CHAPTER 1

Introduction

In this book, we describe the background, rationale, and procedures for "adaptive disclosure," a novel treatment approach for war trauma developed specifically for active duty service members and veterans (Gray et al., 2012; Steenkamp et al., 2011). The aim of adaptive disclosure is to help service members and veterans recover and heal from combat stress injuries and posttraumatic stress disorder (PTSD). It promotes coming to terms with the meaning and implication of the three core types of traumatic war experiences (life threat, loss, moral injury) and reduction of damaging ways of construing their long-term impact.

A key assumption of adaptive disclosure is that dangerous combat and operational experiences such as life threats that elicit fear are not the only source of psychic injury during warfare. This supposition runs counter to the central and often exclusive role that life-threatening trauma and the fear-conditioning model play in extant conceptualizations of the mental and behavioral health consequences of war trauma, chiefly PTSD and the treatment needs of service members and war veterans. Indeed, this state of affairs has been codified in the newest iteration of the PTSD construct (American Psychiatric Association, 2013). In the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5), the only stressor necessary for PTSD entails experiences with death, life-threat, and actual or threatened serious injury (including sexual violence). Although in DSM-5, PTSD is technically no longer classified as an anxiety disorder, it remains a condition that is danger- and threat-based.

Conceptually, adaptive disclosure stems from our belief that family members, service members, clinicians, and communities need to appreciate that dangerous life-threatening experiences in war are not the only potential source of mental, physical, and spiritual injury for combatants. Because of training, professionalism, leadership, support, and the military culture and ethos, dangerous combat experiences may actually not be traumatizing for many service members and may be the least impactful for many veterans over the lifespan. Unlike civilian traumatic event contexts, there is good reason to assume that most threat-based stress reactions are mitigated by military preselection and tough and realistic training and preparation, and, when present, are healed by indigenous military rituals and assets. For example, peer and social supports, subsequent training and preparation, and effective leadership are arguably sufficient to recover from high-danger experiences. There are systematic opportunities for service members exposed to war zone dangers to get respite, unburden, and vent their thoughts and feelings about the experience, and strengthen bonds and derive meaning from the experience by sharing narratives about danger—all of which are resonant with the warrior culture and ideal. In learning theory terms, leaders in the theater of operations typically ensure sufficient exposure to high-fear contexts to provide natural extinction of conditioned fear and exposure to corrective mastery experiences that thwart the development of problematic schemas (beliefs) about safety and control. Even when service members develop a life-threat-based stress injury in theater, arguably the most pressing problem is not high states of fear and arousal, but rather the self-condemnation and guilt that may arise from letting peers and leaders down because of a perceived or real temporary incapacitation in the field. If indigenous mechanisms of recovery are inadequate to resolve danger-based sequelae, conventional exposure-based therapies are likely to be highly effective (Foa, Keane, Friedman, & Cohen, 2008). In contrast to danger-based experiences, there are arguably fewer indigenous military resources to prepare for traumatic loss and to promote resilience and recovery in the face of loss of life (especially the survivor guilt that can ensue; see Pivar & Field, 2004). There are even fewer resources to mitigate and heal the lasting impact of perpetrating, failing to prevent, or bearing witness to war zone acts that produce inner conflict because of moral compromise, that is, "moral injury."

Adaptive disclosure is unique because it employs cognitive-behavioral therapy (CBT) and other therapeutic strategies to target not only life-threatening trauma, but also traumatic loss (and attendant

guilt), and inner conflict produced by moral injury associated with shame and self-handicapping behaviors (Litz et al., 2009; Stein et al., 2012). Adaptive disclosure is designed to help service members and veterans experientially and emotionally process these divergent types of war zone harms, traumas, and losses. The goal is to help service members and veterans gain exposure to corrective and more productive ways of construing the implications of diverse war experiences in terms of their military (or newly found civilian) identity, how they feel about themselves, how they relate to other people, and how they construct a narrative about their future. The assumption is that each of the three war-related principal harms depicted in Table 1.1 entails distinct peri-event reactions, phenomenologies, and unfolding need states and motivations, as shown in this table, and downstream behavioral, psychological, biological, and spiritual impacts (Litz, Steenkamp, & Nash, 2014).

In adaptive disclosure, we ask the question "What do service members and veterans need to heal and recover from the three different harms?" The answer to this question guides the choice of change agents in the therapy.

At the start of the therapy, service members or veterans identify a military experience that is currently haunting and consuming them. This experience is categorized as a *life-threatening event,* a *traumatic loss,* or a *moral injury.* At its core, adaptive disclosure entails exposure-based, experiential and emotion-focused processing of this principal combat or operational experience and a real-time rendering of constructions

TABLE 1.1. Distinguishing Elements of the Three Principal Harms

	Event type		
	Life threat	Loss	Moral injury
Peri-event reactions	Fear, horror, helplessness, panic, dissociation	Sadness (or numbness), rage, shock, anguish	Guilt, shame, rage
Phenomenology	Anxiety, stress, conditioned emotional response	Withdrawal, guilt, haunted	Unforgiven, self-handicapping, anomie
Unfolding need and corrective elements	Safety, mastery, confidence	Reconnection, reengagement	Forgiveness, compassion

about the implications of the event in terms of self-view, professional role (especially if on active duty), expectations about others, and the future. For all trauma types, as with other CBT-based approaches, adaptive disclosure provides a sober but hopeful, evocative, and emotion-focused opportunity for service members and veterans to realize how they have changed as a result of combat and operational experiences, to think about who they want to be, and to get a sense of how to get there experientially. Unlike other CBT for PTSD, adaptive disclosure individualizes treatment for service members with PTSD by employing different strategies to target danger-, loss-, and moral injury-based principal war zone harms.

Life-threatening or danger-focused harms lead to generalized expectancies of future harms and dangers. The needs that arise from intensely horrifying experiences are validation and understanding from others about the legitimacy and universality of vulnerability; comfort; and the expectation of safety, self-control, mastery, and competence. For life-threatening harms, exposure therapies, principally prolonged exposure (PE), are the treatments of choice on conceptual and empirical grounds (Foa et al., 2008). Consequently, the approach to life-threatening harm in adaptive disclosure is similar to that in PE. For events that are loss-related or morally injurious, separate breakout strategies are used to foster exposure to corrective experience and new learning specific to these dynamics.

The unique needs that arise from attachment loss vary with the quality and dependency of the relationship and whether the loss is unexpected, and especially, whether it is due to violence. If a service member or veteran is haunted by a war-related loss, it is safe to assume that the relationship was powerful, that it was due to violence or a tragic circumstance of some kind, and that the person may feel responsible in some way or feel guilty about surviving. The needs that are acquired over time are successful connection and reconnection with healthy and positive attachments, reengagement in pleasurable activities and wellness behaviors, self-forgiveness, and finding ways of paying respect and honoring the lost person. For loss, after an exposure component, which entails raw emotional processing of the loss and a disclosure of unfiltered thoughts about the meaning and implication of the loss (usually self-blame and guilt), adaptive disclosure entails a dialogue in imagination with the lost friend. The aim is for the patient to acknowledge the loss's impact and meaning in real time to the lost friend, then also to voice what the friend says about this in real time. The goal is to promote an emotionally charged accommodation of the

corrective "messages" voiced by the friend who would only want the patient to live well.

If a service member or veteran seeking treatment for putative PTSD endorses a moral and ethical transgression, especially an act of perpetration, he or she is likely to be consumed by shame and guilt, struggle with feelings of unworthiness and anomie, and may be self-handicapping and potentially self-harming (Litz et al., 2009). Needless to say, these experiences are uniquely tarnishing and toxic. The needs that are accessible and at the forefront for patients are antithetical to, and perhaps negate, healing—namely, to suffer, to be punished, and to be unforgiven. What we should infer is that there are deeper needs to be forgiven in order to have self-compassion, and to correct, to make amends. Ideally, service members and veterans recommit to prior values and belief systems and can identify a path forward—a path based on the knowledge that a regrettable action need not be destiny. In adaptive disclosure, we attempt to expose patients to *corrective* learning experiences that counter harm-specific self- and other-expectations. Rather than focusing on (exclusively) reliving a morally injurious event or helping the patient dispute the accuracy of beliefs implicated by the event (as is done in other CBT), one of the main change agents in adaptive disclosure to redress moral injury is an evocative imaginal "confession" and dialogue with a compassionate and forgiving moral authority in order to begin to challenge and address the shame and self-handicapping that accompany such experiences. There are also homework assignments to begin the process of being exposed to goodness, repairing by giving back, and so forth. The assumption of adaptive disclosure is that the treatment starts, but cannot finish, the moral repair process. The goal is not to attempt to eradicate or fully replace self-constructions of moral compromise; this would be impossible. The goal is to foster balance. Adaptive disclosure attempts to help patients accept the part of themselves that did or was subjected to bad acts, without attempting to modify constructions about culpability and the moral implications of the events. At the same time, the therapy is designed to help patients reclaim goodness and humanity, and to have those parts manifested in their lives, we hope, as prominently as possible. Ultimately, the expectation is that self-forgiveness and accommodating the possibility of also living a moral and virtuous life requires life course changes for most veterans of war.

Implementing adaptive disclosure requires clinicians to have a firm grasp and understanding of the military ethos and culture. In addition to providing a background and rationale for the treatment

approach, it is our hope that this book will educate care providers about military values and identity as a platform from which to understand the presentation of a patient and the goals of treatment. The book is designed to help care providers across disciplines (social workers, counselors, psychologists, psychiatrists) in any context (in and outside the Departments of Veterans Affairs and Defense facilities) learn and apply the therapy to service members and veterans who need help recovering and healing from various combat and operational experiences. The book is also designed to educate care providers about the military culture and ethos, military trauma, loss, and moral injury, and to be prepared to help service members who report having problems that stem from loss and moral injury in whatever model of care they use.

BACKGROUND

Approximately 10–20% of the 2 million U.S. troops who have served in the wars in Afghanistan and Iraq experience significant mental health difficulties including PTSD, depression, and anxiety (e.g., Hoge et al., 2004; see Litz & Schlenger, 2009). Because PTSD and other mental and behavioral health problems among veterans of war are pernicious and disabling (e.g., Dohrenwend et al., 2006; Kulka et al., 1990; Prigerson, Maciejewski, & Rosenheck, 2001), a major public health challenge is to redress military trauma-related problems as early as possible and to prevent spiraling dysfunction, suffering, premature discharge, and chronic problems over the life course (see Litz & Bryant, 2009).

While limited, evidence-based mental health treatment such as CBT may be available to some service members in theater (see Cigrang, Peterson, & Schobitz, 2005). For most service members, the most viable and prudent time to provide early treatment is postdeployment, while they are in garrison (at their home base). However, during this time, service members are busy with demanding training regimens and preparations for subsequent deployments that absorb a good deal of attention and mental effort. Consequently, service members' needs and availability for care differ from those of patients receiving trauma-focused CBT in civilian and veteran outpatient settings. Not only is service members' time limited but also their inclination to focus on emotional and psychological matters is constrained by the understandable need (and social and occupational pressures) to "carry on."

Although there is ample evidence that CBT strategies such as PE

and *cognitive processing therapy* (CPT) are effective PTSD treatments among civilian motor vehicle accident and sexual assault survivors (see Foa et al., 2008), these approaches have been shown to be *substantially* less efficacious with complex military trauma (e.g., Rauch et al., 2009; Ready et al., 2008; Schnurr et al., 2007; see Steenkamp & Litz, 2013). We argue that this is the case for at least two reasons, each of which we have tried to redress in the adaptive disclosure approach.

Many care providers in the military and the U.S. Department of Veterans Affairs (VA) have not adequately considered the unique cultural and contextual elements of military trauma, the phenomenology of service members' lived experience, or the clinical issues that arise from combat and operational stressors, such as traumatic loss and experiences that are morally compromising. Too often clinicians assume that life-threatening war zone experiences are necessary and sufficient to explain their patients' experiences and what requires redressing in therapy. They are at risk for failing to realize the contribution of military features, such as leader actions or the quality of connections to unit members. Furthermore, in our opinion, there are significant missing elements in the current CBT care models with respect to treating war trauma.

When considering possible limitations in the application of current CBT treatment models, several factors become apparent. First, it may be argued that in the context of war veterans, CBT may be less effective because the network of war memories is not sufficiently evoked or accessed, and it is possible that without special considerations and tactics in the therapy, the characteristics of war trauma and war veterans preclude sufficient emotional processing and engagement in CBT (see Foa, Riggs, Massie, & Yarczower, 1995). Furthermore, we posit that clinical trials of CBT for complex, war-related PTSD may be disappointing, in part, because the treatments evaluated are based on learning and social-cognitive models developed to account for pervasive and sustained fear and anxiety-based responses to personal life-threat or victimization (e.g., Friedman, 2006). We argue that existing CBT does not sufficiently address the needs of war veterans, because the fear conditioning and learning model (e.g., Foa & Riggs, 1995) and similar cognitive (Ehlers & Clark, 2000) and social-cognitive constructivistic models (e.g., McCann & Pearlman, 1990; Resick & Schnicke, 1993) do not sufficiently explain, predict, or address the needs of many service members and veterans who are exposed to diverse psychic injuries of war. Service members not only face life-threatening, highly fear-based trauma, but they are also exposed to horrific losses and morally injurious

experiences (Nash, 2007). The grief problems that arise from traumatic loss and moral injuries have phenomenology, course, and maintaining factors that are distinct from fear-based traumas (Prigerson et al., 2009; Litz et al., 2009). Indeed, in our view, there has been a false, tacit assumption of the equipotentiality of widely varying types of traumas and traumatic contexts (Litz, 2014). For example, until recently, clinical researchers have assumed that if treatment works well with patients who have experienced civilian traumas (e.g., female rape victims), then this provides sufficient evidence that the approach as generated and tested is sufficient for deployed service members and war veterans.

We created adaptive disclosure to augment and extend existing, well-established treatments for fear-based events to target directly the complications related to moral injury and traumatic loss, as well as life-threatening trauma. In the process of developing the treatment, we considered different treatment targets and mechanisms of change, and incorporated additional intervention strategies.

ADAPTIVE DISCLOSURE

Adaptive disclosure was developed originally for active duty service members seeking care in-garrison (Steenkamp et al., 2011). We selected the term "adaptive disclosure" for two reasons. First, we wanted a name for the approach that did not employ the terms "treatment" or "therapy" because of concerns that this would deter service members who are reluctant to view their problems within a medical model. Second, the term "adaptive disclosure" captures a core goal of the therapy, namely, sharing and processing memories of war zone experiences in a therapeutic manner. In this sense, the approach is a hybrid of existing CBT strategies, specifically, a form of exposure therapy (imaginal emotional processing of a seminal event) that also incorporates some techniques used in other cognitive-based treatments (e.g., CPT), as well as techniques drawn from other traditions (e.g., Gestalt, psychodynamic therapy, mindfulness). Adaptive disclosure extends traditional cognitive and behavioral strategies by integrating them with techniques drawn from other traditions, and packaging and sequencing these techniques to address specifically the three most injurious combat and operational experiences: life-threatening trauma, traumatic loss, and experiences that produce moral injury and inner moral conflict (see Stein et al., 2012).

The therapy consists of eight 90-minute weekly sessions, which is

considerably shorter than standard CBT, in order to accommodate service members' time constraints and potential for deployment or relocation. Importantly, the treatment can be expanded as needed if duration constraints are not relevant. The first session is used to evaluate service member's current status, to establish the event to be targeted (the most currently distressing, haunting, and impairing), to educate the patient about adaptive disclosure, and to establish realistic goals. The middle six sessions incorporate an imaginal exposure exercise whose aim is to facilitate emotional processing of the war experience, unearth relevant associations, and help the service member or veteran to articulate his or her raw, uncensored beliefs about the meaning and implications of his or her experience. If the core event is life-threat-based, these sessions are very similar to PE. However, in cases of moral injury or traumatic loss, after the basic emotional processing of the event, separate experiential "breakout" sessions are employed. In these breakouts, participants are encouraged to engage in imaginal conversations with a key "relevant other" such as the deceased person being grieved or a respected, caring, compassionate, and forgiving moral authority. In developing the treatment, we were especially concerned that sustained and repeated emotional processing of memories of loss or moral injury would be counterproductive, if not harmful, if unaccompanied by additional learning linked directly to the specific psychological injury (e.g., shame, guilt, betrayal). Consequently, the goal of the breakout sessions is to engender alternative emotional experiences that plant corrective information such that the experience and internalization of the original trauma is modified positively. Because self-condemnation is common—especially in instances of moral injury—these imagined dialogues offer important opportunities for perspective taking and experiencing forgiveness. The mechanics and the flow of the middle six sessions are depicted in the schematic in Chapter 7. The last session is used to review experiences, underscore positive lessons learned, and plan for the long haul in light of what was learned or at least touched upon in the sessions.

Foundational Assumptions for Adaptive Disclosure

Adaptive disclosure is predicated on a number of core assumptions and preconditions. First, adaptive disclosure is specifically designed to train care providers to understand, honor, and accommodate the military ethos, and the unique phenomenology of war trauma among service members who may be struggling, yet preparing for their next

deployment or their military roles. We also assumed that if clinicians were knowledgeable and empathic about the military culture and were reasonably well prepared to hear about any dimension of warfare and the war experience, then service members would be more willing to build trust and feel confident that the intensively evocative and challenging disclosure and experiencing that adaptive disclosure requires are worth it.

Second, we based our approach on the premise that when treating active duty troops in garrison, the goal of the therapy should be to create a foundation for healing, repair, and recovery by presenting the treatment as an introduction of a different way of dealing with the psychological, behavioral, and spiritual legacy of combat and operational events, rather than an an endpoint. We believe that for many service members the idea of total cure or complete eradication of symptoms is unrealistic; a number should prepare themselves for lifelong challenges, especially in the context of traumatic loss or moral injury. Additionally, the complexity of the life course challenges related to exposure to war trauma, traumatic loss, and moral injuries, and the extensive treatment necessary to address these issues fully would be difficult to sustain while service members are training or otherwise preparing for future deployments.

Third, we assume that active duty service members and veterans who are new to treatment are not well-versed in sharing and disclosing their experiences. We expect that veterans' narratives will often be disorganized and unduly limited. Consequently, we assume that narratives of war zone events need to be uncovered; there is likely more to the story than the service member is willing or able to share or articulate at the start of treatment. When developing the therapy, we were mindful that disclosure and processing of shame- or guilt-based experiences would typically require more time and the development of a trusting therapeutic relationship. Yet we also knew that we did not have a lot of time to do the preparatory relationship and trust building. We assumed that honoring, respecting, and understanding the military ethos, utilizing a "no-nonsense, let's get right to it" experiential approach, and targeting issues that would resonate deeply with stress-injured service members would create a trust that would otherwise take much longer to cultivate. In this book, we provide extensive information about the military values and culture, and the multidimensional nature and sources of combat stress injuries.

Fourth, ultimately, *meaning making* is an essential change agent in all forms of psychotherapy. We were therefore especially keen to

employ strategies to help service members *uncover* and clarify the *unfolding* meaning they ascribe to the experiences that haunt them. Perhaps because of the stoicism reinforced by military identity and training, prior to treatment, many service members have not sufficiently reflected on the meaning and implication of war zone harms, let alone articulated and shared these ideas. Consequently, in our view, service members need evocative experiential strategies to unearth constructions of the meaning and implication of war zone harms. We also strategically bring military roles and expectations into the therapy room. It is important for clinicians to know what a service member's job is, what his or her aspirations are or were, the degree of leadership responsibilities he or she has or wants, or would have wanted, and so forth. This knowledge helps clinicians conceptualize ways to help service members think about the implications of their damning and self-destructive ways of construing traumatic events, in terms of their identity and behavior as service members, future veterans, husbands or wives, and so forth.

Especially for nonmilitary clinicians and researchers, it is important to appreciate that the military culture and ethos foster an intensely moral and ethical code of conduct and, in times of war, that being violent and killing is normal, and bearing witness to violence and killing is, to a degree, prepared for and expected. Most service members are able to assimilate most of what they do and see in war because of training and preparation, the warrior culture, their roles, the exigencies of various missions, rules of engagement and other context demands, the messages and behavior of peers and leaders, and the acceptance (and recognition of sacrifices) by families and the culture at large. Nevertheless, service members and units face unanticipated moral choices and demands, and even prescribed acts of killing or violence may have an immediate or delayed but lasting negative impact. We contend that it is because service members have high moral standards that events that transgress deeply ingrained moral expectations cause so much inner turmoil (see Chapter 3).

Therapeutic Strategies in Adaptive Disclosure

We developed strategies to promote accommodation of the meaning and implication of various combat and operational experiences by facilitating "hot cognitive processing" (i.e., processing that is emotional, experiential, provocative; see Edwards, 1990; Greenberg & Safran, 1989) of injurious events. This is done through a combination of

imaginal exposure and subsequent cognitive restructuring and meaning making (akin to the postexposure cognitive restructuring dialogue in PE). We assumed that service members would be less defensive and more open to alternative ways of construing their experience if they just shared, in a viscerally and emotionally vivid way, a poignant and painful deployment experience. In the Gestalt and emotion-focused therapy traditions, such "hot cognition" is assumed to trigger or reveal unexpressed or previously unavailable feelings, desires, and needs (e.g., Greenberg & Safran, 1989). It fosters thinking that is motivated, engaged, and focused. In a hot cognitive frame of mind, individuals are less motivated to analyze critically and their self-reflections are more raw, accessible, and immediate. This approach also helps to circumvent the defensiveness that may arise when service members are asked to think differently about a situation or event by a caregiver who does not share their experience or background. Finally, we also assumed that repeated exposure to memories of traumatic loss, acts of perpetration, or betrayal experiences without a strategic therapeutic frame for creating corrective appraisals and experiences would be counterproductive at best and even potentially harmful. Our viewpoint is that the most efficient use of time in between sessions is to foster reparation, reengagement, reconnection, and consolidation of positive meanings and improved self-care. Homework is assigned to focus on these themes (and final session strategic planning).

Similar to what takes place in cognitive therapies (Ehlers & Clark, 2000; Resick & Schnicke, 1993), we assumed that we needed to get service members to increase their awareness and insight, and to modify toxic ways of making sense of their traumas, losses, and moral injuries. Consequently, after each emotional disclosure and processing experience, the therapist ensures that there is time for a dialogue about the meaning and implication of the military trauma, and takes a very active role in addressing and influencing these emerging meanings. As a point of departure from conventional cognitive approaches, adaptive disclosure does not assume that troubling interpretations or appraisals are necessarily errant or "irrational." In some instances, self-blame may not be altogether inaccurate. In these instances, the therapist may spend less time challenging the accuracy of the belief relative to conventional cognitive therapies and comparatively more time promoting more adaptive future possibilities.

It should be noted that CPT also targets traumatic loss-related beliefs. The goal in CPT is to address/remove cognitive barriers that get in the way of an otherwise normal grief process, rather than target

the loss specifically as a separate injurious experience. In CPT, patients write an impact statement about what the loss means to them, focusing on meanings regarding safety, trust, power/control, esteem, and intimacy. They also write about how the death has affected their memory of the deceased. By contrast, in order to uncover and process previously inaccessible (or nonarticulable) emotional content, we employ a "hot" cognitive experiential strategy to uncover thoughts and feelings related to the loss, somewhat akin to the approach by Shear, Frank, Houch, and Reynolds (2005). The therapist guides the service member to have an imaginal conversation with his or her lost friend. The dialogue is used to promote exposure to corrective experiences, such as "hearing" the friend say he or she forgives the service member or veteran or wants them to live a good, full life, and so forth. We believe that having the patient actively consider what the deceased would have wanted for the service member, and how he or she might want his or her memory honored, may be more effective in challenging impacted grief and guilt than would direct therapeutic challenge or Socratic questioning.

Unlike traumatic fear and loss, we did not have a precedent on which to base our efforts to heal the wounds of war-related moral injury, such as betrayal by one's leader (i.e., command decisions with lethal consequences) or acts of commission or omission that result in the perpetration of unnecessary and egregious acts of violence. In our experience working with service members, these experiences are the most toxic, yet most therapists will not treat perpetration-based moral injury within a PE or CPT framework (in PE, it is formally proscribed; Foa & Meadows, 1997; but see Smith, Duax, & Rauch, 2013 and Steenkamp, Nash, Lebowitz, & Litz, 2013). If employed to target moral injury, the premise of CPT would be that there are distorted beliefs about moral violation events that cause the ensuing misery. This, however, may not be true. In the case of morally injurious combat and operational experiences, there are instances in which judgments and beliefs about the transgressions may be appropriate and accurate, *as well as* psychologically toxic and excruciating. Furthermore, attempts to attribute these actions to the "context of war," even when appropriate, may ring hollow and/or undermine a therapist's credibility to a service member steeped in a culture of personal responsibility and moral accountability. Finally, in cognitive therapy, in-session Socratic questioning and homework assignments are used to challenge automatic thoughts about guilt and shame. In the case of moral injury, the patient would be instructed to find evidence to support or refute attribution of culpability and bad character, and so forth. We would argue that this

task is enormously conflict-laden and difficult in the case of serious undeniable moral transgressions and when the war trauma is colored by betrayal stemming from previously trusted others' grave moral and ethical wrongdoing. Thus, we argue that different techniques must be used to address morally injurious military events.

Comparing Adaptive Disclosure with CPT and PE with Regard to Moral Injury

CPT (Resick, Monson, & Chard, 2014) and PE (Foa, Hembree, & Rothbaum, 2007) are disseminated as prescriptive evidence-based treatments for war-related PTSD. Proponents of these two therapies have recently attempted to argue that their respective interventions treat moral injury. Because each of these therapies explicitly attempts to address traumatic loss at least to a degree, we describe in this section we describe in this section these models' approach to moral injury, as well as the limitations of these approaches.

PE and CPT manuals do not mention the construct of moral injury, and until recently, contained minimal guidance for addressing guilt, shame, and anger related to transgressions. More recent publications have elaborated on applications of and modifications to CPT and PE for these issues (see below), briefly acknowledging a need for seeking forgiveness and making amends for deliberate acts of perpetration, but they continue to emphasize cognitive restructuring techniques designed to contextualize the transgression. "Contextualizing" entails helping patients understand that their behavior or experience was a result of the circumstances (fog) of war and that culpability is an inappropriate judgment because of role and context.

CPT was originally tested on civilian assault victims and examined in two trials with Vietnam veterans. With respect to problems related to war zone transgression, CPT attempts to alleviate guilt and anger by modifying the distorted cognitions, or stuck points (presented in the patient materials as "maladaptive," "unrealistic," or "problematic") that manufacture shame and guilt. Cognitive restructuring of stuck points related to blame and diminished self-worth, along with behavioral assignments that entail giving and receiving compliments and engaging in self-care, are CPT strategies available to alleviate the consequences of transgression. The newest version of the CPT manual (Resick et al., 2014) contains brief sections on perpetration and morality, which, again, encourage therapists to contextualize the perpetration event in terms of "who he was then with what his values and behavior

are now" (p. 20) and also suggests acceptance, repentance, seeking out self- or religious-forgiveness, making restitution, or community service. Betrayal-related events are targeted by strategies that focus on seeking alternative explanations, challenging overgeneralized beliefs, and granting forgiveness to the perpetrator to attain "some peace of mind" (p. 21). No guidance is provided for implementing these new techniques, nor have they been subjected to testing as part of the treatment protocol.

It appears that the CPT framework assumes that any currently distressing event that does not involve deliberate perpetration of unnecessary violence is caused by distorted thinking that needs to be reappraised. The new CPT manual suggests forgiveness and remediation for deliberate perpetration of harms (Resnick et al., 2014, p. 78), and recommends Socratic questioning about intentionality and restructuring of distorted cognitions about control for other, potentially morally injurious (the authors do not use this term) war zone experiences (pp. 20, 76, 78). In effect, CPT appears to treat troubling war zone events as either accidents, role-consistent acts, or reactions prompted by rage, fear, or helplessness, unless the person consciously intended all the specific negative outcomes and had good choices in the moment, yet behaved badly anyway. In this way, the only way for service members to reach the threshold for real culpability is that they behaved in a sociopathic manner. This is anathema to military culture, which is deeply rooted in the moral responsibility of the intentional (not accidental) carrying of lethal weapons in war zones. In other words, CPT appears to interpret the so-called contextual morality of actions taken or not taken in combat without taking into account the warrior ethos, which allows little room for accidents or behaviors motivated by untempered emotions. Indeed, moral expectations may be violated in war through many actions or failures to act that service members consider blameworthy, even though their consequences were unintended. Examples include friendly fire, a road accident at night in the dark, or a peer being killed in a moment in which his or her trusted team member was not paying close enough attention to threats. Moral emotions can be evoked by accurate appraisals of culpability even without malicious intent. For a therapist who is unfamiliar with the military culture to assume otherwise is problematic in our view.

PE also purports to relieve guilt through *contextualizing*. The PE manual states that the combination of imaginal exposure and postexposure processing "will help the client to view the trauma in context and . . . put the events in realistic perspective" (Foa et al., 2007, pp. 28–29).

More recently, Smith et al. (2013) suggested that PE is appropriate for treating guilt associated with perceived perpetration, or harm enacted "as a consequence of the trauma context" (p. 462), which can include intentional killing while enraged. The authors state that "through repetition, new learning and disconfirmation of trauma-related beliefs can be incorporated into the [fear] structure, resulting in a reduction in PTSD symptoms" (p. 464), particularly "a more realistic view of the amount of responsibility and control during the event" (p. 468). In applying PE to transgression, the therapist elicits and explores maladaptive meanings and feelings of guilt during assessment, expands the scope of the imaginal exposure to include exculpatory contextual elements (e.g., pre- or peri-event fear or anger, postevent remorse), probes for these contextual details during the imaginal exposure, and reflects back the patient's acknowledgments of the context during processing. The suggested in-session procedures are based on the assumption that repetition will lead to therapeutic insight regarding these contextual elements and do not specify whether the therapist may be more directive and targeted in restructuring rigid beliefs (Steenkamp et al., 2013). The PE techniques for eliciting benign reappraisals are "open-ended prompts, encouragement, and reflective listening," without challenging the validity of cognitions (Paul et al., 2014, p. 280). In contrast, the therapist in adaptive disclosure is more directive, if necessary, by prompting the patient to articulate meanings in the dialog with the moral authority (e.g., "What does he or she want to tell you?"). Finally, Smith et al. (2013) state that contextualizing the transgression may be enhanced by *in vivo* exposure assignments that involve seeking disconfirming evidence of negative self-beliefs through interactions with others and seeking forgiveness or making amends. However, the incorporation of strategies promoting forgiveness and making amends (Rauch, Smith, Duax, & Tuerk, 2013) has yet to be examined empirically in service members whose traumatic events include elements of perpetration, and the relationship of moral distress to fear and fear structures remains unexplained.

In both PE and CPT, attempts at contextualizing war zone transgressions might be considered moral reassurance rather than moral repair. "Moral reassurance" is a ubiquitous coping skill in society; we use it to reassure ourselves or others (e.g., "I did the best I could," "They didn't mean to hurt me," or "Look at all the things I do right"). We suggest that for some war zone transgressions, moral reassurance might provide only short-lived relief or at worst feel disingenuous to service members. This is because moral reassurance cannot negate or

invalidate troubling and painful moral truths, though it can serve as a distraction. "Moral repair," by contrast, must involve acceptance of inconvenient truths, after drawing them into as objective a focus as is possible, and tolerance of painful moral emotions, so that a new context can be created for the traumatic events going forward (e.g., by making amends, asking forgiveness, or repairing moral damage symbolically). In contrast to PE and CPT, adaptive disclosure attempts to help the patient integrate the discomfort of the moral injury through experiencing forgiveness, self-compassion, and engaging in reparative behaviors. The latter appears to be a new feature of PE and CPT, which is encouraging, but these components are not technically PE or cognitive therapy, respectively (they fit into a unique behavioral activation frame, it seems), and there are no specific instructions for carrying the assignments out or using the experiences in treatment in a sustained manner. There is also no guidance on how to proceed if moral reassurance is not possible.

In summary, to the credit of CPT researchers, in the new CPT manual (Resick et al., 2014) there is some content about how intentional perpetration should be "contextualized" or "processed" but there are no explicit exercises or developed dialogue to illustrate how that might be done. Without the latter, it is doubtful that therapists will know with confidence what to do when confronted by moral injury or whether their approach is replicable based on some operationalized standard. Other content acknowledges that self-forgiveness and separation of a past act from present totality of self are valued therapeutic goals, but detailed techniques to advance such possibilities are largely lacking. Also, to the credit of PE researchers, Smith et al. (2013) started a discourse in the PE framework to address moral injury (although the clinical recommendations are for "perceived" perpetration only). The impression we have is that CPT and PE are best prepared to help service members who are haunted by "should haves" (hindsight bias), and who shoulder an excessive amount of perceived responsibility due to a known, unequivocal, noncontingent, and horrible outcome. In these cases, it is safe to assume that self-blame is the result of unwarranted and overgeneralized distortion. However, it is unclear how CPT and PE address what we consider to be the crux of moral injury among service members, namely, guilt and shame from acts of commission or omission that entail culpability from the service member's point of view given military training and the requirements of battle. By contrast, adaptive disclosure was designed to give the military culture a place in the therapy room, place validity in the voice of the service member,

accept a range of culture-consistent culpability, and target damage to moral identity by focusing on moral repair.

In adaptive disclosure, we ask the morally injured patient to have a dialogue in his or her imagination with a forgiving and compassionate moral authority or, if need be, other highly salient meaningful figures (a subordinate service member, the harmed victim, etc.). In this therapist-guided conversation, patients disclose what they have done (or how they were harmed by betrayal) and what they see as the implication of such experiences (self-handicapping, self-loathing, shame, self-destruction and abnegation, externalizing behaviors, etc.). The goal is to promote new learning through corrective feedback about the appraised implications and to introduce actively the possibility of forgiveness, compassion, reparation and repair. The approach is designed to facilitate perspective taking and to shift beliefs from blameworthiness (which may be objectively true) to forgiveness and compassion (which are nonetheless possible), and in so doing to facilitate the potential for living a moral and virtuous life going forward. Homework exercises are essential to provide exposure to corrective information to reinforce this sense of goodness and to begin the process of repair by making amends. The following assumptions guide our approach to the treatment of moral injury: (1) Pain means hope. Anguish, guilt, and shame are signs of an intact conscience and self- and other-expectations about goodness, humanity, and justice; (2) goodness is reclaimable over the long haul; and (3) forgiveness (of self and others) and repair are possible regardless of the transgression.

SUMMARY

In this chapter, we have reviewed the core conceptual underpinnings and foundational assumptions of adaptive disclosure and compared it to other treatments for PTSD. As is the case with all cognitive-behavioral treatments, adaptive disclosure employs a core set of strategies and change agents that are common to CPT, and especially PE. We repurposed some of these change agents (principally real-time evocative narration of events, i.e., exposure) and generated some novel approaches to help service members and veterans start to heal from loss- and moral injury-based harms.