Evidence-Based Trauma Treatment: Problems With a Cognitive Reappraisal of Guilt

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Across the U.S. Veterans Affairs health care system, there have been programmatic initiatives to implement evidence-based psychotherapies (EBPs) for posttraumatic stress disorder, such as Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) (Chard, Ricksecker, Healy, Karlin, & Resick, 2012). Several thousand clinicians have been trained, which makes these manualized treatments some of the most widespread and influential clinical training tools in the country. This article contends that these approaches are inadequate in responding to what is arguably the most important impact of military trauma: an enduring sense of guilt, remorse, and regret. A dialogue from the CPT training manual is highlighted as an example of how a therapist’s assumptions about, inattention to, or underestimation of clients’ moral horizons can cause harm. The author situates this critique in a broader discussion of some of the ways that psychology in general has dismissed guilt by divorcing it from the traditional contexts and value systems that give it meaning. This includes the cognitive–behavioral propagation of guilt as the byproduct of an irrational and unhelpful cognitive style, and recent research on moral injury conceptualization and treatment.

Keywords: guilt, moral injury, trauma, treatment

When the U.S. Veterans Affairs (VA) health care system established a national policy requiring that all veterans with posttraumatic stress disorder (PTSD) have access to Cognitive Processing Therapy (CPT) and/or Prolonged Exposure (PE), thousands of providers began to be trained in these approaches (Chard et al., 2012). There have been some critiques of the fact that this widespread dissemination was based on relatively few randomized controlled trials on veterans with combat-related PTSD—in their response to a Karlin and Cross article in American Psychologist in January 2014, Steenkamp and Litz (2014) said there had only been one such study—still, these evidence-based psychotherapies (EBPs) are widely regarded as the “gold standard” for PTSD treatment. Given that the VA is the largest health care network in the United States, and the largest training environment for psychologists (Karlin & Cross, 2014), it is difficult to overestimate the effect that these treatments are having, not just on the patients who receive them but on the clinicians who learn to conceptualize trauma through the worldview(s) that these treatments espouse. The purpose of this article is to critically examine the very complex and reciprocal way that EBPs define and influence what is arguably the most important impact of military trauma: an enduring sense of guilt, remorse, and regret. Although there are multiple types of guilt identified in psychological literature (Shapiro & Stewart, 2011), this article uses the generic term, which is not inconsistent with how guilt is used in most clinical settings and resources (e.g., the Diagnostic and Statistical Manual of Mental Disorders, fifth edition [DSM–5]). It is hoped that readers will gain an appreciation for the ways that guilt has been pathologized by the discipline of psychology at large, that is, characterized as something intrapsychic rather than intrapersonal.

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relational, and maladaptive rather than inherently valuable. Current EBPs for combat-related trauma have adopted this view of guilt in a way that makes treatment interventions for it dangerously acontextual, insensitive, and unreflective. As the EBP that has the most explicit interventions for guilt, CPT will be the focus of this analysis.

**The Devaluation of Guilt in Psychological Discourse**

There is a CPT motto which avers that “guilt is a feeling, not a fact.” It is used to counter patients’ guilt-related “stuck points” in a global way: just because they feel guilty about something, that does not mean they are guilty. With the help of the therapist, they are to learn rational thought processes to challenge the irrational feeling. Yet this conceptualization of guilt only makes sense in a certain frame of discourse. Using another hermeneutical framework, we may just as well say that guilt is a fact, not a feeling. Indeed, CPT is rooted in the cognitive-behavior therapy (CBT) tradition, which has an ethic of its own (Slife, Reber, & Richardson, 2005). A significant thread in the early development of CBT was the idea that religiosity was an indication of an irrational, inflexible, and unhelpful thinking style with psychological by-products like guilt that had little meaning or value. Albert Ellis determined guilt to be the antithesis of pleasure, self-expression, and good sex (Ellis, 1958). Although CBT has supported and promoted a general devaluation of guilt, it is also not the origin of that devaluation. Philosophers and social theorists have argued that understandings of selfhood have shifted such that the modern psychological subject is radically independent and autonomous, an individual inherently geared toward self-actualization on his or her own terms and free from traditional moral values (e.g., MacIntyre, 1981; Taylor, 2007). Freud (1959/1975) encapsulated and popularized this movement when he theorized that everyone suffers from the death instinct, and that energy not directed outward in will to power turns inward as masochism and guilt. Phillip Rieff summarized:

Its origins having been explained thus naturalistically, the sense of guilt can hardly be considered a reliable index of real felony and warrantable remorse. Since no distinction is drawn in the Freudian scheme between natural and moral evil, no room is left for guilt as distinct from ignorance. The overscrupulous and science-ridden person is in the grip of certain prepossessions of which he is unaware; and the presumption is that his guilt will dissolve in the rational self-consciousness fostered by therapy. Guilt indicates lack of self-understanding, a failure of tolerance toward himself on the part of the natural man. (Rieff, 1979, p. 275)

Thus stripped of any value or function, guilt becomes nothing more than an affliction, an individual style of appraisal marked by rigidity and neuroticism. One example of how reflexively this view is incorporated is Lee, Scragg, and Turner’s (2001) clinical formulation of guilt-based PTSD. They initially note that guilt is separate from shame and humiliation in that guilt relates to “a violation . . . from standards of behavior” (p. 461), but in the remainder of the article they refer to “a feeling [emphasis added] of responsibility for causing harm to others” as if actual culpability or responsibility is irrelevant. This is further developed in their explanation that guilt is experienced intrapsychically due to “rules for living . . . [that] have been set up to avoid activation of underlying maladaptive core beliefs” (p. 462)—they credit Aaron Beck for this idea. In their clinical example (a civilian who has guilt-based PTSD after a bank robbery from which he escaped without trying to help others), the identified dysfunctional assumptions are “I must always act benevolently towards other people” and “other people’s well-being is my responsibility, therefore I must always look after people” (p. 462). The authors then work to identify the origin of these beliefs. They are looking for a shame schema (despite the original separation of shame and guilt, they get confounded here) and it is not hard to find one: The only way the patient could get his distracted parent’s approval was by being helpful and responsible; this led to a core belief that he was not good enough; he develops dysfunctional assumptions about acting benevolently and looking after others. In sum, the authors invoke childhood history to make a case for guilt as a style of cognitive appraisal that is separate from objective reality, unattached to value systems or traditions, and maladaptive by definition.

In accordance with its supposed uselessness, guilt is included as one of the “negative trauma-related emotions” of PTSD in the DSM–5 (American Psychiatric Association, 2013) and
assumed by many clinicians to contribute to maladaptive behaviors like social withdrawal. It is also often contrasted with self-forgiveness, which is another way of implying that there is no actual “Other” that has been neglected or harmed. In this context, the therapy room in which a patient mentions guilt is a relational vacuum, where the therapist’s role is to help the patient change his or her perspective or experience of the self.

However, a consistent research finding is that guilt is on the whole not just a moral emotion, but an adaptive one, with real interpersonal significance. Numerous studies have demonstrated that, as an emotional disposition, guilt-proneness correlates with measures of perspective-taking and empathic concern (Joireman, 2004; Leith & Baumeister, 1998; Tangney, 1991, 1995; Tangney & Dearing, 2002; Zechmeister & Romero, 2002) and that feeling guilty is correlated with prosocial interpersonal behavior such as confessions, apologies, and undoing the consequences of behavior (Baumeister, Stillwell, & Heatherton, 1994, 1995; Hoffman, 1982; Tangney, 1991, 1995; Tangney & Dearing, 2002; Tangney, Wagner, Fletcher, & Gramzow, 1992). In their review of guilt literature, Tangney et al. (2007) noted that empirical studies that find a correlation between guilt-proneness and symptoms like anxiety or depression (e.g., Boye, Bentsen, & Malt, 2002; Fontana & Rosenheck, 2004; Ghatavi, Nicolson, MacDonald, Osher, & Levitt, 2002; Harder, 1995; Jones & Kugler, 1993; Meehan et al., 1996) use adjective checklist-type measures that are globally worded or otherwise fail to distinguish between guilt and shame. Studies on guilt and PTSD reveal the same lack of precision and depth in measuring guilt: Henning and Frueh (1997) determined that combat-related guilt accounted for 30% of the unique variance in a composite of reexperiencing and avoidance symptoms, but their measure of guilt was one they developed for the study.

To be clear, to see guilt as an emotion with inherent value despite the fact that it does not feel good is not about trying to make patients feel guilty for things using a moral code that they do not adhere to, nor is it about preventing patients from finding ways to relieve guilt. But it does include a clinical stance that does not assume that feelings of guilt are a priori mistaken or exaggerated, which is what the CPT treatment manual seems to do. There are some who have expressed this point already: Singer (2004) considers expression of guilt and remorse a pivotal part of therapy, and cautions therapists against automatically reassuring patients that there were mitigating circumstances for what they did, especially in the case of war atrocities (p. 383). However the interventions designated as EBPs are certainly more mainstream, and they set the standard for how many therapists learn to interact with patients’ guilt.
Guilt in EBPs for PTSD: Alignment and Misalignment

The following dialogue, under the heading “Stuck Points Specifically Related to Self-Blame and Other Assimilation Using Socratic Questioning,”1 is given as an example of how the therapist needs to help the veteran understand the full context when evaluating his or her actions in a traumatic event (Resick, Monson, & Chard, 2010 p. 73).

T: Earlier you mentioned that you were feeling angry about the reports from Abu Graib. Can you tell me what makes you angry?

P: I cannot believe that they would do that to those prisoners.

T: What specifically upsets you about Abu Graib?

P: Haven’t you heard the reports? I cannot believe that they would humiliate and hurt them like that. Once again, the U.S. military’s use of force is unacceptable.

T: Do you think your use of force as a member of the U.S. military was unacceptable?

P: Yes. I murdered innocent civilians. I am no different than those military people at Abu Graib. In fact, I’m worse because I murdered them.

T: Murder. That’s a strong word.

P: Yah?

T: (Realizing that there was minimal flexibility in the patient’s thinking at this point) I agree that there is no changing the fact that they died, and that your shooting had something to do with that. However, I think we might disagree on the use of the term ‘murder.’ It is clear that their deaths have been a very difficult thing for you to accept, and that you are trying to make sense of that. The sense that you appear to have made of their deaths is that you are a ‘murderer.’ I think this is a good example of one of those stuck points that has prevented you from recovering from this traumatic event. (pp. 73–74)

Although it is not clear from this dialogue whether the patient is feeling guilt, shame, or both, the therapist’s response reveals an immediate judgment that, whatever the feeling is, it is inappropriate. The feedback to the patient—that he is using an inaccurate label, and if he tweaks his definition of what it means to murder someone he will be able to find some reprieve from the fact that he killed people, and perhaps will feel better about the military’s use of force in other contexts as well—turns out to be confusing, invalidating, and ultimately condescending for the patient.

When psychologists working in a CBT modality assume that guilt feelings are irrational

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1 The authors seem to use self-blame and guilt interchangeably in this portion of the manual. Just before the dialogue, they identify self-blame as a form of cognitive assimilation that “occurs because the patient is looking for ways in which he could have prevented or stopped the particular outcome that occurred. . . . People imagine ways they could have changed personal outcomes; they have regrets about not saving others; they feel guilty about things they did or did not do, and about feelings they did or did not feel during or after the event. This ‘if only’ type thinking serves as assimilation in that it is an attempt to undo the event in retrospect” (p. 73).
and meaningless, they often try to direct patients toward greater objectivity. In addition to attempting to make sure labels are flexible and/or accurate, they teach patients to evaluate guilty feelings by determining whether the personal beliefs that lead to those feelings are “realistic.” The favored tool for identifying thoughts and feelings is the “A-B-C Worksheet.” The process requires that the patient compare him or herself to an established norm (e.g., “would someone else in that circumstance have done the same thing?”). Although this line of questioning seems appropriate for neurotic guilt, it has potential to fall short in conversations about combat-related guilt, both because the “A” (activating event) is often tragic, and because moral codes or values are not usually based on meeting a minimum standard. Insisting on realism, one loses the sense of the model or the ideal. Religions with divine models inspire and challenge followers to live out higher callings or virtues. People who identify as agnostic or atheist likewise have moral codes or ideals that they aspire to.

As a brief example, “George” is a Vietnam veteran who expressed long-lasting guilt about a time that he threw rocks at children from the back of a truck as he and some fellow soldiers rode through a village. To question George’s guilt here, to bring up context and intention and outcome, would be easy to do, and within a CPT treatment protocol it would be done automatically. George was under an immense amount of pressure while deployed, he was 19 years old—“just a kid,” and throwing rocks did not cause enough harm at the time that George should worry about it so many years after the fact. But George identified as a Christian when he was drafted and at the time of his treatment. He saw this event as an indication that he was not immune to peer pressure or the normalization of violence from the back of that truck; more generally, he saw that, while deployed, he lost sight of what Emmanuel Levinas (2004) calls “the Other” and our ontological/ethical responsibility toward the Other. The difference this framework makes is the difference between the therapist attempting to convince George that he should not have expected more of himself (because to rise above situational context is unrealistic), and taking George’s guilt seriously as a confession of wrongdoing. Not surprisingly, relieving all guilt was not a particularly meaningful treatment goal in this case. However George was engaged in talking through what repentance looked like for him now, whether he should share this story with his wife and children or not, and how he might be less susceptible to participating in various forms of group violence in the future.

These observations underscore one part of the problem with a cognitive reframe of guilt: it takes a moral or ethical quandary and provides an answer in a completely different language. Psychological discourse, and especially the rationality and flexibility that are deemed so essential in CBT, is grounded in individualism, anonymity, and positivism. It is difficult to neatly summarize this argument, but Fromm presented the dilemma like this:

The ideas of the Enlightenment taught man that he could trust his own reason as a guide to establishing valid ethical norms and that he could rely on himself, needing neither revelation nor the authority of the church in order to know good and evil. . . . The result is the acceptance of a relativistic position which proposes that value judgments and ethical norms are exclusively matters of taste or arbitrary preference. . . . The demands of the State, the enthusiasm for magic qualities of powerful leaders, powerful machines, and material success become the sources for his norms and value judgments. (Fromm, 1947, p. 5)

Freedom from mental anguish and suffering is the perfunctory value of psychotherapy, but without theological and philosophical wisdom on the meaning of suffering and the nature of freedom, therapists script “a virtual recipe for personal shallowness and social fragmentation” (Richardson, Fowers, & Guignon, 1999, p. 5).

This problem is magnified within EBPs for combat trauma, where guilt is targeted as a symptom automatically and divorced from all politics, history, tradition, and frames of moral discourse. That is why the therapist in the CPT dialogue misses the fact that, when the patient says “the bottom line is killing versus no killing,” he is making a moral claim. And that is why, rather than exploring the patient’s theological or ethical horizon on killing, war, torture, “no-win” situations, or human suffering, the therapist assumes the patient is being inflexible. What about the therapist’s inflexibility in this interaction? The therapist is assuming that people should only take responsibility for harm they have intended and planned, that violence is justifiable in certain contexts, that lasting remorse over killing someone is unhealthy and/or
useless. There are religious, spiritual, and ethical worldviews that explicitly disagree with each of these assumptions.

**Moral Injury and the Méconnaissance of Guilt**

In the case of combat-related guilt, psychologists who uncritically utilize the EBP conceptualizations and interventions for it are not just misunderstanding guilt but engaging in a kind of willful ignorance of it (the word *méconnaissance* literally means “mis-knowing” but connotes the latter meaning). The political and ideological import of treating combat-related guilt cannot be missed here: If guilt from war is not contained by the individuals who go to war, is not characterized as extreme or mismanaged affect by treatment providers, and is not presented as something that can be corrected with the right kind of treatment, then everyone else might have to wrestle with some disturbing feelings.² In his seminal work on some of the ways psychology has eluded moral and political consciousness while defining a self that is individual and bounded, Philip Cushman points out that

> in the West, when ideology masquerades as a physical science it becomes more valued and thus more politically effective. . . . It is not a conscious deceit, but from a hermeneutic perspective, mainstream psychotherapists have avoided noticing that they strike moral stances and executed political strategies. (Cushman, 1995, p. 287)

Of interest here are two developments in the conceptualization and treatment of guilt in PTSD. The first is the increasing awareness of what is now referred to as moral injury (MI) among those who go to war. The prevailing definition of a morally injurious experience is something that includes “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009, p. 700). Proponents of MI have argued that it constitutes an integral part of PTSD for many veterans (Shay, 2014), ostensibly including some elements of criterion D in the *DSM–5* such as “persistent and often distorted negative beliefs and expectations about oneself or the world (e.g., ‘I am bad,’ ‘The world is completely dangerous’)” and “persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame”). In a study to validate MI as a construct, veterans’ responses to the question “In what ways has the Vietnam war affected your everyday life?” were analyzed. The following statements were classified by raters as indicative of PTSD: “I feel like you can’t really trust the government to tell you what’s going on” (loss of trust category), “It made me aware of human rights that were being misused over there” (psychological symptoms category), “The biggest thing was being forced to do something I was opposed to,” and “How senseless a lot of the dying was” (spiritual/existential problems category; Vargas et al., 2013, p. 246).

Given what we know about the Vietnam War, these sentiments do not appear to be unreasonable, yet here they were categorized as symptoms. A comment on senseless dying in war points to a spiritual problem? By this account, many of our heroes and role models—Dr. Martin Luther King, Jr., Gandhi, Mother Teresa—have suffered from MI, and any person who feels personal discomfort in response to societal inequality and injustice is diagnosable. The MI research may not be pathologizing negative feelings about war “on purpose,” and in fact many MI researchers explicitly state that they do not want to this. And yet, when they ask what personality, religious beliefs, and social and cultural variables moderate MI (Litz et al., 2009), or cite research that negative attributional style and rumination are cognitive vulnerabilities related to PTSD (Elwood et al., 2009), or promote interventions to identify and treat MI, they are doing just that.

Here is the second development, a striking example of the *méconnaissance* of war-related guilt in our discipline: the development of two adjunctive interventions designed specifically to help veterans recover from killing in war. One of the precursors for this appears to be a study of Vietnam veterans which found that, after controlling for demographic variables, the strongest predictor of PTSD score severity, dissociation symptoms, functional impairment, and violent behavior was whether the veteran had killed during his

service (Maguen et al., 2009). Killing was a stronger predictor than any other combat-related variable, including length of combat. This study is referenced on the website of the National Center for PTSD, where it is acknowledged that existing EBPs for PTSD are not sufficiently addressing symptoms related to the “moral wounds of war” but that researchers are currently testing interventions with the hopes of doing so: one called Impact of Killing in War (IOK) and one called Adaptive Disclosure (AD; Maguen & Litz, 2012). The positivist depiction of these four- to six-session interventions is that they are more efficacious in treating PTSD because they address MI, but the explicit thing they are designed for is to relieve the psychological burden of killing another human being. Of course there are many compassionate ways to frame this treatment goal, not the least being the high suicide rate among veterans and our desire to decrease their suffering after they return from deployments. But the idea that we might get good, as a profession, at talking people out of guilt following their involvement in traumatic incidents is frightfully short-sighted in more ways than one.

It is worth noting that AD encourages the patient to dialogue in imagination with a moral authority figure to move past shame and guilt. In what context other than a secular, individualistic, atraitional society would a person choose his or her own moral authority, and dialogue with that authority figure only imaginally? And in what context other than a military-industrial complex would psychologists posit, that “forgiveness and repair is possible in all cases” (Litz et al., 2009, p. 701) after war?

**Conclusion**

When Viktor Frankl was writing to advance logotherapy, he said that, in responding to patients’ moral questions,

> What is needed . . . is to meet the patient squarely. We must not dodge the discussion, but enter into it sincerely. . . . Our patient has a right to demand that the ideas he advances be treated on the philosophical level. . . . A philosophical question cannot be dealt with by turning the discussion toward the pathological roots from which the question stemmed, or by hinting at the morbid consequences of philosophical pondering. (Frankl, 1946/1965, p. 13)

Frankl’s thoughts seem especially relevant in cases of war-related trauma and associated guilt, where patients are often struggling through multiple, competing, sometimes incomplete value systems. “Tony” shared in therapy about how he had automatically fired at and killed a 13-year-old boy in Iraq. Although he later learned that the youth was indeed working for the insurgent group Tony’s unit was fighting against, he also learned that the boy had been bribed to join after threats were made toward his family. With tears in his eyes, Tony said, “If I were him, I would’ve done the same thing. I’m not religious, but I know I’m going to hell.” A therapist’s desire to relieve Tony’s self-condemning statement is not problematic, but to proceed with treatments that assume that any guilt he feels is maladaptive, that a cognitive reframe of his distress will be adequate (CPT), that he suffers from moral injury which can be dissipated in four to six therapy sessions (IOK and AD), or that the therapist is a neutral party in this equation—these things are problematic.

The implications of this critique of the way EBPs for PTSD direct clinicians to interact with guilt in the therapy room are that some radical shifts are in order. The two most critical are (a) viewing guilt as an important, adaptive, relational emotion that can lead to valuable commitments and/or reparations, and (b) willingness to examine war-related guilt within particular political, philosophical, and moral frameworks that are relevant for the patient—even if this challenges ideological commitments that are invisible so long as they are accepted as objective and helpful. Concrete examples of these shifts include: if a patient expresses disengagement and distrust regarding the kind of authority he was under while in the military, then psychology researchers not call that a symptom; if a patient believes that killing civilians is wrong regardless of how it happens, then clinicians not argue with this viewpoint on the basis that it is irrational or too rigid without considering

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3 Other studies have also found some evidence that, independent of combat exposure, involvement in or witnessing atrocities in war is linked to PTSD (King, King, Guadanowski, & Vreven, 1995; Laufer, Brett, & Gallops, 1985).
the patient’s ethical horizon(s); and if a patient has a belief that he or she should always act benevolently toward others, then therapists will avoid labeling the belief as dysfunctional simply because it sometimes results in guilt. These shifts would also entail psychologists acknowledging upfront that moral injury is a reasonable consequence of war for many veterans—one that therapy alone might not be equipped to fix, certainly not quickly or easily. These shifts make the work considerably more complicated, but not less effective. Indeed, the therapist who meets the patient squarely, in the midst of moral injury, long-standing guilt, or unresolved questions, has a chance to interact at a level that holds every reasonable consequence of war for many veterans.

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