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Commentary

When Self-Blame Is Rational and Appropriate: The Limited Utility of Socratic Questioning in the Context of Moral Injury: Commentary on Wachen et al. (2016)

Matt J. Gray, *University of Wyoming*
William P. Nash, *Headquarters, Marine Corps*
Brett T. Litz, *VA Boston Healthcare System and Boston University*

In this commentary, we argue that a generally sound therapeutic technique—Socratic questioning—is ill-suited to address a common variant of combat-related emotional and psychological distress. Specifically, moral injury is a term used to describe a syndrome of shame, self-handicapping, anger, and demoralization that occurs when deeply held beliefs and expectations about moral and ethical conduct are transgressed. Importantly, moral injury can and often does result from instances of intentional perpetration. We contend that challenging the accuracy of self-blame in such cases is conceptually problematic and potentially harmful. Such an approach is based on a questionable premise—i.e., that self-blame and resulting guilt are inherently illogical or inaccurate. Though this is often the case, it is not invariably so. We briefly describe an alternate approach—Adaptive Disclosure—that allows for accurate and legitimate self-blame when warranted but also promotes the possibilities of self-forgiveness, compassion, and moral reparation.

Wachen et al. (2016) described clinical considerations and tactical alterations to Cognitive Processing Therapy (CPT) that may be necessary when applying it to active-duty military populations. This paper is important and timely because first-line psychotherapies for PTSD were developed to treat civilian victims of usually isolated sexual assaults or accidents—a population very different from military personnel who participated in protracted counterinsurgency warfare. As Wachen et al. noted, there has been very limited research on the efficacy and acceptability of CPT and other front-line PTSD treatments in active-duty military settings. We concur with many of the observations and recommendations offered in this paper. In particular, we appreciate the recognition of the impact of rank and duty obligations on clinical presentation, as well as the unique stigma in the military associated with mental disorders and their treatment, and the corresponding potential for symptom minimization. Wachen et al. also provide a reasonable and evidence-based path forward for applying CPT to treat war-related fear- and anxiety-based traumatic stress, appropriately using Socratic questioning to address distressing errant appraisals and cognitions in these contexts.

We have some concerns, however, about the appropriateness of applying conventional cognitive restructuring techniques, particularly Socratic questioning, to the treatment of war-related traumas that entail real moral and ethical transgressions rather than merely threats to life and safety. A prescriptive application of Socratic questioning for the restructuring of war zone–related distressing appraisals and cognitions can indeed alleviate suffering in many cases, but in other cases may erroneously assume that because appraisals are distressing that they are necessarily inaccurate or faulty in some way and that reductions in resulting guilt, shame, and anger are best achieved by challenging the rationality of such appraisals. This is problematic because there are instances in which inordinately distressing cognitions are not errant, but rather, may well be reasonable and appropriate.

The case examples cited by Wachen et al. (2016) lend themselves to a Socratic questioning approach because they largely entail instances of hindsight bias (i.e., the experience of blame following an unexpectedly tragic outcome that simply could not have been foreseen).

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However, not all instances of blame related to war zone events are the result of hindsight bias or any other form of cognitive distortion. Indeed, moral injury events are those, by definition, that involve acts or failures to act that genuinely conflict with preexisting ethical and moral standards, including culturally sanctioned and deeply held beliefs about personal responsibility. It must be recognized that individuals can and do occasionally act intentionally in ways that violate their values and standards of conduct, and that such actions—when reflected upon rationally—may give rise to significant guilt, shame, and distress. A subset of war zone traumas involve real culpability, albeit shared and incomplete, not mere misconstruals of cause-and-effect relationships. In cases in which at least partial culpability is real and rational, the assignment of blame to oneself or others must also be rational, appropriate, and accurate. At best, challenging the veracity of appraisals in such cases is likely to be inert, since they are grounded in culturally sanctioned and even revered worldviews and identifications about which the therapist may not speak authoritatively. At worst, such an approach may be perceived as an empathic failure that undermines the credibility of the specific treatment, or even mental health care more generally. We further discuss these concerns in greater detail below.

Distressing But Accurate Appraisals: Why Socratic Questioning Is Poorly Suited to Address Moral Injury in Particular

The central tenet guiding cognitive therapy is that psychopathology is caused by distorted, overgeneralized, or inaccurate appraisals and interpretations of life events, and that "correcting" or supplanting these erroneous thoughts with more accurate ones will alleviate emotional distress (Beck, 1995; pp. 14-15). Certain symptoms of depression, such as dysphoria, hopelessness, and anhedonia, may in part be precipitated by overgeneralized and pervasively negative views of oneself, others, and the future; similarly, anxiety disorders may be largely defined by an exaggerated perception of threat or an overestimation of the likelihood and significance of a feared outcome (e.g., Beevers, 2005; Williams, Shahar, Riskind, & Joiner, 2005). Using the same logic, self-blame as a symptom of posttraumatic stress following exposure to a life- or integrity-threatening event to which the person was a passive victim, such as an accident or sexual assault, may be understood as a distortion of the facts resulting from faulty postevent appraisals. Even in situations in which an assault victim may have made decisions that increased the likelihood of an assault (e.g., drinking to the point of incapacitation), there is still an important distinction to be made between risk-taking and counterfactual thinking on the one hand, and ultimate culpability for the crime on the other hand. It is axiomatic that appropriately dispelling such distorted self-blame is necessary for optimal posttraumatic adjustment. Overgeneralization of this conceptualization to other populations and contexts can be problematic, however. Although clinicians should *always* explore the degree to which blame toward self or others for a traumatic event *may be* misplaced or erroneous, and should be prepared to challenge inaccurate self- or other-condemnations, clinicians who work with military personnel or veterans must be equally mindful of the possibility that some instances of inordinately distressing guilt, shame, or anger may well be the result of very accurate and appropriate appraisals of intentional acts. The nature of war is the planned and deliberate commission of acts that would be unethical or even illegal in any other context, often by young adults of sound character who are determined to do the right thing in often impossible situations, while undergoing severe and prolonged stress. Fear is arguably not the only—or perhaps even most—powerful or prevalent emotion on the battlefield; love, honor, and shame are prominent as well (Pressfield, 2011). War veterans who, under Socratic questioning, are asked evocative questions to challenge their thoughts and feelings of responsibility for their own actions or failures to act may experience new, iatrogenic moral conflicts from betraying the values, trust, and commitment to their country and fellow service members they assumed when they went to war. A participant in a morally injurious event who minimizes responsibility for their own real culpability may successfully deflect their share of blame onto someone else or attribute intentional actions to the fog of war; in the short term, this may feel less distressing, but in the long term, greater harm may be done.

Conceptualization and Treatment of Morally Injurious Events Within CPT

CPT was originally tested on civilian assault victims and examined in two trials with primarily Vietnam veterans and one trial with soldiers (Resick et al., 2015). 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 self-worth, along with behavioral assignments that entail giving and receiving compliments and engaging in self-care, are suggested CPT strategies to alleviate the consequences of transgression. The newest version of the CPT manual (Resick, Monson, & Chard, 2014) contains brief sections discussing 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. Although these are intuitive and arguably important considerations, no guidance is provided for implementing these new techniques, nor have they been subjected to testing as part of the treatment protocol.

The new CPT manual contains brief and limited content about forgiveness and remediation for deliberate perpetration of harms (p. 78), yet, the manual nevertheless recommends Socratic questioning about intentionality and restructuring distorted cognitions about control for other, potentially morally injurious war zone experiences (pp. 20, 76, 78). In effect, CPT appears to generally treat troubling war zone events as either accidents, role-consistent acts, or reactions prompted by rage, fear, or helplessness. Stated differently, 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. Compared to nonmilitary cultures, the values and ideals that comprise the military ethos instill high levels of personal responsibility, which doubtless increases the likelihood of the experience of shame, guilt, or anger following perceived failures to live up to those ideals. In a brief cognitive-behavioral therapy, the appropriateness of postexposure appraisals must be gauged against the standards that service members or veterans held at the time of their traumatic events, not some other set of post-hoc standards chosen simply because they generate less distress. Socratic questioning may uncover preexisting conflicts within the service member or veteran caused by their simultaneous participation in both military and civilian value systems, which may open possibilities for alternate appraisals. Attempting to generate such conflicts for the sake of symptom resolution may do the greater harm of undermining service members' and veterans' sustaining identifications and attachments.

Some may reasonably argue that military culture and warrior ethos can also be overly rigid and/or distorted at times and that such rigid expectations can themselves give rise to inordinate guilt or misplaced perceptions of failure. Though this may well be true in some instances, it would arguably be very difficult for a civilian clinician to productively and credibly challenge such worldviews—especially when working with active-duty military personnel. In the context of relatively brief psychotherapy, a noncombatant would likely experience considerable difficulty challenging the legitimacy of a service member's beliefs about appropriate basic, core standards of conduct in combat as these arise from years of training and enculturation. Though some therapists may have military and combat experience, this is typically not the case.

In any case, 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 their trusted team member wasn't paying close enough attention to threats. Moral emotions can be evoked by accurate (or worldview-consistent) appraisals of culpability even without malicious intent. For a therapist unfamiliar with the military culture to assume otherwise is problematic in our view.

We contend that, at times, CPT attempts to contextualize war zone transgressions in a way that 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."). In many situations—especially comparatively minor lapses on ethical judgment—such an approach is arguably helpful and often appropriate in allaying distress. We suggest that for some war zone transgressions, moral reassurance might provide only a short-lived relief and may well 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 reassurance does not compellingly dispel accurate but upsetting beliefs about many morally injurious acts; it merely covers them with a more appealing veneer. When used to palliate pronounced guilt over major violations of one's values or in the context of particularly egregious acts (e.g., atrocity perpetration), its benefits are likely to be fleeting if they can be attained at all. 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). Future research should examine the relative impact of moral reassurance (e.g., attempting to dispel self-blame and guilt) and moral repair (e.g., amends-making or commitment to prosocial action going forward) in the context of perpetration of morally injurious events. To the credit of CPT researchers, in the new CPT manual there is some content advocating that 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 questionable whether 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.

Arguably, CPT is 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 indeed at least partially the result of unwarranted and overgeneralized distortion. However, it is unclear how CPT addresses what we consider to be the crux of moral injury among service members: guilt and shame from acts of commission or omission that entail culpability from the service member's point of view given military training, warrior ethos, and the requirements of battle. Again, it may well be that military training and the warrior ethos themselves are not inerrant and can precipitate pronounced guilt, but we contend that these beliefs—the end product of intense and protracted enculturation—would be very difficult to productively challenge.

Conceptualization and Treatment of Morally Injurious Events Within Adaptive Disclosure

Our approach (Adaptive Disclosure; Litz, Lebowitz, Gray, & Nash, 2015) was designed to give the military culture a place in the therapy room, validate the voice of the service member, accept a range of culture-consistent culpabilities, and target damage to moral identity by focusing on moral repair. Adaptive Disclosure (AD) 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 consideration within CPT, which is encouraging, but there are no specific instructions for carrying the assignments out or using the experiences in treatment in a sustained manner. There is also no specific guidance on how to proceed if moral reassurance is not possible. In contrast, the AD treatment manual provides numerous therapeutic prompts for processing and considering self-blame that may be tenable and well-placed, in a manner that—rather than disputing the veracity of such appraisals—encourages a recommitment to pre-event personal ethical and moral standards. It also offers a number of behavioral, written, and contemplative homework assignments designed to foster self-forgiveness while still taking ownership over egregious acts and to seek reparative action where feasible and to the extent possible. Although it is beyond the scope of this commentary to describe AD homework assignments in detail (or, for that matter, to enumerate all of them), examples include writing about self-forgiveness and compassion, real (when possible) or symbolic apologies to individuals impacted by a moral transgression, symbolic repayment for the offense (e.g., contributing to a charity representing those afflicted by this or similar transgressions), and general prosocial behavioral activation (i.e., engaging in charitable actions or philanthropic activities in order to promote alternative possibilities of self if the patient deems himself or herself to be wholly evil).

Among other techniques, in AD we ask morally injured patients to invoke another perspective—e.g., that of a forgiving and compassionate moral authority or respected other. In this therapist-guided therapeutic dialogue, patients disclose what they have done and what they see as the implication of such experiences (e.g., self-handicapping, self-loathing, shame, self-destruction and abnegation, externalizing behaviors, etc.). As noted, there are also specific homework assignments and behavioral exercises designed to promote reparative action and a recommitment to predeployment principles and moral standards. Though the morally injurious act cannot be undone, it need not be destiny and it need not preclude virtuous acts going forward. In this manner, the patient's reality and the accuracy of his or her appraisal is honored. Rather than disputing that which may well be objectively true, the patient is encouraged to take ownership of the act, pursue real or symbolic reparative action, consider self-forgiveness, and recognize that self-flagellation and self-condemnation (e.g., "I am evil")—taken to an extreme—also cannot undo the horrific act but can prevent moral and virtuous behavior going forward.

The goal of AD in the context of moral injury then is to promote new learning through corrective feedback about the appraised implications and to actively introduce the possibility of forgiveness, compassion, and reparation. *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 doing so, to facilitate the potential for living a moral and virtuous life going forward.* This latter goal is especially crucial for those who are likely to be redeployed. Homework exercises are essential to provide exposure to corrective information to reinforce this sense of goodness and to begin the process of repairing by making amends. The following assumptions guide our approach to the treatment of moral injury: (a) pain means hope—anguish, guilt, and shame are signs of an intact conscience and self- and other-expectations about goodness, humanity, and justice; (b) goodness is reclaimable over the long haul; and (c) forgiveness (of self and others) and repair are possible regardless of the transgression. Though a good deal more empirical work remains to be done in order to shed light on which techniques are most impactful, preliminary work has demonstrated that AD is associated with large reductions in distress, that negative views of self can be rectified *even in the absence of self-blame disavowal*, and that active-duty military personnel are highly satisfied and would recommend it to other combatants who are experiencing similar difficulties (Gray et al., 2012).

In fairness, neither CPT nor AD have been extensively tested with respect to distress relating to moral injury in

active-duty military contexts (though trials are currently under way). Nevertheless, the lack of definitive data regarding how best to treat moral injury should not preclude the recognition that moral injury can and often does result from instances of intentional perpetration, and that challenging the accuracy of the belief in such cases is conceptually problematic and potentially harmful. It is conceptually problematic in that it is based on a questionable premise—i.e., that self-blame and guilt are inherently illogical or inaccurate. Though this is often the case, it is not invariably so. It is potentially harmful in active-duty military contexts as a therapist may be complicit in "whitewashing" an objectively immoral act that was intentionally perpetrated. Not only does doing so fail to honor the importance and legitimacy of moral emotions following actions that are not truly accidental, but it potentially provides a framework for continuing to explain away such actions in the context of future deployments.

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Address correspondence to Matt J. Gray, Ph.D., Dept 3415, University of Wyoming, 1000 E University Ave., Laramie, WY 82071; e-mail: gray@uwyo.edu.

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