treat the vast number of veterans in crisis (Croom, 2015). As emphasized by Albright (2015), "The way forward includes stronger conceptual and theoretical linkages; the identification and measurement of appropriate concepts related to creative expression, perhaps based in constructivist, existentialist, and social learning theories; and testing the effectiveness of these interventions" (p. 71). A review of the literature in Chapter Two illustrates the specific treatment needs of veterans, the types of treatment modalities that are currently available, types of creative arts therapies, and the utilization of poetry therapy with other populations that have proven successful.

Research Question

The research question guiding this research was:

How, if at all, does a veteran's participation in poetry group counseling affect their levels of depression, anxiety, and stress as measured by the Depression Anxiety Stress-Scales-42 (DASS-42)?

These sub questions will also be answered:

1) How, if at all, does a veteran's participation in poetry group counseling affect their levels of depression, as measured by the Depression Anxiety Stress-Scales-42 (DASS-42)?
2) How, if at all, does a veteran's participation in poetry group counseling affect their levels of anxiety as measured by the Depression Anxiety Stress-Scales-42 (DASS-42)?
3) How, if at all, does a veteran's participation in poetry group counseling effect their levels of stress as measured by the Depression Anxiety Stress-Scales-42 (DASS-42)?

Definitions

A *veteran* is anyone who has served on active duty in one of the five branches of the military, regardless of peacetime or combat exposure (Rubin et al., 2013).

Mazza (2017) explained that *poetry therapy* refers to the utilization of poetry and related forms of literature and creative writings in order to improve psychological functioning (Stepakoff, 2009).

The term *poem* originated in the Greek poiema, meaning "something made," hence, a poem's structure draws attention to its "made-ness," to heighten the intention of its message (Mann, 2010).

The *Department of Defense (DoD) military health system* provides care for active-duty military members and their dependents, eligible military retirees and their families, as well as some reserve component members and their families (Burnam, 2009).

The *Veteran Health Administration (VHA)* provides health care services to eligible veterans and some active-duty service members.

The World Health Organization defines *health* as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (Schnurr et al., 2009).

Summary

Current findings suggest first-line psychotherapies do not effectively manage military-related PTSD in large portions of patients and do not outperform non-trauma focused interventions (Steenkamp et al., 2020). With the number of veterans needing mental health services growing continuously, new approaches to care must be developed and implemented. This research will answer the question: Can poetry in therapy delivered in a group setting affect levels of depression, anxiety, and stress within a veteran sample as measured by the Depression Anxiety Stress-Scales-42 (DASS-42)?

The purpose of this research is to examine if poetry in therapy provided in a group setting decreases the symptoms of depression, anxiety and stress in veterans as measured by the DASS-42. Stepakoff's (2009) research emphasized the benefits of utilizing preexisting poems and expressive writing in the context of a formal clinical relationship. This study focused on receptive methods of poetry therapy that rely on the utilization of preexisting poems (Mazza, 2017). Appendix D lists all poetry used in this research. Chattarji (2014) explained that poetry seems to be a major mode of literary expression during and after the war for veterans and further inquiry is warranted.

To date, empirical support for the use of poetry therapy in clinical practice and its use in various forms is relatively widespread, as evidenced by the existence of organizations providing platforms to disseminate ideas and evidentiary support, and the training and licensing of practitioners (Mazza & Hayton, 2013). The need to further the existing research was well documented by Heimes (2011) as "borrowing some elements from the realm of qualitative

research, in which qualitative criteria such as subjectivity, in-depth description and research in everyday environments are valued in which general patterns are sought from a plethora of observations and isolated results" (p. 7). Albright (2015) posited that, "Creative expression affords veterans opportunities to characterize their experiences; humanize the brutality of war and moral ambiguities; and share the cognitive, emotional, psychological, and spiritual effects of combat" (p. 71). Given the overwhelming prevalence of PTSD in veterans, it is important to consider alternative treatments to assist in the reduction of symptomology, such as anxiety, depression, and stress (Corley, 2012; Currier et al., 2017; Rodak et al., 2018).

Chapter Two: Literature Review

Overview

As a nation, the United States has continually been in conflict since October 7, 2001 (Rubin et al., 2013). With the invasion of Afghanistan after the events of September 11, 2001, the need to find alternative treatments for depression, anxiety, and trauma for more than 2.2 million veterans is paramount. This is reflective of the ongoing challenge of the Veteran's Health Administration (VHA) to care for the wounded, ill, and injured service members returning from Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) (Levy et al., 2018). A veteran is anyone who has served on active duty in one of the five branches of the military, regardless of peacetime or combat exposure (Rubin et al., 2013). With the drawdown of forces, the military is smaller than usual and yet must maintain the safety and security of the world at the same standard. Therefore, these service members are recycled over and over to deployments abroad and their invisible wounds of war are becoming more recognized in society as a whole.

The veteran population itself is expansive and the treatment needs vary depending on the visible and invisible wounds of war. Currently the VHA administration recognizes three treatments for post-traumatic stress disorder (PTSD) including: prolonged exposure (PE), cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR) (Levy et al., 2018). As the need for treatment continues to grow, the VHA in local communities have implemented creative art therapies to assist veterans struggling with symptomology consistent with PTSD (Kopytin et al., 2013). According to Zoroya (2013), there were 50,000 new veterans diagnosed with PTSD in 2012, including 16,531 added in just the last quarter of that year, making that 184 new PTSD cases per day.

There is a plethora of information about the different types of creative art therapies and their usage with traumatized clients, as well as the veteran population. PTSD was previously referred to as shell shock, battle fatigue, soldier's heart, nostalgia, and 1000-yard stare (Walker et al., 2016). Trauma exposure is not limited exclusively to combat deployments for veterans. It can occur in anyone suffering severe, life-threatening trauma such as domestic or sexual violence or abuse, traffic accidents, and environmental disasters (Tick, 2013). Modern combat includes multiple deployments, prolonged exposure, moral ambiguity, and the abysmal realities of being placed in kill-or-be-killed situations; therefore, military PTSD is especially wounding and prevalent among veterans (Tick, 2013).

Tick (2013) explained how this era of veterans has so-called "signature wounds," such as PTSD, military sexual trauma (MST), and traumatic brain injury (TBI). Another invisible wound of this war is moral injury. A moral injury causes lasting emotional distress and inner turmoil for a veteran when they experience potential conflicts between their experiences and their moral standards (Blinka & Harris, 2016). Understanding this disjunction takes time and creative imaginative effort to overcome because the veterans' war and the nation's war are not always the same experience (Modell & Haggerty, 1991). Morally injurious experiences include those in which the individual perpetuates, fails to prevent, bears witness to, or learns about acts that transgress deeply held moral beliefs and experiences (Blinka & Harris, 2016).

Due to the complex nature of these signature wounds, the utilization of a multidisciplinary group of clinicians for the identification and treatment of veterans suffering from traumatic experiences is a sizable need and warrants further research (Lande et al., 2010; Matthieu et al., 2017). This type of approach calls for more holistic healing and the amalgamation of different practices to assist the veteran in becoming "whole" again and

reintegrating not only back into society but also reconnecting with their family, friends, and community again.

Conceptual/Theoretical Framework

The research problem to be explored throughout this proposal is what, if any, the effect of poetry therapy delivered in a group setting has on depression, anxiety, and stress in a veteran sample. There is a significant amount of research concerning veterans' mental health and the types of traditional treatments available. The gap in the literature, however, is a systematic investigation of the use of poetry therapy methods to assist veterans suffering with anxiety and depression due to traumatic experiences. To date, there have been several qualitative studies, however this specific approach has not been researched and further inquiry could potentially produce new approaches to help the many veterans in need.

Related Literature

Types of Creative Arts Therapies

Creative arts therapy is a term used to describe therapeutic modalities including visual arts, dance, drama, creative music, and dance (van Westrhenen et al., 2017). Bibliotherapy, journal therapy, narrative therapy, general expressive arts therapy, and even music, dance, art, and drama can fall within the creative arts therapies (Chilton et al., 2015; Collins et al., 2006; Mazza & Hayton, 2013). These types of therapies have proven to be beneficial for different populations as well as different types of mental health concerns. Collins et al. (2006) described one of the limits to their research as, "Both cognitive and poetry therapies rely on higher-order linguistics and some of these techniques might overwhelm clients prone to disorganized patterns of thinking" (p. 186).

Traditional cognitive therapies focus on changing one's thoughts in relation to the traumatic event and are mostly experienced in the mind (Collins et al., 2006; Sarid & Russ, 2010), whereas creative art therapies create actual sensory experiences based on the manipulation of art providing an opportunity to evoke the senses (Sarid & Huss, 2010). Through the engagement of processing mindfulness and art therapy, different aspects of the individual's experience and social context of the trauma can be examined (Kalmanowitz & Ho, 2016; Levy, 2014). This serves as an alternative to traditional "talk-therapy" where a person must discuss the trauma out loud, essentially creating an exposure therapy approach. Sarid and Russ (2010) explained in their research how cognitive behavioral interventions can be conceptualized as working from "top-down" as compared to art therapy that works from "bottom-up." Their research offered great insight into how art therapy can be beneficial when used in conjunction with cognitive behavioral intervention; however, it did not evaluate the clinical implications of this finding using a multi-faceted approach (Sarid & Russ, 2010).

Expressive Arts

Expressive arts therapy sets itself apart from other creative arts therapies by its multimodal approach to formulating clinical interventions (Kim et al., 2011). These elements include visual art making, music, dance/movement, poetry, and drama in therapeutic work with individuals, families, groups, and communities (Kim et al., 2011; Sutton & Backer, 2009). Guided imagery and music therapy have been shown to reduce depression and anxiety symptomology among female veterans (Story & Beck, 2017). Music therapy has been used across a spectrum of disorders, such as PTSD (Arruda et al., 2016), with traumatized soldiers and children and as well as oncologic pain relief (Bensimon et al., 2012; Sassen, 2012). Expressive arts do not focus on pathology in the client's artwork, but instead use the artistic product to

increase self-expression and deepen self-awareness (Kim et al., 2011; Levy, 2014). This is an important dynamic as a client might be more willing to share their art if they feel they will not be judged on the consents of said project.

Organizations such as the National Endowment for the Arts and Americans for the Arts have specifically recognized benefits of the arts and creative arts therapies for service members and their families across all stages of the military continuum (Americans for the Arts, 2016; National Initiative for Arts & Health in the Military, 2013). Veterans often write of their post-war experiences in order to gain perspective and understanding (Geer, 1983; Harris, 201; Hill, 2008; Rayneard, 2011; Spence et al., 2014; Sychterz, 2018). This type of writing or journaling could also be referred to as narrative therapy, where a person can choose to share their written words or keep them for themselves.

Narrative Therapy

Writing is a method of inquiry that can make unexpected connections and go deeply into the nature of experience (Anderson, 2014; Dorman, 2017). Dorman (2017) found that "both poetry and counseling, go beyond the individual, into the creative dynamic between writer, reader and text, the intersubjective dialogue of counselor and client, or the constellation of context and relationships that is a person's life" (p. 103). Several findings have revealed that narrative writing leads to decreases in anxiety and depression (Sloan et al., 2013; Stephenson & Rosen, 2015). In addition to the reduction in anxiety and depression scores, physiological markers of trauma improved as evidenced by fewer doctor visits and reductions in overall symptomatology (Stephenson & Rosen, 2015). According to Dorman (2017) there is a direct correlation between the process of counseling and the process of writing poetry. However, even with the recognition that a process is taking place during poetry therapy, the ability to replicate

this process so that each individual has the same experience would be impractical, based on the knowledge of individual personalities, linguistic skills, and trauma-related experiences.

The option of writing about one's traumatic experiences is a cornerstone for such therapy approaches as cognitive processing therapy, where the client is asked to not only write an impact statement, but also a trauma narrative (Resick et al., 2017). Trauma has been seen as leading to narratives that are threatening, negative, and isolated from the wider set of past and current experiences, thus leading to distress and symptoms of post-traumatic stress disorder (Erbes et al., 2014; Merscham, 2000). By having the client write about their trauma, it becomes something tangible; something they can hold in their hands and work through as opposed to a cycle of thoughts replaying in their mind. Wachen et al. (2016) discussed how research has found that CPT is effective in treating a variety of populations including rape victims, physical assault victims, and military veterans.

Art Therapy

Golub (1985) developed an art therapy intervention to assist veterans in addressing their trauma symptoms and explained that the creation and transformation of visual symbols provided veterans a new approach to achieving self-integration and mastering of trauma. The art provided a safe medium in which the sufferer could emotionally process the trauma without feeling threatened (Ramirez, 2016; Walker et al., 2016). Golub's (1985) research explained how a "recurring stylistic feature suggested commonalities in the way veterans symbolized their confrontations with death or the threat of death" (p. 295). Golub (1985) further noted that the appearance in artwork of clearly a dichotomous self-perception supports the view that an aftereffect of combat trauma may be to freeze the veteran in their trauma. Art materials and imaginal exposure modify emotional-physiological responses which assist in desensitizing

physiological reactions (Chilton et al., 2015; Sarid & Huss, 2010). Drawing and coloring have shown to yield both mental health and cognitive benefits, especially for veterans with PTSD (Rodak et al., 2018).

Poetry Therapy

Poetry therapy is defined as "the intentional use of poetry for healing and personal growth" (McArdle & Byrt, 2001, p. 518). The term *poem* originated in the Greek poiema, meaning "something made," hence, a poem's structure draws attention to its "made-ness," to heighten the intention of its message (Mann, 2010). It involves the use of the language arts in therapeutic capacities (Barron, 1974; Gantt & Tinnin, 2009; Mazza, 2003). Poetry therapy is often encompassed by other related disciplines and methods that utilize language arts in some form or another, such as narrative therapy or bibliotherapy (Mazza & Hayton, 2013).

Poetry tends to fill the dimensions of sight and sound, as well as physical medium and the metaphysical meaning (Barron, 1974; Mann, 2010). It is distinguished from art therapy and body movement therapies based on its focus on literature as the catalyst (Hynes, 1988). Therefore, the words become the purpose for healing. Poetry attempts to overcome the death and separation of individuals by bringing us into contact with our ultimately shared experience (Mann, 2010). Poetry has been used to make sense of themed experiences in childhood and adolescence such as subjugation, powerlessness, defeat, and sacrifice of one's own needs and rights (Roe & Garland, 2011). Making sense of a shared theme or experience is something veterans understand implicitly due to the nature of their work environments.

Poetry, like narratives, tells stories and evoke powerful feelings, although not always in a linear fashion (Furman, 2004; Malekoff, 2007). Poetry typically uses figurative language (metaphors), imagery, rhythm, and sound (Hilse et al., 2007; Witney, 2012). Language and

experience can feel woven together with the words we use to articulate our emotions (Carroll, 2005; Dorman, 2017). Poetry sometimes articulates the complexities of the inner world and experiences of the writer (Bolton, 1999; Jones, 2011).

Previous Research on Poetry Therapy

An extensive review of poetry research found that most studies appeared in the fields of psychiatry, psychotherapy, and psychology; however, it was also noted that poetry therapy was utilized in a wide range of contexts such as cancer treatment and addictions (Heimes, 2011; Smith et al., 2017). Hilse et al. (2007) discussed their research, including that poetry is easier to write for some people, but that the benefits of writing and sharing poetry cannot be generalized based on a small sample. Their recommendation for further research included involving more participants with varying mental health conditions and further exploration to develop the central concept of personal meaning for poetry writing (Hilse et al., 2007).

Research explains the expressive and therapeutic paradigm of how poetry has shaped and influenced the therapeutic process in cognitive behavioral psychotherapy treatment from the perspective of the recipient of therapy and the therapist (Gustavson, 2000; Luhmann, 2001; McArdle & Byrt, 2001; Roe & Garand, 2011; Silverman, 1986). Several studies emphasized the benefits of using poetry therapy with people who have serious mental health conditions, dementia, cancer, and schizophrenia (Bembry et al., 2013; Kozodoy, 2011; Rickett et al., 2011; Seymour & Murray, 2016; Swinnen, 2016). Additionally, poetry has been used during the process of logotherapy to facilitate meaning and awareness (Lantz & Harper, 1991).

The exploration of depression through autoethnographic poetry has been shown to be beneficial for those participating in the research (Gallardo et al., 2009). Poetry therapy is a recognized form of psychotherapy in which poetry and the arts are used as the framework for

design and is strengths-based (Furman et al., 2002; Jones, 2011). Poetry and prayer offer a deep connection between the experience of a poem and liturgical prayer (Feld, 2012; Robinson, 2004). An analysis on the use of visual arts and poetry intervention with abused adolescents suggested that they were able to address their issues, make sense of their lives, and create positive alternative stories for themselves (Bowman & Halfacre, 1994; Brillantes-Evangelista, 2013). Brillantes-Evangelista's (2013) research included only eight sessions for their different types of groups (poetry and visual arts); therefore, evaluating the effectiveness of a program to alleviate depression and PTSD symptomology could take longer based on the individual experiences. Also, given the fact that the participants were creating their own stories through poetry, they were facilitating their own therapy. Through their poems they could relate with their circumstances, faith, hope, thoughts, sentiments, and feelings (Brillantes-Evangelista, 2013).

Benefits of Poetry Therapy

Wakeman (2015) observed and recorded the ways poetry has been therapeutic for both the writer and for the reader or listener. Alvarez and Mearns (2014) explained that one of the large motivating factors in sharing poetry with an audience is the sense of unification it creates through life's struggles. Their findings suggested that "connecting with a community, having a forum of communication, emotional development, and having an internal drive to write and perform help the poet to feel balanced in everyday life" (p. 263). A limitation of this study was that the sample was pooled from the same geographic area creating the possibilities of some shared experiences (Alvarez & Mearns, 2014). Additionally, due to the nature of qualitative research there is the component of subjective interpretation of the context to consider (Alvarez & Mearns, 2014).

Maddalena (2009) described how performing poetry aids in the resolution of internal conflict. Different types of poetry intervention groups have taken place based on the needs of the clients, such as the use of preexisting materials, completing blank spaces in a poem, and collaborative writing (Furman, 2003; Mohammadian et al., 2011). Furman (2003) found that for the "existentially oriented practitioner, the use of poetry is an ideal tool for helping people come to terms with the realities of existence" (p. 199). A study by Gozashti et al. (2017) showed that group poetry therapy could be used to improve breast cancer patients' quality of life. Mazza (2017) developed a model for poetry therapy practice that has helped delineate its therapeutic components. These components include receptive/prescriptive: involving the introduction of literature into therapy; expressive/creative: involving the use of client writing in therapy; and symbolic/ceremonial: involving the use of metaphors, rituals, and storytelling (Mazza, 2017).

Veterans and Poetry Therapy

According to the National Veterans Foundation (2016), veterans face several barriers to treatment for mental health issues and this could be a contributing factor in the lack of treatment options. Some of the barriers veterans include personal embarrassment about service-related mental disabilities, long wait times to receive mental health treatment, shame and stigma over needing to seek mental health treatment, a lack of understanding or lack of awareness about mental health problems and treatment options specifically for veterans, long travel distances in order to receive this type of care, concerns over the type of veteran mental health treatment offered by the VA, and false perceptions based on demographics such as age or gender. Additionally, Wachen et al. (2016) noted that veterans often perceive admitting to a psychological problem to be more stigmatizing than admitting to a medical condition and feel it could affect their careers.

According to Tanielian et al. (2017), some of the challenges faced after deployment for 2.8 million veterans included: 13–20% experience PTSD, 10–15% experience depression, 19–23% have a traumatic brain injury, 5–39% have issues with alcohol dependence, 48% experience strains in family life, and 47% feel sudden outbursts of anger frequently. As the extent of veterans' mental health needs has become clearer, efforts to expand access to care and improve quality have also become national priorities. The Military Health System (MHS) and the U.S. Department of Veterans Affairs are the government agencies charged with meeting the health care needs of veterans (Tanielian et al., 2017). These agencies received substantial budget increases to hire more providers, invest in research to identify other improvements, and create clinical and research consortia to improve capabilities (Tanielian et al., 2017).

Community-based treatment options for veterans now include options for some of the different types of creative therapies. The premises behind these initiatives is that a veteran may benefit from a wide range of therapeutic approaches, not only "talk therapy" and pharmacology. Therapies involving the use of art therapy along with cognitive processing therapy have been successful in the reduction of symptomology among veterans suffering with post-traumatic stress disorder (Campbell et al., 2016; DeLucia, 2016). Fiction and poetry can be incorporated as a therapeutic adjunct to help patients gain knowledge and insight (Furman, 2003; McArdle & Byrt, 2001). Carroll's (2006) findings articulated that "writing exercises can give a whole array of health benefits including reductions in emotional and physical health complaints and enhanced social relationships and role functioning" (p. 170).

Collins et al. (2006) explained that the goal of poetry therapy is the "magnification and clarification of being" (p. 186), and not only for poetry and cognitive therapies, but for most types of psychotherapy concerns with human potential. Within the safety and security of a poetry

group, participants can begin to express their pain and fear (Kopytin & Lebedev, 2013; Robinson, 2004). Creating a poetry therapy group for only veterans develops an environment of trust, camaraderie, and hope, due to their like-minded culture. Group art therapy has been shown to facilitate parenting adjustment with post-war veterans upon returning to their families (Creech & Misca, 2017; Mandić-Gajić, 2016).

Several articles have addressed the benefits of poetry therapy for couples, families, and veterans (Hedberg, 1997; Lantz, 1997; Lerner, 1997; Mazza et al., 1987; Raingruber, 2004; Wadeson, 1981). Brillantes-Evangelista (2013) emphasized how poetry interventions empower the participants to engage actively in their own healing and recovery. Honesty, empowerment, and collaboration are some of the key components in most treatment strategies involving veteran clients (Kintzle et al., 2018).

When a veteran leaves the military and begins civilian life, there is often a loss of social connectedness. This social connectedness impacts interpersonal relationships, peer affiliation, memberships, social behavior, and overall social integration; a higher sense of social connectedness may serve as a protective factor against psychological distress, depression, and PTSD (Kintzle et al., 2018). With the loss of a sense of belonging, due to leaving the military, the inability to find a new sense of social connection may lead to isolation and withdrawal among veterans. Gallagher (2021) described how war trauma and lack of support during homecoming were significantly tied to PTSD. Creating a group environment with fellow peers, led by a veteran clinician, could serve as a valuable tool to not only reduce the symptoms of depression and anxiety, but also create an environment where the participants feel a sense of belonging again.

Additionally, if a moral injury is present those symptoms must be addressed accordingly, such as understanding and working with the client's religious and spiritual worldview and values (Tick, 2013). Tick (2013) pointed out that there can be a disconnect in the understanding that war and religion are linked, although simultaneously apparently contradictory to human relationships. The challenge is to not allow your fellow service members to be killed, but take someone else's life instead, in order to save your own and the people around you (Bryan et al., 2016). This is often justifiable and does not begin to cause the veteran great mental torment until they realize that the "enemy" was someone's son, husband, father, and friend. The moral injury normally begins to take place when war becomes humanized (Tick, 2013).

Future Considerations

To date, empirical support for the use of poetry therapy in clinical practice and its use in various forms is relatively widespread, as evidenced by the existence of organizations providing platforms to disseminate ideas and evidentiary support, and the training and licensing of practitioners (Mazza & Hayton, 2013). The need for further research was well documented by Heimes (2011) who explained how "borrowing some elements from the realm of qualitative research, in which qualitative criteria such as subjectivity, in-depth description and research in everyday environments are valued and general patterns are sought from a plethora of observations and isolated results" (p. 7). Given the overwhelming prevalence of PTSD in veterans, it is important to consider alternative treatments to assist in the reductions of symptomology, such as anxiety, depression, and stress (Corley, 2012; Currier et al., 2017; Rodak et al., 2018).

There is plentiful information about the different types of creative art therapies and their usage with traumatized clients, as well as the veteran population. There is also a significant

amount of research concerning veteran's mental health and the types of traditional treatments available. Poetry therapy lends itself to a different understanding of trauma processing. War transforms the ways people love, connect, and bond so profoundly that they may seem obsessed, terrified, abusive, distant, numb, or uninterested when they connect (Tick, 2013). Poetry provides a platform to discuss experiences while not exclusively going into a detailed trauma narrative. Could poetry therapy assist in changing the landscape from post-traumatic stress disorder to post-traumatic growth?

The gap in the literature, however, is a systematic examination of the use of poetry therapy methods to assist veterans suffering with anxiety and depression due to traumatic experiences. To date, this specific topic has not been researched and further inquiry could potentially produce new approaches to help the many veterans in need. The research question that emerged from this was: How, if at all, does veteran's participation in poetry group counseling affect their levels of depression, anxiety, and stress as measured by the Depression Anxiety Stress-Scales-42 (DASS-42)?

Chapter Three: Methods

Overview

The intent of this research was to examine if the use of poetry in group counseling would decrease the levels of depression, anxiety, and stress in veterans as measured by the DASS-42. Given the prevalence of these symptoms among the 2.6 million veterans in the United States, it is paramount to find additional treatment strategies to help these veterans alleviate their "invisible wounds" of war. Most of the articles in this field consist of descriptive rather than empirical studies on the use of poetry therapy, so there is a scarcity of empirical research on implementing poetry therapy (Mazza, 2017). This research expands on the empirical evidence for in poetry in group counseling as a valid treatment modality for the veteran population.

Design

An experimental, pretest-posttest randomized control group design was used in the present study to compare the depression, anxiety, and stress scores of veterans participating in poetry group counseling to the scores obtained by veterans participating in traditional group counseling. Once the volunteers were recruited, they completed a pre-survey questionnaire to gather demographics and inclusion/exclusion data. All 12 participants who completed the survey were selected to participate and were sent the informed consent, DASS-42, and group participation details (Appendix B). Participants were randomly assigned to participate in either the treatment or control group. The participants in the treatment group participated in seven 90-minute group poetry counseling sessions and participated in at least one poetry technique per session. The poetry techniques included reading of preexisting poems, completing blank spaces in a poem, and collaborative poetry writing. The participants in the control group also participated in seven 90-minute group counseling sessions across a seven-week period.

Following the completion of group counseling, all participants completed the postsurvey consisting of the DASS-42. Data were analyzed to determine if veterans across the two groups differed in their depression, anxiety, and stress symptom scores.

This design is appropriate as it is similar to the research designs employed by Mohammadian et. al (2011) and Tegnér et al. (2009) who also examined the effect of poetry group counseling. Mohammadian et al. (2011) employed an exploratory clinical trial design to examine the effect of a group poetry intervention on the depression, anxiety, and stress in 29 Iranian female students. The researchers randomly assigned the students to a treatment or control group, where the treatment group participated in poetry group counseling using techniques similar to the ones planned for the present study. Also, similar to the present study, the duration of the group counseling for both the treatment and control group was seven weeks. Participants attended seven sessions of 90 minutes each. In the Mohammadian et al. (2011) research, the two groups were compared. Likewise, Tegnér et al. (2009) used a crossover design to examine the effect of a group poetry therapy intervention with female cancer patients on post-traumatic growth, adjustment, depression, and stress. Twelve female cancer patients participated in six poetry group sessions, while six patients acted as a waitlist control group. The two groups were compared. These studies, although slightly different in design, provide support for the design of the present study.

Research Question

How, if at all, does a veteran's participation in poetry group counseling affect their levels of depression, anxiety, and stress as measured by the Depression Anxiety Stress-Scales-42 (DASS-42)?

These sub questions will also be answered:

How, if at all, does a veteran's participation in poetry group counseling affect their levels of depression, as measured by the Depression Anxiety Stress-Scales-42 (DASS-42)?

How, if at all, does a veteran's participation in poetry group counseling affect their levels of anxiety as measured by the Depression Anxiety Stress-Scales-42 (DASS-42)?

How, if at all, does a veteran's participation in poetry group counseling affect their levels of stress as measured by the Depression Anxiety Stress-Scales-42 (DASS-42)?

Hypothesis

H_a1: There is a statistically significant difference in veterans' levels of depression, anxiety, and stress as measured by the Depression Anxiety Stress-Scales-42 (DASS-42) between those who participated in poetry group counseling, compared to those who participated in traditional counseling.

Participants

The population for this study were military veterans, over 18 years of age, who have been referred for group counseling by the local veteran's treatment courts and community counseling services. A convenience sample of 12 participants was recruited from those who had been referred for therapy. While research suggests sample sizes of 15 to 30 for experimental and group comparison designs, it was not achievable because this study took place during the COVID-19 pandemic, making it difficult to recruit and maintain volunteers (Creswell, 2005; Gall et al., 2003; Gay & Airasian, 2003; McMillan & Schumacher, 2001). Advertisements in the local veteran resource offices, social media outlets for the local community, and outreach to the Veterans Treatment Courts were avenues to recruit participants for this research. The recruitment flyer for this research is found in Appendix A and was the same used for each recruitment source.

All participants completed a presurvey questionnaire consisting of demographic and experience questions (Appendix B). In addition to serving as a presurvey for the study, this survey was used to screen participants and ensure that they qualified for the study. Inclusion criteria included: 18 years of age or older, a military veteran, a willingness to participate in a poetry therapy group, and have no foreseeable barriers to treatment for the duration of the group (i.e., seven weeks). Exclusion criteria included participants with mental health diagnoses such as psychotic disorders or disorders not appropriate for a group therapy environment (e.g., schizophrenia). The presurvey asked participants if they had a mental health diagnosis to ascertain inclusion or exclusion. Participants with circumstances that would prevent them from consistent treatment over the seven weeks of the study were also excluded. When a potential participant was found qualified for admittance into the study, they received an email with the informed consent (Appendix C), the DASS-42, and group setting/meeting instructions.

Setting

The group was offered via a telehealth setting (Zoom) and was password protected. When the participants were chosen, they were sent an email with the login information, date, and time for their group. Participants in both the treatment and control groups participated in weekly 90-minute group counseling sessions for seven weeks. Each session began with a short check-in and introduction to the theme for the week. To maintain treatment fidelity, treatment and control groups used the same seven themes: healing, safety, trust, suffering, mourning, reconnection, and empowerment. These themes were chosen based on best practices for trauma-informed care with the veteran population (Currier et al., 2017).

The treatment group used one of three common poetry techniques in each session or a combination of them. These techniques included reading preexisting poems, completing blank

spaces in a poem, discussing the poem, and collaborative poetry writing. Each session had a pre-existing poem that addressed the theme of the session. Appendix D lists the poems chosen for this research and Table 1 explains the session, technique, theme, and poem for the treatment group. The control group followed the same theme schedule but did not include poetry to articulate the themes.

The "completing a blank space" poem technique required individual group members to create a poem using an outline with missing words. The collaborative writing technique provided group members with a writing prompt or theme. The group members then worked together during session to develop an original poem. It was a collaborative exercise because the participants asked for help from a fellow peer or from the group instructor. Example techniques and weekly themes that were used are outlined in Table 1 for the treatment group and Table 2 for the control group.

Table 1.

Treatment Group Weekly Techniques, Themes, and Poetry Chosen

Session	Technique	Theme	Poem Chosen
1	Pre-existing Poem -Open Discussion	Suffering	Darkness Falls (Ely)
2	Pre-existing Poem -Open Discussion	Power and Control	Invictus (Henley)
3	Pre-existing Poem -Blank Space	Safety	The Road Not Taken (Frost)
4	Pre-existing Poem -Collaborative Writing	Healing	Mountains (Ely)
5	Pre-existing Poem -Open Discussion	Trust	The Charge of the Light Brigade (Tennyson)
6	Pre-existing Poem -Blank Space	Reconnection	Veteran (Ely)
7	Pre-existing Poem -Collaborative Writing	Empowerment	Compass (Ely)

Table 2.

Control Group: Weekly Techniques, Themes, and CPT Module

Session	Theme	CPT Handouts and Discussion (CPT session # noted)
1	Suffering	Introduction, education phase, post-trauma reactions, PTSD symptoms, stuck points, negative beliefs (Session 1).
2	Power and Control	Ways of giving and taking power, challenging beliefs (Session 10).
3	Safety	Beliefs about self and beliefs about others regarding safety: environments or experiences (Session 8).
4	Healing	The meaning of the event, identifying emotions, and stuck points (Session 2).
5	Trust	Beliefs about self and beliefs about others regarding trust (Session 9).
6	Reconnection	Beliefs related to others; a realistic view of others is important to psychological health (Session 11).
7	Empowerment	Self-esteem is the belief in your own worth, which is a basic human need (Session 11).

Instrumentation

Participants completed a recruitment survey for entry into the research and then a DASS-42 at sessions one and seven. The recruitment survey collected demographic information about the participants and asked a series of questions related to the inclusion and exclusion criteria. Those participating in the group sessions were asked to sign an informed consent for treatment in the first group (Appendix C). They were informed of the process of the study, the different types of techniques, reasons for termination or withdrawal, and commitment to participate in all seven sessions of the study.

The Depression Anxiety Stress Scale (DASS-42) created by Lovibond and Lovibond (1995) consists of 42 negative emotional symptoms that measure depression, anxiety, and stress. There are three scales that contain 14 items. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia, and

inertia (Lovibond & Lovibond, 1995). The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect (Lovibond & Lovibond, 1995). The stress scale assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive, and impatient (Lovibond & Lovibond, 1995). The participants are provided with items that outline symptoms and asked to rate the extent to which they have experienced each symptom over the past week. A four-point Likert-type severity or frequency scale is used for each item. The scores for the depression, anxiety, and stress scales are determined by summing the scores for the relevant 14 items (Lovibond & Lovibond, 1995). Higher scores on each subscale indicate increasing severity of depression, anxiety, or stress.

The DASS-42 was chosen over a different questionnaire because it assesses mood disturbance without assessing for somatic items that are likely to reflect the client's presenting condition rather than mood disturbance (Crawford & Henry, 2003). The DASS was created with somatic symptoms items excluded to provide clinicians an accurate assessment of their patients' symptoms of depression, anxiety, and stress (Crawford & Henry, 2003). Due to the nature of this research design to measure these specific variables, an assessment tool that would measure somatic items in combination with these three variables would appear to be problematic. For example, in measuring for somatic symptoms one could misinterpret them as having a relevant impact on the items the study is trying to measure without that influence (depression, anxiety, stress).

The internal consistencies for each subscale for the DASS are typically high with a Cronbach's α of 0.96 to 0.97 for DASS-Depression, 0.84 to 0.92 for DASS-Anxiety, and 0.90 to 0.95 for DASS-Stress (Lovibond & Lovibond, 1995). The convergent and divergent validity have been shown to be satisfactory in multiple studies, such as Nieuwenhuijsen et al. (2002). A

factor analysis revealed a three-factor solution which corresponded well with the three subscales of the DASS (Nieuwenhuijsen et al., 2002). Construct validity was further supported by moderately high correlations of the DASS with indices of convergent validity (0.65 and 0.75) and lower correlations of the DASS with indices of divergent validity (range −0.22 to 0.07) (Nieuwenhuijsen et al., 2002). Support for criterion validity was provided by a statistically significant difference in DASS scores between two diagnostic groups. Additionally, a cut-off score of 5 for anxiety and 12 for depression is recommended (Nieuwenhuijsen et al., 2002). Using systems theory, the study hoped to predict the cause-and-effect relationship between the independent and dependent variables, allowing for causal inferences.

Procedures

The institutional review board (IRB) approval was obtained prior to the start of this research study. Approval was received November 2020 and recruitment started in January 2021. Due to the COVID-19 pandemic it was difficult to obtain participants; therefore, the study had 12 participants, instead of the originally planned 26 to 30. There were six participants in each the control and treatment groups.

As explained earlier, the participants were recruited through the advertisement shown in Appendix A. All potential participants completed the recruitment survey and consent forms. Participants were randomly assigned to either the treatment or control group. For seven weeks, participants attended their assigned group therapy sessions. In the final session, before leaving, participants completed the DASS-42.

Treatment Group

According to Tegnér et al. (2009), poems included for therapy should be chosen for both their accessibility and imagery and for the developmental phase of the group. The

implementation of each technique followed the same structure as the Mohammadian et al. (2011) study and are as follows:

> The therapeutic procedure may be summarized via three techniques and/or tasks: (a) the use of different types of poetry to illicit various emotions in participants and to motivate and initiate discussion of the content as well as an opportunity to express emotions. (b) Participants will be required to fill in gaps in the poems using their own words. This allows for active participation and proactive involvement in the analysis of emotions and feelings. (c) Participants will be required to actively partake in the collaborative writing through brainstorming sessions as well as drawing on the results of their individual deliberations. (p. 60)

The treatment group took part in seven sessions of group poetry therapy using one of the above-mentioned techniques, theme, and poetry as outlined in Table 1. The example below illustrates the technique and the interaction with participants.

(a) Pre-existing Poem - Open Discussion: Each session began with a short check-in. Next, the author read the chosen theme and poem aloud to the group. The participants were then encouraged to respond to the poem and openly discuss the theme, how it resonated with them, or the emotions it provoked. Some of the questions posed by the therapist were: "Does the poem resonate with you? Which aspect of it? And why?" In the first session, a poem by Ely (2020), *Darkness Falls*, was read aloud.

> Darkness falls, we run and hide
>
> Screams echo far and wide
>
> The piecing cries that haunt our soul
>
> Riveting flashbacks take their toll

Delusions of peace give us reprieve

One moment of clarity is all we conceive

We welcome the sandman and the reaper too

Bringing with them hallucinations of you

Of course, I see you when I sleep

The only chance I get to have a peak

I close my eyes to bring you here

Just have to fight the blood curdling fear

You're gone and I know

This pain I still show

It beacons me near, from my core

To squander my hope forever more

The darkness falls I won't run and hide

Listen to my screams as we stand side by side

Together we can tackle this nightmare of mine

Because you're haunted too by father time

The author asked if they felt connected with the words emotionally or intellectually. The poem references nightmares, praying for peace, and suffering with living. Most participants expressed understanding and discussed the relatability to their own experiences of coming home with combat trauma and trying to relate to their family and friends once again. One participant emphasized how the line "together we can tackle this nightmare of mine" as what he felt like coming into this group environment with other veterans. He explained feeling for the first time

that he might be able to unpack some of his experiences while surrounded by others who have been suffering in the same manner as he was for the last few years.

The poetry and themes were chosen to lead the client on a journey through healing with the hardest subjects (themes) in the beginning and ending with empowerment. Gradually the theme was changed so that the first few poems were congruent with the participants depressed and anxious moods and as the discussions progressed, the themes began to brighten.

(b) Pre-existing Poem-Blank Space: During the blank space technique the participants were asked to fill in blank spaces of a poem with their own words. At the end of the session, they were asked to share some of the lines they had created. The participants were asked questions about the words they had changed, if it changed the meaning of the poem or conveyed a new message. Robert Frost's, *The Road Less Traveled,* was chosen as a blank space poem and they were given the below portion of the poem to change:

Two roads diverged in a yellow wood,

And sorry I could not travel both

And be one traveler, long I stood

And looked down one as far as I could

To where it bent in the undergrowth.

Then took the other, as just as fair,

And having perhaps the better claim,

Because it was grassy and wanted wear

Participants used statement such as "and I wish I could have travelled both" and "I did not look as far as I could, to where the end draws near." An open discussed followed these statements

where the participants shared the imagery, feelings, and thoughts they had about the new message of the poem they created.

(c) Pre-existing Poem-Collaborative Writing: During sessions four and seven they were asked to complete a collaborative poem. Both sessions focused on important interpersonal skills such as healing and empowerment. Together the participants spoke about their "shared experiences, growth, and suffering," "wanting to be alone but desperately wanting to connect with others," and "learning to have the power to choose an outcome based on what they want in the future." The author shared the poem for the group and then the participants shared their own poems with the group. Using the ideas, they had mentioned already in class, one of the participants shared their poem in the last session:

Lonely is how I saw my life
Destined for isolation and strife
Stop telling me to heal and move on
I'm trying here, was my song
I decided to try one more time
Took a leap of faith

Turns out there are others like me
That want so bad to feel again, to be free
That want love, family, and friends
No more hiding with all this shame
Because I finally love me
My purpose in this burning flame.

This poem clearly shows the progress the clients as seeing themselves in others, finding a connection within this community, and most importantly finding a new sense of purpose in life. During the last session they completed a second DASS-42.

Control Group

The control group sessions were set up according to the same weekly themes; however, CPT worksheets were used to guide the discussions for each specific theme instead of poetry. The handouts were taken directly form the Cognitive Processing Therapy Veteran/Military Version: Therapist and Patient Materials Manual (2014). Appendix F includes all handouts that were used for each session.

The group began with a short check-in and then the reading of the theme and corresponding handouts. The participants were asked to share their perspectives, emotions, and thoughts about the specific theme. For example, during session one the focus was on suffering and the handouts discussed stuck points, recovery or non-recovery from PTSD symptoms, and other core reactions. The participants shared their experiences with aggression, self-harm, social withdrawal, dissociation, and cognitive avoidance. They discussed how PTSD had impacted their lives both professionally and personally.

An example of the participants working through the session theme and the discussion is presented here for further understanding. During session five the theme was trust and the issues surrounding it, both positive and negative. The participants discussed their idea of what trust meant to them as it related to being a veteran. They explained how each veteran trusts another veteran quicker than a civilian because the veteran took an oath to protect the lives of others, their comrades next to them as well as people they have never met. One participant shared the example: “Trust means you are willing to die for those around you. If someone were to open the

classroom door and throw a grenade inside the room, who would jump on the grenade to save the lives of the people around them? The veterans in the room would be willing to sacrifice their lives for strangers, would the civilians?" This was a powerful example, and each veteran shared their experiences with trust in personal relationships as well as with employers.

Another example of the participants working through one of the themes was session six and the discussion about reconnection. They described finding it difficult to connect with others and setting unrealistic expectations in relationships. Further exploration of these thoughts led to comments such as "I just want things the way I want them, is that so hard to do?" "They say I have impossible standards, but I don't know how to be any other way," "My children have said they feel like they are not allowed to make mistakes. That destroys me as a dad." These statements led to deeper conversations and the connection between the group members seemed to grow with each new theme explored, because there was a sense of shared suffering between them and a desire to make a change.

In each session the participants were able to listen to the explanation of the theme, CPT information, and then openly discussed their personal experiences with the theme of the week. Throughout the weeks the themes transitioned from a sad outlook to an encouraged and more hopeful view. The last session focused on empowerment and the beliefs of worth and esteem. The participants described feeling more connected to others in the group, to their families, and wanting to share what they had learned with fellow veterans. During the last session they completed a second DASS-42.

Data Analysis

A multivariate analysis of covariance (MANCOVA) was planned because MANCOVA enables the testing of significant differences on a combination of associated variables between

the two groups, while controlling for the covariate (Harlow, 2014; Warner, 2012). Unfortunately, the MANCOVA could not be completed due to the small sample size. The MANCOVA requires a larger sample size to ensure good statistical power.

Alternatively, three Mann-Whitney U tests were conducted to determine if there were differences of the Depression Anxiety Stress Scale (DASS-42) subscales of the depression, anxiety, and stress postsurvey scores between the control and treatment groups. The Mann-Whitney U is a rank-based nonparametric test that can be used to determine if there are statistically significant differences between independent groups on a continuous or ordinal dependent variable when a sample size is insufficient to run a parametric analysis. Prior to conducting the analysis, assumption testing was completed to determine whether the control group and treatment group distribution of scores for each subscale were similar in shape. Additionally descriptive statistics and percentage of change statistics were computed for the presurvey Depression Anxiety Stress Scale (DASS-42) subscales.

Validity

Internal Validity

The internal validity is the degree to which the results of a study can be used to make causal inferences and it increases with greater experimental control of extraneous variables (Warner, 2013). This study was not conducted in a laboratory setting and therefore would have potential threats to validity because there was less control in this type of setting. Some of the pros for between-group designs include pre-scores to select/remove cases, pre-scores to describe participants, and pre-post scores to examine individual performances (Heppner et al., 2016).

The treatment component was conducted using a pre-made set of protocols that were pre-selected, which helped standardize parts of the experiment. To ensure the poetry therapy

protocols were presented and utilized uniformly, the treatment provider for the group was same therapist/researcher. Another possible threat to validity was experimenter expectations, due to the therapist also being the researcher in this study.

External Validity

The degree to which the results of a study can be generalized to apply to real world situations is considered external validity (Warner, 2013). Correlations among the independent and dependent variables were determined, however generalizability and causality were limited due to uncontrolled factors such as group setting and individuals' war-time experiences. A group setting allowed several members to participant at one time and the participants shared openly. Additionally, because poetry can be interpreted in many ways, this led to another possible limitation on generalizability.

Type I and Type II Errors

If a researcher rejects the H_0 when it is actually correct, they have committed a Type I error. However, if the researcher fails to reject the H_0 when it is false, they have committed a Type II error. Several factors come into account when limiting the risk of a Type I error, such as ensuring all the assumptions are satisfied, the rules for significance testing are followed, and the appropriate alpha level is chosen by the researcher (Warner, 2013). Unfortunately, in real-life research situations, one or more of these conditions are frequently not satisfied.

On the other hand, a Type II error depends on several factors including sample size and statistical power, because if there is an increase in statistical power, there is a decrease in the risk of a Type II error (Warner, 2013). In this study, the sample size was relatively small and even with random selection, a control group, and specific treatment protocols, the probability of creating a Type I error was significant. Therefore, the statistical power would be impacted if the

researcher could not reject the null hypothesis to demonstrate the treatment did actually do what the researcher hoped it would accomplish.

Chapter Four: Findings

Overview

Data was collected via a presurvey and postsurvey that consisted of the Depression Anxiety Stress Scale (DASS-42) along with demographic questions. Twelve male veterans completed both surveys and participated the study, with six being in the control group and six being in the treatment group. In the control group, the participants identified as Asian (n = 1, 16.7%), White (n = 3, 50%), and Hispanic (n = 2, 33.3%). They reported being between the ages of 31 and 51, with a mean age of 39.67 (SD = 6.65). In the treatment group, the participants identified as African American (n = 1, 16.7%), White (n = 4, 66.77%), and Other (n = 1, 16.7%). They reported being between the ages of 33 and 62, with a mean age of 42.83 (SD = 11.48).

Descriptive Statistics

Descriptive statistics and percentage of change on each subscale of the Depression Anxiety Stress Scale (DASS-42) for both the presurvey and the postsurvey were calculated for each group (see Table 3). While the treatment group's levels of depression, anxiety, and stress decreased at rates of more than 50% from the presurvey to postsurvey; the control group's levels of anxiety and depression increased. The control group's level of stress; however, decreased. The treatment and control groups had similar depression, anxiety, and stress presurvey scores, with three Mann-Whitney U tests demonstrating there were no significant differences between the group's scores on any subscale.

Table 3.

Descriptive Statistics

	Treatment Group (*n*=6)			Control Group (*n*=6)		
	Pre *M/Mdn(SD)*	Post *M/Mdn(SD)*	% of change	Pre *M/Mdn(SD)*	Post *M/Mdn(SD)*	% of change
Depression	16.83/13.00 (16.67)	4.50/3.00 (4.32)	-73.26%	16.17/17.50 (9.827)	16.00/16.00 (9.83)	+2.04%
Anxiety	14.00/12.50(12.78)	5.00/ 5.00 (4.561)	-64.29%	12.00/10.50 (9.81)	16.17/19.00 (10.59)	+39.17%
Stress	20.17/19.00 (16.65)	8.67/3.50 (10.85)	-57.02%	24.17/27.00(12.18)	19.00/18.00(10.56)	-29.39%

Results

While a MANCOVA analysis was originally planned for this study, three Mann-Whitney U tests were conducted instead due to the small sample size and were used to determine if there were differences of the Depression Anxiety Stress Scale (DASS-42) subscales of the depression, anxiety, and stress postsurvey scores between the control and treatment groups. Prior to conducting the analysis, assumption testing was completed to determine whether the control group and treatment group distribution of scores for each subscale were similar in shape. Unfortunately, the distributions of the depression and anxiety scores for the control and treatment groups participants were dissimilar, as assessed by visual inspection of population plots (see Figures 1 to 3). Therefore, inferences about the median differences in median depression and anxiety scores between groups cannot be made; difference in distributions for the lower/high scores and mean ranks are discussed instead. Distributions of the stress scores for the control and treatment group participants were similar, as assessed by visual inspection population plots.

Figure 1.

Population Plot for Depression

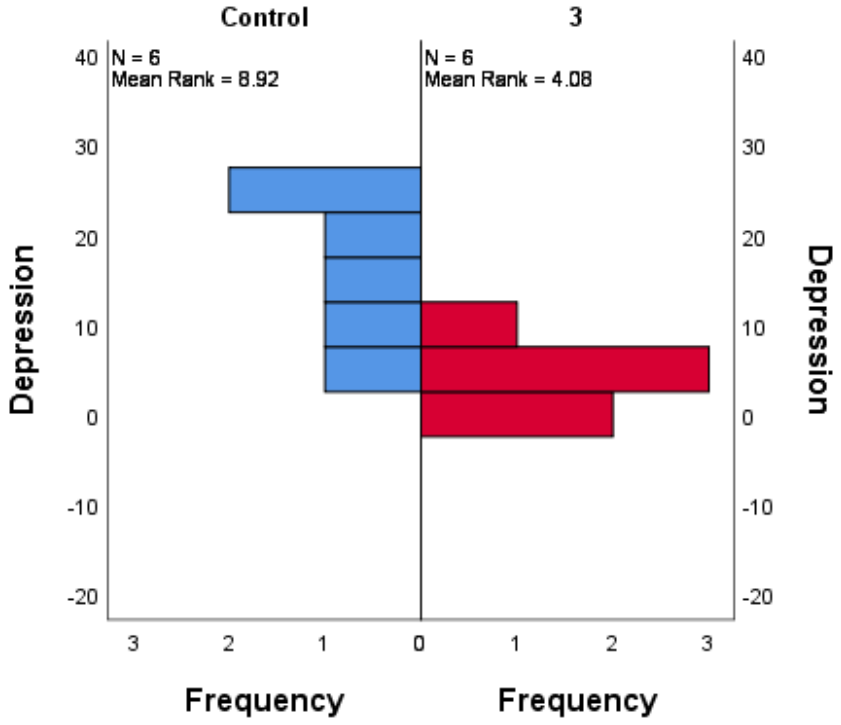


Figure 2.

Population Plot for Anxiety

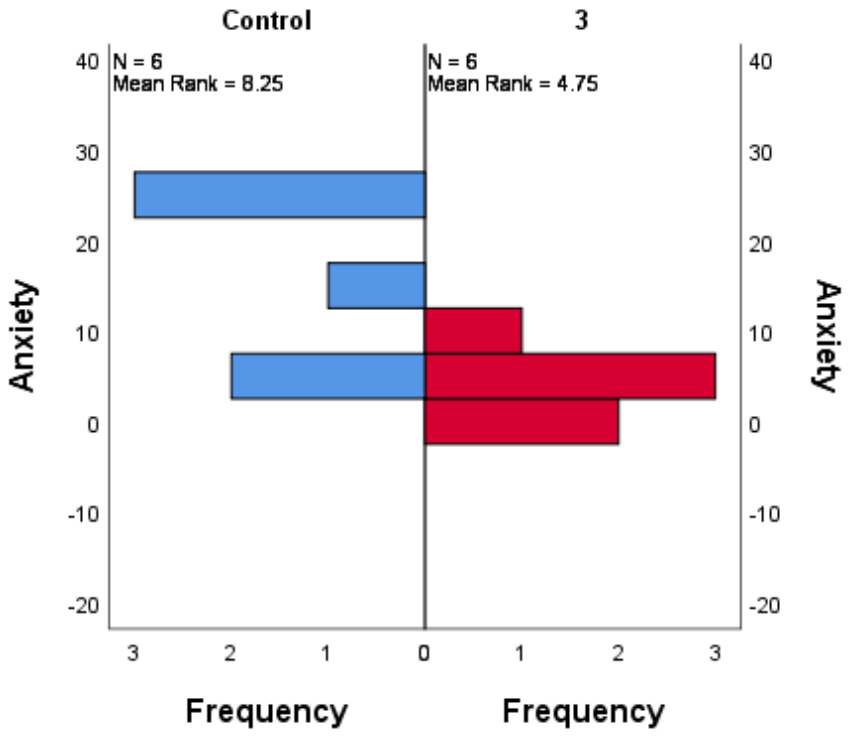
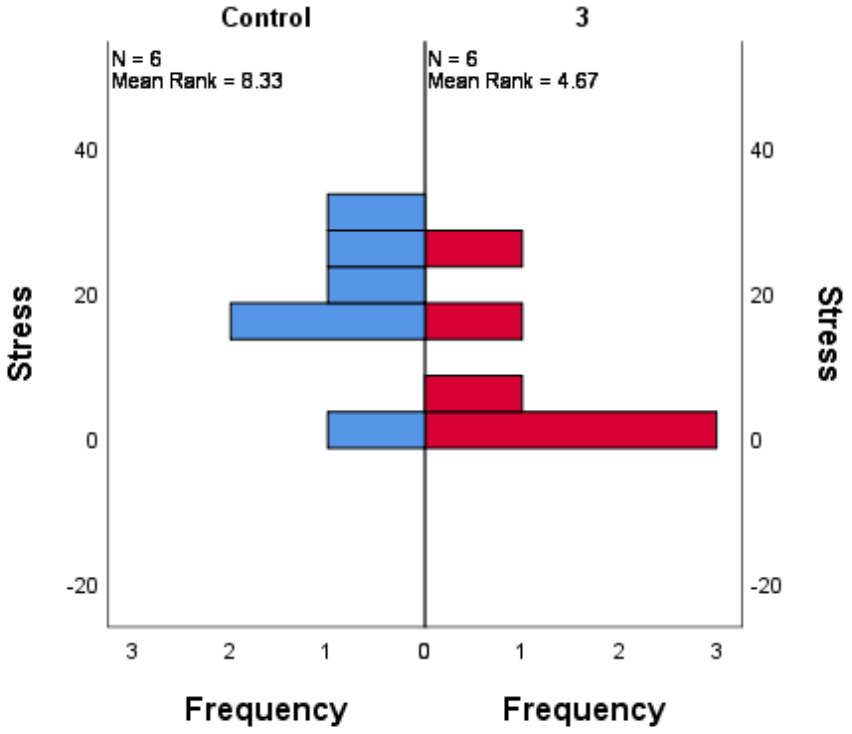


Figure 3.

Population Plot for Stress



Following assumption testing**,** a Mann-Whitney U test was run to determine if there were differences in depression scores between control and treatment group. Depression scores for the treatment group (mean rank = 4.08) were statistically significantly lower than the depression scores for the control group (mean rank = 8.92), U =2.30, z = -2.342, p = .019. However, there was no significant difference between the groups' anxiety or stress scores. A Mann-Whitney U test demonstrated that anxiety scores for the treatment group (mean rank = 4.75) were not significantly different from the control group (mean rank = 8.25)., U = 7.50, z = -1.690, p = .0.91. Moreover, the Mann-Whitney U test demonstrated that anxiety scores for the treatment group were not significantly different from the control group, U = 7.00, z = -1.774, p = .076. Table 6 provides a summary of the results and the decisions made about the null hypotheses.

Table 4.

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of Post D is the same across categories of GROUP.	Independent-Samples Mann-Whitney U Test	.015[a]	Reject the null hypothesis.
2	The distribution of Post A is the same across categories of GROUP.	Independent-Samples Mann-Whitney U Test	.093[a]	Retain the null hypothesis.
3	The distribution of Post S is the same across categories of GROUP.	Independent-Samples Mann-Whitney U Test	.093[a]	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is .050.
a. Exact significance is displayed for this test.

Chapter Five: Conclusions

Overview

Due to the conflicts fought by the United States under the Global War on Terror it is estimated one in five veterans will exhibit symptoms of post-traumatic stress disorder, suffer from traumatic brain injury, develop substance abuse issues, and/or be diagnosed with a mental illness such as major depression or anxiety (Lucas, 2018). The research problem explored in this dissertation was if poetry in therapy provided in a group setting would decrease the symptoms of depression, anxiety, and stress in veterans as measured by the DASS-42. The study was exploratory in nature, with the intention to investigate the possibility of employing poetry as a tool to make a potential difference, as previously studied by Mohammadian et al. (2011).

The depression scores as indicated on the Mann-Whitney U test was the only variable to reject the null hypothesis. The scores between groups were not statistically significant. This result supports previous research findings confirming positive effects of poetry as a tool for use in therapeutic programs to alleviate suffering (Mohammadian et al., 2011; Tegnér et al., 2009). Poetry and writing have been shown to increase self-esteem, self-exploration, and self-expression in group participants (Mazza, 2017; Mohammadian et al., 2011).

Discussion

There is no debate on whether additional treatment options are needed to assist the veteran population as they return from these decades of war. This study expanded the current research on using expressive arts therapy, specifically poetry, to assist veterans in processing their traumatic experiences. The treatment and control groups were led by the author and used the same themes. The treatment group processed the themes with the aid of poetry and the control group processed the themes with the use of CPT handouts. Although the treatment group

did not have statistically significant improvement in all three domains (anxiety, depression, and stress) both groups did show improvement.

The use of writing as a therapeutic tool allows the participants to put their thoughts on paper and in doing so are more willing to share them orally (Canada et al., 2015). For example, the Veteran Writing Project, Warrior Writers, and the Black Hills Writing Veterans Writing Group provide opportunities to tell their stories (Canada et al., 215). The poetry chosen for this research spanned centuries with Tennyson's poem from 1854, Henley's 1875, Frost's 1916, and the others from the 21st century. The age of the poem did not influence the impact of the message it gave to the participants in this research. *The Charge of the Light Brigade* that Tennyson wrote in 1854 spoke of trust, camaraderie, and dying for a purpose bigger than they could see but believed in. These core values ring true in the veteran community that we serve today.

Implications

Both groups did show improvement in their overall scores in symptomology. In previous studies there were high drop-out rates for veteran participation. There was a zero drop-out rate with this study and participants expressed gratitude for it being offered in a tele-health setting instead of in person. In a study by Taylor et al. (2020) with a large sample of veterans who had been diagnosed with PTSD, engagement rate was low and dropout rate was high, although only one-third of participants received at least three sessions of treatment.

The participants explained that COVID-19 limited their access to treatment, further validating the need for alternative treatment options for veterans in local and rural communities. The participants shared their thoughts about how the writing of poetry helped to promote self-reflection and allowed them to share their stories. This could be attributed to everyone being a veteran in the groups and struggling with the same concerns: stress, anxiety, and depression.

Additionally, since both groups showed improvement, the recommendation for veterans-only specific groups appears to be a necessity.

Limitations

Women were not represented in either treatment or control groups. Systematic gender differences in the severity or intensity of the trauma, as well as the cognitive and behavioral responses to the trauma, should be studied further. Research by Finlay et al. found among female veterans the prevalence of substance use and mental health disorders of 58% and 88%, respectively, compared with 72% and 76% among male veterans. Lehavot et al. (2018) discussed two studies that found a higher prevalence of PTSD among women veterans, echoing gender differences. Future studies should include female veterans with males, or in female-only veteran groups. Finlay et al. (2015) emphasized trauma-informed treatment options attentive to women's unique experiences and women-only programming may prove to be particularly valuable.

Another limitation to the study was the small sample size, due to issues with recruitment and retainment of participants. This could be attributed to the study being started during the COVID-19 pandemic and having limited access to veterans in the local community. Additionally, loss of jobs, illness, and other outside stressors contributed to people withdrawing from the study prior to the start dates.

Holding the sessions in person vice Zoom might have elicited longer conversations. In one aspect, emotionally connecting was difficult in the Zoom setting because many were quiet until they felt comfortable sharing. However, once they opened up, the conversation and discussions flowed more easily which could have been due to the online nature of the groups. Alternatively, the participants could have felt more safety and control because they were in the comfort of their own home while processing these different themes. An alternative explanation is

that some veterans do not like group environments; therefore, allowing them to participate from home was beneficial.

Recommendations for Future Research

Future research on how stressful life events may influence PTSD treatment is needed and may provide insight into whether these events serve as barriers to treatment retention or symptom reduction. Replication of this study with the use of a wait-list comparison or "treatment as usual" (none) would be useful to ascertain if the veterans' scores improved due to receiving treatment vice none at all. According to a report by Ogrysko (2020) the VA was forced to cancel nearly 20 million appointments during the height of the COVID-19 outbreak, and veterans waited an average of 42 days for an initial appointment. Further exploration of the value of telehealth groups versus traditional therapy may reflect the advantages due to work schedules, illness, geographic location, and accessibility to resources.

This research highlighted the need for shared social connections among veterans and further research should focus on developing veteran specific treatment options that allow for peer support. "Wars may end, but they continue to reverberate in the lives of those who fought them and within the soldier's societies" (Modell & Haggerty, 1991). The need for continued clinical support for our nations veterans will rise in the coming years due to the complex and extended types of wars they face. Novel interventions are needed to mitigate dropout rates, such as treatment with motivational components, shorter time frames, and social connection enhancements. Society has to accept that the VA cannot keep up with the demands and needs of its nations warriors and must develop, implement, and grow access to care for them. We ask them to do an impossible task: protect us from our enemies those seen and unseen. Now they need us to stand and fight for their needs at home after years of sacrifice.

References

Albright, D. L. (2015). Bridging the gap: Creative expression and military veterans. *Journal of Poetry Therapy: Bridging the Gap: Creative Expression and Military Veterans, 28*(2), 71–72. doi:10.1080/08893675.2015.1031461

Alvarez, N., & Mearns, J. (2014). The benefits of writing and performing in the spoken word poetry community. *The Arts in Psychotherapy, 41*(3), 263–268. doi:10.1016/j.aip.2014.03.004

Americans for the Arts. (2016). NEA and DOD launch creative forces: NEA military healing arts network. http://www.americansforthearts.org/news-room/americans-for-the-arts-news/nea-and-dod-launch-creative-forces-nea-military-healing-arts-network

Anderson, S. M. (2014). Applied literature for healing. *International Journal of Applied Linguistics and English Literature, 3*(6), 89-97. doi:10.7575/aiac.ijalel.v.3n.6p.89

Arruda, M. A. L. B., Garcia, M. A., & Garcia, J. B. S. (2016). Evaluation of the effects of music and poetry in oncologic pain relief: A randomized clinical trial. *Journal of Palliative Medicine, 19*(9), 943–948. doi:10.1089/jpm.2015.0528

Barron, J. (1974). Poetry and therapeutic communication: Nature and meaning of poetry. *Psychotherapy: Theory, Research & Practice, 11*(1), 87–92. doi:10.1037/h0086324

Bembry, J. X., Zentgraf, S., & Baffour, T. (2013). Social skills training through poetry therapy: A group intervention with schizophrenic patients. *Journal of Poetry Therapy, 26*(2), 73–82. doi:10.1080/08893675.2013.794534

Bensimon, M., Amir, D., & Wolf, Y. (2012). A pendulum between trauma and life: Group music therapy with post-traumatized soldiers. *The Arts in Psychotherapy, 39*(4), 223–233. doi:10.1016/j.aip.2012.03.005

Ben-Tovim, R. (2017). "Buoyed up by that coffin": Contemporary soldier poetry and the poetic prosthesis. *Symplokē, 25*(1–2), 389–404. doi:10.5250/symploke.25.1-2.0389

Blinka, D., & Harris, H. W. (2016). Moral injury in warriors and veterans: The challenge to social work. *Social Work and Christianity, 43*(3), 7.

Blosnich, J.R., Brenner, L.A., & Bossarte, R.M. (2016). Population mental health among US military veterans: Results of the veterans' health module of the behavioral risk factor surveillance system, 2011-2012. *Annals of Epidemiology, 26*(8), 592–596. doi:10.1016/j.annepidem.2016.06.009

Bolton, G. (1999). Every poem breaks a silence that had to be overcome. *Feminist Review, Contemporary Women Poets (2),* 118–133. https://www.jstor.org/stable/1395653

Bowman, D. O., & Halfacre, D. L. (1994). Poetry therapy with the sexually abused adolescent: A case study. *The Arts in Psychotherapy*, *21*(1), 11–16. doi.org/10.1016/0197-4556(94)9003

Brillantes-Evangelista, G. (2013). An evaluation of visual arts and poetry as therapeutic interventions with abused adolescents. *Arts in Psychotherapy*, *40*(1), 71–84. doi.org/10.1016/j.aip.2012.11.005

Brooks Holliday, S., & Pedersen, E. R. (2017). The association between discharge status, mental health, and substance misuse among young adult veterans. *Psychiatry Research, 256*, 428-434. doi:10.1016/j.psychres.2017.07.011

Bryan, C. J., Bryan, A. O., Anestis, M. D., Anestis, J. C., Green, B. A., Etienne, N., Morrow, C. E., Ray-Sannerud, B. (2016). Measuring moral injury: Psychometric properties of the moral injury events scale in two military samples. *Assessment, 23*(5), 557–570. doi:10.1177/1073191115590855

Burnam, M. A., Meredith, L. S., Tanielian, T., & Jaycox, L. H. (2009). Mental health care for Iraq and Afghanistan war veterans. *Health Affairs, 28*(3), 771–782. doi:10.1377/hlthaff.28.3.771

Campbell, M., Decker, K. P., Kruk, K., & Deaver, S. P. (2016). Art therapy and cognitive processing therapy for combat-related PTSD: A randomized controlled trial. *Art Therapy, 33*(4), 169–177. doi.org/10.1080/07421656.2016.1226643

Canada, K. E., Brinkley, A., Peters, C., & Albright, D. L. (2015) Military veterans: Therapeutic journaling in a veterans treatment court. *Journal of Poetry Therapy*, 28:2, 113-128. doi.org/10.1080/08893675.2015.1011373

Carroll, R. (2005). Finding the words to say it: The healing power of poetry. *Evidence-Based Complementary and Alternative Medicine, 2*(2), 161–172. https://doi.org/10.1093/ecam/neh096

Chattarji, S. (2014). Poetry by American women veterans. *Alea : Estudos Neolatinos, 16*(2), 300–316. doi:10.1590/S1517-106X2014000200004

Chilton, G., Gerber, N., Councill, T., & Dreyer, M. (2015). I followed the butterflies: Poetry of positive emotions in art therapy research. *Cogent Arts and Humanities*, *2*(1). doi.org/10.1080/23311983.2015.1026019

Cohen, B. E., Gima, K., Bertenthal, D., & Seal, K. H. (2010). Mental health diagnoses and utilization of VA non-mental health medical services among returning Iraq and Afghanistan veterans. *Journal of General Internal Medicine, 25*(1), 18–24. doi:10.1007/s11606-009-1117-3

Cohen, J. (1969). *Statistical power analysis for the behavioral sciences.* Academic Press.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Erlbaum.

Collins, K. S., Furman, R., & Langer, C. L. (2006). Poetry therapy as a tool of cognitively based practice. *Arts in Psychotherapy, 33*(3), 180–187. https://doi.org/10.1016/j.aip.2005.11.002

Corley, L. (2012). Reconsiderations: "Brave words": Rehabilitating the veteran-writer. *College English, 74*(4), 351.

Crawford, J. R., & Henry, J. D. (2003). The depression anxiety stress scales (DASS): Normative data and latent structure in a large non-clinical sample. *The British Journal of Clinical Psychology, 42*(Pt 2), 111–131. doi:10.1348/014466503321903544

Creech, S. K., & Misca, G. (2017). Parenting with PTSD: A review of research on the influence of PTSD on parent-child functioning in military and veteran families. *Frontiers in Psychology, 8*. doi.org/10.3389/fpsyg.2017.01101

Croom, A. M. (2015). The importance of poetry, hip-hop, and philosophy for an enlisted aviator in the USAF (2000-2004) flying in support of operation enduring freedom and operation Iraqi freedom. *Journal of Poetry Therapy: Bridging the Gap: Creative Expression and Military Veterans, 28*(2), 73–97. doi:10.1080/08893675.2015.1008732

Currier, J. M., Stefurak, T., Carroll, T. D., & Shatto, E. H. (2017). Applying trauma-informed care to community-based mental health services for military veterans. *Best Practices in Mental Health, 13*(1), 47–64.

DeLucia, J. M. (2016). Art therapy services to support veterans' transition to civilian life: The studio and the gallery. *Art Therapy, 33*(1), 4–12. doi:10.1080/07421656.2016.1127113

Deshpande, A. (2010). Recon mission: Familiarizing veterans with their changed emotional landscape through poetry therapy. *Journal of Poetry Therapy, 23*(4), 239–251. doi:10.1080/08893675.2010.528222

Dorman, F. (2017). Recognition: An exploration of the processes of counselling and poetry. *Counselling and Psychotherapy Research, 17*(2), 95–103. doi:10.1002/capr.12099

Erbes, C. R., Stillman, J. R., Wieling, E., Bera, W., & Leskela, J. (2014). A pilot examination of the use of narrative therapy with individuals diagnosed with PTSD: Narrative therapy for PTSD. *Journal of Traumatic Stress, 27*(6), 730–733. doi:10.1002/jts.21966

Faraway, J. J. (2015). *Linear models with R* (2nd ed.). CRC Press.

Fawson, S. (2019). Sustaining lamentation for military moral injury: Witness poetry that bears the traces of extremity. *Pastoral Psychology, 68*(1), 31–40. doi:10.1007/s11089-018-0855-8

Feld, E. (2012). Poetry and prayer. *Crosscurrents, 62*(1), 71–74. doi:10.1111/j.1939-3881.2012.00220.x

Finlay, A. K., Binswanger, I. A., Smelson, D., Sawh, L., McGuire, J., Rosenthal, J., Blue-Howells, J., Timko, C., Blodgett, J. C., Harris, A. H. S., Asch, S. M., & Frayne, S. (2015). Sex differences in mental health and substance use disorders and treatment entry among justice-involved veterans in the veterans health administration. *Medical Care, 53*(4), S105–S111. doi: 10.1097/MLR.0000000000000271

Fitzpatrick, J. J. (2017). The challenge of mental health care for veterans and their families. *Archives of Psychiatric Nursing, 31*(3), 233–233. doi:10.1016/j.apnu.2017.04.001

Forbes, D., Lloyd, D., Nixon, R. D. V., Elliott, P., Varker, T., Perry, D., Bryant, R. A., & Creamer, M. (2012). A multisite randomized controlled effectiveness trial of cognitive processing therapy for military-related posttraumatic stress disorder. *Journal of Anxiety Disorders, 26*(3), 442–452. doi.org/10.1016/j.janxdis.2012.01.006

Furman, R. (2003). Poetry therapy and existential practice. *Arts in Psychotherapy*, *30*(4), 195–200. doi.org/10.1016/S0197-4556(03)00052-2

Furman, R. (2004). Using poetry and narrative as qualitative data: Exploring a father's cancer through poetry. *Families, Systems, & Health, 22*(2), 162–170. doi:10.1037/1091-7527.22.2.162

Furman, R., Downey, E. P., Jackson, R. L., & Bender, K. (2002). Poetry therapy as a tool for strengths-based practice. *Advances in Social Work, 3*(2), 146–157.

Gallagher, J. M. (2021). Perceptions of legal legitimacy in veterans treatment courts: A test of a modified version of procedural justice theory. *Law and Human Behavior, 45*(2), 152–164.

Gallardo, H. L., Furman, R., & Kulkarni, S. (2009). Explorations of depression: Poetry and narrative in autoethnographic qualitative research. *Qualitative Social Work, 8*(3), 287–304. doi:10.1177/1473325009337837

Gantt, L., & Tinnin, L. W. (2009). Support for a neurobiological view of trauma with implications for art therapy. *Arts in Psychotherapy*, *36*(3), 148–153. doi.org/10.1016/j.aip.2008.12.005

Geer, F. C. (1983). Marine-machine to poet of the rocks: Poetry therapy as a bridge to inner reality: Some exploratory observations. *The Arts in Psychotherapy*, *10*(1), 9–14. doi.org/10.1016/0197-4556(83)90013-8

Goetter, E. M., Bui, E., Ojserkis, R. A., Zakarian, R. J., Brendel, R. W., & Simon, N. M. (2015). A systematic review of dropout from psychotherapy for posttraumatic stress disorder among Iraq and Afghanistan combat veterans. *Journal of Traumatic Stress, 28*(5), 401–409. doi:10.1002/jts.22038

Golub, D. (1985). Symbolic expression in post-traumatic stress disorder: Vietnam combat veterans in art therapy. *The Arts in Psychotherapy*, *12*(4), 285–296. doi.org/10.1016/0197-4556(85)90041-3

Goodwin, G. F., Blacksmith, N., & Coats, M. R. (2018). The science of teams in the military: Contributions from over 60 years of research. *American Psychologist*, *73*(4), 322–333. doi.org/10.1037/amp0000259

Gozashti, M. A., Moradi, S., Elyasi, F., & Daboui, P. (2017). Improvement in patient–reported outcomes after group poetry therapy of women with breast cancer. *Social Determinants of Health, 3*(2), 58–63. doi:10.22037/sdh.v3i2.17845

Gustavson, C. B. (2000). In-versing your life: Using poetry as therapy. *Families in Society: The Journal of Contemporary Social Services*, *81*(3), 328–331. doi.org/https://doi.org/10.1606/1044-3894.1023

Harris, A. M. (2013). After "A youth on fire": The woman veteran in Iulia Drunina's postwar poetry. *Aspasia, 7*, 68–91. doi:10.3167/asp.2013.070105

Hedberg, M. (1997). The re-enchantment of poetry as therapy. *The Arts in Psychotherapy, 24*(1), 91–100. doi.org/10.1016/S0197-4556(97)00002-6

Heppner, P. P., Wampold, B. E., Owen, J., Thompson, M. N., & Wang, K. T. (2016). *Research design in counseling* (4th ed.). Cengage.

Heimes, S. (2011). State of poetry therapy research (review). *Arts in Psychotherapy*, *38*(1), 1–8. doi.org/10.1016/j.aip.2010.09.006

Hill, M. (2008). Talking the real war: Jargon, guilt, and Vietnam veteran poetry. *Journal of American Culture, 31*(2), 175–184. doi:10.1111/j.1542-734X.2008.00671.x

Hilse, C., Griffiths, S., & Corr, S. (2007). The impact of participating in a poetry workshop. *The British Journal of Occupational Therapy, 70*(10), 431–438. doi:10.1177/030802260707001004

Hynes, A. M. (1988). Some considerations concerning assessment in poetry therapy and interactive bibliotherapy. *The Arts in Psychotherapy, 15*(1), 55–62. doi:10.1016/0197 4556(88)90052-4

Jones, A. (2011). Poetry, creative writing and therapy. *Healthcare Counselling & Psychotherapy Journal*, *3*(3), 44–46.

Kalmanowitz, D., & Ho, R. T. H. (2016). Out of our mind: Art therapy and mindfulness with refugees, political violence and trauma. *Arts in Psychotherapy, 49*, 57–65. https://doi.org/10.1016/j.aip.2016.05.012

Kashdan, T. B., Breen, W. E., & Julian, T. (2010). Everyday strivings in war veterans with posttraumatic stress disorder: Suffering from a hyper-focus on avoidance and emotion regulation. *Behavior Therapy, 41*(3), 350–363. doi:10.1016/j.beth.2009.09.003

Kim, J. B., Kirchhoff, M., & Whitsett, S. (2011). Expressive arts group therapy with middle-school aged children from military families. *Arts in Psychotherapy*, *38*(5), 356–362. doi.org/10.1016/j.aip.2011.08.003

Kintzle, S., Barr, N., Corletto, G., & Castro, C. A. (2018). PTSD in U.S. veterans: The role of social connectedness, combat experience and discharge. *Healthcare, 6*(3), 102.

Kirchner, J. E., Farmer, M. S., Shue, V. M., Blevins, D., & Sullivan, G. (2011). Partnering with communities to address the mental health needs of rural veterans. *The Journal of Rural Health*, *27*(4), 416–424. doi:10.1111/j.1748-0361.2011.00362.x

Kopytin, A., Lebedev, A., & Petersburg, S. (2013). Art therapy: Group art therapy with war veterans' humor, self-attitude, emotions, and cognitions in group. *Journal of the American Art Therapy Association 30*(May), 37–41. doi.org/10.1080/07421656.2013.757758

Kozodoy, M. (2011). Medieval Hebrew medical poetry: Uses and contexts. *Aleph: Historical Studies in Science and Judaism, 11*(2), 213–288. doi:10.2979/aleph.11.2.213

Lande, R. G., Tarpley, V., Francis, J. L., & Boucher, R. (2010). Combat trauma art therapy scale. *The Arts in Psychotherapy, 37*(1), 42–45. doi:10.1016/j.aip.2009.09.007

Lantz, J. (1997). Poetry in existential psychotherapy with couples and families. *International Journal of Family Therapy*, *17*(3), 371–381. doi. 10.1007/BF02252670

Lantz, J., & Harper, K. V. (1991). Using poetry in logotherapy. *The Arts in Psychotherapy*, *18*(4), 341–345. doi.org/10.1016/0197-4556(91)90073-J

Lehavot, K., Goldberg, S. B., Chen, J. A., Katon, J. G., Glass, J. E., Fortney, J. C., Simpson, T. L., & Schnurr, P. P. (2018). Do trauma type, stressful life events, and social support explain women veterans' high prevalence of PTSD? *Social Psychiatry and Psychiatric Epidemiology*, *53*(9), 943–953. doi.org/10.1007/s00127-018-1550-x

Lerner, A. (1997). A look at poetry therapy. *Art Psychotherapy*, *3*(1), 81–89. doi.org/10.1016/0090-9092(76)90009-0

Levy, C. E., Spooner, H., Lee, J. B., Sonke, J., Myers, K., & Snow, E. (2018). Telehealth-based creative arts therapy: Transforming mental health and rehabilitation care for rural veterans. *Arts in Psychotherapy*, *57*, 20–26. doi.org/10.1016/j.aip.2017.08.010

Levy, F. J. (2014). Integrating the arts in psychotherapy: Opening the doors of shared creativity. *American Journal of Dance Therapy*, *36*(1), 6–27. doi.org/10.1007/s10465-014-9171-8

Li, J., Zweig, K. C., Brackbill, R. M., & Cone, J. E. (2018). Comorbidity amplifies the effects of post-9/11 posttraumatic stress disorder trajectories on health-related quality of life. *Quality of Life Research*, *27*(3), 651–660. doi:10.1007/s11136-017-1764-5

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*. *33*(3), 335–343. doi:10.1016/0005-7967(94)00075-U.

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the depression anxiety & stress scales*. Psychology Foundation.

Lucas, P. A. (2018). An exploratory study of veterans treatment court peer mentors: Roles, experiences, and expectations. *Drug Court Review*, (1), 59–85.

Luhmann, N. (2001). Notes on the project "poetry and social theory." *Theory, Culture & Society, 18*(1), 15–27. doi:10.1177/02632760122051616

Maddalena, C. J. (2009). The resolution of internal conflict through performing poetry. *Arts in Psychotherapy, 36*(4), 222–230. doi.org/10.1016/j.aip.2009.04.001

Malekoff, A. (2007). Demystifying and celebrating group work through poetry. *Social Work with Groups, 30*(1), 71–96. doi:10.1300/J009v30n01_07

Mann, D. W. (2010). Practical poetry. *Psychoanalytic Review, 97*(5), 717–732. doi.org/10.1521/prev.2010.97.5.717

Matarazzo, B. B., Signoracci, G. M., Brenner, L. A., & Olson-Madden, J. H. (2016). Barriers and facilitators in providing community mental health care to returning veterans with a history of traumatic brain injury and co-occurring mental health symptoms. *Community Mental Health Journal, 52*(2), 158–164. doi:10.1007/s10597-015-9926-9

Matthieu, M. M., Wilson, A., & Casner, R. W. (2017). Interdisciplinary issues at the intersection of assessing and treating substance use disorders and post-traumatic stress disorder: Clinical social work and clinical behavioral analysis with veterans. *Advances in Social Work, 18*(1), 217–234.

Mazza, N. (2017). *Poetry therapy: Theory and practice*. Routledge.

Mazza, N. F., & Hayton, C. J. (2013). Poetry therapy: An investigation of a multidimensional clinical model. *Arts in Psychotherapy, 40*(1), 53–60. doi.org/10.1016/j.aip.2012.10.002

Mazza, N., Magaz, C., & Scaturro, J. (1987). Poetry therapy with abused children. *The Arts in Psychotherapy, 14*(1), 85–92. doi.org/10.1016/0197-4556(87)90038-4

McArdle, S., & Byrt, R. (2001). Fiction, poetry and mental health: Expressive and therapeutic uses of literature. *Journal of Psychiatric and Mental Health Nursing, 8*(6), 517–524. doi:10.1046/j.1351-0126.2001.00428.x

Merscham, C. (2000). Restoring trauma with narrative therapy: Using the phantom family. *The Family Journal: Counseling and Therapy for Couples and Families*, *8*(3), 282–286. doi.org/10.1177/1066480700083013

Modell, J., & Haggerty, T. (1991). The Social Impact of War. *Annual Review of Sociology, 17*, 205–224. http://www.jstor.org/stable/2083341

Mohammadian, Y., Shahidi, S., Mahaki, B., Mohammadi, A. Z., Baghban, A. A., & Zayeri, F. (2011). Evaluating the use of poetry to reduce signs of depression, anxiety and stress in Iranian female students. *Arts in Psychotherapy*, *38*(1), 59–63. doi.org/10.1016/j.aip.2010.12.002

National Initiative for Arts & Health in the Military. (2013). Arts, health and well-being across the military continuum: White paper and framing a national plan for action. Americans for the Arts. https://www.americansforthearts.org/sites/default/files/pdf/2013/by_program/legislation_and_policy/art_and_military/ArtsHealthwellbeingWhitePaper.pdf

National Veterans Foundation. (2016). *Troubling veteran mental health facts and statistics that need to be addressed.* Lifeline for vets. https://nvf.org/veteran-mental-health-facts-statistics/

Nevinski, R. L. (2013). Self-expressive writing as a therapeutic intervention for veterans and family members. *Journal of Poetry Therapy, 26*(4), 201–221. doi:10.1080/08893675.2013.849044

Nieuwenhuijsen, K., de Boer, A. G. E. M., Verbeek, J. H. A. M., Blonk, R. W. B., & van Dijk, F. J. H. (2003). The depression anxiety stress scales (DASS): Detecting anxiety disorder and depression in employees absent from work because of mental health problems. *Occupational and Environmental Medicine, 60*(suppl 1), i77-–i82. doi:10.1136/oem.60.suppl_1.i77

Ogrysko, N. (2020, October 1). Without clear standards, veterans are in the dark on community care wait times. *Federal News Network.* https://federalnewsnetwork.com/veterans-affairs/2020/10/without-clear-standards-veterans-are-in-the-dark-on-community-care-wait-times/

Painter, J. M., Gray, K., McGinn, M. M., Mostoufi, S., & Hoerster, K. D. (2016). The relationships of posttraumatic stress disorder and depression symptoms with health-related quality of life and the role of social support among veterans. *Quality of Life Research, 25*(10), 2657–2667. doi:10.1007/s11136-016-1295-5

Palmer, E., Hill, K., Lobban, J., & Murphy, D. (2017). Veterans' perspectives on the acceptability of art therapy: A mixed-methods study. *International Journal of Art Therapy, 22*(3), 132–137. doi:10.1080/17454832.2016.1277250

Raingruber, B. (2004). Using poetry to discover and share significant meanings in child and adolescent mental health nursing. *Journal of Child and Adolescent Psychiatric Nursing, 17*(1), 13–20. doi.org/10.1111/j.1744-6171.2004.00013.x

Ramirez, J., Erlyana, E., & Guilliaum, M. (2016). A review of art therapy among military service members and veterans with post-traumatic stress disorder. *Journal of Military and Veterans' Health*, *24*(2), 40–51.

Ramsey, C., Dziura, J., Justice, A. C., Altalib, H. H., Bathulapalli, H., Burg, M., Decker, S., Driscoll, M., Goulet, J., Haskell, S., Kulas, J., Wang, K. H., Mattocks, K., & Brandt, C. (2017). Incidence of mental health diagnoses in veterans of operations Iraqi freedom, enduring freedom, and new dawn, 2001-2014. *American Journal of Public Health, 107*(2), 329–335. doi:10.2105/AJPH.2016.303574

Rayneard, M. (2011). "Let me tell you the story of how": U.S. military veterans, performing memory, and the telling project. *The Theatre Annual, 64*, 1–26.

Reiter, S. (2004). In memoriam-Jack J. Leedy (1921-2004). *Journal of Poetry Therapy, 17*(4), 231–238. doi:10.1080/0889367042000325139

Resick, P. A., Monson, C. M., & Chard, K. M. (2014). *Cognitive processing therapy: Veteran/military version: Therapist and patient materials manual*. Department of Veterans Affairs.

Resick, P. A., Monson, C. M., & Chard, K. M (2017). *Cognitive processing therapy for PTSD: A comprehensive manual*. The Guilford Press.

Rickett, C., Greive, C., & Gordon, J. (2011). Something to hang my life on: The health benefits of writing poetry for people with serious illnesses. *Australasian Psychiatry, 19*(3), 265–268. doi:10.3109/10398562.2011.562298

Robinson, A. (2004). A personal exploration of the power of poetry in palliative care, loss and bereavement. *International Journal of Palliative Nursing, 10*(1), 32–39. doi:10.12968/ijpn.2004.10.1.12017

Rodak, J., Alloway, T. P., & Rizzo, M. (2018). PTSD's true color: Examining the effect of coloring on anxiety, stress, and working memory in veterans. *Mental Health and Prevention*, *12*, 50–54. doi.org/10.1016/j.mhp.2018.09.007

Roe, C., & Garland, A. (2011). The use of poetry in the construction of meaning in cognitive behavioural psychotherapy and mental health studies. *Mental Health Review Journal*, *16*(3), 93–101. doi.org/10.1108/13619321111178032

Rubin, A., Weiss, E. L., & Coll, J. E. (2013). *Handbook of military social work*. John Wiley & Sons.

Russell, R. T. (2009). Veterans treatment court: A proactive approach. *New England Journal on Criminal and Civil Confinement, 35*(2), 357–372.

Sarid, O., & Huss, E. (2010). Trauma and acute stress disorder: A comparison between cognitive behavioral intervention and art therapy. *Arts in Psychotherapy*, *37*(1), 8–12. doi.org/10.1016/j.aip.2009.11.004

Sassen, G. (2012). Drums and poems: An intervention promoting empathic connection and literacy in children. *Journal of Creativity in Mental Health*, *7*(3), 233–248. doi:10.1080/15401383.2012.711712

Schnurr, P. P., Lunney, C. A., Bovin, M. J., & Marx, B. P. (2009). Posttraumatic stress disorder and quality of life: Extension of findings to veterans of the wars in Iraq and Afghanistan. *Clinical Psychology Review, 29*(8), 727–735. doi:10.1016/j.cpr.2009.08.006

Scott, M. J. (2020). Post-traumatic stress disorder: An alternative paradigm. *American Journal of Applied Psychology 9*(1), 1–6. doi: 10.11648/j.ajap.20200901.11

Scotland-Coogan, D. (2019). Relationships, socialization and combat veterans: The impact of receiving and training a service dog. *The Qualitative Report, 24*(8), 1897–1914.

Seymour, R., & Murray, M. (2016). When I am old I shall wear purple: A qualitative study of the effect of group poetry sessions on the well-being of older adults. *Working with Older People, 20*(4), 195–198. doi:10.1108/WWOP-08-2016-0018

Silverman, H. L. (1986). Poetry therapy. *The Arts in Psychotherapy, 13*(4), 343–345. doi:10.1016/0197-4556(86)90035-3

Sloan, D. M., Lee, D. J., Litwack, S. D., Sawyer, A. T., & Marx, B. P. (2013). Written exposure therapy for veterans diagnosed with PTSD: A pilot study. *Journal of Traumatic Stress, 26*(6), 776–779. doi:10.1002/jts.21858

Smith, J., Newby, J. M., Burston, N., Murphy, M. J., Michael, S., Mackenzie, A., Kiln, F., Loughman, S. A., O'Moore, K. A., Allard, B. J., Williams, A. D., & Andrews, G. (2017). Help from home for depression: A randomized controlled trial comparing internet-delivered cognitive behaviour therapy with bibliotherapy for depression. *Internet Interventions, 9*, 25–37. doi:10.1016/j.invent.2017.05.001

Spence, M., Rose, D., & Tucker, J. A. (2014). Some wounds don't bleed: An examination of unresolved trauma in Vietnam veterans and its ethical implications through the lens of one man's story and beyond. *Ethical Human Psychology and Psychiatry, 16*(3), 140–157. doi.org/10.1891/1559-4343.16.3.140

Steenkamp, M. M., Litz, B. T., & Marmar, C. R. (2020). First-line psychotherapies for military-related PTSD. *JAMA, 323*(7), 656–657. doi:10.1001/jama.2019.20825

Stepakoff, S. (2009). From destruction to creation, from silence to speech: Poetry therapy principles and practices for working with suicide grief. *The Arts in Psychotherapy, 36*(2), 105–113. doi:10.1016/j.aip.2009.01.007

Stephenson, K., & Rosen, D. H. (2015). Haiku and healing: An empirical study of poetry writing as therapeutic and creative intervention. *Empirical Studies of the Arts, 33*(1), 36–60. doi.org/10.1177/0276237415569981

Story, K. M., & Beck, B. D. (2017). Guided imagery and music with female military veterans: An intervention development study. *Arts in Psychotherapy, 55*, 93–102. doi.org/10.1016/j.aip.2017.05.003

Sutton, J., & De Backer, J. (2009). Music, trauma and silence: The state of the art. *The Arts in Psychotherapy, 36*(2), 75–83. doi:10.1016/j.aip.2009.01.009

Swinnen, A. M. C. (2016). Healing words: A study of poetry interventions in dementia care. *Dementia, 15*(6), 1377–1404. doi:10.1177/1471301214560378

Sychterz, J. (2018). Poetry, the Iraq war, and the ethics of trauma. *War, Literature and the Arts, 30*, 434–440.

Szto, P., Furman, R., & Langer, C. (2005). Poetry and photography: An exploration into expressive/creative qualitative research. *Qualitative Social Work, 4*(2), 135–156. doi:10.1177/1473325005052390

Tan, S. (2011). *Counseling and psychotherapy: A Christian perspective*. Baker Academic.

Tanielian, T., Batka, C., & Meredith, L. S. (2017). *The changing landscape for veterans' mental health care*. RAND Corporation. https://www.rand.org/pubs/research_briefs/RB9981z2.html

Taylor, E. N., Timko, C., Nash, A., Owens, M. D., Harris, A. H. S., & Finlay, A. K. (2020). Posttraumatic stress disorder and justice involvement among military veterans: A systematic review and meta-analysis. *Journal of Traumatic Stress, 33*(5), 804–812. doi.org/10.1002/jts.22526

Tegnér, I., Fox, J., Philipp, R., & Thorne, P. (2009). Evaluating the use of poetry to improve well-being and emotional resilience in cancer patients. *Journal of Poetry Therapy, 22*(3), 121–131. doi:10.1080/08893670903198383

Thompson, B. L., & Waltz, J. (2010). Mindfulness and experiential avoidance as predictors of posttraumatic stress disorder avoidance symptom severity. *Journal of Anxiety Disorders, 24*(4), 409–415. doi:10.1016/j.janxdis.2010.02.005

Tick, E. (2013). PTSD: The sacred wound. *Health Progress, 94*(3), 14–22.

van Devanter, L., & Furey, J.A. (1991). *Visions of war, dreams of peace: Writings of women in the Vietnam War*. Warner Books.

van Westrhenen, N., & Fritz, E. (2014). Creative arts therapy as treatment for child trauma: An overview. *Arts in Psychotherapy, 41*(5), 527–534. doi.org/10.1016/j.aip.2014.10.004

Veterans Writing Project. (2020). *What we do*. https://veteranswriting.org/

Vogt, D., Fox, A. B., & Di Leone, B. A. L. (2014). Mental health beliefs and their relationship with treatment seeking among U.S. OEF/OIF veterans. *Journal of Traumatic Stress, 27*(3), 307–313. doi:10.1002/jts.21919

Wachen, J. S., Dondanville, K. A., Pruiksma, K. E., Molino, A., Carson, C. S., Blankenship, A. E., Wilkinson, C., Yarvis, C. O. L. J. S., & Resick, P. A.. (2016). Implementing cognitive processing therapy for posttraumatic stress disorder with active duty U.S. military personnel: Special considerations and case examples. *Cognitive and Behavioral Practice, 23*(2), 133–147. doi.org/10.1016/j.cbpra.2015.08.007

Wadeson, H. (1981). Self-exploration and integration through poetry-writing. *The Arts in Psychotherapy, 8*(3), 225–236. doi:10.1016/0197-4556(81)90035-6

Wakeman, B. E. (2015). Poetry as research and as therapy. *Transformation: An International Journal of Holistic Mission Studies*, *32*(1), 50–68. doi.org/10.1177/0265378814537767

Walker, M. S., Kaimal, G., Koffman, R., & DeGraba, T. J. (2016). Art therapy for PTSD and TBI: A senior active duty military service member's therapeutic journey. *Arts in Psychotherapy*, *49*, 10–18. doi.org/10.1016/j.aip.2016.05.015

Warner, R. M. (2013). *Applied statistics: From bivariate through multivariate techniques* (2nd ed). Sage.

Weigl, B. (2001). *The circle of Hahn*. Grove Press.

Witney, M. N. (2012). Using metaphor and narrative ideas in trauma and family therapy. *HTS Teologiese Studies / Theological Studies*, *68*(2), 1–6. doi.org/10.4102/hts.v68i2.1165

Worthen, M. (2011). The relations between traumatic exposures, posttraumatic stress disorder, and anger in male and female veterans. *Journal of Feminist Family Therapy: Women and the Military: Feminist Perspectives, 23*(3–4), 188–201. doi:10.1080/08952833.2011.604535

Wray, L. O., Pikoff, E., King, P. R., Hutchison, D., Beehler, G. P., & Maisto, S. A. (2016). Veterans' mental health beliefs: Facilitators and barriers to primary care-mental health use. *Families, Systems & Health: The Journal of Collaborative Family Healthcare*, *34*(4), 404–413. doi:10.1037/fsh0000231

Zoroya, G. (2013, February 20). Ailing veterans turn to charities in record numbers. *USA Today*. https://www.usatoday.com/story/news/nation/2013/02/20/ailing-veterans increasingly-turn-to-charities/1934207/

Appendix A

Recruitment Flyer

Research Participants Needed

Veteran Poetry Therapy Group Study

✓ ***Are you a Veteran that is 18 years of age or older?***
✓ ***Would you like to participate in poetry incorporated group therapy?***

If you answered **yes** to these questions, you may be eligible to participate in a poetry group therapy research study.

The Details

The purpose of the study is to examine if using poetry in a group counseling setting will influence veteran's level of depression, anxiety, and stress as measured by the Depression Anxiety Stress Scale (DASS-42).

- First step is to complete a screening survey to see if you meet the requirements for participation.
- If chosen, then you will be randomly placed in either the treatment group or control group.
- Prior to the start of the group, you will be emailed the Zoom link details, a consent form, and a DASS-42 to complete and return prior to the first session. This will take approximately 15 minutes to complete.
- The groups will last for seven weeks and consist of weekly sessions via Zoom lasting 90 minutes each. Each group will offer cognitive behavioral therapy; however, the treatment group will include poetry techniques in their sessions. Each week you will discuss your thoughts, feelings, and behaviors towards different topics including healing, safety, trust, suffering, mourning, reconnection, and empowerment.
- After seven weeks you will be asked to complete another DASS-42 and these results will be compared to the first DASS-42 you took prior session one. This will take approximately 15 minutes to complete.
- Benefits of participation include increased knowledge about symptomology and coping skills development.

Your name and other identifying information will be requested as part of your participation, but this information will remain confidential.

The study is being conducted via ZOOM, therefore travel time and COVID-19 restrictions will not interfere with the weekly sessions.

Misty Ely, LCSW, a doctoral candidate in the School of Behavioral Sciences at Liberty University, is conducting this study.

Please contact [redacted] **or** [redacted] **more information or to participate.**

Appendix B

Recruitment Survey

for

Participation in a Veteran Poetry Therapy Group

Name:	
Phone Number:	
Address:	
Email:	
Military Veteran	**Yes or No**
Gender:	
Age:	
Ethnicity:	

Are you interested in participating in a poetry therapy group, that will meet once a week for seven weeks, for 90 minutes? Yes or No

Do you have a current mental health diagnosis? Yes or No

If yes, please describe:

_____
_____
_____
_____
_____
_____
_____

Appendix C

Informed Consent

Title of the Project: Evaluating the use of poetry to reduce the signs of depression, anxiety, and stress in veterans.

Principal Investigator: Misty Ely, LCSW-S, Graduate Student, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be 18 years of age, a military veteran, willing to participate in poetry group counseling, and have no foreseeable barriers to treatment for the duration of the group (seven weeks). Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the study is to examine if using poetry in a group counseling setting will influence veteran's level of depression, anxiety and stress as measured by the Depression Anxiety Stress Scale (DASS-42).

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Complete screening form and return by email.
2. Read and sign consent form and return by email
3. Complete the Depression Anxiety Stress Scale (DASS-42). This should take 15 minutes to complete.
4. Participant in a 7-week therapy group. Consisting of open discussions around the poetry chosen for the session. In some sessions you will be asked to fill in blank spaces of a poem and in other sessions you will be asked to collaborate with group members to create poetry based on the sessions theme. Each session will last 90-minutes.
5. Complete the Depression Anxiety Stress Scale (DASS-42) at the end of session 7. This should take 15 minutes to complete.

**This study will consist of a treatment group and a control group. Participants will be randomly assigned to a group. There will be a maximum of 15 participants in each study group."

How could you or others benefit from this study?

The direct benefits participants should expect to receive from taking part in this study are an increased knowledge about symptomology and coping skills development.

Benefits to society include helping to find new and innovative treatment approaches to assist veterans in need.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. One minimal potential risk that participants may experience is discomfort in being vulnerable in a group setting. Additionally, there is a small potential risk of being triggered by listening to others' stories shared in the group by fellow veterans. If these occur, I will address them after the session and ensure you have the support and resources needed for stability.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be kept confidential through the use of codes. Group will be conducted over Zoom and will be password protected so that only those allowed into the group will have access.

- All forms retuned from the participants by email (screening and DASS-42) will saved to the researchers' password locked computer.
- Data will be kept electronically on the investigator's laptop with an external hard drive, which are password protected and kept in locked office at home. Data will be deleted from investigator's computer following publication and within three years following the end of data collection. The data will be kept on an external hard drive and it will be reformatted at the end of the three years in order to destroy the data.
- Confidentiality cannot be guaranteed in focus group settings. While discouraged, other members of the focus group may share what was discussed with persons outside of the group.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data

collected from you will be destroyed immediately and will not be included in this study. Group data will not be destroyed, but your contributions to the group will not be included in the study if you choose to withdraw.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study Misty Ely, LCSW-S. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact [redacted] or [redacted]. You may also contact the researcher's dissertation chair, [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the

study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

_____

Printed Subject Name

_____

Signature & Date

Appendix D

Poetry Chosen for this Research

Week 1: Theme: Suffering

Darkness Falls

Darkness falls, we run and hide

Screams echo far and wide

The piecing cries that haunt our soul

Riveting flashbacks take their toll

Delusions of peace give us reprieve

One moment of clarity is all we conceive

We welcome the sandman and the reaper too

Bringing with them hallucinations of you

Of course, I see you when I sleep

The only chance I get to have a peak

I close my eyes to bring you here

Just have to fight the blood curdling fear

You're gone and I know

This pain I still show

It beacons me near from my core

To squander my hope forever more

The darkness falls I won't run and hide

Listen to my screams as we stand side by side

Together we can tackle this nightmare of mine

Because you're haunted too by father time

Misty Ely, Pearls of Wisdom, 2020

Week 2 Theme: Power & Control

Invictus

Out of the night that covers me,
Black as the pit from pole to pole,
I thank whatever gods may be
For my unconquerable soul.
In the fell clutch of circumstance
I have not winced nor cried aloud.
Under the bludgeoning's of chance
My head is bloody, but unbowed.
Beyond this place of wrath and tears
Looms but the Horror of the shade,
And yet the menace of the years
Finds and shall find me unafraid.
It matters not how strait the gate,
How charged with punishments the scroll,
I am the master of my fate,
I am the captain of my soul.

By William Ernest Henley

Written in 1875. Published in *Book of Verses*, 1888

Week 3 Theme: Safety

The Road Not Taken

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth.
Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,
And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.
I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I—
I took the one less traveled by,
And that has made all the difference.

By Robert Frost

Published in Mountain Interval in 1916

Week 4 Theme: Healing

Mountains

I'm standing at the base and wondering why I want to climb
Another mountain to conquer, maybe another place in time
With each step I take, I remember another place I've been
The battles I've lost and all the sin
I remember each face, because they are burned in my soul
The piercing cries of agony, the misfortunes untold
My face burns in the sun, my feet blister in their shoes
But I climb ever more, because I'm not facing the truth
I'm trying so hard to live, but I'm barely getting by
I try to focus on the good, but the mountains stack high
They're vast and wide, and too many to count
The conquest doesn't matter, because they surmount
I walk, I run, I climb and crawl
Always waiting to break my fall
Each step I take brings me closer to the end
It's not the summit I want, it's the ascend
But these mountains are mine and mine alone
Each beautifully complicated, majestically shown
I climb them with pride and my dignity intact
I might not always have the strength, but I'm coming back
And they'll be there, waiting for when I can
Because these are my mountains, they're in my hands.

Misty Ely, Pearls of Wisdom, 2020

Week 5 Theme: Trust

The Charge of the Light Brigade

Half a league, half a league,
Half a league onward,
All in the valley of Death
  Rode the six hundred.
"Forward, the Light Brigade!
Charge for the guns!" he said.
Into the valley of Death
  Rode the six hundred.
"Forward, the Light Brigade!"
Was there a man dismayed?
Not though the soldier knew
  Someone had blundered.
  Theirs not to make reply,
  Theirs not to reason why,
  Theirs but to do and die.
  Into the valley of Death
  Rode the six hundred.
Cannon to right of them,
Cannon to left of them,
Cannon in front of them
  Volleyed and thundered;
Stormed at with shot and shell,
Boldly they rode and well,
Into the jaws of Death,
Into the mouth of hell
  Rode the six hundred.
Flashed all their sabres bare,
Flashed as they turned in air
Sabring the gunners there,
Charging an army, while
  All the world wondered.
Plunged in the battery-smoke
Right through the line they broke;
Cossack and Russian
Reeled from the sabre stroke
  Shattered and sundered.
Then they rode back, but not
  Not the six hundred.
Cannon to right of them,
Cannon to left of them,
Cannon behind them
  Volleyed and thundered;

Stormed at with shot and shell,
While horse and hero fell.
They that had fought so well
Came through the jaws of Death,
Back from the mouth of hell,
All that was left of them,
  Left of six hundred.

When can their glory fade?
O the wild charge they made!
  All the world wondered.
Honour the charge they made!
Honour the Light Brigade,
  Noble six hundred!

By Alfred, Lord Tennyson

Published 9 December 1854 in The Examiner

Week 6 Theme: Reconnection

Veteran

Amongst them all, a few did stand

Men and women joined hand in hand

They fight for America, at all cost,

Put their lives in danger and some lost.

When hearing the anthem, it makes them cry

A song devoted to them, their lullaby.

Some are off in faraway lands

Writing letters and playing to be home again.

They hold their own, depend on none

Knowing this is how it must be done.

So then you question the reasons why

This service member is ready to die.

On our behalf they took an oath

To defend against all, foreign and home.

These are the veterans that proudly service,

Give them the respect that they deserve

Misty Ely, Pearls of Wisdom, 2020

Week 7 Theme: Empowerment

Compass

I've lost my way a time or two
At a crossroad, not knowing what to do
Off the beaten path, I've taken the long way
Every misdirection, brought me to this day
I've been so lost that I couldn't find north
This ever-winding journey, bringing me back & forth
The unanswered prayers, misguided course
Like evil always beckoned without remorse
My magnetic north was thrown off balance
Yet I stayed the course without malice
I knew eventually I'd find my place
In due time and at my pace
When I was ready she'd come to me
My compass to guide & set me free
Finally free for the last leg of travel
To put on my armor & face this battle
With you at my side, true north at my back
The time is now for my final attack
Lead the way, for I will follow
And where we walk, it shall be hallowed

Misty Ely, Pearls of Wisdom, 2020

Appendix E

Depression Anxiety Stress Scale-42

DASS ***Name:*** ***Date:***

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

Appendix F

CPT Handouts

Session 1

Overview of Cognitive Processing Therapy

Session 1 - Introduction and Education: Symptoms of PTSD; explanation of symptoms (cognitive theory); description of therapy. Practice assignment: Write Impact Statement.

Session 2 - The Meaning of the Event*: Patient reads Impact Statement. Therapist and patient discuss meaning of trauma. Begin to identify stuck points and problematic areas, and add to Stuck Point Log. Review symptoms of PTSD and theory. Introduction of A-B-C Worksheets with explanation of relationship between thoughts, feelings, and behavior. Practice assignment: Complete 1 A-B-C sheet each day, including at least one on the worst trauma.

Session 3 - Identification of Thoughts and Feelings: Review A-B-C practice assignment. Discuss stuck points with a focus on assimilation. Review the event with regard to any acceptance or self-blame issues. Begin Socratic questioning regarding stuck points. Practice assignment: Reassign A-B-C Worksheets. Assign written trauma account.

Session 4 - Remembering Traumatic Events: Have patient read full trauma account aloud with affective expression. Identify stuck points. Start to help patient challenge self-blame or assimilation with Socratic questions. Explain difference between responsibility and blame. Practice assignment: Rewrite trauma account, read full written trauma account on a daily basis, complete A-B-C sheets daily.

Session 5 – Second Trauma Account: Have patient read second written trauma account aloud. Identify differences between first and second account. Help patient challenge self-blame or assimilation with Socratic questions. Introduce Challenging Questions Worksheet to help patient challenge stuck points. Practice assignment: Challenge one stuck point per day using the Challenging Questions Worksheet, continue to work on trauma account if not finished, read trauma account daily.

Session 6: Challenging Questions - Review practice assignment. Review Challenging Questions Worksheet. Continue cognitive therapy regarding stuck points. Introduce Patterns of Problematic Thinking Worksheet. Teach patient to use the new worksheet to challenge his cognitions regarding the trauma(s). Practice assignment: Identify stuck points and complete Patterns of Problematic Thinking worksheets for each. Look for patterns in thinking. Continue to read trauma account if still having strong emotions about it.

Session 7 - Patterns of Problematic Thinking: Review Patterns of Problematic Thinking Worksheets to address trauma-related stuck points. Introduce Challenging Beliefs Worksheet with a trauma example. Introduce Safety Module. Discuss how previous beliefs regarding safety might have been disrupted or seemingly confirmed by the index event. Use Challenging Beliefs Worksheet to challenge safety beliefs. Practice assignment: Daily identification of stuck points, including one on safety using the Challenging Beliefs Worksheet. Read Safety Module. Continue to read trauma account if still having strong emotions about it.

Session 1

Session 8 - Safety Issues: Review Challenging Beliefs Worksheets and help patient to challenge problematic beliefs they were unable to complete successfully on their own. Introduce Trust Module. Pick out any stuck points on self-trust or other-trust. Practice assignment: Read Trust Module and complete at least one Challenging Beliefs Worksheet on trust. Continue to challenge stuck points on a daily basis using Challenging Beliefs Worksheets. Continue reading trauma account if still having strong emotions about it.

Session 9 - Trust Issues: Review Challenging Beliefs Worksheets. Introduce module on Power/Control. Discuss how prior beliefs were affected by the trauma. Practice assignment: Read Power/Control Module and complete at least one Challenging Beliefs Worksheet on Power/Control issues. Continue to challenge stuck points on a daily basis using Challenging Beliefs Worksheets. Continue to read trauma account if still having strong emotions about it.

Session 10 - Power/Control Issues: Review Challenging Beliefs Worksheets. Introduce module on Esteem (self-esteem and regard for others). Practice assignment: Read module and complete Challenging Beliefs Worksheets on esteem, as well as assignments regarding giving and receiving compliments and doing nice things for self. Continue to challenge stuck points on a daily basis using Challenging Beliefs Worksheets. Continue to read trauma account if still having strong emotions about it.

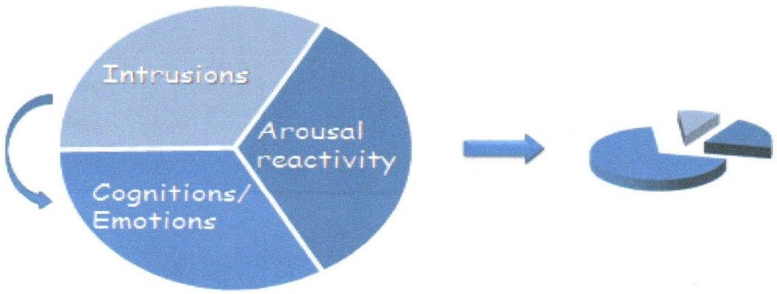
Session 11 - Esteem Issues: Review Challenging Beliefs Worksheets. Discuss reactions to two behavioral assignments – giving and receiving compliments and engaging in a pleasant activity. Introduce final module on Intimacy. Practice assignment: Continue giving and receiving compliments, read Intimacy Module and complete Challenging Beliefs Worksheets on stuck points regarding intimacy. Continue to read trauma account if still having strong emotions about it. Final assignment: Write final Impact Statement.

Session 12 - Intimacy Issues and Meaning of the Event: Go over the Challenging Beliefs Worksheets. Have patient read the final Impact Statement. Therapist reads the first Impact Statement and then compares the differences. Discuss any intimacy stuck points. Review the entire therapy and identify any remaining issues the patient may need to continue to work on. Encourage the patient to continue with behavioral assignments regarding compliments and doing nice things for self. Remind patient that he is taking over as therapist now and should continue to use skills he has learned.

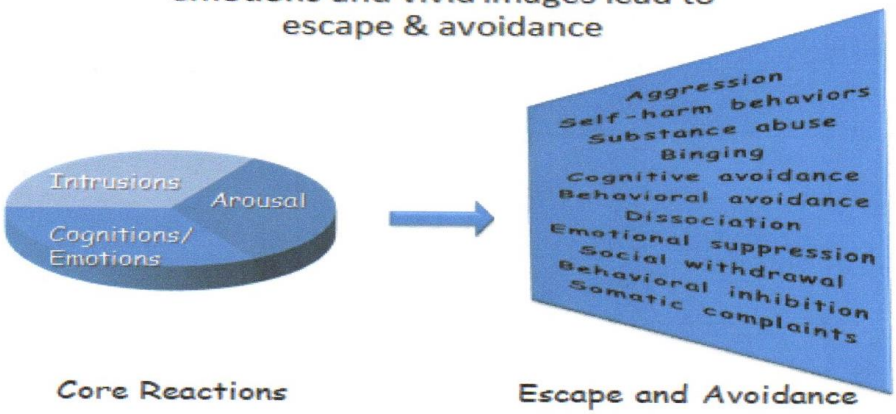
Session 1

Recovery or Non-recovery from PTSD Symptoms Following Traumatic Events

In normal recovery, intrusions and emotions decrease over time and no longer trigger each other



However, in those who don't recover, strong negative emotions and vivid images lead to escape & avoidance



The avoidance prevents the processing of the trauma that is needed for recovery and works only temporarily

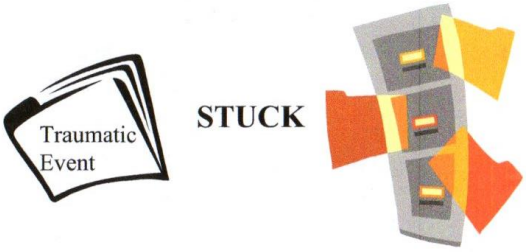
D2

Session 1

Stuck Points—What Are They?

Throughout the rest of therapy we will be talking about stuck points and helping you to identify what yours are. Basically, stuck points are conflicting beliefs or strong negative beliefs that create unpleasant emotions and problematic or unhealthy behavior. Stuck points can be formed in a couple of different ways:

1. Stuck points may be conflicts between prior beliefs and beliefs after a traumatic experience.



Prior Belief — Harmed During Military Service

I am able to protect myself in dangerous situations. — I was harmed during my military service, and I am to blame.

Results

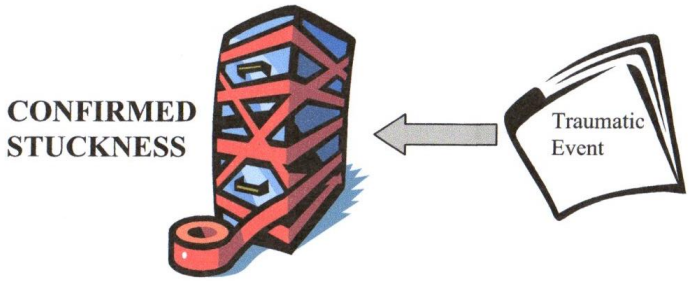
- If you cannot change your previous beliefs to accept what happened to you (i.e., it is possible that I cannot protect myself in all situations), you may find yourself saying, "I deserved it because of my actions or inactions. I am responsible for what happened."
- If you are questioning your role in the situation, you may be making sense of it by saying, "I misinterpreted what happened…I didn't make myself clear…I acted inappropriately…I must be crazy or I must have done something to have caused it …"
- If you are stuck here, it may take some time until you are able to get your feelings out about the trauma.

Goal

- To help you change the prior belief to "You may *not* be able to protect yourself in all situations." When you are able to do this, you are able to accept that it happened and move on from there.

Session 1

2. Stuck points may also be formed if you have prior negative beliefs that seem to be confirmed or are reinforced by the event.



Prior Belief
Authority is not to be trusted.

Harmed During Military Service
I was harmed during my military service, and because of leadership.

Results

- If you see the trauma as further proof that authority (i.e., leadership) is not to be trusted, you believe this even more strongly.
- If you are stuck here, you may have strong emotional reactions that interfere with your ability to have successful relationships with authority. It may feel "safe" for you to assume all authority is untrustworthy, but this belief may keep you distressed, negatively impact your relationships, and possibly lead to legal, work, and social problems.

Goal

- To help you modify your beliefs so they are not so extreme. For example, "*Some* authority figures can be trusted in *some* ways and to *some* extent."

Session 2

Power/Control Issues Module

Beliefs Related to SELF: The belief/expectation that you can solve problems and meet challenges. Power is associated with your capacity for self-growth.

Prior Experience

Negative	Positive
If you grew up experiencing inescapable, negative events, you may develop the belief that you cannot control events or solve problems even if they are controllable/solvable. This is called learned helplessness. Later traumatic events may seem to confirm prior beliefs about helplessness.	If you grew up believing that you had control over events and could solve problems (possibly unrealistically positive beliefs), the traumatic event may disrupt those beliefs.

Symptoms Associated With Negative Self-Power/Control Beliefs
➢ Numbing of feelings ➢ Avoidance of emotions ➢ Chronic passivity ➢ Hopelessness and depression ➢ Self-destructive patterns ➢ Outrage when faced with events that are out of your control or people who do not behave as you would like

Resolution

If you previously believed that…	A possible self-statement may be…
…Overcontrol—It is important to understand that no one can have complete control over his emotions or behavior at all times. While you may be able to influence external events, it is impossible to control all external events or the behavior of other people. Neither of these facts is a sign of weakness, but only an understanding that you are human and can admit that you are not in control of everything that happens to you or your reactions.	"I do not have total control over my reactions, other people, or events at all times. I am not powerless, however, to have some control over my reactions to events, or to influence the behavior of others or the outcome of some events."

Session 2

If you previously believed that…	A possible self-statement may be…
Helplessness or powerlessness—To regain a sense of control and decrease the accompanying symptoms of depression and loss of self-esteem that often go along with believing you are helpless, you will need to reconsider the ability to control events.	"I cannot control all events outside of myself, but I do have some control over what happens to me and my reactions to events."

Beliefs Related to OTHERS: The belief that you can control future outcomes in interpersonal relationships or that you have some power, even in relation to powerful others.

Prior Experience

Negative	Positive
If you had prior experiences with others that led you to believe that you had no control in your relationships with others, or that you had no power in relation to powerful others, the traumatic event will seem to confirm those beliefs.	If you had prior positive experiences in your relationships with others and in relation to powerful others, you may have come to believe that you could influence others. The traumatic event may shatter this belief because you were unable to exert enough control, despite your best efforts, to prevent the event.

Symptoms Associated With Negative Others-Power/Control Beliefs
➢ Passivity ➢ Submissiveness ➢ Lack of assertiveness that can generalize to all relationships ➢ Inability to maintain relationships because you do not allow the person to exert any control in the relationships (including becoming enraged if the other person tries to exert even a minimal amount of control)

Session 2

Ways of Giving and Taking Power

	GIVING POWER	TAKING POWER
POSITIVE	• Being altruistic (helping others without expecting anything in return) • Helping others in need or crisis • Sharing yourself with another person as part of the give and take in relationships **Example**: You are on your way to the store when a friend asks for a ride to the doctor, and you decide to take her.	• Being assertive • Setting limits and boundaries with others • Being honest with yourself and others **Example**: Telling someone you cannot help her now, but you schedule a time to meet later when it fits into your schedule.
NEGATIVE	• Basing your actions or behaviors solely on the reactions you expect from others • Always placing the needs of others above your own • Allowing others to easily access your "buttons" to get you emotionally upset **Example**: Having a strong negative reaction to someone who is clearly manipulating you to feel that way.	• Giving ultimatums • Testing limits • Intentionally upsetting others for personal gain • Behaving aggressively **Example**: Telling your partner you will not have sex with him until he does what you want.

Session 3

Safety Issues Module

Beliefs Related to SELF: The belief that you can protect yourself from harm and have some control over events.

Prior Experience

Negative	Positive
If you are repeatedly exposed to dangerous and uncontrollable life situations, you may develop negative beliefs about your ability to protect yourself from harm. The traumatic event serves to confirm those beliefs.	If you have positive prior experiences, you may develop the belief that you have control over most events and can protect yourself from harm. The traumatic event causes disruption in this belief.

Symptoms Associated With Negative Self-Safety Beliefs
➢ Chronic and persistent anxiety ➢ Intrusive thoughts about themes of danger ➢ Irritability ➢ Startled responses or physical arousal ➢ Intense fears related to future victimization

Resolution

If you previously believed that…	Possible self-statements may be…
"It can't happen to me," you will need to resolve the conflict between this belief and the victimization experience.	"It is unlikely to happen again, but the possibility exists."
"I can control what happens to me and can protect myself from any harm," you will need to resolve the conflict between prior beliefs and the victimization experience.	"I do not have control over everything that happens to me, but I can take precautions to reduce the possibility of future traumatic events."
… you had no control over events and could not protect yourself, the traumatic event will confirm these beliefs. New beliefs must be developed that mirror reality and serve to increase your beliefs about your control and ability to protect yourself.	"I do have some control over events and I can take steps to protect myself from harm. I cannot control the behavior of other people, but I can take steps to reduce the possibility that I will be in a situation where my control is taken from me."

Session 3

Beliefs Related to OTHERS: The belief about the dangerousness of other people and expectancies about the intent of others to cause harm, injury, or loss.

Prior Experience

Negative	Positive
If you experienced people as dangerous in early life or you believed it as a cultural norm, the traumatic event will seem to confirm these beliefs.	If you experienced people as safe in early life, you may expect others to keep you safe and not cause harm, injury, or loss. The traumatic event causes a disruption in this belief.

Symptoms Associated With Negative Others-Safety Beliefs
➢ Avoidant or phobic responses ➢ Social withdrawal

Resolution

If you previously believed that…	Possible self-statements may be…
"Others are out to harm me and can be expected to cause harm, injury, or loss," you will need to adopt new beliefs in order to be able to continue to feel comfortable with people you know and to be able to enter into new relationships with others.	"There are some people out there who are dangerous, but not everyone is out to harm me in some way."
"I will not be hurt by others," you will need to resolve the conflict between this belief and the victimization.	"There may be some people who will harm others, but it is unrealistic to expect that everyone I meet will want to harm me."

Session 3

Challenging Beliefs Worksheet

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use **Challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
My boss said that I did a good job.	*She liked my work!—80%* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Happy—75%*	Evidence For? *She said she liked it and she has criticized my work in the past, so she's not just always being nice.* Evidence Against? *None.* Habit or fact? *Fact.* Not including all information? All or none? *Maybe she liked more than she disliked, but on the whole I think she liked it.* Extreme or exaggerated? *I don't think so.* Focused on just one piece? *No.* Source dependable? *It was her.* Confusing possible with likely? Based on feelings or facts? *Facts.* Focused on unrelated parts? *None.*	Jumping to conclusions: *No.* Exaggerating or minimizing: *I don't think so.* Ignoring important parts: *She was smiling when she said it, so no.* Oversimplifying: Over-generalizing: Mind reading: *She actually said she liked my work.* Emotional reasoning: *I sort of think I didn't do as good of a job as I had wished, so I don't feel great about my job. I can see that I think that based on my feelings rather than what she actually said.*	*She liked my work—90%* **G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% *90%* **H. Emotion(s)** Now what do you feel? 0-100% *Happy—90%*

C63

Session 4

CPT-C Session 2: The Meaning of the Event

Practice Assignment:
Please complete the A-B-C Worksheets to become aware of the connection among events, your thoughts, feelings, and behavior. Complete at least one worksheet each day. Remember to fill out the form as soon after an event as possible. Complete at least one worksheet about the worst traumatic event. Also, please use the Identifying Emotions Handout to help you determine what emotions you are feeling.

Session 2 Handouts:
Stuck Point Log
Identifying Emotions Handout
A-B-C Worksheet (six copies included)
Examples of completed A-B-C Worksheets

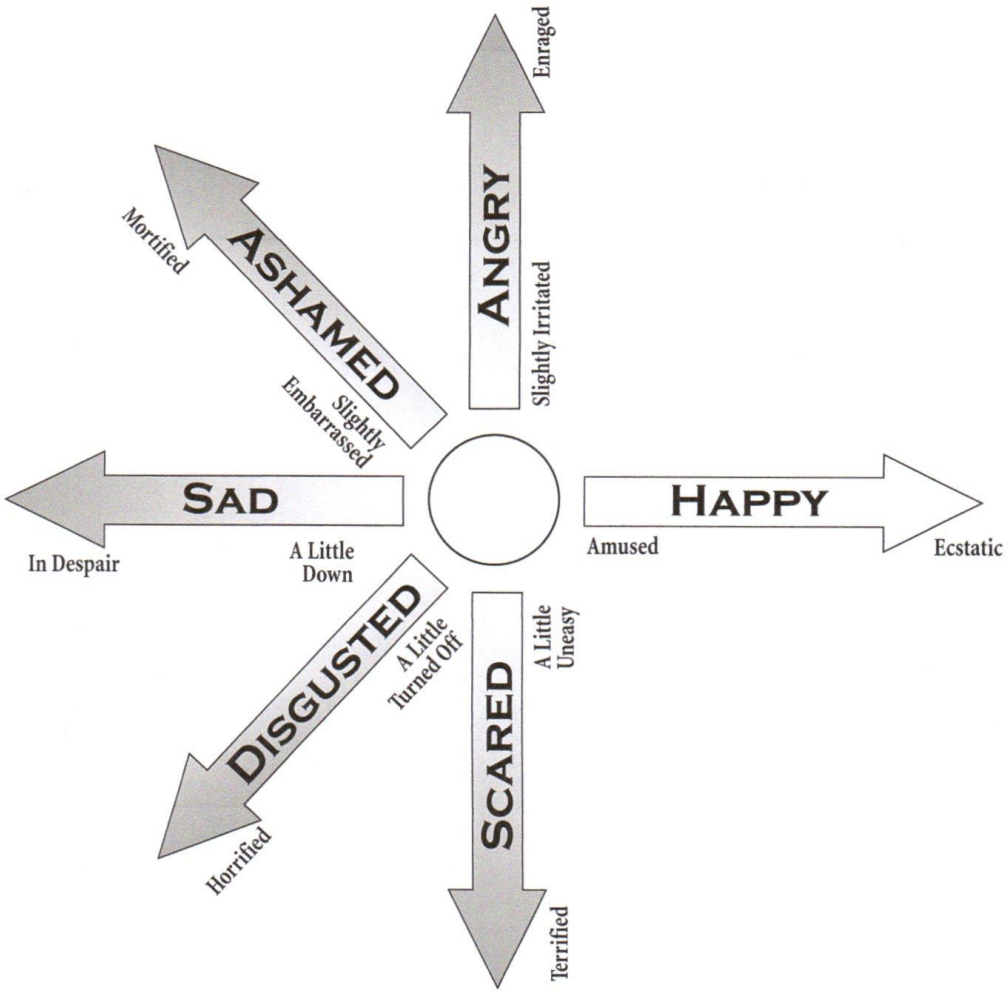
Session 4

Stuck Point Log

D6

Session 4

Identifying Emotions Handout



Session 4

A-B-C Worksheet

Date: _____ **Patient:** _____

ACTIVATING EVENT **A** "Something happens."	**BELIEF/STUCK POINT** **B** "I tell myself something."	**CONSEQUENCE** **C** "I feel something."

Are my thoughts above in "B" *realistic*?

_____

What can you tell yourself on such occasions in the future?

_____

_____

_____

C9

Session 4

Patterns of Problematic Thinking Worksheet

Listed below are several types of patterns of problematic thinking that people use in different life situations. These patterns often become automatic, habitual thoughts that cause us to engage in self-defeating behavior. Considering your own stuck points, find examples for each of these patterns. Write in the stuck point under the appropriate pattern and describe how it fits that pattern. Think about how that pattern affects you.

1. **Jumping to conclusions** or predicting the future?

2. **Exaggerating or minimizing** a situation (blowing things way out of proportion or shrinking their importance inappropriately).

3. **Ignoring important parts** of a situation.

4. **Oversimplifying** things as good/bad or right/wrong.

5. **Over-generalizing** from a single incident (a negative event is seen as a never-ending pattern).

6. **Mind reading** (you assume people are thinking negatively of you when there is no definite evidence for this).

7. **Emotional reasoning** (using your emotions as proof, e.g. "I feel fear so I must be in danger")

Session 5

Trust Issues Module

Beliefs Related to SELF: The belief that one can trust or rely on one's own perceptions or judgments. This belief is an important part of self-concept and serves an important self-protection function.

Prior Experience

Negative	Positive
If you had prior experiences where you were blamed for negative events, you may develop negative beliefs about your ability to make decisions or judgments about situations or people. The traumatic event serves to confirm these beliefs.	If you had prior experiences that led you to believe that you had great judgment, the traumatic event may disrupt this belief.

Symptoms Associated With Negative Self-Trust Beliefs
➢ Feelings of self-betrayal ➢ Anxiety ➢ Confusion ➢ Overcaution ➢ Inability to make decisions ➢ Self-doubt and excessive self-criticism

Resolution

If you previously believed that…	A possible self-statement may be…
…you could not rely on your own perceptions or judgments, the traumatic event may have reinforced your belief that "I cannot trust my judgment" or "I have bad judgment." To come to understand that the traumatic event was not your fault and that your judgments did not cause the traumatic event, you need to adopt more adaptive beliefs.	"I can still trust my good judgment even though it's not perfect." "Even if I misjudged this person or situation, I realize that I cannot always realistically predict what others will do or whether a situation may turn out as I expect it to."
… you had perfect judgment, the traumatic event may shatter this belief. New beliefs need to reflect the possibility that you can make mistakes but still have good judgment.	"No one has perfect judgment. I did the best I could in an unpredictable situation, and I can still trust my ability to make decisions even though it's not perfect."

Session 5

Beliefs Related to OTHERS: Trust is the belief that the promises of other people or groups can be relied on with regard to future behavior. One of the earliest tasks of childhood development is trust versus mistrust. A person needs to learn a healthy balance of trust and mistrust and when each is appropriate.

Prior Experience

Negative	Positive
If you were betrayed in early life, you may have developed the generalized belief that "no one can be trusted." The traumatic event serves to confirm this belief, especially if you were hurt by an acquaintance.	If you had particularly good experiences growing up, you may have developed the belief that "All people can be trusted." The traumatic event shatters this belief.

Posttraumatic Event Experience

If the people you knew and trusted were blaming, distant, or unsupportive after the traumatic event, your belief in their trustworthiness may have been shattered.

Symptoms Associated With Negative Others-Trust Beliefs

- Pervasive sense of disillusionment and disappointment in others
- Fear of betrayal or abandonment
- Anger and rage at betrayers
- If repeatedly betrayed, negative beliefs may become so rigid that even people who are trustworthy may be viewed with suspicion
- Fear of close relationships, particularly when trust is beginning to develop, active anxiety and fear of being betrayed
- Fleeing from relationships

Session 5

Resolution

If you previously believed that…	Possible self-statements may be…
If you grew up believing that "no one can be trusted," which was confirmed by the traumatic event, you need to adopt new beliefs that will allow you to enter into new relationships with others instead of withdrawing because you believe others to be untrustworthy.	"Although I may find some people to be untrustworthy, I cannot assume that everyone is that way." "Trust is not an all-or-none concept. Some may be more trustworthy than others." "Trusting another involves some risk, but I can protect myself by developing trust slowly and including what I learn about that person as I get to know him or her."
"Everyone can be trusted," the traumatic event will shatter this belief. To avoid becoming suspicious of the trustworthiness of others, including those you used to trust, you will need to understand trust is not either/or.	"I may not be able to trust everyone, but that doesn't mean I have to stop trusting the people I used to trust."
If your beliefs about the trustworthiness of your support system were shattered, it will be necessary to address general issues before you assume that you can no longer trust the support system. Of central importance is to consider their reaction and the reasons why they may have reacted in an unsupportive fashion. Many people simply do not know how to respond and may be reacting out of ignorance. Some respond out of fear or denial because what has happened to you makes them feel vulnerable and may shatter their own beliefs. Practicing how to ask for what you need from them may be a step in assessing their trustworthiness.	
If your attempts to discuss the traumatic event with them leaves you feeling unsupported, you may use self-statements such as "There may be some people I cannot trust talking with about the traumatic event, but they can be trusted to support me in other areas." If that person continues to blame you and make negative judgments about you, you may decide that this person is no longer trustworthy. It's unfortunate, but sometimes you find out that some people you thought of as friends do not turn out to be true friends after a trauma. However, you may also be pleasantly surprised to find that some people have better reactions than you expected.	

Sessions 6 & 7

Esteem Issues Module

Beliefs Related to SELF: Self-esteem is the belief in your own worth, which is a basic human need. Being understood, respected, and taken seriously is basic to the development of self-esteem.

Prior Experience

Negative	Positive
If you had prior experiences that represented a violation of your own sense of self, you are likely to develop negative beliefs about your self-worth. The traumatic event may seem to confirm these beliefs. Prior life experiences that are associated with negative beliefs about the self are likely to be caused by: - Believing other people's negative attitude about you - An absence of empathy and responsiveness by others - The experience of being devalued, criticized, or blamed by others - The belief that you had violated your own ideals or values	If you had prior experiences that served to enhance your beliefs about your self-worth, then the traumatic event may disrupt those beliefs (your self-esteem).

Examples of Negative Self-Esteem (Self-Worth) Beliefs
➢ I am bad, destructive, or evil ➢ I am responsible for bad, destructive, or evil acts ➢ I am basically damaged or flawed ➢ I am worthless and deserving of unhappiness and suffering

Symptoms Associated with Negative Self-Esteem (Self-Worth) Beliefs
➢ Depression ➢ Guilt ➢ Shame ➢ Possible self-destructive behavior

Session 6 & 7

Resolution

If you previously believed that…	A possible self-statement may be…
…you were worthless (or any of the beliefs listed above) because of prior experiences, the traumatic event may seem to confirm this belief. This can also occur if you received poor social support after the event. To improve your self-esteem and reduce the symptoms that often go along with it, you will need to reevaluate your beliefs about your self-worth and be able to replace maladaptive beliefs with more realistic, positive ones.	"Sometimes bad things happen to good people. Just because someone says something bad about me, that does not make it true. No one deserves this, and that includes me. Even if I have made mistakes in the past, that does not make me a bad person deserving of unhappiness or suffering (including the traumatic event)."
If you had positive beliefs about your self-worth before the traumatic event, you may have believed that "nothing bad will happen to me because I am a good person." The event may disrupt such beliefs, and you may or what you did to deserve it (i.e., "Maybe I was being punished for something I had done, or because I am a bad person.") To regain your prior positive beliefs about your self-worth, you will need to make some adjustments, so that your sense of worth is not disrupted every time something unexpected and bad happens to you. When you can accept that bad things might happen to you (as they happen to everybody from time to time), you let go of blaming yourself for events that you did not cause.	"Sometimes bad things happen to good people. If something bad happens to me, it is not necessarily because I did something to cause it or because I deserved it. Sometimes there is not a good explanation for why bad things happen."

Beliefs Related to OTHERS: These are beliefs about how much you value other people. In addition, a realistic view of others is important to psychological health. In less psychologically healthy people, these beliefs are stereotyped, rigid, and relatively unchanged by new information.

Prior Experience

Negative	Positive
If you had many bad experiences with people in the past or had difficulty taking in new information about people you knew (particularly negative information), you may have found yourself surprised, hurt, and betrayed.	If your prior experiences with people had been positive, and if negative events in the world did not seem to apply to your life, the event was probably a belief-shattering event. Prior beliefs in the basic goodness of other people may be

Sessions 6 & 7

Negative	Positive
You may have concluded that other people are not good or not to be respected. You may have generalized this belief to everyone (even those who are basically good and to be respected). The traumatic event may seem to confirm these beliefs about people.	particularly disrupted if people, who were assumed to be supportive, were not there for you after the event.

Examples of Negative Others-Esteem Beliefs
➢ The belief that people are basically uncaring, indifferent, and only out for themselves ➢ The belief that people are bad, evil, or malicious ➢ The belief that the entire human race is bad, evil, or malicious

Symptoms Associated With Negative Others-Esteem Beliefs
➢ Chronic anger ➢ Contempt ➢ Bitterness ➢ Cynicism ➢ Disbelief when treated with genuine caring compassion ("What do they really want?") ➢ Isolation or withdrawal from others ➢ Antisocial behavior justified by the belief that people are only out for themselves

Resolution

If you previously believed that…	Possible self-statements may be…
It will be important for you to reconsider the automatic assumption that people are no good, and consider how that belief has affected your behavior and social life in general.	
When you first meet someone, it is important that you do not form snap judgments because these tend to be based on stereotypes, which are not generally true for the majority of people you will meet. It is all right to adopt a "wait and see" attitude, which allows you flexibility in developing your perceptions about the other person and does not penalize	

Sessions 6 & 7

If you previously believed that…	Possible self-statements may be…
the person whom you are trying to get to know.	
If, over time, this person makes you uncomfortable, or does things that you do not approve of, you are free to stop trying to develop the relationship and end it. Be aware, however, that all people make mistakes, and consider your ground rules for friendships or intimate relationships. If you confront the person with something that makes you uncomfortable, you can use that person's reaction to your request in making a decision about what you want from that person in the future (i.e., if the person is apologetic and makes a genuine effort to avoid making the same mistake, then you might want to continue getting to know this person. If the person is insensitive to your request or belittles you in some other way, then you may want to get out of this relationship.) The important point is, like trust, you need time to get to know people and form an opinion of them. It is important that you adopt a view of others that is balanced and allows for changes.	"Although there are people I do not respect and do not wish to know, I cannot assume this about everyone I meet. I may come to this conclusion later, but it will be after I have learned more about this person."
If those you expected support from let you down, don't drop these people altogether at first. Talk to them about how you feel and what you want from them. Use their reactions to your request as a way of evaluating where you want these relationships to go.	"People sometimes make mistakes. I will try to find out whether they understand it was a mistake or whether it reflects a negative characteristic of that person, which may end the relationship for me if it is something I cannot accept."

CPT Extras

Ahrens, J., & Rexford, L. (2002). Cognitive processing therapy for incarcerated adolescents with PTSD. *Journal of Aggression, Maltreatment and Trauma, 6*, 201– 216.

Alvarez, J., McLean, C. Harris, A. H. S., Rosen, C. S., Ruzek, J. I., & Kimerling, R. (2011). The comparative effectiveness of cognitive processing therapy for male Veterans treated in a VHA posttraumatic stress disorder residential rehabilitation program. *Journal of Consulting and Clinical Psychology, 79*, 590–599.

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

Chard, K. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73*, 965–971.

Chard, K. M., Resick, P. A., & Wertz, J. J. (1999). Group treatment of sexual assault survivors. In B. H. Young & D. D. Blake (Eds.), *Group treatments for post-traumatic stress disorders: Conceptualization, themes, and processes* (pp. 35–50). Philadelphia: Brunner/Mazel.

Chard, K. M., Ricksecker, E. G., Healy, E. T., Karlin, B. E., & Resick, P. A. (2012). Dissemination and experience with cognitive processing therapy. *Journal of Rehabilitation Research & Development, 49,* 667–678.

Chard, K.M., Schumm, J.A., McIlvain, S. M., Bailey, G.W., & Parkinson, R. B. (2011). Exploring the efficacy of a residential treatment program incorporating cognitive processing therapy – cognitive for Veterans with PTSD and traumatic brain injury. *Journal of Traumatic Stress, 24*, 347–351.

Chard, K.M., Schumm, J.A., Owens, G.P., & Cottingham, S.M. (2010). A comparison of OEF and OIF Veterans and Vietnam Veterans receiving cognitive processing therapy. *Journal of Traumatic Stress. 23*, 25–32.

Chard, K. M., Weaver, T. L., & Resick, P. A. (1997). Adapting cognitive processing therapy for child sexual abuse survivors. *Cognitive and Behavioral Practice*, *4*, 31–52.

Clarke, S.B., Rizvi, S.L., & Resick, P.A. (2008). Borderline personality characteristics and treatment outcome in cognitive-behavioral treatments for PTSD in female rape victims. *Behavior Therapy, 39,* 72–78.

Difede, J., & Eskra, D. (2002). Cognitive processing therapy for PTSD in a survivor of the World Trade Center bombing: A case study. *Journal of Trauma Practice, 1,* 155–165.

Ellis, L. F., Black, L. D., & Resick, P. A. (1992). Cognitive-behavioral treatment approaches for victims of crime. In P. A. Keller & S. R. Heyman (Eds.), *Innovations in clinical practice: A source book* (pp. 11, 23–38). Sarasota, FL: Professional Resource Exchange.

Falsetti, S. A., Resnick, H. S., Davis, J., & Gallagher, N. G. (2001). Treatment of posttraumatic stress disorder with comorbid panic attacks: Combining cognitive processing therapy with panic control treatment techniques. *Group Dynamics, 5*(4), 252–260.

CPT Extras

Falsetti, S. A., Resnick, H. S., & Lawyer, S. R. (2006). Combining cognitive processing therapy with panic exposure and management techniques. In L. A. Schein, H. I. Spitz, G. M. Burlingame, P. R. Muskin, & S. Vargo (Eds.) *Psychological effects of catastrophic disasters: Group approaches to treatment* (pp. 629–668). New York: Haworth Press.

Forbes, D., Lloyd, D., Nixon, R. D. V., Elliott, P., Varker, T., Perry, D., … Creamer, M. (2012). A multisite randomized controlled effectiveness trial of cognitive processing therapy for military-related posttraumatic stress disorder. *Journal of Anxiety Disorders, 26,* 442–52.

Galovski, T. E., Blain, L. M., Mott, J. M., Elwood, L., & Houle, T. (2012). Manualized therapy for PTSD: Flexing the structure of cognitive processing therapy. *Journal of Consulting and Clinical Psychology, 80,* 968–981.

Galovski, T. E., Monson, C., Bruce, S. E., & Resick, P. A. (2009). Does cognitive-behavioral therapy for PTSD improve perceived health and sleep impairment? *Journal of Traumatic Stress, 22*, 197–204.

Galovski, T. E. & Resick, P. A. (2005). Cognitive processing therapy and the treatment of posttraumatic stress disorder. In A. Freeman (Ed.) *International Encyclopedia of Cognitive Behavior Therapy*. Kluwer Academic/ Plenum Publishers.

Galovski, T. E. & Resick, P. A. (2008). Cognitive processing therapy for posttraumatic stress disorder secondary to a motor vehicle accident: A single-subject report. *Cognitive and Behavioral Practice, 15,* 287–295.

Gilman, R., Schumm, J. A., Chard, K. M. (2012). Hope as a change mechanism in the treatment of posttraumatic stress disorder. *Psychological Trauma: Theory, Practice and Research, 4*, 270–277.

Hall, C. A., & Henderson, C. M. (1996). Cognitive processing therapy for chronic PTSD from childhood sexual abuse: A case study. *Counseling Psychology Quarterly, 9*(4), 359–371.

House, A. S. (2006). Increasing the usability of cognitive processing therapy for survivors of child sexual abuse. *Journal of Child Sexual Abuse, 15,* 87–103.

Kaysen, D., Lostutter, T. W., & Goines, M. A. (2005). Cognitive processing therapy for acute stress disorder resulting from an anti-gay assault. *Cognitive and Behavioral Practice, 12*, 278–289.

Kaysen, D., Schumm, J., Pedersen, E. R., Seim, R. W., Bedard-Gilligan, M., & Chard, K. (2014). Cognitive processing therapy for Veterans with comorbid PTSD and alcohol use disorders. *Addictive Behaviors, 39*, 420–427.

Kelly, K. A., Rizvi, S. L., Monson, C. M., & Resick, P.A. (2009). The impact of sudden gains in cognitive behavioral therapy for posttraumatic stress disorder. *Journal of Traumatic Stress, 22*, 287–293.

Liverant, G. I., Suvak, M. K., Pineles, S. L., & Resick, P. A. (2012). Changes in posttraumatic stress disorder and depressive symptoms during cognitive processing therapy: Evidence for concurrent change. *Journal of Consulting and Clinical Psychology, 80*, 957–967.

CPT Extras

Messman-Moore, T. L., & Resick, P. A. (2002). Brief treatment of complicated PTSD and peritraumatic responses in a client with repeated sexual victimization. *Cognitive and Behavioral Practice, 9,* 89–99.

Monson, C. M., Price, J. L., & Ranslow, E. (2005, October). Treating combat PTSD through cognitive processing therapy. *Federal Practitioner*, 75–83.

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,* 898–907.

Nishith, P., Nixon, R. D. V., & Resick, P. A. (2005). Resolution of trauma-related guilt following treatment of PTSD in female rape victims: A result of cognitive therapy targeting comorbid depression? *Journal of Affective Disorders, 86,* 259–265.

Nishith, P., Resick, P. A., & Griffin, M. G. (2002). Pattern of change in prolonged exposure and cognitive processing therapy for female rape victims with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 70,* 880–886.

Owens, G. P., Pike, J. L., & Chard, K. M. (2001). Treatment effects of cognitive processing therapy on cognitive distortions of female child sexual abuse survivors. *Behavior Therapy, 32*(3), 413–424.

Petrak, J. (1996). Current trends in the psychological assessment and treatment of victims of sexual violence. *Sexual and Marital Therapy, 11*, 37–45.

Resick, P. A. (1992). Cognitive treatment of crime-related post-traumatic stress disorder. In R. D. Peters, R. J. McMahon, & V. L. Quinsey (Eds.), *Aggression and violence throughout the life span* (pp. 171–191). Newbury Park, CA: Sage Publications.

Resick, P. A. (2001). Cognitive therapy for posttraumatic stress disorder. Journal of Cognitive Psychotherapy, 15(4), 321–329.

Resick, P.A., Galovski, T.A., Uhlmansiek, M. O., Scher, C.D., Clum, G. A., & Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology, 76,* 243–258.

Resick, P.A., Monson, C.M., & Rizvi, S.L. (2007). Posttraumatic stress disorder. In D.H. Barlow (Ed.), *Clinical handbook of psychological disorders (4th ed.): A step-by-step treatment manual* (pp. 65–122). New York: Guilford Press.

Resick, P. A., Nishith, P., & Griffin, M. G. (2003). How well does cognitive-behavioral therapy treat symptoms of complex PTSD? An examination of child sexual abuse survivors within a clinical trial. CNS Spectrums, 8, 340–355.

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*, 867–879.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 748–756.

CPT Extras

Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual.* Newbury Park, CA: Sage Publications.

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,* 201–210.

Resick, P. A., Suvak, M. K., Johnides, B. D., Mitchell, K. S., & Iverson, K. M. (2012). The impact of dissociation on PTSD treatment with cognitive processing therapy. *Depression and Anxiety, 29*, 718–730.

Rizvi, S. L., Vogt, D., & Resick, P. A. (2009). Cognitive and affective predictors of treatment outcome in cognitive processing therapy and prolonged exposure for posttraumatic stress disorder. *Behaviour Research and Therapy, 47,* 737–743.

Schulz, P. M., Huber, L. C. & Resick, P. A (2006). Practical adaptations of cognitive processing therapy for treating PTSD with Bosnian refugees: General implications for adapting practice to a multicultural clientele. *Cognitive and Behavioral Practice, 13,* 310–321.

Schulz, P. M., Resick, P. A., Huber, L. C., & Griffin, M. G. (2006). The effectiveness of cognitive processing therapy for PTSD with refugees in a community setting. *Cognitive and Behavioral Practice, 13,* 322–321.

Sobel, A. A., Resick, P. A., & Rabalais, A. E. (2009). The effect of cognitive processing therapy on cognitions: Impact statement coding. *Journal of Traumatic Stress. 22,* 205–211.

Surís, A., Link-Malcolm, J., Chard, K., Ahn, C. & North, C. (2013). A randomized clinical trial of cognitive processing therapy for Veterans with PTSD related to military sexual trauma. *Journal of Traumatic Stress, 26,* 28–37.

Walter, K. H., Bolte, T. A., Owens, G. P., & Chard, K. M. (2012). The impact of personality disorders on treatment outcome for Veterans in a posttraumatic stress disorder residential treatment program. *Cognitive Therapy and Research, 36*, 576–584.

Walter, K. H., Keifer, S. L., & Chard, K. M. (2012). Relationship between posttraumatic stress disorder and postconcussive symptom improvement after completion of a posttraumatic stress disorder/traumatic brain injury residential treatment program. *Rehabilitation Psychology, 57,* 13–17.

Westwell, C. A. (1998). Cognitive processing therapy in the treatment of marital rape. *Psychotherapy in Private Practice, 17*(2), 63–77.

Appendix G

Copyright Information

1. Appendix D: Poetry Chosen- The poems Invictus (Henley, 1888), The Road Not Taken (Frost, 1916), and The Charge of The Light Brigade (Tennyson, 1854) are all listed as public domain and copyright approval is not required. The poems Darkness Falls, Mountain, Veteran, and Compass are from the authors' published works; therefore, copyright was not required.
2. Appendix E: DASS-42- The DASS questionnaire is public domain. The DASS questionnaire forms may be downloaded and copied without restriction. However, the scales may not be modified or sold for profit. They were not modified during this research and monetary profit was not gained.
3. Appendix F: CPT Handouts- 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. The author is a trained CPT therapist and has purchased this manual for use with her clients.