*“We can’t solve problems if we use the same kind of thinking that created them.”*

 Albert Einstein.

On Sunday January 18, 2015 the New York Times Week in Review had a lead article by Dick Morris, a veteran of the Iraq war diagnosed with PTSD. He was very compelling in describing his negative experience with an intervention called Prolonged Exposure Therapy (PET). PET includes regular re-exposure, over time, to the images, sights, sounds, smells, etc of a traumatic event. Originally developed with rape survivors it has now become one of only four treatment modalities approved by DoD.

I was relieved, frankly, to see someone writing about the extreme and hurtful impact of PET because ever since it started gaining visibility I have been alarmed. Some will say that every intervention for PTS or any other mental health challenge will have people for whom it doesn’t work. This is certainly true. However, there is a fast-growing body of research coming from neuroscience that gives us new understandings about how the mind-body responds to perceived threat and fear and how we can reduce symptoms in respectful ways that don’t require a deep plunge into the darkest part“ of traumatic memory.

The neuroscience research alone would be reason enough to stop PET. But, there are also ethical considerations as well. Some people clearly can tolerate PET and receive benefit if they remain in treatment long enough to complete the protocol. But, we need to ask ourselves: “Do any means of obtaining symptom reduction justify the ends?” As a clinician it has always been my conviction that it shouldn't have to be an ordeal to heal. And...it doesn't. There are gentle ways of processing traumatic events that are effective, preserve dignity, don't rely on a lot of talking, and don't create a multi-sensory intensification of the trauma state repeated over many weeks. So, if these methods exist why would anyone use methods that are so harsh for so many?

From what we know about neuroplasticity (the brain's capacity to change based on what it pays attention to) it should be clear that our clinical interventions need to "wire-in" resilience, not hyper or hypo-arousal. Recent research shows that paying attention to something for 8-16 weeks can wire it in...what are we wiring in when we use a method like prolonged exposure therapy? Hyper/hypo-arousal.?

I have heard from a number of VA therapists who are required to use PET that they don’t like it or want to use it. What level of moral distress accrues when therapists are required to use a method they believe can be hurtful? Have there been studies asking those required to use it what the impact is on them?

Further...let's discuss "evidence-based" approaches. Unfortunately, for those of us who are committed to the importance of research and evidence-based studies, there are few, if any, studies that follow people beyond 6 months. This is primarily because funders won't fund long term follow-up. What we know about PTSD is that it can wax and wane over many years, if not decades. As a researcher I am always skeptical when studies claim to be “evidence-based” but are claiming "success" after only 6 months, and often less, of follow-up? How do we know whether the person being assessed has been in a state of freeze since multi sensory prolonged exposure to traumatic replays and is responding to questionnaires from a place of deadened affect and sensory awareness? How do we know how stable any positive effects are when we do not know if they remain beyond the follow-up data point? And, what do we know about the people who drop out of the studies? Is it only a certain type of person who can tolerate prolonged exposure therapy for an entire course of treatment? I have never seen a study on those who drop out...just on those who complete the study protocol.

There are many ethical issues that must be considered any time we treat vulnerable people. The amount of suffering a method like prolonged exposure therapy requires is unconscionable and unnecessary. There are methods that can be tolerated by many, don't generate suicidal thoughts and actions in some, and preserve dignity and hope. Our troops and veterans deserve the very best. The DoD and VA need to take a closer look at what is being recommended.