

# Psychotherapy

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Online First Publication, March 17, 2014. <http://dx.doi.org/10.1037/a0036025>

### CITATION

Keenan, M. J., Lumley, V. A., & Schneider, R. B. (2014, March 17). A Group Therapy Approach to Treating Combat Posttraumatic Stress Disorder: Interpersonal Reconnection Through Letter Writing. *Psychotherapy*. Advance online publication. <http://dx.doi.org/10.1037/a0036025>

# A Group Therapy Approach to Treating Combat Posttraumatic Stress Disorder: Interpersonal Reconnection Through Letter Writing

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Many who have served in a war zone carry deep emotional wounds that go beyond the typical symptom clusters of reexperiencing, avoidance/numbing, and hyperarousal that comprise a diagnosis of posttraumatic stress disorder (PTSD). Specifically, many combatants experience unresolved grief, guilt, and shame caused by losses and traumatic experiences suffered in war, called “moral injury” by some clinicians and researchers (e.g., Litz et al., 2009; Shay, 1994). We describe the aspects of human attachment that set the stage for grief, guilt, and shame, and outline the 3-phase group therapy model we have implemented in a clinical setting to foster the reconnection of severed human bonds. Special attention is paid to killing and related phenomena that are unique to combat PTSD. The program phases include psychoeducation, trauma-focused therapy, and aftercare, which focuses on assisting the veterans in reconnecting with their families and communities. The use of letter writing as an intervention is illustrated through case examples, and clinical outcomes are anecdotally described.

*Keywords:* combat, trauma, PTSD, moral injury, group therapy

As the number of combat veterans diagnosed with posttraumatic stress disorder (PTSD) continues to grow, so does the literature on how best to serve them. A salient feature of the increasing body of literature is the expanded view of PTSD for combat veterans. Experienced practitioners have contributed a great deal of this literature. Dewey (2004) notes that the traditional PTSD diagnosis centers on the conditioned responses that develop owing to trauma. He states, however, that although those symptoms may be the most apparent (e.g., nightmares, increased startle response, hypervigilance), they are not the most distressing symptoms to veterans. Rather, he has observed that grief for their fallen comrades, guilt about killing, and fear that they let their buddies down in some way (i.e., shame) are what disturb combat veterans most throughout their lives.

Shay (1994) discusses the traumatic grief that many combat veterans have experienced, and also states that “moral injury” sustained during combat produces lifelong psychological wounds (p. 20). He discusses the “undoing of character” that results from witnessing or participating in acts that transgress against the moral

values they were raised with (p. 104). Tick (2005) conceptualizes PTSD as an identity disorder that results from such combat experiences, and uses the term “soul wound” (p. 5) to describe the impact.

In addition to agreeing on the impact of traumatic grief, guilt, and shame on combat veterans, these clinicians also agree on the critical elements for treating these emotional injuries. Specifically, they all emphasize the importance of telling one’s story in healing trauma. Shay (1994) discusses the importance of “communalization of the trauma” (p. 4), which he defines as feeling safe to share one’s story with a person who can be trusted to listen and to retell the story to others. Dewey (2004) believes that combat veterans need to speak about their traumas and to feel completely heard. Tick (2005) discusses at length the healing power of storytelling, and uses it extensively in his work with combat veterans.

As important as this notion of telling one’s story is, it seems to be a difficult concept for clinicians to embrace. Shay (1994) describes a failing on the part of many mental health professionals. He states that many clinicians focus on sorting words into categories for intellectual categorization; he notes that such a failure to truly listen destroys trust. It may be that clinicians engage in such behaviors because they are unprepared to hear what the veterans have to say. Litz et al. (2009) point out that therapists may unconsciously display nonverbal behaviors that convey judgment and thereby shut veterans down from telling their stories. Dewey (2004) notes that when he started working with combat veterans he was unable to “go there” with them. Over time he realized that he was afraid of hearing what they had to say, partly owing to the graphic and disturbing nature of the accounts, but more so because it forced him to acknowledge that he, as a human being just like them, would be capable of doing the same things they had done.

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The views expressed are those of the authors and do not reflect the official policy of the Vet Center program, the Department of Veterans Affairs, or the U.S. Government.

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Briere (2009) describes this as looking into the “Devil’s Mirror.” That is, therapists must be willing to hear the story of the trauma unflinchingly, while knowing in their hearts that they could have behaved in the same way, under the same circumstances, no matter how horrifying the act.

As a society we are loath to confront death, particularly when the discussion turns to killing. Grossman (1995) discusses society’s collective denial regarding the true nature of war. His book is the first to really describe what those who have killed experience, both in that moment and subsequently throughout their lives. The importance of this subject cannot be overstated, as research has shown that the impact of killing contributes uniquely to a variety of emotional and behavioral difficulties, beyond that of other traumatic events experienced during war (e.g., MacNair, 2002; Maguen et al., 2009, 2010, 2012). In fact, recent research indicates that combat veterans who have killed report suicidal ideation at twice the rate of those who have not killed (Maguen et al., 2012).

The Department of Veterans Affairs (VA) has begun the important work of disseminating specific treatments to help combat veterans, including Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007; Foa & Kozak, 1986; Foa, Steketee, & Rothbaum, 1989), and Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2008). Although these approaches have data to support their effectiveness in decreasing hyperarousal symptoms and behavioral avoidance (PE) and correcting distorted cognitions (CPT), it is not clear that they place adequate attention on the unique aspects of PTSD experienced by many combat veterans. Litz et al. (2009) have begun researching a program to address moral injury experienced by combat veterans, which they define as “the lasting psychological, biological, spiritual, behavioral, and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectation” (p. 697).

The purpose of this article is to augment the PTSD treatment literature by describing what we have learned from working with combat veterans in a clinical setting. We use a method of intervention that we believe is essential to healing the unresolved grief, guilt, and shame associated with combat trauma, and that includes the components touted as being necessary to effectively treat PTSD, which are education, stress inoculation, cognitive restructuring, exposure, and narration (VA and DoD, 2010; Hoge, 2011). Our approach emphasizes the flexible application of these elements while placing a central focus on the reconnection of human bonds. We will outline the treatment targets and interventions that we use to address these areas, providing the rationale for this model and discussing the outcomes we have achieved.

### **Targets for Therapy**

This program addresses the emotional wounds that result from losing loved ones (grief) and from causing harm to others (guilt and shame). Because our approach emphasizes the interpersonal aspects of combat trauma, we use a group format to foster the connection and trust that results from sharing painful experiences with others who can relate. We believe that the group dynamic is essential to overcoming emotional detachment and numbing, and for rebuilding the connection to self and others.

### **Grief and Loss**

Attachment is an instinctive behavior directly connected to survival (e.g., Ainsworth, 1991; Bowlby, 1969). Bowlby (1969) defined attachment as a “lasting psychological connectedness between human beings” (p. 194). In a war zone, bonding with others is essential for emotional and physical survival. Those who have been to war describe the bond as “closer than blood,” such that the loss of a buddy is like losing a part of oneself, causing indescribable feelings of loss and anguish (Dewey, 2004; Shay, 1994).

The combat veterans who have participated in our treatment program have endured significant, often-repetitive loss. As noted by Shay (1994), “We can never fathom the soldier’s grief if we do not know the human attachment which battle nourishes and then amputates” (p. 39). Additionally, Dewey (2004) states that the magnitude of love for one’s comrades enables persistence in the face of unimaginable horror; this love is greater than the fear of death and the natural aversion to killing, and is what sustains a warrior through the ordeal of combat. When such a bond is violently severed, the depths of emotional pain that result from the loss are profound.

The psychological process by which one heals from loss is grieving. However, grieving in the combat zone is often impossible because it makes one vulnerable. Many veterans have described witnessing the medical evacuation of fellow troops because they could no longer function psychologically. Thus, emotional numbness can facilitate survival. However, continued experiences with death may result in anger toward the enemy that can evolve into feelings of hate and rage. Notably, anger is an adaptive emotion in the combat zone because it keeps combatants motivated and alive. However, it may manifest in rash and destructive behaviors that perpetuate dehumanization and set the stage for transgressing against others and one’s own value system.

### **Guilt and Shame**

In addition to unresolved loss, our program addresses feelings of guilt and shame that result from various scenarios in combat. One example is survivor guilt, a feeling of wrongdoing that commonly arises from surviving a catastrophic event that resulted in the injuries or deaths of others; this phenomenon has been studied among survivors of a wide variety of traumatic experiences, including combat, concentration camps, abusive homes, and plane crashes (e.g., Herman, 1997; Matsakis, 1994). Matsakis (1994) believes these guilt feelings may function to help one avoid feeling powerless or helpless, resulting in self-blame rather than accepting that events in life can be arbitrary. In the context of war, Shay (1994) discusses the tendency to blame oneself for a comrade’s death, regardless of whether there is any actual responsibility for the events that led to the death. Similarly, Grossman (1995) notes that combat troops tend to feel deeply responsible and accountable for things going on around them, even when they bear no culpability. Field medics and corpsmen provide a classic example of survivor guilt. It is ingrained that they must save lives, which is often impossible in combat. However, these individuals often express unrelenting feelings of guilt for not being able to save troops that were impossible to save, or for making triage decisions about whom to work on and whom to let die.

The second type of guilt our program addresses is that in which the veteran was directly involved in a negative outcome, either

through action or inaction. An example is “friendly fire,” in which mistakes are made that result in the deaths of one’s own troops. For instance, we have treated many veterans who served in artillery units that inadvertently fired on their own. Similarly, veterans have described ambushes in which they fired on fellow troops in the fog of war, killing and wounding them owing to lack of information on the other unit’s position.

Combatants may also carry guilt and shame when they witness atrocities but do nothing to stop them. Litz et al. (2009) emphasize that bearing witness to acts that transgress against another causes intense shame, similar to the experience of perpetrating such acts; shame develops when one fails to take into account the situational factors that compelled his or her inaction.

Arguably the deepest source of guilt stems from killing. Grossman (1995) details the way in which killing changes people, causing great pain and guilt. Karl Marlantes, a Marine Corps Vietnam veteran, provides a firsthand account of the experience of war, including killing (2011). He states that in combat killing can be exhilarating, a concept that can be difficult for civilians to grasp. Part of military training is dehumanizing the enemy so that it is possible to kill them. They are not people; rather, they are “gooks,” “haji,” and so forth (Grossman, 1995). There often comes a point, however, at which that enemy is perceived as being human. For Marlantes, it came when his son reached the approximate age of an enemy he had killed. Suddenly that enemy was no longer a “gook”; he was a son, a brother, a husband. For many veterans that moment came when they had to search a dead enemy for intelligence. In doing so they often found such things as pictures of loved ones, letters, or religious talismans. Whenever it happens, the realization of having killed another human being can take a profound psychological toll (MacNair, 2002; Maguen et al., 2009, 2010, 2012).

That toll can be further compounded by circumstances in which the combatant encounters a shockingly unexpected aspect of warfare. In the combat zone, the enemy is not always an adult male member of the military. The enemy may be wearing civilian clothes, and the enemy may be a woman or child. Hoge et al. (2004) found that 20% of a sample of Iraq and Afghanistan veterans reported causing the deaths of noncombatants. Maguen et al. (2009) found that 13% of Vietnam veterans reported involvement in events resulting in the wounding or death of children, women, or the elderly. Consider the example of a Marine in Vietnam who was clustered with a group of other Marines when a Vietnamese girl, about 6 years old, started walking toward their group.<sup>1</sup> As she drew closer he saw the wires for the bomb she had that was meant to kill those Marines (and her in the process). He did the only thing he could do to mitigate the loss of life; he shot and killed her. The degree of torment he suffered as a result was immense.

In the above example, the veteran had little choice but to fire. There can be circumstances, however, in which the veteran is not firing for the sake of saving lives. Killing for revenge (vs. for survival or to achieve a military objective) can produce a deep sense of shame for having violated one’s own moral code. A veteran who served in Vietnam became enraged after seeing his best friend shot in the head by a sniper. Shortly thereafter he encountered an enemy who attempted to surrender; the veteran killed him anyway. Many veterans have spoken about reaching a

point where they no longer attempted to determine what was an appropriate target.

Another phenomenon is going beyond simply killing to the point of committing atrocities, including torture, mutilation, desecration of bodies, and purposeful killing of one’s own (i.e., fragging). Beckham, Feldman, and Kirby (1998) found a relation in Vietnam veterans between committing atrocities and PTSD. As noted by Matsakis (1992), “blood lust” . . . has served soldiers in combat throughout history” (p. 328). It is later, however, that these acts cause distress to those who committed or witnessed them. Litz et al. (2009) point out that feelings of guilt and shame indicate an intact conscience. Matsakis (1992) notes that after war it is those with the highest moral code that suffer the greatest emotional pain. Notably, Dutra, Callahan, Forman, Mendelsohn, & Herman (2008) found that shame is significantly correlated with a number of suicide variables, including suicide risk, recent attempts, and current suicidal ideation and plans.

### Group Treatment Program

Because the traumatic events that produce grief, guilt, or shame result from severed interpersonal connections, we believe that treatment needs to focus on restoring the connection to self and others. The power of group therapy stems from the relationships among group members; at a basic level, group therapy is beneficial with respect to normalizing experiences, receiving social support from peers, and learning from others who have had similar experiences (Yalom, 2005). At a deeper level though, we have observed veterans learn how to reconnect with others in an intimate way. A hallmark symptom of PTSD is emotional numbing, which for many has negatively impacted marriages/intimate partnerships, relationships with children, and so forth (Herman, 1997; Matsakis, 1994). Many veterans we have treated initially reported that they had no friends, and recognized that they had kept an emotional distance from the important people in their lives for fear of losing them.

To address unresolved grief, guilt, and shame, we use a group treatment program that consists of three phases. The program was initially designed in 2001, and its current form is the culmination of what we have learned by working with the veterans who have participated in the program. Our program parallels the three stages of healing described by Herman (1997) in her classic work *Trauma and Recovery*, which are Safety, Remembrance and Mourning, and Reconnection; in each stage the veteran must accomplish a particular therapeutic task. Like Herman’s work, our program focuses on healing severed bonds of interpersonal connection and mitigating feelings of guilt and shame. We will first describe the theoretical foundation and core content of our group program, and then outline the factors related to its clinical application.

### Phase 1—Psychoeducation

As described by Herman (1997), the initial phase of treatment should be educational rather than exploratory; it should serve to

<sup>1</sup> To protect the confidentiality of the veterans we referred to in this article, we adhered to APA guidelines regarding de-identification or disguise. Specifically, we limited the information we provided in the briefer examples. In the lengthier examples, we altered details about the veterans and their traumas so as to render them unrecognizable.

increase understanding of posttraumatic stress and its associated symptoms, as well as teach stress- and emotion-management skills. In our program, we call this phase a “class,” and the format is very much like a classroom. Each week a facilitator presents on a particular symptom area associated with trauma reactions (e.g., anger, depression, sleep disturbance, stress and anxiety management). The intention is to give veterans a framework to understand PTSD, their feelings and symptoms, and to facilitate the development of basic stress management skills. During this phase, we begin to develop our credibility as providers, and veterans become more comfortable with being in a group atmosphere. Rapport develops among group members and with the facilitators. Toward the end of the series, we introduce the core emotional themes of grief, guilt, and shame that will be addressed in Phase 2, and discuss the concept of letter writing as an intervention to address these areas. This phase also provides an opportunity to assess the veterans’ readiness to participate in trauma work.

## Phase 2—Trauma Group

In this phase of treatment, the focus is on helping veterans to describe their traumas in detail and to develop a cogent narrative of their experiences. This phase parallels Herman’s “Remembrance and Mourning” phase (Herman, 1997, p. 175). The overall goal is to identify and address unresolved grief, as well as any experiences that have caused feelings of guilt or shame.

In the initial sessions, the therapist focuses on the commonalities among the group members’ service as a means of building rapport, specifically guiding the group discussion toward military experiences. Although members are welcome to begin discussing their traumas, the therapist does not explicitly lead them there. The objective in the early stages of group is developing feelings of safety and trust, which Herman (1997) emphasizes as paramount to creating an environment in which trauma can be explored. Consistent with this perspective, Horvath, Del Re, Flückiger, and Symonds (2011) found a significant relation between therapeutic alliance and treatment outcome; they emphasize the importance of fostering collaboration early on in the therapy process.

Yalom (2005) describes a number of therapeutic factors distinctive to groups that contribute to members’ healing and growth. Two of the most powerful are—(1) universality, the realization that one is not alone in having certain difficulties; and (2) cohesiveness, the members’ bonding and mutual respect in the group. Universality may be particularly helpful for Vietnam veterans, for whom the isolation inherent in PTSD has been exacerbated by the distinctive societal maltreatment they received on coming home. The “esprit de corps” (p. 48) central to cohesiveness is likely to be a particularly potent factor for combat veterans in general, as military training and war-zone experience have imbued them with a sense of shared mission, and many veterans describe a feeling of lost camaraderie after their military service ends. As the group progresses, veterans often express sentiments like: “I’m back in my squad again.” These factors help members overcome initial reticence to discuss their experiences, which many have actively avoided because of the emotional pain.

The recognition that the other group members have had similar experiences facilitates further discussion of trauma. Many veterans seek treatment feeling isolated, believing that nobody could ever understand what they went through or what they did. As Litz et al.

(2009) note, a common response to shame is to hide or withdraw. It is common for veterans to disclose events that they have never shared before, even with a therapist (and some have participated in years of individual therapy prior to being referred to the group). What allows for this disclosure is the sharing of similar events by other group members and, more importantly, an environment of acceptance where the therapist and the group become what Herman (1997) describes as “the witness and the ally” (p. 175).

After these group dynamics have been established, the therapist begins to guide the discussion toward the trauma narrative. Veterans typically share relatively milder traumas at first, progressing over time to the most distressing. Although we do not implement a formal exposure therapy protocol, we do use principles of exposure. Foa and Kozak (1986) posit that two factors are necessary for reducing fear. One is that the “fear structure” (p. 21) be activated, which is accomplished by the veteran’s contact with the traumatic memories, and the other is that information incompatible with that fear learning be introduced, which occurs when those traumatic memories do not result in a tangible negative consequence.

The therapist also implements cognitive restructuring techniques as described by the pioneers in field (e.g., Beck, 1976; Meichenbaum, 1977). Specifically, we use Socratic questioning techniques to address veterans’ expressions of guilt (e.g., “I should have saved him”) or shame (e.g., “I am a monster”). To address veterans’ beliefs about their actions, Litz et al. (2009) recommend a strategy in which an individual therapist guides the veteran through an imaginary conversation with a “benevolent moral authority” (p. 703). The purpose is to assist the veteran in disclosing the transgression committed, describing how that transgression has impacted his or her self-image, and stating what he or she thinks the consequences should be. In our program these objectives are addressed via the group process; receiving empathic feedback from respected peers is powerful and helps the veterans to conceptualize their actions differently. In addition, when a veteran expresses compassion to another group member who committed similar acts, it provides a new perspective that can further that veteran’s own healing (i.e., mirroring forgiveness).

**Letter writing as an intervention.** We believe that exposure and cognitive restructuring elements are necessary but not sufficient for addressing combat PTSD. Specifically, exposure is integral to reducing the anxiety associated with traumatic memories, and cognitive restructuring helps the veterans to understand their actions logically, but in our experience these techniques do not fully address the emotional impact of the traumatic loss or the feelings of guilt and shame. Our program uses a narrative technique consisting of letter writing designed to address the severed interpersonal connections experienced by many combat veterans. The letters provides a vehicle for reconnection and for reparation of transgressions, and is the key therapeutic element of our program.

Importantly, Hoge (2010, 2011) notes that of the five essential components of effective therapies, narration is likely the most therapeutic; he believes that narration helps one to accept one’s traumatic experiences and to move forward with life. Indeed, therapeutic writing has a literature supporting its effectiveness regarding psychological benefits, health benefits, and social benefits (Baikie & Wilhelm, 2005; Pennebaker, 1997), and has even been shown to significantly decrease posttraumatic intrusions and

avoidance (Klein & Boals, 2001). We have observed that letter writing goes a step beyond the verbal narrative in reprocessing the trauma; it creates a shift in the veterans' relationship to their trauma in a fundamental way.

The letter writing technique is unique in that the veterans write directly to those lost or harmed as a way of addressing unresolved grief, guilt, or shame. Simply put, to address unresolved grief for an individual who died, the veteran writes a letter to that individual and reads it aloud to the group. Many veterans have tried to avoid thinking about their friends who died because it is too emotionally painful and often involves vivid recollections of that individual's death. The letter cuts through that avoidance and provides a platform for establishing reconnection with the person who died (i.e., the positive memories). Likewise, for the guilt and shame engendered by transgressions against others, the veterans write letters directly to those involved. The therapist encourages the veterans to address the traumas that elicit the most frequent or intense reexperiencing symptoms. A strategy we use to identify what letters need to be written is to query the veterans about the faces or people they see in their memories or dreams.

The only requirement for participating in trauma group is that each member agrees to write at least one letter and read it aloud to the group, though he or she is welcome to write more. There is no assigned timeframe for writing, no minimal length for a letter, and no specified format. The only expectations are that the letter be written in the second person (i.e., addressed to the person involved in the trauma), and that it address the emotions about the trauma (vs. solely recounting the factual events). Notably, by the time the veteran writes a letter he or she has discussed the traumatic event in the group. We have consistently observed that the letters represent a deeper emotional processing of the traumatic event. In group discussion, the veterans are talking about a traumatic event. In a letter, the veterans are writing directly to a person involved in the traumatic event. As such, the letter facilitates the reestablishing of connections with those lost or harmed, allowing the writer to grieve or make amends for any transgressions.

Grief letters are typically the first to be shared during the group (via natural progression, not owing to any prescription by group leaders). Those veterans who also have experiences of guilt or shame then progress to letters in those areas. The letter provides a mechanism for addressing the transgression and a vehicle for seeking forgiveness. Notably, we never try to talk veterans out of their feelings of guilt or shame; rather, we offer understanding and acceptance that their feelings are their own and are valid. Consider the example of a veteran who had served in both Iraq and Afghanistan. After several months in trauma group, he spoke about an incident that he had never before disclosed. He was on guard duty at an entry control point in Iraq. A van was approaching, and he signaled for the van to stop but it did not. He signaled more emphatically; still the van did not stop. He fired warning shots at the van hoping it would stop, but it did not. Next, per protocol, he fired on the van, which caused it to catch fire. An examination of the aftermath revealed several dead children. The fact that this veteran was a father no doubt compounded his horror. His chain of command and peers tried to convince him that he should not feel guilty, because he followed protocol and did not mean to kill those children. Although he knew this logically, and had been trying to convince himself of that fact since it had happened, he continued to experience deep guilt and shame. Our approach was for the

veteran to write a letter to those children. In his letter, he described the events that led up to his shooting, and then articulated the emotions that he felt then and had been feeling since. He asked their forgiveness and expressed his hope that they were at peace. The letter was instrumental in decreasing his distress regarding that incident. Through the compassion and acceptance of the group, he no longer felt like a "monster." In fact, he had not previously told his wife about the incident for fear that she would leave him. He was able to share his letter with her, and her supportive response further aided his healing.

Litz et al. (2009) note that in the case of moral injury, the veterans' perceptions about their actions may be appropriate. They discuss the importance of self-forgiveness in working with those who have transgressed; the concept of forgiveness is an integral factor in healing, and one of the most difficult to achieve. In our society, we are taught that the morally appropriate action to take if we have hurt somebody is to accept responsibility for what we did, apologize, and try to make amends. A problem for many veterans is that the person they harmed is dead, or is unreachable logistically (e.g., in another country; of unknown identity), which may make it feel like forgiveness is impossible. The letter provides a way for the veteran to ask forgiveness from the person harmed, which we believe is key to feeling forgiven. In our experience, veterans who have sought out and received forgiveness by a religious leader, but who have not addressed the person they harmed, often report they are still unable to forgive themselves. We would argue that because they have not repaired the severed bond with the person they hurt they do not feel worthy of forgiveness. Notably, Litz et al. (2009) discuss the tendency for veterans to isolate, which deprives them of opportunities for validation and affirmation by others, thereby perpetuating their feelings of being undeserving of forgiveness. The group provides the opportunity for validation and affirmation by peers and professionals.

The obvious question we typically get is how to deliver a letter to somebody who is dead. Our reply is that those who are dead often feel more real to the veterans than the people who physically exist in their lives. They are dreaming about them at night, thinking about them during the day, and some are having flashback episodes in which they encounter the dead. They exist almost tangibly in these veterans' lives; therefore, when the veteran reads the letter aloud, the message gets "delivered."

**Healing transformations.** Many veterans describe some type of transformation with respect to how they experience the people involved in their trauma after reading a letter aloud to the group. This phenomenon was described by Shay (1994), who stated that providing a narrative can transform distressing reexperiencing symptoms into welcomed memories, allowing the veteran to gain control of the traumatic recollections. One Vietnam veteran had dreaded going to bed every night because he knew he would be reliving the incident in which he witnessed a friend die brutally in combat. After reading the letter he wrote to this friend aloud to the group, he began to look forward to going to bed at night because he knew he would be "seeing" his friend. Specifically, he had started dreaming about the good times they had when his friend was alive. Instead of continuously reliving the tragic moments of his friend's gruesome death, he now had him back as a whole person and a treasured memory.

The transformation of individuals lost or harmed that often manifests in dreams is, we believe, a reflection of the repair to the

interpersonal breach. One veteran we worked with described a transformation dream of his best friend. This veteran had often discussed Sam in session and stated they had become close because they were both avid fishermen and frequently talked about fishing to pass the time. The veteran witnessed Sam burn to death after a rocket-propelled grenade hit the gun truck he was manning and exploded in flames. This veteran had labeled himself a coward because he thought he had not done enough to save Sam. After reading the letter in which he expressed his feelings for Sam and asked for forgiveness for not saving him, the veteran reported a dream in which he received a card with his name on the front and a smiling picture of Sam on the inside. Sam had written about how much he admired and missed the veteran, and that he was well and happy because he was living on a houseboat surrounded by fish. After describing his dream, the veteran looked into his therapist's eyes and said, "I know where that card came from; it came from Heaven." Notably, this transformation occurred within the veteran's own spiritual framework and clearly reflects the shifting perception of his feelings of guilt, as well as the reconnection he established with his fond memory of Sam.

**Ceremonies and rituals.** Shay (1994) states that traumatic events will have a longer-term and more severe impact without a communal ceremony; he emphasizes the importance of both formal social rituals and informally sharing one's story with others rather than bearing the burden alone. Litz et al. (2009) emphasize that the reconnection or corrective experience often needs to have a behavioral component. In our experience, rituals are especially effective for memories of those individuals who are no longer intact (i.e., those who were maimed or dismembered). This observation is important, as McCarroll, Ursano, and Fullerton (1993, 1995) found that Operation Desert Storm Veterans who worked in mortuary affairs experienced greater intrusive thoughts and avoidance than those who had not handled human remains. We have found that when veterans lay these individuals to rest in a ceremonial fashion, they nearly always either leave entirely or return as a whole person in their imagination and dreams.

Some veterans in our program hold some type of ritual or ceremony that includes their letters. For example, one veteran described his "first kill" and how the image of the man's body lying in the wire all night had replayed in his dreams several times a week for >40 years. After completing a letter to this enemy soldier in which he communicated his sorrow regarding the event and expressed his wish that they both gain peace, the group performed a burial ceremony in which the veteran burned his letter, said a prayer, and laid the soldier to rest. The rock shrine remains outside of the clinic, reminding the veteran and tangibly expressing what he has done to make amends for killing. The image of the enemy soldier at the moment of his death no longer intrudes on the veteran. He states he no longer feels "haunted" by this man.

### Phase 3—Aftercare

This phase is designed to assist veterans in moving forward in their lives once they have addressed the traumatic events that have been keeping them stuck in the past. The therapist provides a general topic for each meeting focused on the theme of reconnection, which is the therapeutic task of the veteran at this stage of treatment (Herman, 1997). Topics such as relationships, commu-

nity involvement, spirituality, and finding meaning are introduced and discussed. Litz et al. (2009) include a similar component in their program, focused on fostering reconnection in the community. A major goal of this phase is to bolster the veterans' ability to develop and maintain emotional support outside of the clinic setting. As such, the group is encouraged to meet independently on alternating weeks as a means of peer support, and members are also encouraged to set personal goals for fostering reconnection in their lives. We find that many veterans begin to engage in activities they once avoided, often with other group members.

### Program Implementation

This program has been implemented in multiple clinics with varying resources.

The length of each treatment phase has varied over the course of development, as a function of the availability of resources and also clinical judgment, and we have made changes over time based on what we judged to be most effective and efficient. The trauma group (Phase 2) is the main therapeutic segment of the program; the first iteration was 2 years in length, which was shortened owing to limited resources. The briefest offering was 6 months in length, which proved to be inadequate to thoroughly address the trauma themes. The current iteration of the program (9 months of weekly trauma group as its core component) seems to be the most efficient and still the most thorough.

With respect to selection criteria, individuals with severe substance abuse or dependence would be referred for substance treatment prior to participating in trauma work. Furthermore, for veterans who recently attempted suicide or are deemed to be high risk for suicide, it is important to focus on decreasing that risk prior to initiating trauma work. We take these steps to ensure an appropriate client-treatment fit, and have not had any adverse events in the course of treatment. Otherwise there are no exclusionary criteria (i.e., the veteran may have comorbid mental health diagnoses). To progress to Phase 2, the only requirements are a commitment to regular attendance and a willingness to write at least one letter to read aloud to the group. Veterans who would have difficulty writing a letter (e.g., owing to a learning disability) are offered assistance with constructing a narrative.

Professionals from multiple disciplines and with varying levels of experience have participated in facilitating all phases of the program (e.g., psychologists, social workers, graduate students, and peer counselors).

**Phase 1.** To increase commitment in veterans who are apprehensive about being in groups, we explain that they do not need to speak at all in the education phase if they choose, aside from brief introductions during the first meeting. This is a way to facilitate the integration of anxious or avoidant veterans into the group process. We also explain that they do not have to commit to the entire process. We encourage the veterans to try Phase 1, and to make the decision about progressing to Phase 2 when the time comes. Notably, Phase 1 would be applicable for any veteran with a PTSD diagnosis, and some veterans participate in this phase only. Phase 2 would only be an appropriate option for veterans who have unresolved grief and loss, guilt, or shame. These areas are assessed at the initial intake; veterans who are presenting with more fear- or anxiety-based symptoms are referred to an appropriate treatment targeting these areas (e.g., PE).

Veterans may join the class at any time (i.e., it is an open vs. a closed group), though if they present later than halfway through the series, it is recommended they wait until the next class offering (so they do not feel like an outsider in an already bonded cohort, and because they have not been sensitized to the more emotionally laden topics presented later in the series). Class sizes have ranged from 8 members to >40.

The class meets weekly for 90 min, and our series contains 13 different class topics. Our curriculum has evolved over time, and includes topics that we have selected or that the veterans have requested. However, clinicians could tailor the curriculum based on available resources. We employ multiple instructors in the series, which maximizes resources and offers multiple perspectives and areas of expertise (to include “guest lecturers” such as psychiatrists or addiction therapists). Handouts summarizing the material are provided for each lecture to maximize retention. We believe it is essential to introduce the grief, guilt, and shame concepts that will be addressed in trauma group. The final session serves to inform veterans of their options for continued care, including review of other options in the community (such as VA services and any other locally available programs).

Dropouts tend to occur in this phase. We estimate attrition to be approximately 20%, though many who drop out do return to the program later. It is rare for a veteran to drop out of treatment once they have begun trauma work (likely owing to the bond that has formed with fellow veterans). Accordingly, one of the functions of Phase 1 is to determine readiness for Phase 2. However, this phase of the program could be shortened. Similarly, Phases 1 and 2 could be combined if the clinician felt confident that commitment had been established.

**Phase 2.** The trauma group may be composed of individuals who attended different education classes (i.e., there may or may not be a cohort that completes all three phases together, depending on the size of the clientele). We have found that a trauma-group size of nine veterans is optimal. Much larger and the members tend to have difficulty bonding, and cliques may occur. Much smaller and there may be insufficient breadth of experiences such that some veterans may not be able to relate well to others’ experiences. Also, if the group attendance drops below six, there is a substantial loss of therapeutic rhythm in the group. These functional-size parameters (of six to nine group members) are similar to clinical recommendations of noted experts on group psychotherapy who describe the ideal balance between interactional richness and individual attention that is afforded by a group size of seven to eight members (Corey & Corey, 2002; Yalom, 2005).

This phase is a closed group that meets for 90 min weekly for 9 months. We have found no need to sort groups based on generation (e.g., Vietnam vs. Iraq/Afghanistan), gender, military occupation, or rank (officer vs. enlisted). In fact, blending the groups can be beneficial. For example, seeing that PTSD is chronic and does not go away on its own (evidenced by the veterans who served in Vietnam, Korea, or during WWII) can help to solidify commitment in the younger veterans. With respect to differences in rank or type of job (e.g., combat arms vs. support troops), exposure to other perspectives can provide information useful in understanding traumatic events, and can help in developing empathy for others’ experiences. For example, many medics believe that others blame

them for deaths; in the group setting they come into contact with the respect and gratitude that the other veterans actually feel.

The guidance of the therapist is paramount in this process, and we recommend cofacilitation for several reasons. One, the absence of one facilitator does not impede the group. Two, multiple perspectives undoubtedly enrich the process. Three, doing this intensive trauma work can be emotionally difficult for a therapist, and having a cofacilitator to process the material with is optimal for therapist self-care. This model is also an efficient way for a less experienced therapist to gain experience by cofacilitating with an experienced trauma therapist. However, the group can be facilitated by one therapist who is experienced in treating PTSD.

The therapist plays an active role in directing the group process, especially in the early stages. Because avoidance is a hallmark symptom of PTSD, without direction veterans often avoid discussing their traumas, instead focusing on subjects that they are comfortable discussing. Those topics may be benign but lack therapeutic content (e.g., hobbies, current events), or may consist of anger toward a variety of institutions or events (e.g., the government, the VA, protestors). For that reason, we establish a group rule that prohibits discussion of politics and government. We provide the rationale that we cannot change those institutions, and the goal of therapy is to facilitate healthy change within the client. We also explain our belief that expressing anger can be an avoidance strategy; specifically, anger is often perceived to be a more comfortable emotion than grief, guilt, or shame, thus many veterans default to anger to avoid these emotions. It is essential that therapists can tolerate listening to gruesome details about the carnage of war; otherwise the therapist may unknowingly reinforce or foster avoidance behaviors.

In the initial sessions the therapist provides information on how the group process works and on the composition of letters, and reiterates the point made in the educational phase that symptoms will likely increase initially owing to contacting traumatic memories. In the next few weeks, veterans are guided toward dialogue about general military experiences (not necessarily combat), as well as discussion of how life has changed since combat. The purpose is to build rapport and trust.

After approximately a month the therapist specifically guides the discussion toward the traumatic events that occurred during combat. Direction by the therapist is initially needed, but by about the third month veterans typically begin to share their more traumatic combat experiences without needing to be prompted. The therapist provides direction and feedback during verbal discussion to prepare the veterans for writing their letters (e.g., reflective statements about their losses or the actions that are disturbing them). Questions like “What would you want to say to him now?” are used to assist veterans in contacting their emotions.

The majority of the letters are read and processed by the group during the fifth through the eighth month. During the ninth month, the therapist introduces the topic of memorial ceremonies or rituals. These activities are concrete behavioral manifestations that can further aid the reconnection with those lost or harmed.

**Phase 3.** We conduct Aftercare for one year; the group meets twice monthly for the first 4 months, and then monthly for the remaining 8 months. Group size has ranged from 9 members (a trauma group that continues to this phase together) to 18 members (blending two trauma groups together). Blending two trauma groups together is ideal, both because of the efficiency in utilizing

resources, and because it provides an opportunity for the veterans to expand their support networks and to practice managing anxiety that may result from contending with larger numbers of people and changes to routine. We consider the phase to be an optional adjunct to the trauma group; therefore, clinicians can tailor this portion of the program to fit their clients' particular needs within available clinical resources. For example, because this portion of the program is present-focused versus trauma-focused, it is not necessary to employ experienced trauma therapists. We have utilized peer counselors and graduate students more extensively in this phase. Although we still prefer utilizing cotherapists, it is not critical. Also, this phase could be shortened, or veterans could be referred to existing groups with similar objectives (i.e., personal growth and community integration).

### Discussion

According to the National Institutes of Health (2009), PTSD is a growing epidemic; as such, the need for intervention is great. An increasing body of literature is focused on the aspects of war experience that tend to inflict deep and lasting emotional wounds, known as moral injury (e.g., Litz et al., 2009; Shay, 1994). This perspective has evolved out of close therapeutic work with combat veterans, and posits that those who have experienced trauma during war need to discuss those experiences in order to heal. Ironically, the topics that veterans most need to discuss are the topics that people are least able to hear. In sharing his own healing process, Marlantes (2011) speaks to the extreme discomfort that most people (including mental health providers) have in addressing matters that involve death. He notes, "We don't talk about death in our society. Even the chaplains. Even when it's all around us" (p. 16). He also states simply that a large part of treating PTSD is helping veterans to remember and speak about their experiences. Accounts such as Marlantes' are indispensable to our understanding of combat trauma. Although we can never assume that one veteran's experiences or feelings are identical to another's, by learning from those who have so openly shared their personal experiences, we are better equipped to listen effectively to what our clients are telling us.

There is potential for moral injury-based treatments to augment the empirically supported therapies offered to combat veterans (e.g., PE or CPT), or to be implemented in cases in which such treatments may not be indicated. For example, consider the veteran who stayed back from a patrol owing to a minor injury. A close friend went in his place and was killed, resulting in tremendous grief and survivor guilt. Such a scenario would not be appropriate for PE, though this veteran could clearly benefit from treatment to address his grief and guilt.

Our program contains the elements considered to be necessary for effectively treating PTSD (Hoge, 2011; VA & DoD, 2010), but the clinical implementation allows for flexibility in tailoring the treatment based on clinical judgment. We use a unique narrative technique that we believe is essential to addressing unresolved grief, guilt, and shame. In our view, existing treatment protocols may be of insufficient length to fully treat the myriad problems that combat veterans may experience. Many combat veterans have served multiple combat tours, equating to years of exposure to multiple forms of trauma (e.g., threat to their own safety, witnessing carnage, losing close friends, killing); a 12-session protocol

seems insufficient to address the depth of their experiences. Our program focuses on addressing trauma in service of broad goals of reconnection with self, others, and community. This program affords the time to develop a trusting therapeutic relationship, to delve deeply into the traumatic experiences that are troubling the veterans, and to facilitate improving quality of life (e.g., personal relationships, achieving occupational or educational goals). As such the therapeutic techniques are applied flexibly over the course of an extended treatment program versus ensuring that specific strategies are implemented in any given session.

Our approach is primarily supported by anecdotal outcomes that we have consistently observed over the past 12 years, but is limited by the absence of initial efficacy or effectiveness data derived from standard measures of psychological symptoms. Working in a high-volume, high-acuity clinical environment precludes the stringent control of variables necessary for scientific research (e.g., randomization to treatment conditions), and regular standardized assessment of psychological symptoms is not standard in our clinic. However, future work should evaluate change in psychological symptoms from pre to post intervention. We hope that the clinical information we are sharing will be of use to practitioners and to researchers who are in a position to empirically evaluate this model. In addition to standard measures of PTSD, measures of quality-of-life improvements could provide vital information for both clinical and research purposes.

Although the concept of moral injury has been studied and developed by various professionals (e.g., Litz et al., 2009; Shay, 1994; Tick, 2005), empirical support for the construct has not yet been firmly established (Litz et al., 2009); therefore, further analysis is needed. To that end, the use of a reliable and valid tool to assess moral injury is necessary; the Trauma-Related Guilt Inventory (Kubany et al., 1996) is one measure that might be effectively used in such research.

The ever-growing number of treatment programs and research studies on combat PTSD is heartening. We hope that future research will continue to focus on the deep emotional wounds that are unique to combat PTSD, providing veterans with the necessary tools for healing.

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Received April 22, 2013

Revision received January 10, 2014

Accepted January 20, 2014 ■