Managing Posttraumatic Stress Disorder: A Present-Centered Approach

Dennis H. Grant, MD

Reliving the traumatic event is a major component of traditional PTSD treatment. Recent evidence, however, suggests that this method may be ineffective and even detrimental for some patients. This article offers an alternative.

For many years, VA programs for treating posttraumatic stress disorder (PTSD) related to combat experiences have emphasized trauma-focused group therapy. Such therapy relies heavily on reexposure to combat trauma, an experience thought to be critical for successful treatment. In 2003, however, a VA Cooperative Study comparing trauma-focused group therapy with a present-centered approach in Vietnam combat veterans with PTSD failed to identify a treatment effect for trauma-focused groups and, in fact, found dropout rates to be higher in these groups than in the present-centered groups.[1]

Trauma-focused group therapy was a mainstay of PTSD treatment programs at the Carl T. Hayden VA Medical Center, Phoenix, AZ until the reorganization of the outpatient PTSD program in 1999 revealed that nearly all of our Vietnam veterans no longer wished to participate in therapy that had them relive their combat experiences. They felt that describing their experiences to the group—and listening to others do the same—at weekly, 90-minute sessions did not help them resolve their conflicting feelings and thoughts. Furthermore, these sessions triggered residual effects and symptoms that persisted for hours or even days before settling down, only to be reactivated at the next group meeting.

In response to these problems, we at the clinic built upon our professional experience to develop a unique PTSD treatment program. Although this program is based on traditional cognitive therapy principles, it de-emphasizes past trauma exposure while employing an existential perspective to help patients deal with the realities of their war experience.

In this article, I define our concept of PTSD as it relates to combat experiences and describe our overall treatment strategy. I also discuss, in more detail, the therapeutic principles and processes we use to help our veteran outpatients manage the psychological and cognitive problems arising from their traumatic combat experiences. Although some of the ideas and concepts incorporated into our program may be used one way or another by others, to our knowledge, the overall process has not been described previously in a similar manner. The stimulus for our program was the Vietnam War and its combat veterans—though the approach is applicable to other conflicts.

Dr. Grant is the clinical coordinator of the outpatient Posttraumatic Stress Disorder Clinic at the Carl T. Hayden VA Medical Center, Phoenix, AZ.

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OUR CONCEPT OF PTSD

Combat PTSD begins with exposure to the stresses and traumatic events that occur in the combat environment. According to our concept of the disease, this exposure results in a physiologic change in the complex stress response system of the body. The stress response system, now heightened, interacts continually with the memories, thoughts, and feelings from the combat experience in such a way that fuels or exacerbates such symptoms as nightmares, interrupted sleep patterns, anger problems, depression, and flashbacks, forming the basis of PTSD.

To approach combat PTSD using cognitive therapy requires the patient and clinician to accept two additional ideas: first, that combat events are part of the reality of the veteran's life experience and are not erasable; and second, that the memories, thoughts, and feelings of combat are filtered through the irrational thought processes inherent in the human mind, producing negative, problematic, and irrational cognitions.

OUR TREATMENT STRATEGY

Our treatment approach uses several different modes of therapy to address the various aspects of PTSD. The heightened stress response system is treated with medications and behavioral methods, such as psychological meditation, relaxation techniques, regular exercise, and abstinence from alcohol and illicit drugs (Figure). Such behavioral therapies are important because, in our experience, pharmacologic therapy is not sufficient for the majority of patients with PTSD. The psychological problems that arise from war itself and from patients' irrational thinking processes are addressed through existential discussion and cognitive therapy, respectively.

The psychotherapeutic dimensions of our treatment approach consist of three segments, each with 10 sessions and each conducted in the context of group therapy. The first segment concentrates on helping patients develop an understanding of PTSD and how it manifests in a person's life. Once that is accomplished, we teach patients to manage their traumatic war experiences with an emphasis on existential concepts and cognitive restructuring. During the third segment, we continue to use cognitive restructuring methods to address current life situations. In addition, for those who wish it, a fourth segment provides ongoing support using the principles developed in the previous three therapy segments.

FOCUS ON MANAGING TRAUMATIC COMBAT EXPERIENCES

In order to achieve the second, vital segment of our PTSD treatment approach, the management of traumatic combat experiences, we employ two key elements. The first, an existential orientation, is used to help patients deal with the realities of war. The second, cognitive restructuring, addresses the problem cognitions that result when memories, feelings, and thoughts of combat events are filtered through and distorted by irrational thinking processes.

Existential orientation

Dealing with combat experience itself, independent of PTSD issues, requires an existential perspective—that is, a mature understanding of self and the world at large. In order to help our patients achieve this perspective, we use a Socratic style of directed discussion to develop several existential themes. Unlike many traditional psychotherapeutic processes, the Socratic approach involves a very active and engaging leadership style, in which questions are posed to the group to elicit discussions that lead to a clear expression of truths. In most cases, these truths are known implicitly by group members but have been forgotten or blocked by cognitions that fail to reflect the veterans' fundamental values and beliefs or by the complexities underlying their involvement in war.

Because much of our experience has been with veterans of the Vietnam War (one of the most controversial conflicts in U.S. history), we have come to appreciate that veterans' thoughts and feelings about their involvement in war are not based solely on their experiences in combat but also may be colored by the public's reaction to the war and those involved. Historically, the decision to enter into war has sparked varying degrees of public debate and controversy in the United States and elsewhere, and negative public opinion can seep into a veteran's psyche. Even decades after the Vietnam War, many of its veterans retain negative feelings about themselves as participants.

The first step in our existential exploration with patients is helping them achieve an emotional-cognitive understanding of their own fundamental values and beliefs as American individuals who were willing to participate in war. Because multiple reasons are ascribed to every war (direct national defense, future national security threats, political or economic security, or even personal gain), it's im-

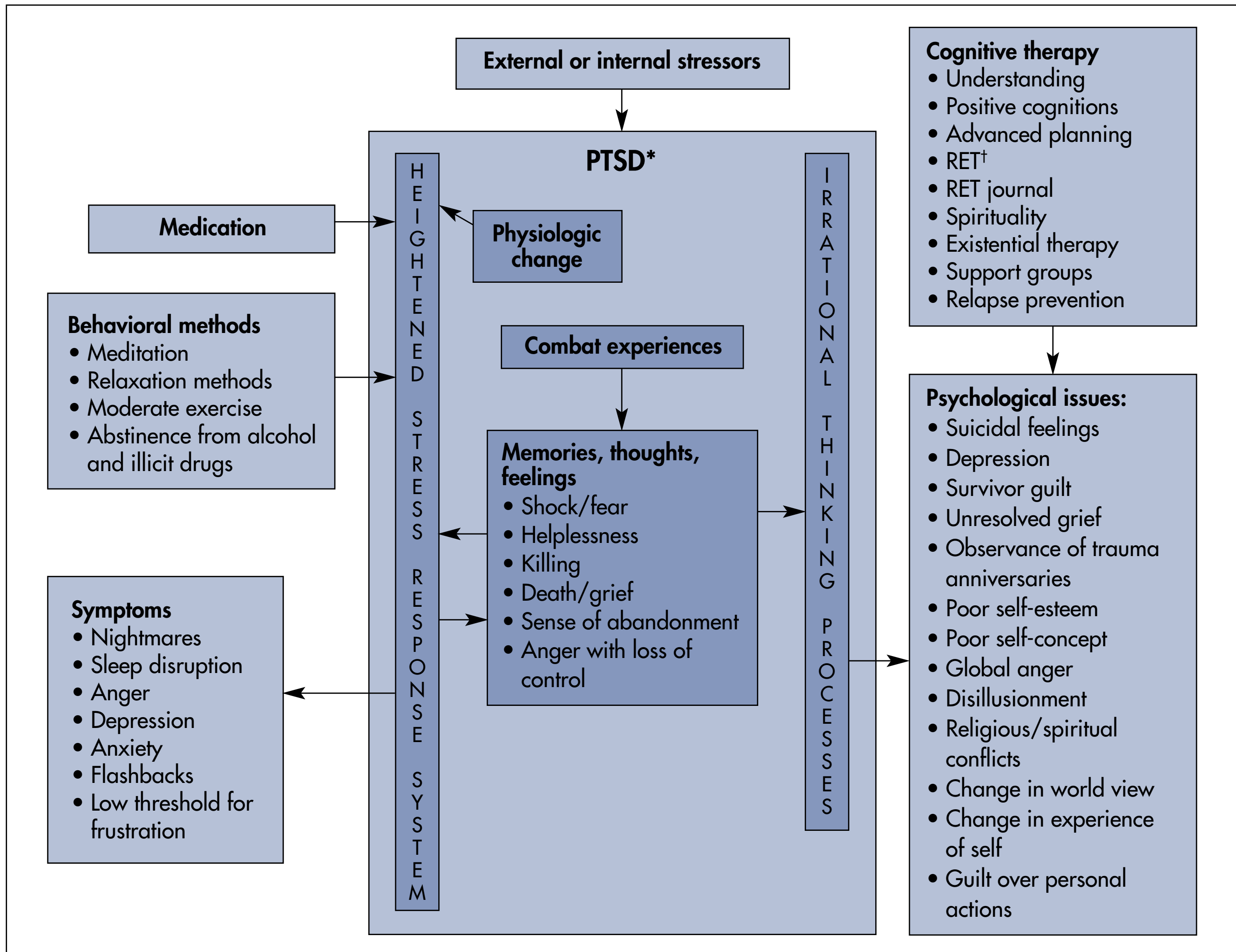

Figure. Concept of PTSD and treatment approach used in the outpatient PTSD clinic at the Carl T. Hayden VA Medical Center. *PTSD = posttraumatic stress disorder. †RET = rational emotive therapy.

portant for veterans to recover and reclaim their own personal, intrinsic beliefs as Americans. The existential values that define the American individual are found in the second paragraph of the *Declaration of Independence*, the document that formed the prelude to the first American war. In it, Thomas Jefferson wrote, "We believe these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness."[2]

The fundamental values and the fundamental way in which human beings come to live together as described in this document are part and parcel of our cultural heritage and represent the ingrained values that unite Americans as a nation. These values influence national decisions about going to war and decisions by American individuals about participating in the fight. Although a myriad of other reasons for going to war—such as, "I was drafted," "A judge gave me no better alternative," "I wanted to get away from home," or "I needed the benefits promised"—may have been involved in the veteran's decision, none of these nullify that which is written on the American soul. When our veteran patients replace the "we believe…" in Jefferson's statement with "I believe…" in the context of group therapy, they cognitively rediscover and emotionally reexperience these

meaningful imperatives within themselves as personal reasons for which they fought and for which friends and many others died.

The second theme we examine has to do with the question, "Why does a veteran develop PTSD?" A variety of answers have been posited, including insufficient stress training, genetic variations in neuropeptide levels, and childhood abuse. For a psychotherapist, however, existential answers are the most truthful and the most forceful; all the others fall by the wayside when the chips are in and the cards are played.

In the midst of combat, the motives that compel a person to fight are immediate: personal survival, protection of squad members, mission accomplishment, neutralization of the immediate enemy threat. In therapy it's important to emphasize that soldiers are *supposed* to do all these things. From an existential perspective, therefore, PTSD is the outcome of fighting for fundamental values held as self-evident and of facing situations in which the soldier must work to survive, protect the squad, and achieve the mission.

It's also important for the patient to know that these basic truths were the same for his or her fellow service members. Those who died for both deep, personal reasons and for immediate aims would not see their personal history or participation in our nation's history as wasted. When I ask a group if it was worth it to get PTSD from the war, I get a resounding "no," but if I ask them if it was worth it trying to help the guy next to them, I get a resounding "yes."

The third part of the existential exploration is patients' evaluation of their own negative views about the war in which they participated and how these views developed. Before therapists ask veterans to rethink the war in which they fought, however, they must reevaluate their own thoughts. This is particularly important when working with veterans of the Vietnam War: Although much of our society feels this was a "wasted war" and an American tragedy, there are historians who feel the Vietnam War was a necessary one and who present a different historical perspective—one that is useful in our work.[3]

As the fourth theme, we offer veterans positive truths about their war, such as the perspective on the Vietnam War previously mentioned. The goal is not necessarily to eradicate all of veterans' negative feelings about the war in which they fought—which may arise from sound principles and deep feelings—but rather to develop alternative and varied perspectives through Socratic discussion in order to balance or lessen substantial negativity that contributes to irrational cognitions. In our experience, if patients can recognize both the positive and negative aspects of the war and integrate both into their view of the war, they may be able to improve their sense of personal meaning, self-esteem, self-concept, and historical worth.

The fifth existential theme we discuss is a basic concept of spirituality. It is our experience that religious and spiritual concepts, whether ultimately accepted or rejected, form a developmental line in human psychological growth and that participation in war often can derail this development. In order to resume this developmental line, therefore, patients must deal with issues of spirituality one way or another.

The vast majority of the veterans I see believe in God, and this forms the basis of spirituality for them. For these patients, spiritual discussions revolve around having participated in war with all of its difficulties, why God allowed what occurred, why God allowed what happened to them, and their personal relationship to God now. Patients who voice no belief in a god, a higher power, or a spiritual meaning to and in life are left with a view of existence that, by default, is a material one—often unrecognized as such and often contrary to their own values. As with all spiritual explorations, the goal of our work in this part of the program is to help patients find a way to enrich their lives with more meaningful and positive experiences.

Cognitive restructuring

In our experience, it's not uncommon for combat personnel, with or without PTSD, to have their memories, feelings, and thoughts of combat experiences be distorted by irrational thinking patterns. In the case of PTSD, the results are the irrational cognitions underlying suicidal thinking, depression, survivor guilt, the inability to resolve grief, the negative experience of trauma anniversaries, disillusionment, global anger, changes in world view, poor self-esteem and self-concept, and religious and spiritual conflicts (Table 1).

The methods we use in our clinic to deal with irrational cognitions are derived from the restructuring techniques of David Burns and Albert Ellis.[4,5] In group sessions, the three major issues of suicidal thinking, depression, and survivor guilt are addressed. Group members are asked to come up with thoughts a person suffering

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from each of these problems might experience. For example, a person with survivor guilt might think that he or she abandoned his or her unit by staying behind on a particular day (Table 2). These thoughts are written on a presentation pad and the group assesses whether each is rational or irrational—not whether it is true or false. If a thought is considered irrational, a rational one is developed to replace it; if it's deemed rational, an elaboration is offered. This method tackles each topic without delving into the traumas behind it, though a group member may reflect upon specific instances in the course of discussion.

The presentation pad notes are typed up and copies are provided to each group member at the next session. We then review these notes and discuss each subject again. After this, group members are instructed to review the notes each time they experience guilt, depression, or suicidal feelings, adding to it their own thoughts, and disputing their irrational thoughts with rational ones. The therapeutic process is on track when patients' negative feelings subside and they experience a positive emotional state. Both of these events represent essential endpoints.

ONGOING MANAGEMENT

The goal of our group process is to teach members to challenge their own thinking using the restructuring methods practiced and to reassess negative ideation regarding their existential understanding of themselves. Our approach defines PTSD as an ongoing condition requiring continual management. As such, we strongly encourage our patients to keep a journal containing the restructuring exercises

Table 1. Irrational cognitions commonly associated with combat posttraumatic stress disorder (PTSD)

Survivor guilt

- I should have done more than I did; it would have saved many of my friends
- If I hadn't switched places with my friend, he would be alive today
- If I always grieve for my friend who was killed, I am keeping him alive

Suicidal thinking

- Life after combat is not worth living
- Suicide is an option, especially when I feel despondent
- It doesn't matter if I live or die

PTSD-related cognitions

- Having PTSD is a sign of my own weakness
- I will be forever unable to manage my PTSD symptoms
- I am so different now that I cannot regain my previous self
- I will never be able to have any degree of happiness because of the killing I did in the war
- There is no solution to all the things that went wrong in my life since the war

Religious or spiritual conflicts

- I cannot settle the conflicts between having to kill in war and what I learned from my religion
- It is not possible to have a belief in God after all that I saw or did

Value-related cognitions

- It is not necessary to reevaluate the war, even though all the negatives persist in my mind
- My military experience and training should determine all my present and future behaviors, attitudes, ambitions, and values
- Anger and confrontation from others should be met by equal or greater anger and confrontation

Childhood-related cognitions

- My upbringing was so lacking in what is needed for reasonable adulthood, I will never be a reasonable adult
- The physical or sexual abuse I suffered as a child will forever determine who I am or what I am as an adult

Table 2. Example of cognitive restructuring exercise for survivor guilt*

Survivor guilt cognition	Evaluation	Restructured cognition/elaboration
"I abandoned my unit by not going with them on patrol that last week before my date eligible to return from overseas."	Irrational	"Everyone said I should stay back. It was how the unit did things."
"I could have helped my friend survive if I had gone that time. He was never good in the field."	Irrational	"Actually, he helped me when I made mistakes. He saw things faster than I did. It was his 10th month in the field too."
"I abandoned the unit by not extending another six months."	Irrational	"I would not have wanted my friend to extend to stay with me, nor he I."
"It would have been better for me to die than my friend. He had a wife and kid already."	Irrational	"No one knows why one dies and another doesn't. I got married and have kids now too. This is important."
"My life has turned out so badly since I came back, it must be because I deserve to be punished."	Irrational	"I need help from a religious or spiritual person to think more about this. When I feel less guilty about things, this does not seem to me to be true."
"I felt so helpless when I saw the story in the *Stars and Stripes* of what happened after I left to come home."	Rational	"I guess I couldn't have felt any other way. The shock and helplessness I felt made me get drunk and start drinking. I need to keep from reliving this tragedy."

*Group members offer thoughts a person with survivor guilt might experience. These are written on a presentation pad, and the group assesses whether each one is rational or irrational. If a thought is considered irrational, a rational one is developed to replace it; if rational, elaboration is offered. Notes from the discussion are distributed to each group member at the next session and reviewed. When patients experience guilt feelings in the future, they review this lesson, add their own thoughts, and dispute irrational ones with rational ones. The therapeutic goal is achieved when guilt feelings subside and a positive emotional state is experienced.

done in class and to review and add to this journal when irrational cognitions recur. We also support their own development of new restructuring exercises to use during group sessions or in individual meetings with staff. ●

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