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CLINICAL HEURISTICS AND STRATEGIES FOR SERVICE MEMBERS AND VETERANS WITH WAR-RELATED PTSD

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We need to engage all well-trained and competent mental health assets, regardless of discipline and guild or degree to help our nation's veterans recover from the war trauma. The goal of this paper was to highlight salient problems and issues in the assessment and treatment of war-related trauma and posttraumatic stress disorder (PTSD) and to offer strategies and ways of thinking to redress these issues. The clinical issues and concerns I have addressed are: (a) the need to be clear about what PTSD is and isn't; (b) the need for clinicians to learn about the military culture and ethos; (c) the need to broaden the discourse about what is injurious in war, which includes a review of the existing evidence for psychotherapies for war-related PTSD; and (d) the importance of assessment and outcome monitoring in the treatment of PTSD.

Keywords: PTSD, war veterans, clinical guidelines

I presume that anyone who reads this commentary is deeply affected by war professionally or personally. You may be a service member or veteran, you may be caring for or treating service members or veterans, you may have a loved one who is in the military, you may be a concerned citizen wanting to be informed, or you may want to find a way to start treating service members or veterans with PTSD and related problems. My goal was to highlight some of the salient problems and issues in the field of war-related trauma and post-traumatic stress disorder (PTSD) that have emerged from experiences doing clinical work, clinical research, and teaching in the United States military and Veterans Affairs, focused chiefly on ways to prevent and treat war-related PTSD. These remarks are addressed to mental health professionals across disciplines, guild, and theoretical orientation who treat or intend to treat service members or veterans. The clinical issues and concerns addressed are: (a) the need to be clear about what PTSD is and isn't; (b) the need to learn about the military culture and ethos; (c) the need to broaden the discourse about

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what is injurious in war, including a review of the existing evidence for psychotherapies for war-related PTSD; and (d) the importance of assessment, case-conceptualization, target selection, goal setting, and outcome monitoring.

What Is and What Isn't PTSD

As defined, PTSD is a mental illness. Although there are legitimate debates about the construct validity of PTSD as defined in the nosology and even the usefulness and validity of PTSD as a clinical disorder, I believe that it is useful if not essential for clinicians, family members, the media, and veterans to be clear about PTSD as a clinical disorder, with a distinct set of causes, a course, and an approach to treatment. This might seem trivial and obvious, but I believe that in clinical practice, PTSD is overdiagnosed and overutilized in case conceptualization and in terms of explanatory labeling. There is also no doubt that in the culture, among family members, and among service members and veterans, PTSD is far too liberally applied and evoked to explain the diverse biological, psychological, behavioral, spiritual, and social consequences of warzone exposure. Why would clinicians be less immune to this way of thinking?

Before substantiating the argument about why adhering to a narrow view of PTSD as a mental disorder is important, let me first share the common and very real frustrations about the PTSD syndrome. First, PTSD entails a strikingly heterogeneous, poorly defined kitchen-sink set of symptoms and problems, many of which are derived from hunches and pet theories by experienced and putatively sage clinicians and researchers, rather than substantive empirical science. The cutoff point that determines whether a given patient merits the diagnosis is also relatively arbitrary; it is very easy for a patient to be suffering substantially from legitimate and highly distinctive PTSD symptoms to be short a symptom and not be identified as a case. In addition, as I will describe further below, the PTSD syndrome is derived from the questionable and often ill-fitting assumption that trauma is exclusively life-threat-based and symptoms are the downstream systemic results of high fear and fear conditioning.

Notwithstanding these caveats and problems about the PTSD diagnosis, there is good reason to adopt the core ideas behind PTSD defined as mental illness. Chiefly, this is because PTSD is far too readily used as a label to explain and describe a far too wide swath of mental, social, behavioral, spiritual, biological, and cultural war-related maladies. If clinicians use the PTSD label, it should be with acuity and specific purpose in terms of their clinical decision-making. This is not possible if PTSD is used as a catch-all term and all sorts of problems are ascribed to it; it loses its explanatory power and clinical utility.

War is grotesque and unimaginably hellish and we should painfully know as a society that there will be no free lunch in the context of 10–12 year-long wars of insurgency. We should also be vigilant about the very real possibility that insult will be added to injury if the culture is less honoring of the sacrifices of service personnel and their families over time. One way to look at the changes to come is to consider that more than 50% of military personnel were between the ages of 17 and 29 at the start of the war in Afghanistan. This means 12 years later, many have now formatively developed with a war or warrior identity. What this at least translates to is that thousands of now not so young men and women will have difficulty adjusting to military lives while in garrison, with the annoyances and hassles and relationship problems, or to civilian life, with much more unconstrained adversities and demands. If you add to this mix problems with unemployment or

boring and undignified underemployment (relative to military roles) and a culture that quickly forgets to prioritize the needs of veterans and may even forget their sacrifices when years later they are having difficulties, we can predict a host of serious problems that need to be prevented and redressed.

However, problems such as substance abuse, relationship strain, intimacy difficulties, anomie, employment difficulties, law-breaking and justice-system involvement, unsafe driving, inattention to wellness and fitness, and so forth, although clearly implicated by military experiences, are not necessarily caused by exposure to war trauma and are not de facto direct or collateral signs of PTSD. And the solutions to these problems are in no way the special purview of psychotherapists and mental health professionals. Also, the reader should bear in mind that PTSD is not the only mental health problem a given service member or veteran may have; some have valid preexisting personality and mental health problems that are worsened when the self- and other-organizing nature of deployment roles and duties or the structures and constraints of deployed or military life in general are taken away. Added to this is the possibility of the long term impacts of physical and head injury and related limitations of mental status, motivation, and behavioral capacities (see Hill, Mobo, & Cullen, 2009; Vasterling, Verfaellie, & Sullivan, 2009). Yet, the assumption of the primacy of the PTSD explanation and label abounds among most family members, leaders, peers, and care providers in the military and in the veteran community. The best case for restraint is the data about attempted and completed suicides in the military; at least half occur among service personnel who never deployed to war.

Let me offer some suggestions about how to approach PTSD in clinical practice and when communicating with veterans and family members. First, PTSD is a mental disorder conceptualized to be linked to a *specific episodic memory*. In other words, as defined, PTSD requires exposure to a discreet serious threat to survival, viability and unprecedented affects.

In broad terms, PTSD is a collection of symptoms that depict what happens to a person biologically, psychologically, spiritually, and socially when they are haunted and consumed by an unthinkable event. This is the sine qua non precondition. The expectation is that with haunting comes the strong motivation to avoid reminders that trigger recollection of the experience, as well as emotional numbing, which is comprised of problems related to a restricted range of affect, detachment from significant others, and disengagement from previously pleasurable activities. Because in the *DSM* PTSD is construed as caused by life threat and dysregulation of fear circuitry, the *DSM* also requires symptoms of hyperarousal and nervous system hyperactivity. Finally, as would be expected of a mental disorder, these symptoms have to cause or at least be temporally linked to functional impairments in work, relationships, and self-care.

I may be stating the obvious, but it bears underscoring. For war veterans, the PTSD construct is not conceptualized as a maladaptive and altering response to war in general or a collection of awful military experiences. This is not to say that the Gestalt of exposures and experiences are not relevant to how service members change after coming home. War is transformative. If fortunate, some grow and mature; they become more engaged, empathetic, and focused on making life and relationships meaningful and loving. Others are chronically bitter and resentful, if not quick to rage, about mistreatment or the inherent unfairness of sacrifices. But again, most of the maladaptive, painful, and adverse alterations that service members or veterans experience are no less important to families, institutions, the culture, and care providers but they are not mental illnesses.

What should clinicians do to be more specific in their application of the PTSD diagnosis when dealing with veterans of war who have multiple high-magnitude awful

experiences? Formal structured diagnostic instruments employ the following tactic (e.g., Blake et al., 2000; Foa & Tolin, 2000; Weathers, Ruscio, & Keane, 1999; Weathers, Keane, & Davidson, 2001), which I highly recommend. The clinician should ask the service member or veteran what the event is that is the worst and most currently haunting and distressing. Then, questions about the frequency, intensity, and impact of the specific PTSD symptoms should be asked in the context of this worst event (or for some symptoms, since this event occurred, to establish temporal linkage). What does this accomplish? If the service member or veteran does not have clear PTSD in the context of an event that is for them the worst and most currently distressing and haunting, then, although he or she may be suffering and changed by this and other war experiences, PTSD as mental disorder is not the right current focal point to the case and is not the right current target. This process of focusing on the worst and most currently distressing experience and the phenomenology that flows from it can also help a service member or veteran reduce some of the noise they experience about what is going on and to test the limits of the PTSD diagnosis to sufficiently explain what is going on. Service members, veterans, and family members will be helped to know with a degree of confidence that various problems are or are not explained by PTSD and what the PTSD label means.

Learn About the Military Culture and Ethos

Many service members and veterans are, for good reason, suspicious of therapists who don't understand the military culture and of the amount of work it takes to explain their deployment experiences and the idioms of that world. Even the most genuine, caring, empathetic, and curious psychotherapists are not immune. We have to be cautious about failing to appreciate the divide between our value system and a given service member or veteran's values (and upbringing). The goal is to understand and respect the lived experience of military members and veterans and what shapes their understanding of various harms, as well as their views of themselves. Some of this can come from reading and absorbing film, art, and novels that beautifully and poignantly depict the military culture and ethos, the rest can only come from experiences trying to bridge the communication divide.

Of course, no civilian or even veteran care provider "who was not there" can ever really *know* about the military culture and context or life in a military unit, let alone the unique experiences that have crossed that individual and culture-bound threshold which constitutes trauma for robust, experienced, well-trained, well-supported, and prepared service members. And some service members and veterans will use any divide as an excuse to maneuver away from painful material and as a defense from experiencing vulnerability. So, although I am arguing that it is essential for clinicians to learn about the military culture and ethos if they are working with service members and veterans, it is important to appreciate that at the end of the day they will need to find ways of managing uncertainties and respectfully and empathetically helping the individual push through this legitimate divide. The key is to admit to what is unknown and show a genuine respect for and desire to learn more about each individual's unique experience.

Therapists working with service members and veterans need to be mindful of the unique cultural and contextual components of military trauma, the phenomenology of warriors, and the clinical issues that arise from combat and operational stressors, losses, traumas, and experiences that are morally compromising. There are numerous invaluable resources that can provide clinicians sufficient background information about the military experience and the various sources of stress and trauma in war (e.g., French, 2004; Nash,

2007a; Nash 2007b; Pressfield, 2011). It is also important that psychotherapists learn standard military acronyms, abbreviations, and standard idioms. For example, one thing I hear a lot is the generic use of the term "soldier" which can be unnecessarily off-putting to service members from other branches, e.g., marines (Marine Corps) are not soldiers, nor are sailors (Navy). In general, the generic terms troops, service members, and service personnel are more accurate choices.

The aim is for clinicians to be aware of military ethos themes and the role- and culture-bound ways of construing those experiences that affected outcomes and narratives at the time of exposure to specific haunting war experiences. Clinicians should also be familiar with the way military-identity issues continue to play a part in adaptation to civilian life and shape or constrain recovery and healing. Some of the themes that professionals need to be aware of are that service members are trained to be tough and stoic, value the lives of others in their group more than their own, strive to lead and have loving bonds with leaders, tend to dehumanize the enemy, and likely are full contributing members of a culture that reinforces machismo (and sometimes misogyny), all of which may provide advantage in battle. Of course, toughness, stoicism, and dehumanization cannot possibly be sufficient to transcend deeper, and in many respects hard-wired, human responses to potential annihilation, killing, bearing witness to death, and loss of brothers and sisters in arms. And these qualities thwart healing for many. Yet, clinicians also need to be mindful of their biases in this regard. For some veterans, it is adaptive and necessary to be stoic and to keep memories at bay, and this is not a mental disorder.

Recognize That Life-Threat Trauma Is Not the Only Psychic Wound in War

As stated briefly above, the prevailing theory about why acute and chronic stress and trauma are harmful is the neoconditioning, fear-system-based, biological model of uncontrollable stress. This model is doctrine in the medical model of PTSD. The essential necessary precondition is exposure to life-threat trauma, which triggers an unconditioned "fight, flight, or freeze" response, initiating activity in the hypothalamic–pituitary–adrenal axis, the locus coeruleus and noradrenergic systems, and the neurocircuitry of the fear system. This hard-wired response to life threat is richly encoded in memory and conditioned to a variety of peri- and postevent stimuli. In this framework, PTSD is, in effect, the manifestation of traumatic Pavlovian conditioning and learning (e.g., Norrholm et al., 2011). In life-threat contexts, this model is compelling and valid from a variety of perspectives.

However, my colleagues and I have argued that in the military in a time of war (and other complex contexts), life-threat trauma is not the only hazard that threatens resilience (e.g., Litz et al., 2009). Cumulative wear and tear, loss, and inner conflict from morally injurious experiences, such as killing or failing to prevent unethical behavior, are equal challenges to resilience (Nash, 2007a). Each of these resilience challenges has a different phenomenology, etiology, and course than life-threat experiences. Consequently, each requires a different perspective on treatment, but to date the focus has been on stress and fear.

I would also argue that there are fewer cases of PTSD related to life-threat trauma in the modern military. Service members are self-selected (and screened) to be able to be trainable in the face of life threats. The modern military also provides exceptionally tough, realistic training for various roles and potential high-threat experiences. Because of the warrior ethos and training, high-threat experiences are not likely to elicit the kinds of peri-event responses that define life-threat trauma in other contexts, namely intense fear,

helplessness, or horror. Performing duties, assisting peers, and surviving in battle are not laden with internal and social conflicts; those are likely construed as heroic, sources of pride, and resonant with role, self-, and group identity (e.g., Nash, 2007a). For those who develop a high-threat-caused stress injury, arguably the most pressing problem is not high states of arousal but the self-condemnation and guilt that may arise from letting peers and leaders down because of a temporary incapacitation in the field. Moreover, there is reason to assume that most threat-based stress injuries are readily healed by indigenous military rituals and assets. For example, peer and social supports, training, and effective leadership are often sufficient to recover from high-threat experiences. The social element is particularly important; there are ritualized opportunities to operationally unburden and bond by sharing narratives about common high-threat experiences. In addition, in pure learning-theory terms, leaders in the theater of operations typically ensure sufficient exposure to high fear contexts to provide natural extinction of any conditioned fear. Wear and tear challenges are also typically handled well; leaders make sure that service personnel get respite after highly charged and sustained operational demands.

By contrast, I would argue that there are far fewer indigenous military resources to promote resilience and support healing and recovery in the face of loss of life (especially the survivor guilt that can ensue; see Prigerson et al., 2009) and the lasting impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations (i.e., moral injury; Litz et al., 2009). Furthermore, the conditioning and learning model built on the concept of high threat and fear does not sufficiently explain, predict, or address the needs of many who are exposed to the divergent and diverse psychic injuries of war (and many other traumatic contexts). Participants in prevention and treatment efforts need to consider different mechanisms of change, targets, and intervention strategies. What would lead to more lasting mental, spiritual, biological, and social difficulties over the long haul, a personal life-threat experience or a child's suffering, a moral or ethical transgression in a moment of blind rage or the grotesque loss of a special and loved member of a unit?

To put these issues in context, consider this thought experiment: What might promote a service member's healing and recovery from a single life-threat incident, such as a sniper attack when no one was hurt (high threat)? Contrast this with a service member who is plagued by the aftermath of an explosion that killed her best friend, whose death she witnessed (traumatic loss). Contrast that with a service member who is haunted by an incident in which he acted out his rage due to a mortar attack that killed his friend the day before (he was not present when that happened) by killing an unarmed civilian man who was agitated during a house search (moral injury related to perpetration). Compare that with the experience of a service member who is angry and demoralized by a betrayal of a trusted leader whose ruthless and capricious decision led to the unnecessary deaths of civilians. Does the fear-conditioning model fit any case but the first?

Having been critical of the conditioning model, let me also say that we owe a debt of gratitude to the advances that the model has brought to the trauma and PTSD field in the last 20 years or so. There has been a proliferation of clinical trials of prevention strategies (see Litz & Bryant, 2009) and well-designed trials of psychotherapies for chronic PTSD (see Bradley, Green, Russ, Dutra, & Weston, 2005; Cahill, Rothbaum, Resick, & Follette, 2009). This work has led to extraordinary accomplishments, bringing science to bear on the treatment of PTSD, and much of this work informs the care of veterans of war.

Clinical-trials research forms the basis of several noteworthy consensus- and evidence-based best practice recommendations for the treatment of PTSD, which anyone who treats PTSD in their practice should know well (Forbes et al., 2007; National Collabo-

rating Centre for Mental Health, 2005; see Forbes et al., 2010), and one specifically to inform the care of service members and veterans (see Rosen et al., 2004). In addition, the Institute of Medicine (IOM) summarized the scientific evidence that substantiates various treatment modalities, commissioned by the United States Department of Veterans Affairs (VA; IOM, 2007). Based on the available evidence, the most robust consensus recommendation is that cognitive–behavioral therapy (CBT) should be considered as the prescriptive, front-line evidence-based treatment for PTSD, for many valid reasons. I would argue that many core CBT principles and tactics should be used to treat PTSD.

However, unfortunately, because most of the well-designed efficacy trials target civilian motor-vehicle accidents or women rape victims, it is unknown if CBT, as designed and promulgated (standardized, relatively inflexible), is sufficient to help service members and veterans. In addition, because leaders in the CBT field have not adequately considered the unique cultural and contextual elements of military trauma, the phenomenology of warriors or the clinical issues that arise from combat and operational stressors, losses, traumas, and moral injuries, there are significant missing elements to care models built on CBT, especially with respect to treating active-duty service members. The IOM summarized the state of the evidence pertaining to the treatment of military trauma in the following way.

> In applying a rigorous approach to the assessment of evidence that meets today's standards, the committee identified significant gaps in the evidence that made it impossible to reach conclusions establishing the efficacy of most treatment modalities. This result was unexpected and may surprise VA and others interested in the disorder. Important treatment decisions for most modalities will need to be made without a strong body of evidence meeting current standards (IOM, 2007, p. ix).

There have been two large-scale, well-designed randomized controlled trials of CBT with VA patients with chronic PTSD. Because large-scale multisite clinical trials use varied clinical settings, employ broad inclusion criteria so that treated patients are similar to patients in the community, and use well-trained and supervised but nonexpert clinicians, the findings are more generalizable to clinical practice than small-scale clinical trials, and they deserve special critical attention. One of the studies was a large-scale trial of group-based exposure therapy with male Vietnam veterans with very chronic PTSD (Schnurr et al., 2003), and the other was a trial of individual prolonged exposure therapy with women veterans (average age = 45), the majority of whom had experienced sexual assault (Schnurr et al., 2007). In each trial, the CBT was compared with a present-centered, process-oriented group or individual therapy. The trial of male Vietnam veterans was negative (the group-exposure therapy was not effective), and the results of the trial using women veterans were sobering. Although immediately after the therapy ended and at a 3-month follow-up, PTSD symptoms were somewhat lower in the group that was treated with prolonged exposure (with effect sizes of .29 and .24, respectively, reflecting a small advantage of exposure vs. present-centered treatment), there were no differences between the two therapies at a 6-month follow-up.

Why are the results of clinical trials of complex war-related PTSD disappointing relative to outcome studies targeting single-incident, adult-onset, high-threat trauma (see Steenkamp & Litz, 2013), such as accidents (men and women) and sexual assault (women only), and what should be taken from these disparate results? To answer this question, it is important to critically examine the Zeitgeist for understanding the psychological and biological factors responsible for the etiology and maintenance of PTSD, and the treat-

ment needs of traumatized individuals, namely the fear-conditioning model. In one form or another, the fear-conditioning model has guided thinking about the etiology of war-related PTSD since Dollard and Miller's (1950) work with WW-II veterans, through the work of Lawrence Kolb (a Navy psychiatrist during WW II) and his colleagues on the conditioned emotional response in Vietnam veterans (e.g., Kolb, 1987), to the first model of assessment and treatment based on conditioning theory (e.g., Keane, Zimering, & Caddell, 1985) and, currently, via attempts to prescribe prolonged exposure therapy in the VA and in the U.S. military (e.g., Karlin et al., 2010; see Friedman, 2006).

In the fear-conditioning model, trauma is construed as a serious harm or threat. This event is posited to be an unconditioned stimulus (US) that reflexively elicits biological imperatives or unconditioned responses (UR), which entail peritraumatic flight, fight, or freeze behaviors, high physiological arousal, and fear. The UR is automatically paired with a variety of contiguous peritraumatic environmental and internal phenomenological cues (conditioned stimuli or conditional stimulus; CS), causing strong associative bonds (conditioning). When confronted with actual or memorial representations of these CSs, a conditioned response (CR) ensues, which mimics the original peri-event UR.

In the learning framework, PTSD arguably develops because of what individuals do when inevitably faced with CSs. According to the two-factor learning precept, a core supplementary concept to the fear-conditioning model (Keane, Fairbank, Caddell, Zimering, & Bender, 1985), if individuals succumb to the strong motivation to avoid trauma-related CSs (the "first factor"), the reduction in arousal and negative affect that ensues reinforces (via operant conditioning, the "second factor") various avoidance behaviors. Consequently, in PTSD, avoidance behaviors become automatized and habitual (and hard to change). From this, it is not surprising that treatments that have been developed based on conditioning theory for phobias and other anxiety disorders, namely exposure therapies, are the predominant treatments for PTSD (Foa, Rothbaum, Riggs, & Murdock, 1991).

In exposure therapy, the goal is the extinction of CSs so that their association with the US/UR is reduced or eliminated. The change agent is comprised of repeated and sustained exposure to CSs, without avoidance maneuvers, which can be subtle and tenacious. Modern conceptualizations of exposure therapy (in the past the treatment was called "implosive therapy" or "flooding;" the term "prolonged exposure" is currently in vogue) underscore the need for "emotional processing" of the CSs, which are represented in memory in networks of fear-based associations (Foa & Kozak, 1986). The "fear network" is hypothesized to contain CSs, memories of the peri-event UR, constructions related to the experience, and the experience of being harmed by the event (meanings and implications). To be effective, exposure therapy requires sustained exposure to all of these elements, as well as "exposure to corrective information" (experience) such as a reduction in fear and arousal (rather than escalating terror), which creates new countervailing memories (changing the fear network).

Why is exposure less effective with veterans? Pitfalls and failures in exposure therapy are said to occur because avoidance behaviors (or difficulties in the therapeutic relationship or context) interrupt sufficient memory activation and processing, thwarting exposure to corrective experience (Foa & Kozak, 1986). In the context of war veterans, CBT may be ineffective because the network of war memories is not sufficiently evoked or accessed, and it could be that without special considerations and tactics in therapy, the characteristics of war trauma and veterans of war preclude sufficient emotional processing and engagement in CBT (see Foa, Riggs, Massie, & Yarczower, 1995). This may be because current approaches do not provide enough latitude or guidance about uncovering under-

lying toxic memories, nor do they provide sufficient ways to push through service members' and veterans' defenses and avoidance maneuvers during the exposure. However, signs of within-session distress during exposure therapy as practiced do not necessarily lead to posttreatment improvements (e.g., see Pitman et al.'s 1996 open trial of exposure therapy with Vietnam veterans).

It is also important to point out that the most successful trials of exposure therapies entail a combination of in-therapy exposure (via "imaginal" recall) and in vivo exposure to CSs in the environment. One could argue that the results of the exposure therapy trials with motor-vehicle accident and rape survivors are so impressive because extensive in vivo exposure is paired with imaginal therapy (e.g., riding in a car, going to the context that a sexual assault occurred, etc.). These in vivo contexts represent opportunities for bulls-eye exposure to corrective experiences. The same cannot be said of war-trauma, especially highly distal experiences (e.g., combat in Iraq). This is not an insurmountable problem because there are environmental triggers of the network of painful war experiences, such as news reports, conversations, emotional states, anniversaries, and sounds and smells, but their lower intensity and accessibility reduce their therapeutic value; homework assignments need to have a high probability of credibility, occurrence, and success to be effective.

My colleagues and I have argued that there is no need to throw the baby out with the bath water (Gray et al., 2012). There are many CBT strategies and tactics that can and should be leveraged when addressing loss and moral injury among war veterans. We are evaluating a psychotherapy we call *Adaptive disclosure*, which is a manualized therapy that we developed specifically for active duty service members (Steenkamp et al., 2011). The approach is a hybrid of existing CBT strategies, namely, a form of exposure therapy (imaginal emotional processing of a seminal event) that also incorporates some techniques used in other cognitive-based treatments. However, *Adaptive disclosure* also extends these strategies by packaging and sequencing them specifically to address the three most injurious combat and operational experiences, namely, life-threat trauma, loss (principally traumatic loss), and experiences that produce moral injury and inner moral conflict.

Adaptive disclosure consists of eight weekly sessions, considerably shorter than standard CBT (and certainly most psychotherapies) to accommodate service members' time constraints and potential for deployment or relocation. The first session is used to evaluate service members' current status, establish the event to be targeted (the most currently distressing, haunting, and impairing), and to educate the patient and establish realistic goals. The middle six sessions incorporate an imaginal exposure exercise and are devoted to emotionally processing the principally harming war memory, unearthing various elements and associations, as well as helping service members articulate their raw uncensored beliefs about the meaning and implications of their experiences. If the core event was life threatening, these sessions are very similar to exposure therapy as practiced. However, in cases of moral injury or traumatic loss, after the raw emotional-processing of the event, separate "experiential breakouts" are employed. In these breakouts, patients 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. The goal of these sessions is to provide corrective, alternative emotional experiences, such that the experience and internalization of the original trauma is modified positively. We emphasize in the therapy that the treatment is the start, not the finish. Our goal is to plant healing seeds and to hopefully provide a corrective experience that instills hope that repair is possible. We emphasize that the meaning and implication of the traumatic experience is undeniably true as are other pre-event and future truths that are

inconsistent with beliefs about "badness" or "unworthiness" and so forth. The last session is used to review experiences, underscore positive lessons learned, and plan for the long haul in terms of the challenges ahead and the need to do the hard work of finding new ways of healing and recovering.

Use Formal Structured Assessment Processes to Guide Your Work and Track Progress

One of the distinctively attractive aspects of CBT approaches to care is that each patient's treatment is evidence-based; each therapy is a single-case clinical trial, if you will. Service members and veterans are evaluated formally at the outset of therapy with a psychometrically sound, structured diagnostic instrument. The questions that need to be answered are, "Does this patient have PTSD? Is PTSD the right primary and guiding schema to use for the patient at this time?" In both the active-duty military world and in the VA, this is not strictly an issue about the validity of the label, in terms of how to best conduct and focus care (and to determine if formal mental health care is the right path). In these contexts, the label also carries highly significant meaning for service members, peers, leaders, family members, and employers, and it has implications for financial compensation for service-connected disability.

The other questions addressed in standard CBT care are, "How is this patient doing each week? Is he or she getting better?" This is accomplished by at least weekly administrations of a paper and pencil questionnaire, such as the PTSD checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993). I highly recommend this practice regardless of the type of treatment employed. It is a win–win. Patients become better consumers of treatment, for instance. If they have PTSD and the therapy is trauma-focused and designed to specifically reduce symptoms, suffering, and impairment, as conceptualized in the PTSD context, than therapist and patient should be aware of what the patient's PTSD symptom burden is over the course of therapy (and at the end). Also, self-monitoring of PTSD symptoms has been shown to promote change. This is for good reason. Self-monitoring and symptom tracking helps patients realize that symptoms fluctuate for systematic reasons (e.g., a stressful week or a week full of exposure to reminders). An experiential understanding of the link between internal and external events and PTSD symptoms can also reduce confusion and help patients to focus their attention on working strategically to plan, manage, and cope with various provocations, rather than to avoid them altogether, which never works.

Because most service members and veterans seeking treatment for putative war-related PTSD have complicated and interrelated mental, social, and behavioral problems, the initial assessment should also be used to conceptualize a given case, determine if a given professional has the right skill set to address the most pressing or salient problem, generate a treatment plan and prioritize targets for intervention, and plan a therapy that has a beginning, middle, and end (e.g., Steenkamp et al., 2010). It is of note however that this kind of practice is actually out of vogue in the current CBT climate. To put this in context, historically, CBT (in the first few decades, CBT was called behavior therapy), actually exclusively employed an ideographic (*idios* means private or personal in Greek) approach to mental health problems. This predated the current universal acceptance and adherence to the disorder-based categorical or nomothetic (*nomos* is Greek for law) approach to treatment, whereby treatment packages are prescribed mechanistically and systematically to disorders, regardless of individual presentations and contexts. Historically, in behavior therapy, labels (diagnoses) were eschewed; instead, individuals in specific environments/

contexts were the focus of treatment. This is accomplished by conducting a functional analysis, which allows for an ideographic conceptualization of the personal and contextual factors that lead to or maintain specific problems (Haynes & O'Brian, 1990), such as fears in certain situations, communication problems, substance use, eating problems, aggressive behavior, and so forth (e.g., Christensen, Jacobson, & Babcock, 1995).

By contrast, modern CBT employs a standardized nomothetic approach to specific mental disorders. Consequently, CBT manuals for specific conditions and specific approaches are used to ensure that treatments are provided uniformly and systematically. Therapy manuals describe the steps and strategies that are to be employed in a serially ordered, session-by-session fashion. The CBT manual is the prescription for change (it is somewhat akin to a prescription for a type of medication, to be administered at a given time of day, and over a course) and the intent is for the therapy to be applied as described for each case. This is not a bad thing. Manualized and replicable CBT has helped improve care for mental disorders and has made widely disseminated evidence-based care for mental health problems possible.

As a rule, doctrinaire nomothetic approaches to treatment are most appropriate for engaged and well-motivated patients with uncomplicated focal clinical problems. For example, it would be very appropriate to use nomothetic, manualized CBT for service members with focal deployment-related, high-threat, fear-based PTSD and no preexisting history of trauma or abuse. As described, the evidence for this approach is exceptionally strong. However, the clinical evidence gathered in standard therapeutic settings is lacking for complex traumas that involve human malice. Arguably, one of the problems is that the therapy is applied too inflexibly. Rigid adherence to a CBT protocol can understandably strain credulity, cause problems in the therapeutic relationship, and lead to poorer outcomes (e.g., Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996).

In the context of the treatment of war trauma, loss, and moral injury, I would argue that the care needs to be systematic, goal-oriented, collaborative, and monitored in terms of strategy, and clinicians need to adhere to the boundary conditions of a particular change agent. However, in complex cases, the specific type of change agent needs to be flexibly and ideographically chosen, and varied tactics need to be used to give the change agent its best shot at working with a given case. The assessment issue that arises from this is the need to conduct a case conceptualization to establish strategic goals, and a treatment plan needs to flow systematically from that conceptualization. The treatment plan specifies intervention strategies to accomplish strategic goals, which may need to change based on new information and feedback. The feedback requires an empirical approach to symptom monitoring.

There are extensive conceptual and empirical grounds for a flexible approach to the treatment of PTSD, as long as evidence-based principles are employed systematically. For example, Eifert, Schulte, Zvolensky, Lejuez, and Lau (1997) argued that nomothetically applied CBT fosters a disregard for differences between patients with the same *DSM* diagnosis and promotes a blind eye toward assessment of an individual and his or her circumstances (and strengths and weaknesses), and this can account for treatment failures. A more collaborative and flexible approach would be associated with better therapeutic alliances, and flexible but systematic CBT approaches would emphasize individual values, interests, and interests, thereby maximizing engagement and effectiveness in PTSD care. In addition, the flexible ideographic approach more closely mirrors what clinicians actually do (or want to do) in clinical practice when faced with complex or entrenched clinical problems with service members and veterans.

Summary

In this paper, I tried to be true to the complexities and considerable challenges of treating war trauma. I hope to have offered some clarifying and helpful remarks and suggestions about what I see as some of the key issues that should be in the minds of clinicians new to treating service members and veterans for war-related trauma and PTSD. I described the dangers of using the PTSD diagnosis and label too liberally and I offered a way to use the PTSD construct in practice. I emphasized the undeniable need for clinicians to learn about the military culture and ethos and learn to conceptualize their cases in light of the unprecedented, unique, and powerful demands and rewards of war-zone experiences. I provided a historic overview of PTSD treatment and the origins of the fear-based model of PTSD and argued that in the context of war, clinicians will fail their patients if they fail to address head-on the unique sequelae of loss and guilt from survival and moral injury. To put these issues in context, I described a psychotherapy that we have developed to target the three sources of psychic harm during war-time, namely life-threat trauma, loss (principally prolonged grief and guilt), and moral injury. Finally, I underscored the need to formally assess and conceptualize service members and veterans seeking care for various mental wounds as well as the importance of monitoring progress systematically.

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