

**Cognitive Processing Therapy Failure:
Tacit Knowledge in the Treatment of
Post-Traumatic Stress Disorder**

by

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Abstract

This narrative case study explores the phenomenon of manualized evidence-based treatments (EBT) from the perspective of a clinician treating a combat veteran. The Veterans Affairs Administration (VA) mandates two EBT's be made available for veterans suffering from Post-Traumatic Stress Disorder (PTSD): Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE). This paper reflects the use of CPT. While evidence is available that CPT has positive effects relieving symptoms of some veterans, the veteran in this study is one of the many that fail to benefit. Strict fidelity to an EBT diminishes a clinician's flexibility and ability to react with interventions in the moment. Filtered through a treatment manual, a clinician's conception of their client is limited and treatment may be negatively affected. Flexing the manual and allowing for clinician's tacit knowledge to intervene provides the client the principles of CPT in a manner appropriate to his learning style and at a pace comfortable for him.

There was a pause in the conversation and stillness in the room while what I had said sunk in. Mike stared at the floor between us without a word. I was dreading this moment. I could not know what would happen. I had no idea how he would react. I believed he could handle the news but if he lost control it would be very bad for the both of us. Mike had angry and often violent outbursts; he would black out and not remember what occurred.

Mike's eyes darted from the floor and found my eyes immediately staring back. His breathing quickened and he was gripping the armrests of the leather chair. His body wanted to launch in my direction. The jugular veins in his neck distend as he struggled to contain himself. He took a deep breath and began. His words came slow at first and sped up, coming out in bursts as if he was firing them from an M16 semi-automatic rifle:

Mike: I try to do it, you know I do. Things just come up and I can't get it done. I'll write the first sentence and that's all I can do before something comes up.

It's not like I'm not trying.

I'm working, doing what you ask me, tell you everything else but I don't want to think about that one thing, can't go there, "avoidance" or whatever you want to call it I don't care and this is fucked up. What the hell have we been doing this for?

Engaging with Mike

Mike was an imposing figure when I first met him. He was over six feet tall and built like a bull, solid thick muscle. His body eclipsed the doorway blocking the light from the hallway from getting through. He wore shorts and a t-shirt so there was no bulky clothing adding his girth, he was a giant. Besides his size there was this look in his eyes that kept me at a distance. It was cold and searching. His eyes darted everywhere all around the room initially and then stared that "thousand yard stare" that is often described in cases of combat trauma looking in the direction of the middle of my body. It somewhat felt he was looking through me. I stood to welcome him into my office.

ME: Hey Mike? Bill just called me and told me you were walking over. I was going to come to walk with you but you beat me to it. Want to take a seat?

I was worried that Mike might not fit in my available chairs. I was relieved when he squeezed into one without much trouble. His gait was unremarkable and there was nothing that was

**Privacy Disclaimer: To protect the confidentiality of the client, identifying information has been disguised and certain details have been concealed.*

apparent in his mannerisms that seemed out of the ordinary. Just that he would look around and then that stare. I volunteered a variation on a question:

ME: I know you were talking with Bill for a bit, could you tell me what's been going on?

Bill was my supervisor and a Vietnam veteran. He often screened clients and determined which therapist might benefit a client the most. After speaking with Mike, Bill asked that he come see me. I was going to meet him in Bills office which was a short distance down the hall, but Mike had made it to my office before I had a chance to leave my seat.

Mike: I'm just fucked up. I fuck everything up. I need this shit to get out of my head....

There was a pause and I noticed him catch me with his eyes and then look away. His lips would quiver as if he was starting to speak... and then nothing would come from him. He was hurting and he didn't know what to do about it. His eyes would stare off as his mind would drift into some war hell and then when "it", whatever "it" was that scraped the insides of his skull and set his body into panic mode, would try to enter into the space between us... his eyes would find me with a demonic speed. Whatever it was that was going to rip into our reality that day—into that small office where I treated combat veterans day in and day out—demanded all the energy in the room. With a slow draw Mike's eyes lost me as they were pulled, as if by gravity, down towards the floor. The air returned to the room. This is what Mike was living with, a contagious terror that affected all his relationships; he could not form a single word to give a face to this enemy. This might have been just my experience of what was happening in the room, my anticipation of what he was about to tell me. It really did seem that he wanted to get something horrible out in the way he looked, stared, tensed up and, I suppose after he decided not to say what it was part of him wanted to say, relaxed and sank back into the seat. It was only a minute or two but it seemed much longer.

Me: What do you feel like talking about? It seems that there is something you want to say but some part of you doesn't want to. We can talk about whatever you like.

Mike: My wife is gone. My kids are gone. I blacked out on some guy at work and really hurt him. I could have killed him. I get lost at work. I mean I go down to get a tool out of the truck and I don't come back. I just sit there at the truck reliving things... for hours sometimes. That's what I told Bill. I just can't do it anymore. I need to get this out.

There was a pause as Mike stared at his hands. Although I would usually sit and wait for a client to continue speaking, there was something Mike said that needed to be confronted.

ME: When you say "I just can't do it anymore", what do you mean? Mike's eyes met mine. He looked defeated.

Mike: I'm not going to kill myself if that's what you're asking. I tried that once and I won't do it again.

ME: You tried it before? What happened?

Mike's hands came to life and began acting out what he was describing.

Mike: I had a handgun and I put it to my head. I pulled the trigger and nothing. It misfired. After that I was sick and lost all desire to do that.

ME: It misfired? I've heard stories about that happening before. Dakota Meyer, I heard he admitted to doing something like that. What did it mean to you that it misfired? Dakota Meyer is a Medal of Honor recipient. He is a "hero" and he also struggled with suicide. I heard that he had admitted to doing the exact same thing that Mike did and with the same result. It amazes me sometimes how such well-trained warriors can have weapons malfunction at these moments.

Mike: I don't know. I just didn't feel like doing it again. Maybe somebody wants me here.

ME: Do you still have the gun?

Mike: No. I got rid of all my guns.

Bill had sent Mike to me because he thought I might be able to relate to him better. Bill is a Vietnam veteran and I served in Iraq, the same place Mike had served. Mike is also closer to my age than Bill. Bill thought that referring Mike to me would help him open up since our experiences were similar. It did help. There were times when Mike would say "you were there" when sharing some point about the oppressive heat, the endless desert and those massive sandstorms. We never compared war stories; just being in the same area at a similar time helped me engage with him.

Mike had many issues that continued to affect him. He had lost his wife and his children through a recent divorce, he had flashbacks that affect his ability to work, and he would lose control and get violent. He had also attempted suicide once already four years ago. This suicide confession provided a clue suggesting how much and for how long his symptoms have affected him.

It was our second session together when Mike started telling me about his experiences. All I had to ask him is if he wanted to talk about his deployment to Iraq for him to volunteer what follows:

Mike: The rocket landed and we were all ducking, waiting for it to explode. We waited for what seemed like forever and nothing happened. Someone yelled "GAS!!! GAS!!! GAS!!!" and without thinking we rushed to put on our masks and suits. People were running around and it was just confusion. I pulled some skinny Marine into a ditch with me as we watched the chaos. People running... and then falling... only a couple... but we didn't know what was going on. We thought maybe the gas got to them.

Mike had avoided talking about traumatic military incidents up until he came to see me. Mike described this as one of the first traumatic experiences he went through in Iraq and related the terror he felt in the confusion.

Mike: Tim... He looked at me dead in the eyes. All of the arm flailing that came with acting out the scene suddenly stopped.

Mike: I can't even put words to it. That feeling you get. You know what I'm talking about - you were there. I thought that was it. I just watched and waited for... for whatever.

Mike returned to staring through me. It turned out the rocket was a dud and that the other Marines were just collapsing from heat exhaustion after running around wearing suffocating gas masks in 100 plus degree heat. I can picture myself digging into that ditch there with Mike, trying to get as deep as possible and away from what was happening, being the skinny Marine and watching this scene. I can imagine what it might be like to be seeing all those Marines running around and collapsing; wondering if I am next. It made me think of an incident from my own basic training:

We were all standing in formation and the drill sergeant walked up and popped a can of CS gas (tear gas). My training said- stay and do not move... to cough and take it... we were in formation and at attention. The Drill Sergeant yelled "What the fuck you supposed to do when there's gas privates?!" and immediately in a chorus of panicked cracked coughing voices "GAS! GAS! GAS!!!" was yelled. I was able to get my mask on in time to see another private run out of the formation and out of the cloud of gas. I can still imagine hearing the "Ding" as he ran into the dumpster and sliced open his head.

I knew I was not dying in that training incident. The only injury that would come of it was that

poor private who was not able to clear his mask of the gas and ended up getting his head cut open. The confusion and the panic that came to mind paled in comparison to what Mike had experienced. Perhaps it was the word "Gas" or the witnessing of panic that I was sharing with Mike. I did not volunteer to share this experience with him. Although thinking about it did help me empathize with Mike, I do not think sharing the incident would have helped him. Even though they were not often shared, my experiences in Iraq helped me empathize with Mike and shaped how we moved forward in our clinical encounters.

Mike was a 26-year-old Hispanic male who emigrated from Venezuela to the United States when he was eleven years old. He joined the Marines following the attack on the World Trade Center because he felt he had to "give back" to the country that had given him a chance for a life he that he would not have had in Venezuela. Mike's size afforded him respect as a Marine and as a civilian. This respect was something that Mike felt he did not deserve and did not want. His appearance was intimidating though and no matter what he wanted, his size had an effect on people. He started working as a bouncer and in security after he left the Marines. These positions alternately gave him a place where the hyper vigilance, a symptom of his PTSD, was useful and where he was constantly triggered to memories from his service in Iraq. He loved the excitement of having to be ready for anything and the rush of having to get into fights at work. He described himself as an "adrenaline junky". He was an occasionally violent adrenaline junky from an unfamiliar culture that was coming to a Vet Center at the suggestion of a friend because "Vet Center clinicians were vets too". I have heard clients say many things about the discomfort they feel talking to civilians, especially women. "They just don't get it", they have said. I also know civilian therapists who do very well in the treatment of combat veteran clients, including women.

It was a few sessions later, about a month into our sessions when Mike came up with his next traumatic experience. We had been working on some breathing exercises and he was asked to "think of an instance that when you think of it you feel some stress, about a 6 out of 10 where 10 is the worst stress you could have when thinking about it. Now hold that in your mind and practice those deep breaths. Now what do you feel?"

Mike didn't feel much better after that exercise but he was calm enough to discuss this next incident. He took a few more deep breaths and,

looking as if he was about to start running instead of talking he began:

Mike: I had to fix the cooling unit where they kept the bodies...

Mike's eyes fell to his lap. He gulped, his Adam's apple rising and falling as he sank deeper into his seat. I urged him to take the time he needed. His shoulders shrugged and fell forward as if he had given up. Through tears he continued:

Mike: I could not stay in there for more than a few minutes without having to run out and puke. The bodies were wet and hot and rotting... these young kids that never had a chance to live. It's just wrong. They had families some of them... and children.

Mike took a deep breath. There were tears in his eyes. He went on to describe the morgue and the scene in short sentences. The picture he painted was horrifying. "The scent of the Morgue was horrible" Mike remembered. Having to repair the refrigeration unit in the Morgue was something Mike wouldn't wish on anyone. The combination of the heart breaking knowledge that Marines were dead and rotting with the putrid smell carried in the choking heat seemed to physically force Mike out into the blazing sun to vomit over the side of the small metal steps leading back down into the sand. He didn't escape that small, crowded, putrid morgue trailer before the body of a Marine sat up suddenly, a black bag seemingly springing to life.

Mike: It was some scary shit and I wasn't having it. You kinda had to be there but you wouldn't want to be. I was so dizzy from trying to hold my breath I almost couldn't get out of there. When that body popped up I took one breath in... I'll never forget that smell... and it was, like, acidic. I don't know if it was because I was trying to hold my breath or what but it burned.

Mike described this last bit almost whispering. After everything he had shared it was as if he was running out of gas. He even looked spent with his tear stained cheeks and puffy, watery brown, almost black eyes succumbing to gravity—his gaze being pulled, it seemed, to the floor. Mike later learned that it was something with the nerves that made the dead marine move in the bag. This still haunted Mike through nightmares and intrusive thoughts. He is triggered to remember these traumas by so many things. Rotting meat and roadkill created such a reaction within Mike that he had been afraid to drive with the windows open.

Cognitive Processing Therapy

Although the coping skills being taught and practiced seemed to help Mike with some of his symptoms, I wondered if he would be a good candidate for Cognitive Processing Therapy. I had used it with other clients successfully and was using it with two other veterans at the time.

Mike had no contraindications and he seemed stable enough to do the work without severe abreaction. Contraindications for CPT include, "If someone is in imminent danger, such as those being stalked or are in an actively abusive relationship," and when people are, "So dissociative or [have] such severe panic attacks that [they] cannot discuss the trauma at all" (Resnick, Monson & Chard, 2014, p4). Mike had already volunteered traumatic experiences and had a particular trauma in mind to target with the CPT protocol. He had not dissociated significantly or had any panic attacks in session. When collaborating with Mike on this change to his treatment plan he stated he would do "whatever will help".

Cognitive Processing Therapy began with educating Mike regarding what to expect and then assigning his first practice assignment. In an article discussing the dissemination and experience of CPT in the VA, Chard et al (2012) present an overview of the first four phases of treatment:

In sessions one through four, patients are educated regarding the theory behind CPT and asked to explore the 'meaning' of their traumas by writing an impact statement discussing why they believe the traumatic event occurred and how the event has shaped their beliefs about self, others and the world, particularly in the areas related to safety, trust, power/control, esteem and intimacy." (p. 668)

The first four sessions lay the groundwork for the rest of the CPT protocol. They provide the rationale behind the protocol, introduce the client to practice assignments, and begin gathering information from the client to be resolved by the protocol.

During the first session I asked Mike what was the incident that he decided to work with. Determining what incident to use for the intervention can be complicated. Mike had already shared two incidents that were traumatizing for him. The clinician helps the client determine the worst, most disturbing incident and target it for

intervention (Resnick et al, 2014, p35). The protocol urges that, “The therapy will focus to begin with the worst traumatic event, although it can move to other events after Session five” (Resnick et al, 2014, p6). Clients can use CPT concepts on other trauma accounts when not in the session. Once the client overcomes the worst of his traumas, he can turn his newly acquired knowledge and skill toward processing less disturbing incidents.

Mike remained reticent about sharing his worst incident. He froze. He did not want to part with it. Considering he had already provided trauma accounts I did not expect this resistance. The CPT manual (2014) suggests:

If the patient is resistant to writing an account about the worst event, the therapist needs to do some cognitive therapy during Session two and have the patient complete some A-B-C Worksheets on [his] thoughts and feelings about working on the worst event (Resnick p. 35).

Mike did not share his trauma during the first or second session and an A-B-C worksheet was completed during Session two to explore his resistance. Mike endorsed fear that he would lose control with associated nervousness in the pit of his stomach. He felt hot when pressured to think about the unspoken trauma and worried he would be violent. We challenged these thoughts in session and Mike was given more A-B-C sheets to do between sessions.

Mike: We didn't have much to do because the camp was not really built up yet. We were playing cards and he sat on his bunk not far from us. He was cleaning his weapon sitting by himself; he didn't want to play...

Mike began talking about an incident that occurred to him while he was doing the impact statement. It could have been an attempt to avoid talking about the agreed-upon CPT target (which he still had not shared). He continued.

Mike: He didn't want to play... The next thing I knew I was covered in his blood, picking pieces of his head off of my uniform. He put the muzzle up against his temple and pulled the trigger.

This sounded like it was it, the one trauma to work on. I believed that this had to be the worst thing Mike could have experienced. Another dead Marine, a friend, and his blood was literally on Mike's hands... and his face... and in his mouth.

Mike: I should have done something. I knew we all were having a tough time after that. (The gas

incident.)

Mike disagreed that this was the worst incident and he still was not ready to do the trauma account. I was concerned at the resistance and avoidance. We did more A-B-C sheets. We considered this new incident as a way to avoid talking about the target trauma. I wanted to discuss this new incident but worried I would collude with Mike's avoidance of the target trauma.

Mike had told me so much up to this point. There were so many possible experiences to target with the CPT intervention. We could talk about the fear of dying from a gas attack, the sadness that drowns Mike in thoughts about lost, rotting Marines, or the guilt that comes from feeling you should have seen the signs leading to a friend's suicide.

Mike: I can't do it... I don't want to think about it. When I think about it I can't sleep and I can't stop thinking about it, sometimes for days.

Mike came to the fourth session empty-handed. Even the “ABC” sheets and “stuck point log” (a log of thoughts related to his trauma and impact statement) showed little progress. If Mike had done the trauma account we would have explored stuck points and used Socratic dialogue to challenge them. Instead we had to keep using A-B-C sheets to overcome the avoidance keeping Mike from completing the trauma account assignment. Mike was reassigned the trauma account for the fifth session.

Mike missed the next session. He was called and a message was left on his voicemail. It was two weeks later before Mike called to reschedule his session. He stated, “Hey, sorry I had some work stuff come up and I haven't had time to get back to you.” He scheduled a session for the same week. When Mike did arrive, he came empty handed again.

We were failing miserably at sticking within the twelve-session CPT model. The trauma-account was reassigned twice. By the seventh session I was still using Socratic dialogue—a form of questioning—to overcome Mike's avoidance of the assignment. Mike was not ready to reveal his trauma. During consultation with a CPT trainer I was provided more ways of using Socratic dialogue. Nothing worked. The consultant suggested that Mike may not be ready for CPT and to consider it for a later time.

Evidence-Based Treatment

Mike's case led me to conclude that manualized treatments stifle clinician's ingenuity and ability

to react, in the moment, with profound interventions. Through supervised practice, continuing education, and liberal reading clinicians develop expertise in treating trauma and post-traumatic-stress disorder (PTSD). Mistakes and problems encountered in this process provide clinicians opportunities to develop specialized and tacit knowledge. Manualized evidence-based treatments (EBT) interfere with this process. Fidelity to an EBT limits clinician's ability to conceptualize a client to the dictums found within that treatment manual. This limitation impairs clinician development and the promise of expert treatment for trauma related disorders.

The Social Work Profession realizes the importance of research and evidence in the administration of social work services; it does not mandate fidelity in evidence-based treatments. The social work code of ethics states that, "Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice"(NASW, 2015 5.02c), and the Council on Social Work Education (CSWE) maintains, "...Teaching social work students how to access, analyze, interpret, and appropriately employ evidence is critical to effective social work practice" (CSWE, 2015). Both the social work code of ethics and the organization responsible for the education of the next generation of social workers agree that social work practice should be in accordance with critically evaluated evidence employed appropriately. This direction lays the responsibility on using evidence on the social worker. The social worker's assessment of the available research and evidence determines how the evidence will be used.

Evidence-based treatments grew in reaction to biological psychiatry's increasing public presence. In 1993, one year after evidence-based medicine appeared, a task force was called together to, "Consider methods for educating clinical psychologists, third party payers, and the public about effective psychotherapies" (Chambless et al, 1993, p. 1). Advertising empirically supported psychotherapies was in reaction to fear that clinical psychology might not "survive in this heyday of biological psychiatry" (Chambless et al, 1993, p. 1). EBT, far from being psychology's answer to evidence-based medicine, sought to establish psychotherapy as a valid treatment option along-side psychopharmacological interventions. To a large extent the proponents of

EBT have been successful in their mission to publicize available, empirically- valid, psychotherapies. An unintended consequence was the confusion and conflation of EBT and evidence-based medicine or in the case of psychotherapy, evidence-based practice (EBP).

The Veterans Affairs Administration (VA) has made consistent efforts to ensure it remains at the forefront of evidence-based treatment for PTSD. Since mandated by Congress in Public Law 98-528 (1984), the VA has developed the needed research mechanisms to research evidence on the assessment and treatment of PTSD. The National Center for PTSD, created in 1989 as a result of the Congressional mandate, strived (and continues to strive) to develop the evidence base needed to comply with the Congressional mandate. The Institute of Medicine (IOM) review in 2007 (Berg et al, 2008) found that much of the process of acquiring and utilizing evidence in treatment decisions was weak. They provided many recommendations including, "Identify and require investigators to use methods that will improve the internal validity of the research, with particular attention to the standardization of treatment and outcome measures..." (Berg et al, 2008, p. 10). The IOM recommends standardization of both treatment and outcome measures ensuring that what is studied will be uniform across subjects and studies. Constricting treatments into manuals provide this standardization. Whereas the IOM was discussing research, the VA took it one step further mandating that "All veterans with PTSD must have access to Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy as designed and shown to be effective" (VA, 2008, p. 31). All veterans are to have the treatments as designed to be effective. The VA wants the therapies administered as researched. The VA takes a hard line with evidence-based treatment limiting the flexibility of the clinician. In an effort to remain on the forefront of treatment for PTSD the VA has mandated certain treatments and also how these treatments will be administered. Taking this position the VA makes it difficult for clinicians to react in the moment, accommodate client differences in the process of therapy, and limits exploration of the treatment at the practice level.

Evidence-Based Treatment Effect on Treatment and Learning

Being faithful to the CPT protocol, I fought constantly with my own clinical judgment. Each time Mike brought up an incident I wanted to

explore it. The suicide-trauma that we deemed “avoidance” could have been explored deeply had we not the constraints of a manual. I wanted to be where Mike was at the time and not force an artificial protocol on him. Manualized therapy takes away from what the clinician attends to and constricts clinician knowledge and skill to only what can be expressed through the protocol.

Cognitive Processing Therapy is a strict twelve-session intervention that “incorporates psychoeducation, modification of cognition and emotion, a written exposure paradigm, and between-session practice assignments” (Laska, Minami, Smith, Wampold & Wislocki, 2013). It has had a lot of success with various modifications (Blain, Elwood, Galovski, Houle, & Mott, 2012), over tele-health (Chard, Hynes, Mackintosh, Morland, & Resick, 2011), and even with populations such as those with comorbid traumatic brain injury (Chard, Davis, Houston, & Walter, 2013). Given the success of all these “versions”, perhaps it is not CPT at all but the principles behind it that are at work in benefitting the client.

I was using the Veterans Affairs Administration (VA) approved CPT for PTSD manual (Resnick et al, 2014). I was being evaluated for my adherence and fidelity to the CPT model in order to become a VA approved provider. The VA mandates the administration of the protocol as researched and found effective, foreclosing other versions of CPT administration and limiting flexibility.

In an article titled “Manualized Therapy for PTSD: Flexing the Structure of Cognitive Processing Therapy”, Galovski, Blain, Mott, Elwood, and Houle, (2012) review literature on variants of CPT and then present their own study adding sessions to the twelve-session model when the clinician deemed it would be helpful for the client. Galovski et al. found that, “The allowance of separate sessions to address client major life stressors and individually tailoring treatment length by participant did not substantially reduce our attrition rates” (p. 979). The authors demonstrate how “flexing” the protocol by individually tailoring CPT treatment length did not harm the effectiveness of the protocol. They did attempt to stay with the protocol outside of the time constraints. Mike was not ready to reveal his trauma and more sessions could have given him a chance; more time than the VA CPT protocol allowed. With all the symptomatic behaviors that keep Mike isolated, hyper-aroused, and hyper-vigilant there seems to always be outside

stressors affecting him. Separate sessions were found beneficial by Galovski et al. for various reasons and Mike could have benefited from them as well.

Doing evidence-based practice includes finding and using evidence of success in the flexing of CPT. My judgment and clinical acumen was stunted by adhering to the CPT manual. This is the difference between evidence-based practice and evidence-based treatment. Evidence-based practice is a decision making process that would allow for flexibility whereas the evidence-based treatment is strict adherence to a manual. Flexing the protocol for Mike would still have been EBP but it would not have been the Veterans Affairs version of Cognitive Processing Therapy.

Mike shared traumatic stories with disturbing emotions surfacing from each; divulging things he had never told anyone before. It was not good enough. He admitted that he had not been able to share his most difficult trauma in our sessions. I felt he was trying to find a way to make it work, to accomplish the mission of CPT, but could not.

Following the consultant suggesting the Mike might not be ready for this type of treatment the following dialogue ensued:

Me: Mike... I want to talk to you about what we can do from here. Where we can go from here.

Mike: What do you mean? Let's just use the corpse incident. In the morgue... I still think of that all the time.

Me: I think we can definitely talk about that. We can just put Cognitive Processing Therapy off for now. If we try and keep going knowing that we couldn't get over this avoidance then I think it will reinforce that. I think we can work on the morgue incident if you're comfortable looking at that now.

Mike: I try to do it, you know I do. Things just come up and I can't get it done. I'll write the first sentence and that's all I can do before something comes up. It's not like I'm not trying! I'm working, doing what you ask me! Tell you everything else but I don't want to think about that one thing! Can't go there - "avoidance" - or whatever you want to call it I don't care and this is fucked up! What the hell have we been doing this for?!

Unfortunately, CPT did not help Mike. It may have even added to the problems Mike was experiencing through an iatrogenic effect. Mike was having symptoms related to our work in the room. The disappointment or shame of not being

able to fulfill the requirements of Cognitive Processing Therapy was now added to the numerous other concerns he was dealing with. My administration of Cognitive Processing Therapy may have caused further harm to Mike.

Trying to figure out what went wrong, I looked to my supervised treatment of Mike. Why did I follow so strictly the prescription of CPT when my own judgment suggested that this client needed me to be more flexible? The struggle to stay within the guidelines of this particular evidence based treatment may have come from ethical concerns.

When flexing an EBT clinicians are no longer doing the intervention as it was researched and therefore it is no longer an EBT. Bruce Thyer (2004) describes a situation in which a client requests a particular treatment that is not an evidence based practice, "insight oriented therapy", and the clinician must then work to educate the client on the available EBT's. He claims "If evidence-based alternatives are available, then it would be unethical for you to provide such a non-evidence-based treatment" (p. 174) He further states "...at best (and even this may be ethically questionable) you could offer to refer the client to a practitioner who provides insight oriented therapy" (p. 174). Even if the client is asking for a different treatment it would be unethical to provide it. Clinicians must either convince the client to accept an available evidence-based treatment or refer them out. If a clinician decides to refer someone out they are also in jeopardy of being unethical because they know the client will not be getting an evidence-based treatment. This bind is precisely the issue in flexing evidence-based treatment. If I was not doing Cognitive Processing Therapy as researched, I was not doing CPT but some other cognitive intervention that is not an evidenced-based treatment. I would be doing something unethical. The bind is further complicated as I am now either unethical because I am providing treatment outside of EBT's or I am unethical because my treatment, being faithful to CPT, is causing Mike harm. These two choices are untenable.

A third option is to respect experience and tacit knowledge. Use the manual as a guide. Even though I would not be doing the "researched" version and empiricists may object to my work, it is far more ethical to be where the client is and to base treatment on collaboration, experience, training, research from various sources, and consultation with peers. This represents the evidence-based medicine decision-making model:

Step 1: Convert the need for information...into an answerable question

Step 2: Tracking down the best evidence with which to answer that question

Step 3: Critically appraising that evidence for its validity...impact...and applicability

Step 4: Integrating the critical appraisal with our clinical expertise and with our patient's unique biology, values and circumstances... (Strauss et al. 2011, p. 9)

With all the research and evidence acquired, we are to incorporate the client's presentation and our expertise. Flexing a manualized treatment, therefore, represents EBP. Despite the VA mandate to do the protocol as researched and found effective, EBP is not supposed to be devoid of clinical experience and "tyrannized by evidence" or a "cookbook approach" (Sackett, 1996, p. 72). Evidence-based practice is to make treatment better, not complicate it.

Clinicians may be concerned by this bind as it seems that many, if not most seasoned clinicians would be considered unethical in the way they practice given the demands of EBT's. If a manualized evidence-based treatment is available then you ethically must use it. Clinicians will have to give up practices they find effective through experience in favor of treatments that have been found effective through research. It is not that what these clinicians do does not work but that there is no proof that it works.

Strict adherence to evidence-based treatments is bad for clients, bad for clinicians, especially newer clinicians, and bad for developing new knowledge. Being stuck within the pages of a manual and repressing knowledge, experience and curiosity for the sake of fidelity constricts practice and exploration. A clinician following so strictly to a manual closes his mind to other ways of viewing a client and his or her presenting problem. This limits the ability of new clinicians to develop tacit knowledge and expertise in the diagnosis and in the treatment of clients. Seasoned clinicians must abandon their own judgment and skill and develop a mindset that if it is evidence based... it must work. This also narrows exploration into clients and their presenting issues. Mandating the clinician to attend only to certain information and to refrain from exploring other aspects of the engagement not fitting within the highly structured treatments, limits growth in

practice and the field of research. Exploration is needed to identify new research hypotheses and alternative ways of helping specific clients. Ideas are unlikely to flourish when we must discount them in order to remain faithful to an evidence based treatment.

Therapists and their education, experience, and ability to evaluate evidence matter most in the provision of therapy. Evidence based treatments are, at best, good conceptual tools and at worst crutches for uncertain, fearful therapists and agencies. It is the therapist that makes the difference in the therapeutic provision and the push toward “EBTs” may be more damaging than helpful. Michael Polanyi (1966) in *The Tacit Dimension* explores how “We can know more than we are telling” (p. 4). Polanyi is describing how a person comes to have knowledge of anything. When he says, “We can know more than we are telling,” he is referring to the idea that we do not know something by defining all the things parts. We just know it. A book we intend is a book at first glance. We do not have to explore the binding or the pages to figure out what it is. Polanyi uses a face and police sketch as an example. He shows how a person may know a face but find it difficult to describe to a sketch artist without examples of each particular present. Similarly a clinician working with a client may know what they are seeing and experiencing in the presentation of their client without having to examine the aspects of the presentation that bring forth this immediate knowledge. They do not have to deeply explore the specifics of the client or have their resources on various classification criteria open and at the ready to help define each nuance the client presents. It is through education and experience that a clinician develops this tacit knowledge and manualized treatments stunt this process.

The five-step model from beginner to expert described by Dreyfus and Dreyfus in, *Mind over Machine* (1986) exemplifies this process. They explain that, “As human beings acquire a skill through instruction and experience, they do not appear to leap suddenly from rule-guided “knowing that” to experience-based know-how” (p. 19). Polanyi was discussing knowledge of a thing, Dreyfus and Dreyfus focus on skills and the process of becoming an expert in these skills. Already assuming we know everything intended in the initial acquisition of a skill, for instance in order to jump-rope we need to know what a jump-rope is and what it means to jump, we can be instructed on how to jump-rope. This is the rule guided “knowing that”. The instruction gives way

to experience as a person practices and obtains more and more familiarity jumping-rope. He or she becomes more fluid and is able to perform the skill without thought this is “experience-based know how”. EBT’s stunt the growth of a novice therapist at the level of the particular or “knowing that”.

The seasoned therapist may find it frustrating to follow a manual when their intuitive know-how, their tacit knowledge, tries to pull them in other directions. They may follow an evidence-based treatment regardless of these frustrations or they may assimilate the manual into what they know and work with the client using a type of evidence informed treatment.

Evidence based practice requires good clinical judgment. I use “judgment” as described by Hans-Georg Gadamer (2013) in the book *Truth and Method* to identify something about tacit knowledge.” In terms of judgment, “it cannot be taught in the abstract but only practiced from case to case, and is therefore more of ability like the senses. It is something that cannot be learned, because no demonstration from concepts can guide the application of rules (p.29).” Judgment is developed through experience with instances or cases. Gadamer discusses it as a sense, which would then be an ability that is immediate in its interpretation of environmental stimuli. It is also something that cannot be taught.

In therapy each session fits this description. Judgment is developed over time and cannot be taught or learned. In concert with Polanyi and Dreyfus and Dreyfus, Gadamer finds experience necessary for judgment. Fidelity to evidence-based treatment removes the clinician’s ability to utilize these abilities, skills, and tacit knowledge in service of clients. Furthermore, abiding by the “rules” found in manuals will impede the development of judgment.

Treatment at the Clients Pace

Mike and I continued to use principles from cognitive behavioral therapy. We raided the Cognitive Processing Therapy manual and went as slowly as Mike needed using many of the ideas found in the manual and some ideas from other sources. Using just the principles of CPT gave Mike the ability to experience many of the things that CPT tries to teach without holding him to the time and organization constraints. We could go at Mike’s pace and decide what part of the model will work for him and when. He was comfortable enough with the way his sessions were going and

he finally let go of, what he believed was, his worst experience; the experience that he could not admit until then. It seemed to come easily from him after such a long period of avoiding it.

One day, about a month after we gave up on sticking to the manual, Mike confessed his most traumatic incident:

Mike: We were in a HUMVEE driving down and there was some guy standing in the road. It looked like he had something and I didn't know what to do...

Mike stopped talking for a second. He had begun to weep and looked towards the tissue box on my desk. He didn't reach for them though. Confident they were within reach, he continued:

Mike: I started yelling to shoot him and to shoot him because it looked like he had an AK or something. I thought if we didn't shoot him he would shoot us as we got closer...

Mike reached out and grabbed a tissue. He took a deep breath as he wiped his eyes.

Mike: ...Or he would blow us up or something I don't know I just yelled to shoot him. And they opened up on him.

Another pause. Mike took more breaths to sooth himself. He took a sip of water. Mike was taking his time and using his learned skills to overcome the avoidance he had so long used to keep from speaking of this.

Mike: When we got to where he was he didn't have an AK. He was just a farmer and I killed him. The two other Marines with me were yelling at each other afraid they were going to get into trouble. They were higher ranking and that bothers me that they could not take charge. I took an AK that we had in the back and threw it on the body. We weren't going to get in trouble if they had a weapon pointed at us.

Me: Mike, what's going on inside you right now?

Mike: I don't know. I'm sad...scared for some reason.

Me: Guilty?

Mike: I feel guilty when I think I killed an innocent man.

He killed someone. Mike took responsibility for the death of a farmer; he took responsibility for covering it up; he felt he didn't have the support of higher ranking Marines and he kept this to himself until that session. He never even spoke of this to the Marines that were there - ever. It was as if it never happened at all. But it did. It festered within Mike for the years following his service and he avoided thinking about it as much as possible. When it came out in the session it came out with tears. It was not the first time he showed this

much emotion in a session but it felt as if this was an important step for him.

When Mike regained his composure we began, again, to use some of the cognitive skills from the CPT manual. We identified the stuck points and automatic thoughts. These thoughts related to guilt mostly and they were very similar to those thoughts we worked on in the past.

Although it did not seem to help him initially, Mike volunteered some challenges to his own thoughts during the session.

Mike: I guess it wasn't me who shot them. That other Marine saw better than me.

Me: How do you feel when you say that? Instead of 'I killed that farmer,' how do you feel when you say 'it wasn't me who shot him'?

Mike: It doesn't really change how I feel. When I think that I threw that AK down on him it makes it worse.

Me: What does that mean to you? What does it mean that you threw the AK on him?

Mike: Well I guess the stuck point 'I'm a bad person' comes up again...and I know that we already said I am not a bad person because I've done good things too. I mean I have done only a few bad things and that doesn't make me a bad person.

This was similar to the dialogues we had in the past that I did not include here. Working in this manner Mike developed alternative ways of viewing himself and the world that, on occasion, changed the way he felt about his military traumas.

In focusing my attention away from the manualized treatment of CPT I was able to help Mike in the moment. I was able to see past the manual and help Mike cope with certain feelings when they presented themselves in the session. Instead of just using Socratic dialogue and cognitive skills from the CPT manual, I mixed in mindfulness skills and other exercises I would not have used if I remained faithful to CPT. I learned more about Mike and how he experiences his symptoms than I would have if I continued to constrict my perception to what CPT allows me to see. Manualized therapies are powerful tools when used for information and ideas.

Unfortunately Mike and I only saw each other two more times after that session. I saw him once more for a regular session and one last time when he stopped in before moving out of state. It did happen very quickly and Mike was not happy with the situation. He asked if he could call when he was settled and I agreed. I never heard from Mike again. I would like to imagine the most positive of situations for him. Perhaps he is living near his children and developing a relationship with them.

This case study demonstrates evidence-based treatment restricting clinician flexibility and having a potential iatrogenic effect on a client. Evidence-based practice is not synonymous with manualized evidence-based treatment. EBP is a research focused decision-making processes that can help a clinician learn and grow while encountering new ways to understand and treat their client. EBT constricts client conceptualization within the confines of a manual and arrests clinician learning at the particular while foreclosing clinician exploration and development of research questions. Diverting from the manual provided the flexibility needed for Mike to confront unspoken trauma. This evidence-based practice stays true to the principals of a treatment without the artificial constraints of a manual. The principals of such evidence-based treatments require further investigation to isolate the active components responsible for treatment effectiveness.

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