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Employing Loving-Kindness Meditation to Promote Self- and Other-Compassion Among War Veterans With Posttraumatic Stress Disorder

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In this paper, we described how we have recently incorporated compassion training in the form of Loving Kindness Meditation into an existing psychotherapy for war-related PTSD called *Adaptive Disclosure*. We provided background to support the assumption that targeting compassion deficits in war-related trauma may improve mental and behavioral health by helping patients engage in adaptive and potentially reparative behaviors, particularly improving social connections. We also described how compassion training may help veterans suffering from traumatic loss and moral injury, specifically. Throughout, we provide clinical heuristics that may help care providers who work with veterans who have experienced diverse war traumas.

Keywords: war trauma, moral injury, compassion training

Service members deployed to warzones are at risk for enduring and disabling social, occupational, and quality-of-life/wellness deficits and mental health problems, principally posttraumatic stress disorder (PTSD; Kulka et al., 1990; Rodriguez, Holowka, & Marx, 2012). The tacit assumption in the mental and behavioral health communities is that exposure to warzone traumas causes PTSD, which is the chief subsequent cause of functional and quality-of-life problems. Consequently, the main focus of clinical services for addressing the variety of problems stemming from warzone exposure is specialty care PTSD treatment. Yet, current first-line PTSD psychotherapies for war veterans do not explicitly target functional impairments. Further, strategies that have been shown to be highly effective in addressing the sequelae of exposure to a discrete, danger-based experience (e.g., accidents, sexual assault) work substantially less well for veterans' warzone-related PTSD (Steenkamp, Litz, Hoge, & Marmar, 2015). Existing theoretical frameworks and treatment manuals do not provide sufficiently explicit and detailed information about how (or why) the change agents in the respective treatments are expected to improve a wide variety of functional outcomes in veterans. This is a problem from the perspective of the patient and his or her family, because even if clinically significant change in PTSD symptom burden is achieved, many patients are still left with substantial and potentially pressing functional deficits and distress that are caused or worsened by warzone exposures. An alternative model is that PTSD symptom change is a necessary but not sufficient step to a better quality of life, and therapies should foster success ex-

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periences in relationships and work, which will enhance hope, improve mood, and increase veterans' agency and self-efficacy (Litz, Lebowitz, Gray, & Nash, 2015).

The reduced efficacy of first-line psychotherapies for PTSD could be due to the greater complexity of war-related PTSD (Gerger, Munder, & Barth, 2014). Conventional treatments 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). The conditioning and learning model and the cognitive/constructivist models arguably do not sufficiently explain, predict, or address the needs of many service members and veterans who are exposed to diverse war-related psychic injuries, such as moral injury and traumatic grief (Gray et al., 2012; Steenkamp et al., 2011). Existing therapies for PTSD were not developed for service members and veterans and do not sufficiently accommodate the warrior culture and ethos nor the unique and diverse stressors and conflicts that arise in battle. There is an emerging consensus that war-related moral injuries and traumatic losses are associated with unique relational and quality-of-life problems, relative to danger-based traumas (e.g., Maguen et al., 2010; Nash & Litz, 2013; Papa, Neria, & Litz, 2008; Toblin et al., 2012).

Shay (1995) was the first to use the term *moral injury*; he framed it as leaders' betrayal of what is right in battle, causing disorientation and despair in those in their charge: "Moral injury is an essential part of any combat trauma that leads to lifelong psychological injury. Veterans can usually recover from horror, fear, and grief once they return to civilian life, so long as 'what's right' has not also been violated" (p. 20). We operationalized moral injury so that it could be assessed and studied systematically (Litz et al., 2009). We also operationalized the unique outcomes associated with experiences that compromise moral beliefs and, most importantly, offered ideas about intervention strategies to redress them. We defined moral injury as the lasting psychological, biological, spiritual, behavioral, and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations. In our model, any of the following could be morally injurious: (a) perpetration of violence and killing, prescribed or proscribed, in terms of actions taken or witnessing others' actions; (b) betrayal by peers or leaders that leads to dire outcomes; and (c) bearing witness to human maliciousness (Nash, 2007; Nash et al., 2013).

For a large proportion of service members, deployment to a warzone also entails exposure to the loss of fellow warriors and friends. Over 5,300 American service members have been killed in the Afghanistan and Iraq Wars (DCAS, 2014). In surveys of ground combat troops who deployed to Iraq, ~70% reported having seen dead or seriously injured Americans, ~80% reported knowing someone seriously injured or killed, and ~20% reported having a buddy shot or hit who was near them (e.g., Hoge et al., 2004). Approximately 75% of Vietnam veterans reported knowing an American killed in Vietnam, and ~50% reported losing a close friend in the war (Papa et al., 2008). Service members form close, intensely interdependent bonds (Hoge, 2010; Nash, 2007), and these bonds are resilience-promoting resources in the face of warzone demands and potentially traumatizing events. The loss of fellow warriors would therefore arguably pose substantial risks to the mental and behavioral health and mission readiness of service members and the long-term functioning of war veterans. Moreover, a violent cause of death, as is the norm in warzones, increases the chances of a prolonged and severe grief reaction to the loss of a close other (Neria & Litz, 2004), yet little attention has been paid to addressing grief-related problems among war veterans (Papa et al., 2008).

Service members are taught to be selfless and to take responsibility for the safety and welfare of unit members. As a result, grief stemming from warzone losses is arguably akin to that from the loss of children to violence—one of the worst human experiences (Neria & Litz, 2004). Any grief-related distress and impairments can be compounded by survivor's guilt potentiated by the sacred expectation to protect fellow service members from harm. From the beginning of their military training, service members learn to tolerate physical, mental, and emotional suffering in service of mission, but most importantly in service of the protection and care of unit members. Reducing personal suffering is not a paramount goal and service members may not feel worthy of attending to

their own needs of processing and healing a loss. These cultural factors can compound the negative impact of loss-related PTSD in the military context (see Nash, 2007).

Both moral injury and traumatic loss among war veterans with PTSD are associated with decrements in veterans' functioning in multiple domains. For instance, survivor guilt or guilt related to engaging in violence affects family relationships and parenting (Galovski & Lyons, 2004). Emotional numbing, which may be the result of survivor or perpetrator guilt, impairs intimate relationships, friendships, parenting, and work performance (e.g., Galovski & Lyons, 2004; Riggs, Byrne, Weathers, & Litz, 1998). Grief following loss is related to somatic complaints and occupational impairment (Toblin et al., 2012). Anger, which may result from traumatic loss or betrayal-based moral injury, impairs family functioning (e.g., Taft, Street, Marshall, Dowdall, & Riggs, 2007).

Because transgressions and warzone losses pose a threat to social bonds and ways of thinking about the goodness or worthiness of the self, and because these events are uniquely aversive to recall, these experiences intrude into consciousness (e.g., intrusive thoughts, nightmares), and the aversive typically moral emotions (e.g., guilt, shame, anger) that arise lead to attempts at avoidance. Transgressive potentially morally injurious experiences can range from moral violations, such as participating in torture and killing, to making mistakes while performing military duties that results in the harm of others, to being the victim of within-unit hazing or military sexual trauma (Berke, Kline, Carney, Yeterian, & Litz, in press). Moral injury and traumatic loss-induced guilt may severely impact self-esteem and even lead to self-loathing, which would also result in emotional numbing (i.e., disinterest, detachment, and restricted range of affect) as well as symptoms of depression (e.g., dysphoria, guilt/worthlessness, anhedonia, and suicidality). Litz et al. (2009) proposed that perpetration-based moral injury creates risk for shame, social withdrawal, self-handicapping, and self-harming behaviors. Empirically, personal transgressions have been shown to be associated with shame and guilt (Jordan, Eisen, Bolton, Nash, & Litz, 2017) and suicidal ideation and attempts (e.g., Wisco et al., 2017). By contrast, moral injury from betrayal can lead to anger and an externalizing (blaming others) mind set (Jordan et al., 2017). Any moral injury creates risk for demoralization and alienation, as well as altered moral expectations for the self and others (informally termed a "broken moral compass"). These inner experiences and behaviors are detrimental to relationships and work roles.

To begin to redress these problems, we developed an alternative psychotherapy for service members and war veterans with PTSD called *Adaptive Disclosure* (AD; Litz et al., 2015). Unlike first-line psychotherapies for PTSD, AD was developed specifically for active-duty, deployed service members and war veterans, and the approach honors and leverages knowledge about the military culture and ethos. A detailed step-by-step AD therapy guide and manual has been published (Litz et al., 2015). AD integrates emotion-focused experiential strategies with elements of cognitive–behavioral therapy. Importantly, this treatment allows mental health providers to tailor care for danger-based events (chiefly exposure), traumatic loss, or moral injury. The following assumptions guide our approach: (a) pain means hope. Guilt and shame (from perpetration-based moral injury) and anger (from betrayal-based moral injury) are signs of an intact conscience and expectations of the self and others about goodness, humanity, and justice; (b) goodness is reclaimable; and (c) forgiveness (when applicable, feasible, and therapeutically valuable) and repair are possible. Repair of moral injury and loss entails finding and building positive relationships, rebuilding identity by doing good deeds, developing compassion, and reclaiming goodness in the self and others. Targeting moral injury and loss may also reduce the shame, guilt, and demoralization that can lead to PTSD and increase risk for a variety of functional deficits as well as self-harming behaviors. One of the main change agents for moral injury and loss is an evocative imaginal dialogue with a compassionate and forgiving moral authority, or the lost service member, which is used to challenge the shame and self-condemnation that accompany moral injury or loss. Homework is assigned to begin the process of engaging in corrective life experiences (e.g., repairing by giving back). For clinicians interested in a session-by-session how-to guide to AD, please see Litz et al. (2015).

We recently expanded AD to incorporate compassion training, based on Loving Kindness Meditation (LKM; this study has received approval from the VA Boston Health care System Institutional Review Board committee). The aim is to provide veterans with a greater psychological and behavioral foundation to improve relationships and encourage progress toward meaningful social and work goals. The focus on improving functioning is designed to better address service members' and veterans' moral injury- and loss-related social reintegration difficulties and obstacles to quality of life. We believe that compassion training holds the promise of reducing suffering and helping veterans accept their own and others' humanity, thereby increasing social connection and competence, and increasing veterans' motivation to function positively and mindfully (Lang et al., 2012). Increases in self- and other-compassion can also arguably assist veterans to reconnect with family and communities, including spiritual communities that they may be avoiding due to their difficult experiences in war, thereby potentially increasing their openness to the possibility of self- or other forgiveness (see Currier, Drescher, Holland, Lisman, & Foy, 2016). There are diverse definitions of self- and other-forgiveness. McCullough, Worthington, and Rachal (1997) defined the forgiveness of others as a process of replacing relationship-destructive responses with constructive behavior. Hall and Fincham (2005) defined self-forgiveness as shifts in the motivation to avoid stimuli associated with an objective transgression, reduced motivation to be punitive toward the self, and increased motivation to act benevolently toward the self. These definitions fit our thinking about the potential habilitative impact of forgiveness in the context of war-related trauma.

The new AD approach is currently being tested in a randomized controlled trial (https://clinicaltrials.gov/ct2/show/NCT03056157). Consequently, there are no findings or case examples to present. For the rest of this paper, we provide additional background about why and how LKM might help veterans struggling with the psychic and functional wounds of war untouched by traditional psychotherapeutic approaches and a set of clinical guidelines that may help the reader apply LKM in their practice with war veterans.

Evidence

A small number of studies have demonstrated the efficacy of LKM (Hofmann, Grossman, & Hinton, 2011); even fewer have been conducted with psychiatric populations. These trials are limited by small samples, a lack of randomization, and/or a lack of control arms. With respect to these studies, LKM has been associated with increases in positive affect, positive emotions, self-compassion, and life satisfaction and decreases in depressive symptoms, posttraumatic symptoms, anger, anxiety, and distress (Carson et al., 2005; Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Hutcherson, Seppala, & Gross, 2008; Kearney et al., 2013).

Two formal interventions developed to promote compassion for the self and others, each borrowing from LKM, have also been studied: Compassion Focused Therapy (CFT; Gilbert & Procter, 2006) and Mindful Self-Compassion (MSC; Neff & Germer, 2013). In an uncontrolled study of a small clinical sample, a 12-week CFT intervention led to reductions in shame (Gilbert & Procter, 2006). In a randomized controlled trial with a nonclinical sample, 8 weeks of MSC led to increased self-compassion and decreased depression, anxiety, and avoidance, compared to a waitlist control group (Neff & Germer, 2013).

Au et al. (2017) developed a brief compassion-based therapy and assessed its efficacy for reducing trauma-related shame and PTSD symptoms. Using a multiple baseline design, the intervention was evaluated in a community sample of trauma-exposed adults ($N = 10$) with elevated trauma-related shame and PTSD symptoms. Participants completed weekly assessments during a 2-, 4-, or 6-week baseline phase and 6-week treatment phase, and at 2- and 4-weeks after the intervention. By the end of treatment, nine of 10 participants demonstrated reliable decreases in PTSD symptom severity, while eight of 10 participants showed reliable reductions in shame. These improvements were maintained at 2- and 4-week follow-up, with large effect sizes for PTSD symptom severity ($d = 2.26$) and shame ($d = 2.12$), compared to scores at baseline. The intervention was also associated with improvements in self-blame, self-compassion, mindfulness, positive affect, and negative affect. The results suggest that the compassion training may be useful as either a

stand-alone treatment or as a supplement to other treatments.

Foundational Assumptions

In AD, we assume that repairing trauma requires war veterans doing things and being exposed to corrective experiences outside of therapy and over the long haul. Warzone harms cannot be overcome or eradicated by in-therapy activities and solely by virtue of the healing and compassionate therapeutic relationship. In our new model, which we call Adaptive Disclosure-Enhanced (AD-E), we teach veterans Mindfulness and LKM to augment the in-session experiential processes and break through rigidity, numbness, hopelessness, and disconnection, and, in the case of moral injury caused by others, anger and resentment (and potential revenge fantasies). Our assumption is that these Buddhist practices can help repair moral injury, traumatic loss, and life-threat trauma because mindfulness has been shown to reduce rumination (e.g., Nitzan-Assayag et al., 2017), and kind intention and action arguably creates a shared sense of humanity and has been shown to enhance social connection (Hutcherson et al., 2008).

War-related trauma can damage self-schemas that otherwise make connection with others possible, bringing comfort, meaning, and happiness to life. In the case of traumatic loss, service members lose a critical part of their identity when someone they love and rely on for feelings of safety and happiness and who they feel morally bound to protect dies in battle. When service members do things or fail to do things that violate their moral code (perpetration-based moral injury), the experience can radically alter the way they define themselves. Transgressing these deeply ingrained rules can reduce positive feelings about oneself and the sense that life is orderly, predictable, and good. In instances of betrayal-based moral injury, service members can also lose a foundational part of their identity because a trusted individual or group transgressed the rules that otherwise brought a sense that others and the world are inherently good and dependable. Life-threat traumas impact beliefs about personal control and competence (see Foa, 1997). These warzone harms can negatively affect connections with others and, over time, become defining characteristics of the self and negatively impact well-being. Like all traumatic experiences that are enduringly painful, the survivor's attention is focused on the past harm and managing their suffering, which among other things entails avoiding thoughts, feelings, and situations that are expected to trigger worse suffering. This creates a negative feedback loop, thwarting opportunities for healing and repair. Worse yet, some war veterans will tenaciously work to maintain traumatogenic views of themselves because organized self-knowledge is worse than the alternative, namely indeterminate disorganized states of vulnerability.

How can we help service members who are suffering in these ways? What can repair the damage to the body, mind, and spirit brought on by war trauma? In AD-E, our goal is to plant powerful, generalizable, and lasting healing seeds. In service of this, we employ a three-pronged approach. First, the exposure and experiential processing of traumatic harms is designed to help service members unearth, disclose, and in some cases confess the events that harmed them. This process allows the service member or veteran to clarify and articulate in emotional and immediate terms the impact, meaning, and implication of the event in terms of their identity (self), their relationship to others and the world, and their future. Also, the exposure and experiential component helps the service member hear corrective feedback while in an emotionally activated and receptive state. Second, in collaboration with the service member, we give homework assignments that provide opportunities for corrective and positive repairing experiences, which strengthen and extend the in-session work (e.g., giving back to the community, trying on positive wellness activities). The experiential and homework components of AD-E are designed to help service members rebuild trust in themselves and others, rebuild compassion for themselves and others, and when feasible and in keeping with the patients' background and values, to promote forgiveness of themselves and others. We would like to underscore, however, that we treat compassion as a process rather than an outcome and we understand that forgiveness (which is also a process) is sometimes not possible because of the nature of certain traumas and individuals' culture and faith tradition (see Wortmann et al., 2017). Consequently, although improving com-

passion is a necessary change agent in AD-E, forgiveness is not seen as a necessary vehicle to redressing war traumas. The good example of this is in the context of a severe moral violation by a trusted other, such as military sexual assault. A patient does not need to work on the process of forgiving the perpetrator of such a transgression to make gains in AD-E, and enhancing compassion for others, even compassion for the perpetrator, does not need to lead to forgiveness of the perpetrator.

AD-E's third prong, training in mindful LKM and practice, is also designed to build trust, compassion, and when feasible or useful, promote forgiveness in the context of other change agents within AD-E (i.e., experiential exercises). We use the term *compassion training* to describe the approach to patients. There are three parts to compassion training or loving kindness practice (or Metta, the Pali Buddhist term for loving kindness). The first part entails being mindfully aware of moments of one's own and others' suffering and noticing those moments without judging or overidentifying with them. The second part entails appreciating our common humanity, which entails recognizing that suffering, feelings of inadequacy, and the desire to be free from these states are parts of the common human experience. Having flaws makes us feel isolated, but imperfection is part of the human condition. Our collective feelings of frailty and inadequacy can serve to unite us, including, for example, therapist and patient and family member and service member or veteran. In other words, we are all in the same boat. The third part entails intending to be kind and being kind and compassionate, which entails meditations about, and daily practices of being warm and understanding toward ourselves and others, especially when we suffer, fail, or feel inadequate. This is the opposite of trying to force oneself to be perfect with self-criticism or, in the military, ignore suffering and push onward in the pursuit of a collective goal. These three aspects of LKM are designed to bolster service members' and veterans' sense of shared humanity and connection to others. It reduces the distance between oneself and others. There are a host of resources for those interested in adapting LKM in their practice. An excellent place to start is Salzberg (1995).

An Overview of Compassion Training for War Veterans

The assumption of LKM is that cultivating a practice of wishing or intending oneself and various others to be free of harm and safe, to be happy and healthy, and to be free of struggle and to live with ease facilitates compassion for oneself and others and connection to others, the things that are damaged or distorted by traumatic loss, moral injury, and life-threat-based trauma. The following is based on Salzberg's (1995) excellent and clinically and personally useful book on LKM. LKM is built upon developing the capacity for being fully present to experience, otherwise known as mindfulness. Mindfulness is a practice that entails purposefully paying exquisite attention to the present moment without judgment. Increasing one's capacity for mindfulness is intended to reduce suffering and to contribute to a happy and satisfied life. Like all of Buddhist teachings, mindfulness is a simple dictum that can be difficult to achieve without earnest commitment and practice. Fully paying attention to the matter at hand and experiencing the present moment is thwarted by habits we all possess. We are typically inundated or intruded upon by thoughts of the past or concerns about preparing and planning for future events, or we think it is too painful to focus on what we are feeling or experiencing in the present moment. Consequently, we fail to attend to the present moment. Being mindful makes it easier to experience pleasure fully, helps a person fully engage in whatever they are doing, and creates a greater capacity to deal with adversity and aversive emotions. By focusing on the here and now, mindfulness can lessen worry (see Gaynor, 2014) and, arguably, in the case of war trauma intrusive regrets, resentments, and self-condemning thoughts and feelings. Mindful meditation and practice teach people that inner experiences have an ebb and flow (e.g., that all experiences are fleeting), and thereby help people accept their experiences — including painful emotions — rather than react to them with aversion, avoidance, or rumination.

In the therapeutic context, LKM offers a pathway to reclaim and repair what is lost or damaged by warzone traumatic harms. Most warzone traumas are harmful in part because service members believe they have let others

down or others let them down, and their consequent suffering affects their social bonds and beliefs about the goodness or worthiness of themselves and others. The commonality of various types of warzone harms is that they are defined in relationship to other people, create social disconnection (e.g., self-hatred or distrust, which separate one from others), and can be repaired by intentions and deeds that reduce alienation and isolation and facilitate compassion and connection.

Compassion is a skill that can be learned and strengthened, just like other skills. While mindfulness involves awareness and nonjudgmental acceptance of moment-to-moment experience, compassion focuses on mindfully accepting the experiencer (the self or another) with an open heart. If service members or veterans develop an openness and sensitivity to their own suffering and the suffering of others, and cultivate the empathic motivation to reduce that suffering, they will be on the path to repairing loss- or moral injury-related harms. If service members or veterans with PTSD act like a best friend or nurturing parent to themselves and aspire to treat others the same way, they will feel that everyone is in the same boat. This will improve their acceptance of themselves and their connection and comfort with others, which is important to overcoming the isolation and self-condemnation resulting from various war-based trauma.

The practice of loving kindness or compassion is simple on its face but can be very difficult in practice. It teaches people to strive toward an uncritical and nonjudgmental acceptance of experience, detached from the past and unconcerned about future outcomes other than to intend kindness. It targets what is really at the heart of the posttraumatic experience, namely, being consumed with the past and understandably needing things to change in the future to redress what happened. So, the expectation should be that service members and veterans with PTSD will struggle with the practice. Added to the posttraumatic consciousness that would inhibit compassionate focus, service members and veterans share common enculturated prohibitions about showing or accepting compassion. Yet, clinicians and researchers working with this population have to assume that everyone wants to be loved and wants to be happy. Compassion training helps to teach us about our human needs and how this mirrors the needs of others. It is important to note that compassion also brings to awareness that everyone is vulnerable to letting people down and harming others. In Buddhism, LKM is one of the pathways to moral and ethical behavior—thinking, saying, and doing what is right. Rightness is defined as actions that support humanity and compassion. If we consider service members and veterans who have lost faith and confidence in morality, LKM provides the opportunity to reestablish core ethical principles and practices.

LKM can also maximize service members' potential for positive change from the other change agents embedded in AD-E. In any psychotherapy, therapists hope that patients will have an open mindful approach to learning about themselves and trying on new strategies in session and in their lives. Patients cannot benefit from psychotherapy if they distance themselves from emotional experience by trying to outsmart their therapist or think of ways to counter recommendations and feedback. These tactics serve avoidance of emotion-focused experience. Patients may also try to avoid vulnerability and anxiety about being harmed if they allow themselves to focus on and have the therapist bear witness to their immoral past deeds, imperfections, and raw true feelings. If patients are self-condemning and judgmental about themselves, and if they are too judgmental and condemning of others who may support their desire to redress their suffering, they will not have the confidence, hope, or motivation to experience painful, yet corrective, emotional experiences in-session and in their lives. The promise of LKM is that it may teach patients to extend compassion to themselves, thus enabling them to engage in the vulnerability inherent in psychotherapy rather than distancing themselves from emotion-focused experiences. Finally, while patients may be inclined to distance themselves from their therapist, patients cannot make gains in any psychotherapy if they thwart their therapist's compassion. Service members and veterans are no different; in fact, because of machismo and a penchant to be distrustful of outsiders, service members and veterans are more likely to need to learn a mindful and compassionate approach to their psychotherapy.

AD-E is designed to start the process of balancing the scales so that service members' ex-

periences and identity are not dominated by moral emotions, such as guilt, shame, and vengeance, nor condemning moral judgments about the self or others being wholly bad and wholly unworthy. This requires sustained corrective and countering messages, thoughts, and deeds. Homework tasks are assigned to open up these possibilities (giving back, doing good, and receiving good). LKM is designed to support these activities by framing any positive, nonharming action as supporting compassionate intention. LKM is also designed to promote self-compassion and the experience of shared humanity and connection. Lessening distance and enhancing empathy toward the self and others will also help service members be open to the repairing compassion of others and help them make compassionate choices moving forward in order to not inadvertently or deliberately harm others by commission or omission.

Because LKM is simple, not intrusive, can be done anywhere and at any time, and does not take more than a few minutes, the therapist has latitude about how much or how frequently they use session time to teach, model, and discuss LKM and how much homework they assign for LKM practice. Decisions about this may be driven by how resonant and open a service member or veteran is to LKM, or the therapist may decide to emphasize the practice because a patient is struggling with self- or other-compassion and forgiveness in the context of AD-E.

Any experience a service member has while practicing mindfulness and LKM needs to be accepted nonjudgmentally by the therapist and processed within the context of issues arising within AD-E and in the context of other personal and social challenges he or she faces. The goal is to understand and accept struggles with being present and compassionate to oneself or others and, at the same time, not give in to a hopelessness narrative. Any incremental change toward acceptance and compassion including discussing one's experience honestly and openly, in the context of potential stagnation or worse suffering, is an important achievement.

In AD-E, which is a 12-session therapy, mindfulness training begins at the first session. At the end of Session 1, the therapist provides the patient with education material about mindfulness and assigns mindful breathing meditation exercises twice a day. From Session 2 onward, each AD-E session starts with a brief mindful breathing exercise to shift the veteran and therapist's focus to the here and now. In the first few sessions, or until the patient understands what to do, the therapist should model the exercise verbally with the patient and afterward do the same mindfulness exercise in silence. Therapists should also feel free to end sessions the same way.

In AD-E, therapists initiate a dialogue about compassion in the first session. The goal is to determine how the service member understands and defines compassion, how important kindness to themselves and others had been in their lives before their trauma, and how things are now (and whether this is distressing). Doing this establishes respect for, and underscores interest in, the service member's point of view and experience and can quickly build rapport. In this way, the dialogue is win-win. We acknowledge that the ideal case is that the service member had extensive and rich experiences with compassion before their war trauma and his or her suffering is distinctly posttraumatic rather than lifelong. Yet, veterans who had pretrauma deficits in self- or other-compassion, and who have difficulty appreciating even an ideal hypothetical compassionate state of mind in themselves or others, can also be helped. But, the therapist will need to be mindful of this aspect of the service member's experience. In LKM, the assumption is that everyone has a need to be safe, happy, and healthy, and this expectation forms the basis for building compassion in anyone. A mandatory conversation about compassion at the onset and outset of AD-E accomplishes the goal of informing the veteran that the therapy is designed to rebuild (or build) these qualities in support of healing and repairing war trauma.

We formalize the dialogue about compassion at the outset of AD-E by asking veterans a series of questions about compassion. Answers to these questions are intended to be a potential point of departure in real time or at a later time in the therapy. The following are the questions we ask: (a) when you were growing up, were there kind and compassionate people in your life? (Were your parents or siblings kind and compassionate?); (b) what do kindness and compassion mean to you? How important are they? Do you consider yourself to be a kind and compassionate person in general? If not, are there some circumstances where you feel com-

passionate or find yourself acting kindly? (If the service member is unsure, unclear on what compassion means, or if they are defensive about the questions, rephrase. Maybe the idea of the Golden Rule will help); (c) prior to your military service (or your first deployment, or the trauma, if that has been discussed), how would you describe your sense of kindness and compassion (to others and to yourself)? Who were you most kind and compassionate to, and why?; (d) who has been most kind and compassionate to you in your life, and how did this make you feel? Is there anyone whom you admire because you consider him or her to be the best or an ideal example of a kind and compassionate person? (This could be a popular or religious figure, such as Jesus); (e) how kind, compassionate, and forgiving are you of yourself these days? Were you ever kind to yourself? Do you have a sense of how [the trauma] has affected your kindness and compassion to yourself and others? Do you want to be more kind and compassionate to yourself and others? What might change if you were?

The therapist explains to the service member that AD-E is designed to start the process of building self- and other-compassion as one way to reduce suffering and reduce symptom burden related to war trauma. The therapist briefly teaches the patient what LKM is and describes what the patient will be asked to learn and do in the course of the therapy. Finally, the therapist solicits feedback and concerns about this (e.g., how does this sound; is this something that you think could help you; what will be difficult for you as we approach the topic of self- or other-compassion?).

Final Comment

In this paper, we described compassion training in the form of LKM that can be used as a vehicle to augment any psychotherapy for PTSD in service of starting a process of healing and repair through connection. LKM is a tool that holds the promise of helping service members and veterans engage in ongoing healing over the course of their lives. Unquestionably, therapists that use existing frameworks to treat PTSD symptoms want to create opportunities for service members and veterans to redress the impact of traumatic loss and moral injury but, arguably, the prescribed change agents do not address these problems adequately. All care providers want to ensure that service members and veterans experience forgiveness of themselves and others and for them to reclaim identities that were full of potency, hope, and connection. Unfortunately, no psychotherapy can provide this healing completely, and no single life experience can either. Nor can anyone prevent the transgressions and loss that are inherent parts of the human (and military) experience. Our hope is that integrating LKM into Adaptive Disclosure (and other therapies, for that matter) can help service members and veterans engage in lifelong healing through reparative compassionate thinking and actions. This is a skill that we hope they can utilize throughout the course of their lives, even after the duration of their treatment.

References

Au, T. M., Sauer-Zavala, S., King, M. W., Petrocchi, N., Barlow, D. H., & Litz, B. T. (2017). Compassion-based therapy for trauma-related shame and posttraumatic stress: Initial evaluation using a multiple baseline design. *Behavior Therapy, 48,* 207–221. http://dx.doi.org/10.1016/j.beth.2016.11.012

Berke, D. S., Kline, N., Carney, J., Yeterian, J., & Litz, B. T. (in press). Treating moral injury in military members and veterans. In B. A. Moore & W. E. Penk (Eds.), *Treating PTSD in military personnel: A clinical handbook* (2nd ed.). New York, NY: Guilford Press.

Carson, J. W., Keefe, F. J., Lynch, T. R., Carson, K. M., Goli, V., Fras, A. M., & Thorp, S. R. (2005). Loving-kindness meditation for chronic low back pain: Results from a pilot trial. *Journal of Holistic Nursing, 23,* 287–304. http://dx.doi.org/10.1177/0898010105277651

Currier, J. M., Drescher, K. D., Holland, J. M., Lisman, R., & Foy, D. W. (2016). Spirituality, forgiveness, and quality of life: Testing a mediational model with military veterans with PTSD. *The International Journal for the Psychology of Religion, 26,* 167–179. http://dx.doi.org/10.1080/10508619.2015.1019793

Defense Casualty Analysis System (DCAS). (2014). *Conflict casualties*. Alexandria, VA: Defense Manpower Data Center.

Foa, E. B. (1997). Psychological processes related to recovery from a trauma and an effective treatment for PTSD. *Annals of the New York Academy of Sciences, 821,* 410–424. http://dx.doi.org/10.1111/j.1749-6632.1997.tb48295.x

Fredrickson, B. L., Cohn, M. A., Coffey, K. A., Pek, J., & Finkel, S. M. (2008). Open hearts build lives:

Positive emotions, induced through loving-kindness meditation, build consequential personal resources. *Journal of Personality and Social Psychology, 95,* 1045–1062. http://dx.doi.org/10.1037/a0013262

Friedman, M. J. (2006). Posttraumatic stress disorder among military returnees from Afghanistan and Iraq. *The American Journal of Psychiatry, 163,* 586–593. http://dx.doi.org/10.1176/ajp.2006.163.4.586

Galovski, T., & Lyons, J. A. (2004). Psychological sequelae of combat violence: A review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior, 9,* 477–501. http://dx.doi.org/10.1016/S1359-1789(03)00045-4

Gaynor, K. J. (2014). A critical review of mindfulness-based psychological treatments for worry and rumination. *Open Access Behavioral Medicine, 2,* 2.

Gerger, H., Munder, T., & Barth, J. (2014). Specific and nonspecific psychological interventions for PTSD symptoms: A meta-analysis with problem complexity as a moderator. *Journal of Clinical Psychology, 70,* 601–615. http://dx.doi.org/10.1002/jclp.22059

Gilbert, P., & Procter, S. (2006). Compassionate Mind Training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy, 13,* 353–379. http://dx.doi.org/10.1002/cpp.507

Gray, M. J., Schorr, Y., Nash, W., Lebowitz, L., Amidon, A., Lansing, A., . . . Litz, B. T. (2012). Adaptive disclosure: An open trial of a novel exposure-based intervention for service members with combat-related psychological stress injuries. *Behavior Therapy, 43,* 407–415. http://dx.doi.org/10.1016/j.beth.2011.09.001

Hall, J. H., & Fincham, F. D. (2005). Self–forgiveness: The stepchild of forgiveness research. *Journal of Social and Clinical Psychology, 24,* 621–637. http://dx.doi.org/10.1521/jscp.2005.24.5.621

Hofmann, S. G., Grossman, P., & Hinton, D. E. (2011). Loving-kindness and compassion meditation: Potential for psychological interventions. *Clinical Psychology Review, 31,* 1126–1132. http://dx.doi.org/10.1016/j.cpr.2011.07.003

Hoge, C. (2010). *Once a warrior, always a warrior: Navigating the transition from combat to home—Including combat stress, PTSD, and mTBI*. Guilford, CT: Globe Pequot Press.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *The New England Journal of Medicine, 351,* 13–22. http://dx.doi.org/10.1056/NEJMoa040603

Hutcherson, C. A., Seppala, E. M., & Gross, J. J. (2008). Loving-kindness meditation increases social connectedness. *Emotion, 8,* 720–724. http://dx.doi.org/10.1037/a0013237

Jordan, A. H., Eisen, E., Bolton, E., Nash, W. P., & Litz, B. T. (2017). Distinguishing war-related PTSD resulting from perpetration- and betrayal-based morally injurious events. *Psychological Trauma: Theory, Research, Practice, and Policy, 9,* 627–634. http://dx.doi.org/10.1037/tra0000249

Kearney, D. J., Malte, C. A., McManus, C., Martinez, M. E., Felleman, B., & Simpson, T. L. (2013). Loving-kindness meditation for posttraumatic stress disorder: A pilot study. *Journal of Traumatic Stress, 26,* 426–434. http://dx.doi.org/10.1002/jts.21832

Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., . . . Grady, D. A. (1990). *Trauma and the Vietnam War generation: Report of findings from the National Vietnam Veterans Readjustment Study*. Philadelphia, PA: Brunner/Mazel.

Lang, A. J., Strauss, J. L., Bomyea, J., Bormann, J. E., Hickman, S. D., Good, R. C., & Essex, M. (2012). The theoretical and empirical basis for meditation as an intervention for PTSD. *Behavior Modification, 36,* 759–786. http://dx.doi.org/10.1177/0145445512441200

Litz, B. T., Lebowitz, L., Gray, M., & Nash, W. P. (2015). *Adaptive disclosure: A new treatment for military trauma, loss, and moral injury*. New York, NY: Guilford Press.

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review, 29,* 695–706. http://dx.doi.org/10.1016/j.cpr.2009.07.003

Maguen, S., Lucenko, B. A., Reger, M. A., Gahm, G. A., Litz, B. T., Seal, K. H., . . . Marmar, C. R. (2010). The impact of reported direct and indirect killing on mental health symptoms in Iraq war veterans. *Journal of Traumatic Stress, 23,* 86–90.

McCullough, M. E., Worthington, E. L., Jr., & Rachal, K. C. (1997). Interpersonal forgiving in close relationships. *Journal of Personality and Social Psychology, 73,* 321–336. http://dx.doi.org/10.1037/0022-3514.73.2.321

Nash, W. P. (2007). Combat/operational stress adaptations and injuries. In C. R. Figley & W. P. Nash (Eds.), *Combat stress injury: Theory, research, and management* (pp. 33–63). New York, NY: Routledge/Taylor & Francis Group.

Nash, W. P., & Litz, B. T. (2013). Moral injury: A mechanism for war-related psychological trauma in military family members. *Clinical Child and Family Psychology Review, 16,* 365–375. http://dx.doi.org/10.1007/s10567-013-0146-y

Nash, W. P., Marino Carper, T. L., Mills, M. A., Au, T., Goldsmith, A., & Litz, B. T. (2013). Psychometric evaluation of the Moral Injury Events Scale. *Military Medicine, 178,* 646–652. http://dx.doi.org/10.7205/MILMED-D-13-00017

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the Mindful Self-Compassion program. *Journal of Clinical Psychology, 69,* 28–44. http://dx.doi.org/10.1002/jclp.21923

Neria, Y., & Litz, B. T. (2004). Bereavement by traumatic means: The complex synergy of trauma and grief. *Journal of Loss and Trauma, 9,* 73–87. http://dx.doi.org/10.1080/15325020490255322

Nitzan-Assayag, Y., Yuval, K., Tanay, G., Aderka, I. M., Vujanovic, A. A., Litz, B. T., & Berstein, A. (2017). Reduced reactivity to and suppression of thoughts mediate the effects of mindfulness training on recovery outcomes following exposure to potentially traumatic stress. *Mindfulness, 8,* 920–932. http://dx.doi.org/10.1007/s12671-016-0666-x

Papa, A., Neria, Y., & Litz, B. (2008). Traumatic bereavement in war veterans. *Psychiatric Annals, 38,* 686–691. http://dx.doi.org/10.3928/00485713-20081001-07

Riggs, D. S., Byrne, C. A., Weathers, F. W., & Litz, B. T. (1998). The quality of the intimate relationships of male Vietnam veterans: Problems associated with posttraumatic stress disorder. *Journal of Traumatic Stress, 11,* 87–101. http://dx.doi.org/10.1023/A:1024409200155

Rodriguez, P., Holowka, D. W., & Marx, B. P. (2012). Assessment of posttraumatic stress disorder-related functional impairment: A review. *Journal of Rehabilitation Research and Development, 49,* 649–665. http://dx.doi.org/10.1682/JRRD.2011.09.0162

Salzberg, S. (1995). *Lovingkindness: The revolutionary art of happiness*. Boston, MA: Shambhala.

Shay, J. (1995). *Achilles in Vietnam: Combat trauma and the undoing of character*. New York, NY: Touchstone.

Steenkamp, M. M., Litz, B. T., Gray, M. J., Lebowitz, L., Nash, W., Conoscenti, L., . . . Lang, A. (2011). A brief exposure-based intervention for service members with PTSD. *Cognitive and Behavioral Practice, 18,* 98–107. http://dx.doi.org/10.1016/j.cbpra.2009.08.006

Steenkamp, M. M., Litz, B. T., Hoge, C. W., & Marmar, C. R. (2015). Psychotherapy for military-related PTSD: A review of randomized clinical trials. *Journal of the American Medical Association, 314,* 489–500. http://dx.doi.org/10.1001/jama.2015.8370

Taft, C. T., Street, A. E., Marshall, A. D., Dowdall, D. J., & Riggs, D. S. (2007). Posttraumatic stress disorder, anger, and partner abuse among Vietnam combat veterans. *Journal of Family Psychology, 21,* 270–277. http://dx.doi.org/10.1037/0893-3200.21.2.270

Toblin, R. L., Riviere, L. A., Thomas, J. L., Adler, A. B., Kok, B. C., & Hoge, C. W. (2012). Grief and physical health outcomes in U.S. soldiers returning from combat. *Journal of Affective Disorders, 136,* 469–475. http://dx.doi.org/10.1016/j.jad.2011.10.048

Wisco, B. E., Marx, B. P., May, C. L., Martini, B., Krystal, J. H., Southwick, S. M., & Pietrzak, R. H. (2017). Moral injury in U.S. combat veterans: Results from the National Health and Resilience in Veterans Study. *Depression and Anxiety, 34,* 340–347. http://dx.doi.org/10.1002/da.22614

Wortmann, J. H., Eisen, E., Hundert, C., Jordan, A. H., Smith, M. W., Nash, W. P., & Litz, B. T. (2017). Spiritual features of war-related moral injury: A primer for clinicians. *Spirituality in Clinical Practice, 4,* 249–261. http://dx.doi.org/10.1037/scp0000140

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