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how PTSD sufferers get stuck in time

At age forty-five, Kara's life was full. She and her husband, Bud, had been married for twenty years. They'd decided early on that they would forego having children to focus on their relationship and have fun together, and they had done just that. They loved Alaska's outdoor life—riding motorcycles, deep sea fishing, camping, and hunting. Kara's job with the highways division of the State of Alaska Department of Transportation was fine too. She drove a pickup truck and hauled a light board signaling traffic to change lanes for the highway work crews. It was a good job, and it let her have the life she wanted—until one day a young woman driving a large pickup truck came speeding down the road and smashed into Kara's truck, catapulting it into the air where it flipped over, came crashing down, and landed on its roof with a scream of broken glass and metal on asphalt. Kara's coworkers dropped everything and rushed to help.

They found her trapped inside, hanging upside down, suspended by her seat belt, injured but alive. For Kara, everything was happening at once. She was in shock. She knew that her head, neck, shoulder, and back had been injured. She wanted to get out. And she was desperate to

know what had happened to the driver of the vehicle that hit her. Her coworkers, concerned for their friend's life, told her not to worry about the other driver and not to move until the paramedics arrived.

But Kara could smell gas and feared that her truck might explode. Frantic, she tried to release her seat belt. It was jammed. And even if they had tried to, her coworkers would not have been able to help her out of the truck—it had been so flattened by the impact that there was no way for them to get to her. With the clarity that comes with shock, Kara saw that if she could get loose she could find a way out. So she reached into her pocket, found her pocket knife, and cut through the seat belt, falling abruptly and landing on her already injured head, neck, and shoulder.

Kara crawled out of her truck and tried to head toward the other pickup. Despite her many injuries, and even though her coworkers were physically restraining her, she was extremely anxious about the other driver and managed to force her way through the crowd, only to witness the young woman's last moments of life. Strewn all over the back of the cab were signs of family life—an infant car seat, a diaper bag, and baby clothes. But there was no infant, and a search failed to turn up anything. Kara later discovered that the woman who hit her was the mother of a toddler, who thankfully had not been in the vehicle at the time of the crash. But Kara was devastated to discover that the young mother had also been pregnant.

The accident changed Kara's life. She had sustained injuries to her skull, neck, spine, shoulder, abdomen, and knees, and underwent a series of operations and procedures to repair the damage. Physically, she was slowly improving; but the psychological damage was severe and more enduring. She began psychotherapy, including psychiatric and psychological treatment.

Four months into Kara's psychotherapy, Kara's psychologist was worried. Psychological testing confirmed extreme trauma, extreme depression, extreme anxiety, and panic attacks. Kara had severe post-traumatic stress disorder. And now it was the dead of the brutal Alaskan winter. With almost no hours of sunshine, it seemed impossible that

Kara would ever be able to conceive of a world without darkness, both external and internal. Her psychologist thought that a change of scenery to a warmer, sunnier climate might at least help—a lot of Alaskans escaped the winter by flying to Hawaii. Kara's workers' comp adjuster agreed. The psychologist did her homework, and discovered that on the island of Maui a psychologist named Richard Sword was practicing a new therapy that appeared to offer tremendous results for people like Kara.

Kara and Bud spent their first day in Maui settling into an ocean-side condo, and then got to work. During a get-acquainted session with Rick and his wife, Rosemary, also a psychotherapist, Bud told them how his wife had changed. Before the accident, he said, Kara had been an affectionate companion and an active and adventuresome woman—a social, positive person, quick with a smile and a joke. She was attractive, was proud of her appearance, and took great care of herself. But the woman who had returned from the accident was very different.

This new Kara was a depressed, paranoid stranger who didn't care what she looked like, didn't want to be touched, didn't know what fun was, and didn't seem to care about people—or about anything, for that matter. Plus, Bud was doubtful about this Maui doctor. How could Rick help his wife when others had not been able to?

The Swords explained that they would be working with a new therapy based on understanding how the way we feel about the past, present, and future influences the way we conceive of what is possible in our lives. It seemed to be especially helpful with PTSD—even with battered World War II veterans in their upper eighties and nineties who had been suffering for nearly seventy years from debilitating symptoms of PTSD due to the horrors they had lived through. This new treatment was succeeding where all other interventions had failed, making a significant improvement in their mental state and quality of life.

Bud and Kara agreed to give it a shot. "We've got nothing to lose but time," Bud said. In fact, as they learned, there was much to gain through time perspective therapy.

PTSD basics

Post-traumatic stress disorder, commonly called PTSD, is an anxiety disorder that begins with a trauma—a horrific one-time event, like Kara's accident; continuing trauma, such as ongoing physical or verbal abuse; or a terrible event in which you have participated, such as war. You can even have PTSD as the result of being a caregiver or aid worker—an emergency room doctor or nurse, or a volunteer worker in a disaster like the earthquake in Haiti or Hurricane Katrina.

Whatever triggered your PTSD, that horrifying, frightening event overwhelms your ability to cope with daily life and may lead to all sorts of symptoms, including distrust, hyper-vigilance (always waiting for the hammer to fall), and hyper-irritability. Hollywood often portrays PTSD as nightmares, flashbacks, and being lost in past experiences to the point of becoming dysfunctional in the present. As one of the Swords' clients puts it, "If it wasn't for my flashbacks, I wouldn't have any memory at all."

All of this and more can be true. But these symptoms are only a fraction of the turmoil that is going on inside sufferers. Inside they are reliving the event over and over again, reexperiencing the very same emotions; they infuse those fears and emotions into each moment, coloring past, present, and future with the same dark ink of fear.

the official definition: DSM-IV-TR criteria for PTSD

PTSD—once called "shell shock" or "battle fatigue" and ignored or dismissed as something that would disappear with time—is now recognized by the American Psychiatric Association as a real disorder. And it is no longer necessary to be a direct victim to be considered as having been exposed to trauma:

> As long as one is confronted with a situation that involves threat to the physical integrity of one's self or others and one experiences the emotions of fear, horror, or helplessness, then the experience counts as exposure to a PTSD-qualifying stressor.[1]

In 2000 the American Psychiatric Association revised its criteria for this disorder in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders,* commonly called DSM-IV-TR:

Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses [current] functioning.

Criterion A: stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

Criterion B: intrusive recollection

The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Criterion C: avoidant/numbing
Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least **three** of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: hyper-arousal
Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least **two** of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

Criterion E: duration
Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criterion F: functional significance
The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.[2]

stuck in time

The term *post-trauma* says it all: the trauma is in the past, but sufferers are unable to leave it behind and move on. They relive the event over and over—in nightmares that make sleep impossible, in flashbacks that have them time traveling back to a horrible past moment, and in recurrent negative thoughts that they cannot stop. This waking nightmare leaves them stuck in time, always running from the trauma and never able to escape. As one of Rick's clients said, "You leave the war, but the war doesn't leave you."

It's not surprising, then, that they are desperate to avoid anything in their present life that might remind them of the past trauma. This avoidance of people, events, places, noises, smells, and even the possibility that they might have to talk about the traumatic event often causes PTSD sufferers to become socially isolated.

They are always on guard because the traumatic event has set the subconscious regulatory forces within the brain—the adrenaline rush of the fight-or-flight response—to permanent ON. The OFF switch is effectively burned out, leaving them perpetually revved up and on edge. They have a hard time unwinding, going to sleep, being still, and recharging. Even the PAUSE switch, needed for reflection, is jammed. This naturally leads to fatigue and exhaustion. They can't think straight. They watch their lives collapse around them like a house of cards.

Their normal coping skills are shot, replaced with irritability, withdrawal, and alienation. Irrationally, they are drawn back again and again to their traumatic past experiences, which are as vivid and real as they were the day they happened—whether that was last week or sixty years ago. Sufferers eventually become addicted to their own adrenaline and excitability. The PTSD state becomes natural, and their anxious, irritable PTSD personality becomes the one they and others accept as real.

psychological responses to catastrophe

Psychological responses to natural and human-caused disasters have been theorized to occur in stages, as victims experience shock, feel intense emotion, and struggle to reorganize their lives.[3] Survivors typically pass through five stages[4]:

1. Psychic numbness. Immediately after the event, victims experience *psychic numbness,* including shock and confusion, and for moments to days they cannot fully comprehend what has happened. Severe, sudden, and violent disasters violate our basic expectations about how the world is supposed to function. For some, the unimaginable becomes a forced new experienced event.
2. Automatic action. During a phase of *automatic action,* victims have little awareness of their own experiences and later show poor recall of many details about what occurred.
3. Communal effort. In the *communal effort* stage, the sufferer and his or her support network pool their resources and collaborate, proud of their accomplishments but also weary and aware that they are using up precious energy reserves.
4. Letdown. Next, survivors may experience a *letdown.* Depleted of energy, they understand and feel the tragedy's impact. Public interest and attention fade, and survivors feel abandoned, even though the state of emergency may continue.
5. Recovery. An extended period of *recovery* follows as survivors adapt to changes created by the disaster.

These stages don't necessarily apply to everyone who experiences a trauma, but they do summarize commonalities across a range of individual experiences. In this sense, they help us understand what survivors may have experienced and what forms of assistance they may need. They also reflect the kinds of profound changes that contribute to PTSD.[5]

this is your brain on trauma

The brain is the most complex organ in the universe. In his book *Incognito, the Secret Lives of the Brain,* neuroscientist David Eagleman says:

> Your brain is built of cells called neurons and glia—hundreds of billions of them. Each one of these cells is as complicated as a city . . . each cell sends electrical impulses to other cells . . . The cells are connected to one another in a network of such staggering complexity that it bankrupts human language and necessitates new strains of mathematics . . . Given the billions of neurons, this means there are as many connections in a single cubic centimeter of brain tissue as there are stars in the Milky Way galaxy.[6]

That's a lot of connections! When we realize the enormous complexity and diversity of the brain, it becomes easier to understand why such all-encompassing problems as PTSD are so difficult to weed out of one's brain, and subsequently to contain in one's psyche.

When traumatic events happen to us, we enter into a kind of altered state in which our normal thinking processes do not function and another operating system takes over. This is great if you suddenly find yourself in a situation in which you must run into a burning building to save someone or risk your life to save team members under fire—your ordinary mind would tell you it's crazy to do such a thing. That altered state is also a necessity if you are struggling to save your own life, whether you have been thrown from a horse, have been beaten by an abusive spouse, or are simply trying to get through each day in a severely dysfunctional family.

But the same system of brain chemistry that allows us to be heroes or survive extreme situations also imprints the traumatic event deeply within our memory, emotions, consciousness, and subconscious. In fact, neuroscience tells us that the brain stores these disturbing memories not just in one place but in multiple diverse locations, both

in the thinking areas of the frontal cortex and in the emotional regions of the amygdala of the hippocampus.

The brain stores and encodes different types of memories, some of which are long-lived and some of which are easily replaced, using different chemicals. For example, the details of what you ate for lunch yesterday may be written in pencil—easily erased and replaced with the details of tonight's dinner—or its aroma may be saved for future remembrance. The name of a person you just met, or the place where you put your car keys yesterday, may be written in the disappearing ink of your short-term memory. But like that tattoo you wish you had never gotten, and that is now embedded forever just under your skin, a traumatic moment is written in permanent ink that will always be part of your long-term memory.

This complex encoding means that traumatic memories, such as those that generate PTSD, are multidimensional, insidious, and difficult to ferret out and come to terms with. The memories assault sufferers in an overwhelming experience that steals their future and leaves them feeling out of control, stuck in a horrible past and fatalistic present. Here, for example, is how Kara's brain stored the traumatic experiences of her traffic accident:

- **Sight.** The gruesome visual images she saw were encoded and stored in her *visual cortex,* in the rear part of the brain.
- **Sound.** The grinding screech of metal and cries of pain and shock she heard were stored in her *temporal lobes,* the sides of the brain above the ears.
- **Smell.** The vivid smells of the event—hot pavement, burning oil, and blood—were stored in the *olfactory cortex,* the part of the brain that lies just behind the eyes.
- **Touch.** The physical pain she experienced was stored in *muscle memory* throughout her body, affecting the pain and emotional centers of her brain.
- **Thought and memory.** The horrible memories of the other woman's suffering, combined with troubling worries about

the woman's toddler and unborn infant, were recorded in the *prefrontal cortex,* where thought occurs, as well as in the *limbic system,* where emotions are stored, that encircles the middle of Kara's brain. She literally carried the trauma with her everywhere, like worn-out, overstuffed luggage.

Figure 1.1 indicates the different parts of the brain that are affected by a PTSD experience.

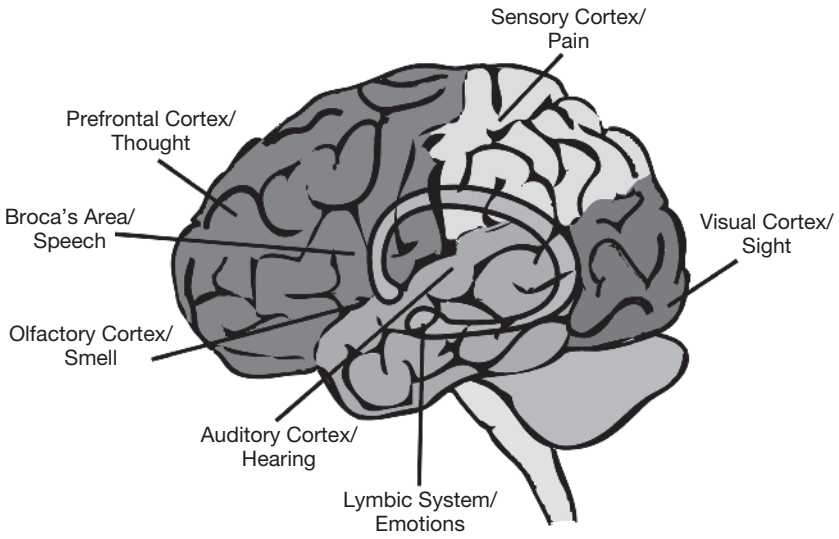

Figure 1.1 **Your Brain on PTSD**

This and other illustrations are based on illustrations by Noah Milich.

when PTSD goes untreated

The experience of PTSD is not the same for everyone. Just as one can be minimally or extremely depressed or anxious, one can suffer from minimal or extreme PTSD. Think, for example, of the range of intensities you have seen in the color blue. In this example, the intensity spectrum of PTSD might range from powder blue (minimal PTSD) to deep cobalt (extreme PTSD).

A person who suffers from minimal PTSD will probably get better over time. For instance, perhaps you've been in a frightening motor vehicle accident in which you didn't suffer physical injury but others did. In time your car is repaired, so you aren't reminded of the accident every time you look at the car. And with a little more time, you can drive by the site of the accident without constantly thinking of the "what ifs": What if I had left home five minutes earlier? What if I had taken a different route to work? What if that hedge had been properly trimmed? With time, you can bleach the pale blue away.

But if you have been brutally physically assaulted and raped, for example, you may be so deeply dipped in the darkest blue of memory that no amount of time will ever completely bleach it away. It might fade a bit, but it's always there; and in some cases, the blue deepens to extreme depression. Almost immediately you start adjusting your thoughts and routines around these dark emotions. And these adjustments cost you dearly. You've kept it a secret, so you don't want to talk about it, much less see anybody. You don't feel good about yourself, so why go to the trouble of trying to look presentable? Because you don't want to see anybody and you don't care about how you look, why go to the gym or take that walk or get out of bed at all? Clearly, Kara ceased caring about her outer appearance because her inner landscape was so tumultuous.

Eventually, the normal things you would do for or with others—going to work, cooking dinner, being interested in what they did that day—become chores that eventually turn into resentment, which causes you to feel irritable and angry toward them. Simple things both at work and at home that would never have bothered you before the trauma—the sound of a pencil tapping on a table, a coworker who throws papers on your desk, finding a parking place in a crowded parking lot, riding the elevator to the office—are now monolithic obstructions that must be dealt with before you can mentally curl up in the fetal position and go over and over the what ifs again and again.

They may seem closed off and uncaring, but deep down inside people with PTSD know they need help. Sometimes getting help seems like one more chore that's just too overwhelming to contemplate. Often they don't get help because they are afraid of being judged, compartmentalized, and deemed mentally ill. And for the rest, fatalism and

cynicism step in and say, "Why bother? Nothing's going to change no matter what you do or what they say."

People with untreated severe PTSD can sink into the deepest, darkest depth of depression with no apparent way out. They don't dare look up, afraid they might find their ugly trauma looking back down at them.

PTSD is mental *injury*, not mental illness

We believe that PTSD should be thought of as a mental injury rather than a mental illness, and research supports this view. Studies show that traumatic experiences can alter the overall structure of the brain,[7] as well as its chemical levels (in particular neurosteroids, which may figure in the body's response to stress),[8] creating and contributing to PTSD.[9]

A study by Alexander Neumeister of Yale University School of Medicine found that veterans diagnosed with PTSD and also suffering a co-morbidity (for example, one or more psychiatric diagnoses, such as depression, anxiety, childhood trauma, or suicidal ideation), had brain images on functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) scans that differed from those of individuals only suffering from PTSD. In summary, "PTSD, depression and substance abuse can all be seen as a physical, chemical injury to the brain that occurs when the brain is exposed to trauma."[10]

The overexcited psychological and physiological state of people suffering from PTSD can, of course, be reduced through medication. And recent research indicates that adding cognitive behavioral therapy to a drug therapy regimen improves the overall results in comparison to control groups.[11] This research makes it clear that the drugs alone are not the best way to go.

This fits perfectly with our philosophy and experience in treating PTSD with time perspective therapy: it is far more effective to teach people to reduce their stress naturally by learning to take control of their own physiology and balancing their own time perspective. When medication helps, it's the meds—not the sufferer—that get the credit for any improvement. When something *you* do makes a difference in the quality of your life, then you can take some of the credit for improvement.

how PTSD affects others

Very often, people with PTSD agree to therapy because their family and friends are worried about them—they are in danger of losing their job, or they get into fights, or they are abusing drugs or alcohol, or their rage is making it very hard for anyone else around them to have a peaceful existence. It is family or friends who typically encourage and persuade sufferers to try a treatment that they were not likely to initiate on their own. This is a common and very sad state of affairs for everyone involved with someone suffering from PTSD.

Imagine the PTSD sufferer as a single drop of water polluted by trauma and all its symptoms: depression, anxiety, avoidance, isolation, fear, anger, and all the rest. This tear-shaped drop splashes into a clear, calm freshwater pond—the person's circle of family and friends—causing ripples that spread out, disturbing the peace of the water and distributing the poison of the trauma throughout the pond. PTSD sufferers don't mean to make waves; it just happens—over and over again. And the effects they cause in their social circles can be enormous and destructive. No wonder they so often choose to simply withdraw into themselves. No wonder their circle of friends often eventually withdraws from their contaminating impact.

Yet when PTSD sufferers isolate themselves in this way, they remove themselves from normal activities and social situations—and that also can affect loved ones negatively. This may mean that children can't talk to their parents or bring friends home, that spouses feel shoved aside and see their own social circle narrow, or that coworkers grow intolerant of colleagues who are rude when they are at work or just don't show up half the time.

People with severe PTSD frequently lose their ability to handle even simple tasks and situations. They can't focus on what is going on around them because they can only see the trauma being replayed over and over in their mind. They are hostages, compulsively bound to the memory of that traumatic moment in time. In this state they might revert to irritability and anger, taking it out on those closest to them. Extreme sufferers may take the show on the road, raging at the waitress

or grocery store clerk, their coworkers, or other drivers they perceive to be cutting them off.

This ripple effect can become a tidal wave of negative, destructive emotions. Friends, family, and coworkers quickly learn to get out of the way. They adapt their behavior and grow sensitive antennae, always on the alert for trouble. The family avoids the sufferer at the first hint of anger. They learn when not to ask for help with his or her homework or for a hand getting the vase out of the upper cabinet. Friends might eventually stop calling because the PTSD sufferer doesn't want to do anything, is "too busy," never shows up, or acts unpredictably. The person behind the counter shrugs and thinks, *What a jerk!* Coworkers stay clear of the "loose cannon." Other drivers on the road may even respond by following the seemingly aggressive driver home and beating him or her up. PTSD affects not only the sufferer but also, to some degree, everyone in his or her world—for the worse.

why PTSD has been so hard to treat

The National Institute of Mental Health estimates that 7.5 million adult Americans currently suffer from PTSD. It is "the most common mental health disorder" among veterans of the conflicts in Iraq and Afghanistan,[12] but it is a problem for veterans of all wars.

Because so many military personnel are men, PTSD tends to be associated with husbands and sons who go off to war and return to their home and family as "zombies" or loose cannons, seeming changed forever by their experiences. But as we have seen in this chapter, women also suffer from PTSD. According to the National Center for PTSD,

> Findings from a large national mental health study show that a little more than half of all women will experience at least one traumatic event in their life . . . The most common trauma for women is sexual assault or child sexual abuse. About 1 in 3 women will experience a sexual assault in their lifetime. Women are also more likely to be neglected or abused in childhood, to experience domestic violence, or to have a loved one suddenly die.[13]

For various reasons, an enormous number of adult Americans—both men and women—are currently suffering from PTSD. And until now psychology has had a very difficult time helping people with PTSD do anything more than learn to cope with their symptoms or medicate the worst of the pain. The following therapies are currently used to treat PTSD:

cognitive behavioral therapy

Cognitive behavioral therapy (CBT), a blend of behavioral therapy and cognitive therapy, focuses on the here and now. To date, it has been the therapy with the most success in overcoming trauma. A talk-based therapy, CBT aims to problem-solve around intense abnormal emotions, behaviors, and thoughts through a methodical, goal-oriented approach. Used in both individual and group therapy, the techniques often include keeping a journal of events and related feelings, thoughts, and behaviors, and implementing different reactions and behaviors.

cognitive processing therapy, prolonged exposure therapy, and virtual reality therapy

Cognitive processing therapy, prolonged exposure therapy, and a new modality called virtual reality therapy are currently employed by the Veterans Administration to treat veterans suffering from PTSD. In all three processes, the veteran relives past military traumas in an attempt to extinguish the negative emotions associated with his or her traumatic military experience.

Sadly, many veterans who have undergone prolonged exposure therapy and cognitive processing therapy have become psychological casualties. Only one veteran who was a client of the Swords shared that these therapies were positive experiences that helped him feel better about himself and his future. The rest of our veteran clients (like Alex, whose story is told in this chapter) reported that these therapies made them regress in gains they had been making through the time

perspective therapy process. They reported an increase in nightmares, flashbacks, social isolation, and anger, as well as suicidal and homicidal thoughts. A number of veterans reported that these processes made them so angry that they returned to their earlier coping skills of hostility and violence.[14]

alexs perspective: a desert storm vet 's experience with cognitive processing therapy and prolonged exposure therapy

Operation Desert Storm, also called the Gulf War, was waged from August 1990 to February 1991. As wars go, it was relatively quick. But for vets like Alex, it never ended.

Over the course of four years, Alex thought he had been making good progress coping with his chronic and severe PTSD. In hopes of making even more progress, he underwent cognitive processing therapy (CPT) and prolonged exposure therapy (PE). In September 2010, after he completed CPT and had tried PE, he wrote this statement to the Veterans Administration:

> I thought [CPT] would be a good step forward, but it wasn't. The can of worms that was tucked away for so long, way back on the top shelf, that I had somewhat managed to control was ripped wide open and the floodgate of emotions and imagery overwhelmed me once again. I suffer a constant barrage of flashbacks and dreams—more so with watching the news footage and death tolls of the Iraq and Afghan Wars. Feeling the guilt and remorse eating at me, knowing all of this should have been prevented if we had just finished the job the first time when we were there in 1991. The CPT process put me back into a state of mind parallel to my original experiences. My mind tells me one thing, but the emotional onset overrules all thought processes.
>
> After CPT, I was asked to partake in Prolonged Exposure Therapy which I was very reluctant to attempt. But after completion of the third session it proved to be a complete disaster. My mental state leaving each session and then having to go deal with the day-to-day grind of my job and home life proved to be just overwhelming. I am in a constant state of rage; everything sends me into an uncontrollable spiral taking out my anger and frustrations on whoever is in front of me at the time. I find myself not

being able to be the bigger man [Alex is 6'7'' tall] and walk away from situations and confrontations. I've reverted back to old habits of self-medicating with alcohol to lessen the sting of the pain and images that haunt me once again—day and night. This is not setting well with my wife; she's seen the results of my alcoholism post Desert Storm to 1991. It wasn't a pleasant road I took my wife and family down. She told me point blank this time around she refuses to travel it again, and if I continue I'll do it alone.

I continue to receive phone calls from my superiors verbally reprimanding me for customer complaints of me being too rigid and stern, unwilling to give, too military; customers threatening to pull out of the business if I don't back down. Knowing that I will be replaced way before they lose a customer. My job entails driving . . . but since CPT and PE, driving puts me in imminent danger. My wife refuses to ride with me if I'm driving and hates it when I am the passenger. But I just don't care. I'm tired of struggling to be everything for everybody and if I can't live up to everyone's standards to include the ones I set for myself—why bother . . . This process is definitely not Veteran friendly.

For vets like Alex, CPT and PE were like psychological water boarding.[15]

drug therapy

For the past several decades, drug therapy has been a common approach to the treatment of anxiety, depression, trauma, and other behavioral disorders. We agree with Youngstown State University professor Stephen Ray Flora, whose fields of expertise are applied behavioral analysis, behavioral intervention techniques, and human learning, who assessed that ''when behavior is out of balance, the body, including the brain, gets out of balance.''[16] When the behavior comes back into balance, then the body and brain return to balance. But Flora states unequivocally, ''There are no drug 'cures' for behavioral problems.''[17] Drugs have provided some help, but they're certainly not a panacea. In addition, numerous studies have found that adding pharmacologic treatments to CBT did not enhance the overall end result.[18] Meds may,

at best, keep the experience from getting worse, but they do not make it any better.

The assumption is that the medications will break up the non-functional pattern of thought, allowing the individual's mental health to return naturally; but this is an overly optimistic assumption. Drugs do not get to the root of the problem. They are a temporary solution that alters behavior, *but drugs do not address the cause.* Predictably, the behavior often returns when the drugs wear off, leaving the PTSD sufferer feeling like nothing will ever change, or simply wanting to use the drugs to mask the pain. Also, when drug therapy does not work, that further promotes a fatalistic perspective that nothing can alter the deeper suffering being experienced.

does critical incident stress debriefing work to head off PTSD before it begins?

Critical Incident Stress Debriefing (CISD), first developed by Jeffrey Mitchell,[19] is sometimes mandated as a treatment for first responders and victims in a number of organizations, including some police and fire departments. The point of this early intervention strategy is to clear the trauma from the brain soon after the incident, defusing PTSD before it has a chance to get ingrained. It seems to make sense, and many believe that it does. Yet despite CISD's popularity, the question of whether it actually works is still hotly debated.

CISD is based on Freudian therapeutic catharsis, whereby a client works in conjunction with a trained psychotherapist in a safe environment. Therapeutic catharsis is careful, controlled, and geared to the client's readiness. When the therapist believes the timing is best for encouraging the client to open up emotionally, psychological catharsis can be very healing. CISD, in contrast, is forced on a group of strangers as soon after the common traumatic event as possible. In addition, listening to the traumas of others adds to the PTSD sufferer's already bleak worldview, further embedding the negative emotional experiences in his or her amygdala.

Although CISD is intended to head off PTSD before it begins, at least seven studies and a meta-analysis reveal that it either does nothing at all or can make PTSD symptoms worse.[20] According to a recent report,

> psychological debriefing—the most widely used method—has undergone increasing empirical scrutiny, and the results have been disappointing. Although the majority of debriefed survivors describe the experience as helpful, there is no convincing evidence that debriefing reduces the incidence of PTSD, and some controlled studies suggest that it may impede natural recovery from trauma. Most studies show that individuals who receive debriefing fare no better than those who do not receive debriefing.[21]

why reliving trauma only goes so far

Research indicates the importance of stories or *narratives* in working through catastrophic experiences. To learn from and make sense of catastrophic loss, our brain naturally formulates an account that describes what happened and why. We are especially likely to develop narratives when an event is surprising or unpleasant,[22] or when it violates our basic expectations.[23] Narratives help us find meaning in loss, which in turn facilitates healing. Given this, you might wonder why traditional psychology—which regularly uses life narratives—has had such a difficult time dealing with PTSD.

Perhaps the reason is overreliance on these stories.

In general, these methods aim to fight fire with fire: they return again and again to the terrible things that happened in the past to try to desensitize the sufferer. For instance, a cognitive processing therapy psychotherapist might ask Kara to speak and write about her trauma numerous times, and then again from various perspectives. First she might write a description of the trauma, and then she would describe what was happening to her physically during the trauma. Then Kara might write about her emotional state during the trauma, how she felt physically right after the trauma, how she felt emotionally right after the trauma . . .

In traditional PTSD therapy, clients must relive the trauma over and over again. Although this may be an effective treatment for some,

the Swords have found that it is more often detrimental to many of their clients. Reliving trauma—which the PTSD sufferer already does every moment of every day, awake or asleep—is painful. *It hurts.* And we all want to avoid pain. To go back in time is painful, yet the present and future seem hopeless. It is not surprising that outcomes from traditional PTSD therapy have been partial at best.

time perspective therapy transforms past, present, and future

Time perspective therapy takes a different approach entirely. It begins by respecting the trauma for what it can teach us rather than dwelling on how it harmed us. This idea, a positive reframing of the event, reflects the ancient Japanese tradition embodied by the veterans of the 442nd Regimental Combat Team. This famous regiment was composed mainly of Japanese Americans and Japanese Hawaiians—many of whom had been classified as enemy aliens, despite the fact that they were U.S. citizens.

Thousands of Japanese Americans living in the continental United States were forced by their own U.S. government to leave their homes, their schools, and their businesses and live in internment camps. Mothers, fathers, sisters, brothers, cousins, aunts, and uncles lived in these camps for the duration of World War II. Yet many young Japanese American men volunteered to fight for the U.S. Army in the war. These men were true patriots. They not only served with distinction but also became "the most decorated unit in U.S. military history for its size and length of service. There were over 18,000 individual decorations for bravery, 9,500 Purple Hearts, and seven Presidential Distinguished Unit Citations."[24] Many of the members of this group, known simply as the 442nd, who survived the terrible battlefields of World War II were afflicted with undiagnosed PTSD; yet, unlike many other war veterans, they were able to come out and continue their positive, "go for broke" spirit in civilian life.

Rick and Rose were honored to meet many of these men, and to know some as clients. And they were intrigued. Why, they wondered, were these men able to remain so positive when the other American veterans would tend to talk about the bad things in the war and how they affected them? The vets of the 442nd would reminisce about the good things that happened to them during the war, the funny moments, and how they enjoyed each other, and they would talk about how they are working for a better future. Their focus on the positive aspects of the past helped them create a positive future. "We look to the past to learn," they told Rick, "but we focus on creating a better future for ourselves and our children."

This nugget of truth was the genesis of what would become a new kind of therapy—one that would fit well within the framework of Philip Zimbardo's work in Temporal Theory. Time perspective therapy understands that we each have a *unique time perspective* based on our personal experiences, and this perspective is the lens through which we view our lives. But our experiences do not need to lock us into a particular way of seeing the world and our place in it—particularly when that way of seeing things is destructive to ourselves and to those we love. No matter what our experiences have been, *we always have a choice.* By changing our time perspective, we can change our lives. For PTSD sufferers, this means gaining the real and lasting ability to move beyond the terrible past and live in a healthy balance of past, present, and future.

The realization that we always have the choice to change how we view the times of our lives is essential to this orientation. Over the course of this exciting new therapy, PTSD sufferers move away from a narrow focus on the traumatic past and a cynical present denial about the possibility of ever achieving a hopeful future, instead journeying toward a balanced time perspective in which it seems possible once again to live a full and promising life.

This concept is reflected in ordinary language that time perspective therapists use. Most people suffering from PTSD have already been labeled as anxious, depressed, or even mentally ill. When they hear these

words, and identify with them, the possibility of ever emerging from such a state feels very distant. Reframing their "illness" as an "injury," and recasting their depression and anxiety as a "negative past" that they can replace with a "positive present" and "brighter future"—and ultimately with a balanced time perspective—may seem overly simplistic, especially to those of us trained in psychotherapy. But to PTSD sufferers, the idea of having a forward-leaning framework in which to understand and work on their issues most often comes as an enormous relief and a welcome ray of light in the darkness.

seeking balance

The goal of time perspective therapy is to establish a balanced time perspective of past, present, and future. The therapist helps the PTSD sufferer move from mental distress—from a time perspective that is seriously tipped toward the negative past—to a time perspective in which a brighter future can be imagined and enabled. To understand this view, take a look at Figure 1.2.

The illustration at the top of Figure 1.2 shows a time perspective typical of someone suffering from PTSD: the negatives of the past—all that junk we carry around with us—far outweigh hopes for a better future. In fact, the future seems to be full of nothing but questions without satisfactory answers. And the balance point of the present is so far removed from the past that it leaves very little room for any kind of future at all. This is the starting point for most people with PTSD when they begin time perspective therapy (TPT).

As TPT progresses, however, the overflowing junk heap of our past begins to get sorted out. We still carry around some bad memories, but they have become more manageable, smaller, and less burdensome "baggage" rather than an overflowing dumpster of despair. In response to this lighter load, the balance point of the present is able to move closer to the center. Now the future has room to exist, and we are able to create some positive hopes and plans to balance out the negative past.

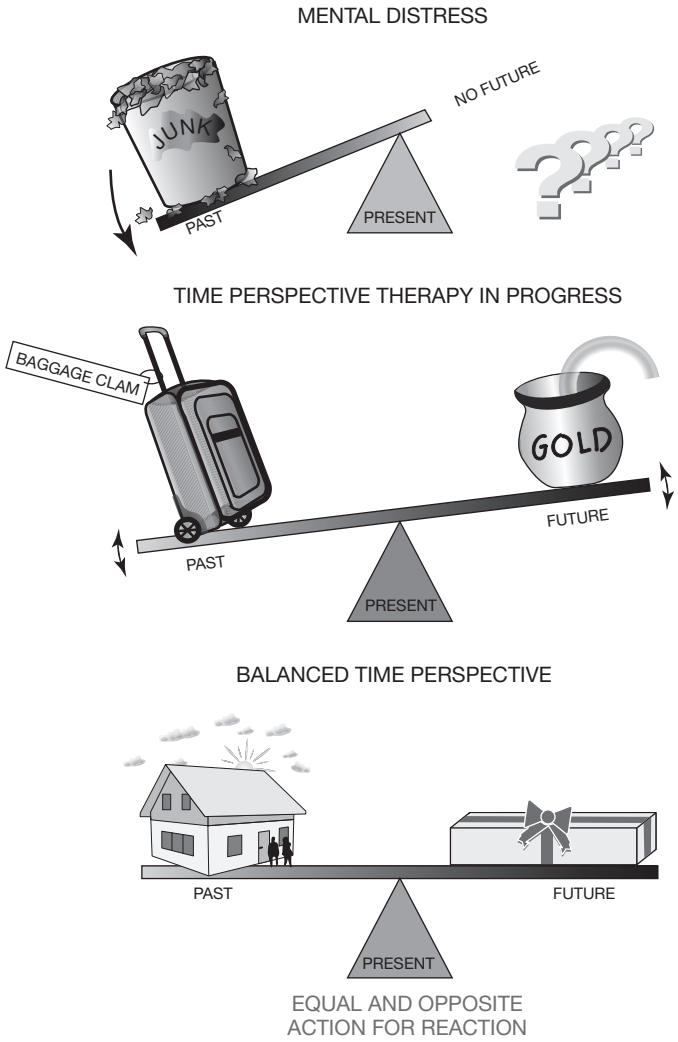

Figure 1.2 **A Question of Balance?**

As we move forward into a more balanced time perspective, we learn to live in the present. The junk of the past has been removed, allowing us to retrieve the more positive memories. And there is now plenty of room in the future not only to plan and dream but also to realize some of those dreams down the line. This seesaw of time balances perfectly when the present acts as the balance point. Living in the present allows us to realize that we can make plans for the future and make peace with our past.

Now we can once again connect to ourselves as well as to our family, our culture, and our legacy. From the present we gain the energy to explore our universe, to seek what is novel and stimulating. From the future we gain the distant vision to soar to new realms of experience, to become whatever we can imagine. In that temporal balance we uncover not only the ideal treatment for PTSD but also a code for the fullest appreciation of our lives and the new guide to realizing our fullest potential—for all of us.

The positive effects of time perspective therapy are real. Not only has TPT been shown to work but also *its benefits last over the long term.*

In this book you will learn about Kara's experiences with TPT, and will read the stories of other men and women who have recovered from PTSD. In the next chapter, you will learn about the revolutionary psychological structure that gives TPT its power: Zimbardo's Time Paradox, a new psychology of time. You will also get a chance to discover your own time perspective by taking the Zimbardo Time Perspective Inventory, an invaluable psychological tool in treating PTSD and other issues.

to sum up

- Post-traumatic stress disorder, or PTSD, is an anxiety disorder that begins with a trauma and overwhelms the individual's ability to cope with daily life. An estimated 7.5 million adult

American men and women currently suffer from PTSD. It is a problem for veterans of all wars.

- PTSD sufferers are "stuck in time," reliving the trauma over and over, unable to leave it in the past and move on.
- With PTSD, the traumatic event is imprinted and stored in many different parts of the brain, which is one reason why it is so difficult to treat.
- It is much more helpful to view and treat PTSD as mental injury rather than mental illness, and research supports this view.
- PTSD doesn't only affect the sufferer; it can negatively affect the sufferer's family, friends, coworkers, and entire social network.
- To date, cognitive behavioral therapy (CBT) has been the therapy with the most success in overcoming trauma. This therapy focuses on the here and now. Drugs have provided some help, but not enough. They are a temporary solution that alters behavior, but they do not address the cause.
- Although all therapies are time based, time perspective therapy takes a different approach. It begins by respecting the trauma, and seeks to create a balance of past, present, and future that allows the PTSD sufferer to leave the past in the past and move toward a more hopeful future. TPT works in the context of Zimbardo's Time Paradox, a new psychology of time.

now it's your turn: past negative to past positive

Find a comfortable position in a safe place, and allow yourself five uninterrupted minutes to replace some of your bad or negative memories with good ones.

Close your eyes. Breathe slowly, deeply, and rhythmically. Allow your body to relax deeper and deeper with each breath.

Once you've completed four of these relaxing breaths, imagine going back in time to the first good memory that comes to mind. This memory may be from yesterday, last week, last year, or as far back as your childhood. Recall as much as you can about this experience: who was there, the time of day, where you were, a particular smell or aroma associated with the event, and so on.

Now move on to the next good memory that comes to mind. And then the next.

You may find this difficult to accomplish at first, especially if you have undergone severe trauma. And it may not happen in the first five minutes of your first attempt. But we've found that once you've remembered one good memory, the next is usually easier.

Just as James learned to replace some of his bad slides with good ones in the ''Kodak Carousel'' of his mind (see the Introduction to read this story), you can begin to draw on your own happy memories to sustain you during tough times.