



Readiness to Change in PTSD Treatment 3 Written Video Transcript

Research findings. I'm going to talk to you first about a study with myself and some colleagues, just really preliminary data on readiness to change PTSD symptoms and related behaviors. This is data on 243 combat vets [00:00.20.00] in a 60 day inpatient VA PTSD program. Collected the data over 18 months from all patients who attended the PTSD motivation enhancement group. It was about 75% of all the patients in the program. What we asked them to do [00:00.40.00] is to list, in open-ended fashion, any or all problems that they thought they might have. We defined "might have" as problems that they wondered if they had or others had told them they had but they disagreed. [00:01.00.00] Because problems—because it was open ended people could say things like "flying off the handle," "losing my temper," and I coded those into problem types for isolation, ignoring people, keeping to myself, [00:01.20.00] trust, distrust, lack of trust, being suspicious, all right. So you're going to see the problem type category labels when we go over the data. Okay, does that make sense? All right, here's the form that we gave them. It doesn't quite look this well organized and colorful, all right. But they basically had three columns. The middle column was divided into two. Patients [00:01.40.00] could list, again, open ended. Anything they felt was "definitely a problem," other side "definitely not a problem," and the middle, "things that they might have." Things they wondered if they have or other people have told them. All right, and then we would collect these forms. They could list anything, anything. [00:02.00.00] This is what we found. Almost 50% of our patients were ambivalent or unaware of—depending on which column they had put it in, I'm putting them all together here—that anger was a problem. Between 30% and 40% for isolation and trust. A little bit under 30% for conflict resolution. [00:02.20.00] About 22%, I think, for restricted affect and it's 16% hypervigilance feel that this is a might have. Important to keep in mind they had the option to say it was definitely a problem for them and they chose not to. Some of the other problems, depression, health. Alcohol a little bit [00:02.40.00] under 30%. Communication between 20% and 30%. Relationships and drug abuse, okay. Now, so there's a lot of potential ambivalence about change for significant [00:03.00.00] PTSD problems. Now, one assumption we have to make here is that if you say something is a "might have," we have to assume or we're assuming in this model that you actually have a problem. Otherwise it's just you're admitting, or realizing, you don't have a problem. All right, so in a readiness to change model you want to be able to show the people who are saying something's a "might have," [00:03.20.00] that they actually have a problem. Now we've done this in a preliminary fashion is I've taken for all those problems you saw up there compared people who said, "might have" for that problem to the people who either didn't list that problem at all or who said it was definitely a problem. And they do not differ [00:03.40.00] on the three (PCL) sub scales. They do not differ. All right, so you've got the same level of problem severity. And anger "might have," we specifically compared them on the (State-Trait) Anger Scale. They looked the same. They looked



the same. All right, [00:04.00.00] let me tell you about a very interesting study by my colleague Craig Rosen and some other of our colleagues. And he looked at just anger among combat vets in the VA PTSD program. He took 60 patients with high (Trait) anger scores. So he selected them for high (Trait) anger on the (STACSE). [00:04.20.00] And then he administered the University of Rhode Island Change Assessment Scale, which basically gives you what stage of change you're at for whatever problem you put at the top of the sheet. Okay, what Craig did is he put anger. Answer all these questions with respect to anger and then [00:04.40.00] you can calculate a stage of change where people are at on anger. Now by definition he selected all high (Trait) anger people. He did a cluster analysis. He got four clusters I'm going to tell you about. Thirty percent of the patients fell into this precontemplation cluster, high incidence of violence [00:05.00.00] but they minimized their anger problems. A much smaller group with the most severe problems who were aware that there were problems but were not changing their behavior, that's only about 5%. But a quarter of the patients were in a group Craig called, "preparation," working somewhat on it but not [00:05.20.00] very committed. And then finally 40% of the patients at high (Trait) anger were committed to working on it, okay. Sixty percent were not in this group from just adding up the other groups, okay. Okay, now it's another study I've done in New Orleans [00:05.40.00] where we used a problem checklist. Because I used the open ended form I showed you before. Now I'm going to talk about a problem checklist we put together. And we assessed 33 combat vets in a VA outpatient clinic using this form which we're calling the PTSD Beliefs About Need to Change Checklist. [00:06.00.00] It's filled out about a month after treatment. What it is is just a list of symptom categories followed by a little list of symptom examples. And then people can check off for that problem, "I've got it," "I've wondered if I have it," or "other people have told me but I don't think so," [00:06.20.00] or "definitely not." And this is part of the form, all right, for three of the problems. All right, does that make sense how that works? All right. Well what did we find? I'm going to go through only some of these. I'm going to go through them, through them fairly quick. [00:06.40.00] Basically, look at isolation. About 60% of the patients say, "Yeah, isolation is a problem for me," 20%, "I've wondered," and a little under 10% for "others have told me." Similar for trust although it's a little higher. Authority, more ambivalence, [00:07.00.00] 30% for "wondered if I have a problem with authority." All right, now anger, what I want you to note here using the checklist the ambivalence is a little lower. All right, because I told you 50% on the open ended. I'm going to talk about this. Conflict resolution more, 25% "wondered," and almost 20% [00:07.20.00] "other people have told me I've got a problem with it, but I don't think so." And very low for hypervigilance here. Now criterion B symptoms, things like nightmares, almost 90% of the patients, "oh yeah that's definitely a problem for me and I want to change that," "intrusive thoughts" [00:07.40.00] over 70%, almost 90% for "upset by reminders," and "sleep problems" between 90% and 100%. What I'm going to propose to you—and I don't think there's any research on this, and I'm going to pursue this—I think patients are coming in for criterion B symptoms [00:08.00.00] and they're a little bit confused as to why we're treating them for the criterion C and D stuff. Because those are the things that they feel are sort of appropriate and consistent with their view of the world. I don't know if there is a lot of research on that and that's a hypothesis but that's what I think. All



right, [00:08.20.00] now the other thing is, patients will come in—what we found with this check list—patients will come in, if you throw a check list in front of them or on admission they're going to tell you they got problems. They've got problems. "I've got hyper vigilance. I've got anger." But I think, unfortunately, that what they're saying on admission or on checklists [00:08.40.00] contradicts with how they feel about whether they really have that problem or not. Now how can this occur? First of all, behavior, the belief they see as different from a symptom you check off or get credit for in a PTSD assessment. All right, for example, [00:09.00.00] patients will gladly check off "hypervigilance, on guard." But if you ask them, "Has anybody ever told you you've got problems 'cause you've got too many weapons or that you've got trust problems?" "Yeah, they tell me, but I don't think that's a problem. Oh yeah, but I've got hypervigilance." Are you, are you following the difference here? Because you will see this. People will say to me, [00:09.20.00] "Well, you know people admit these problems all the time." They'll give you the symptom category, all right. Another issue is the responsibility for problem, externalizing. "Yes, I've got an anger problem, but it's not my problem. The government gave it to me," or [00:09.40.00] "There's a lot of stupid, careless people out there, waiting in line, driving, right?" whether you believe this or not. "That that's why I have an anger problem." So, what our patients I think are asking us a lot of times, especially with anger, "Help me stop having a normal, reasonable response that I'm having all the time." [00:10.00.00] And of course the most well known is that patients when you give them a checklist they're going to check off anything they can that they think is going to give them the PTSD diagnosis. They know the official symptoms, right. The GAF, Xeroxes of the GAF scale [00:10.20.00] float around the unit, or they did when I was there, right, at Menlo all the time. I mean, it's not like, "Oh give me that." I mean what are you, going to take away the GAF scale from a patient? They can get it at Barnes and Noble right down the street. But they clearly know what they're suppose to say. And they know the criterion terms and they know the language. And the open-ended assessment reveals a lack of awareness and ambivalence [00:10.40.00] about those problems. Now, these are the same, each row is the same patient. And somewhere they said this was a problem but then somewhere else said this they didn't think was a problem but somebody told them, right. This is our way of trying to pick up precontemplators, is that question of course. So I had a patient who wrote down [00:11.00.00] "anger" somewhere and then felt that, well people were bugging him all the time. He's a very hostile person. So, when he leaves treatment what is he going to relapse around? He's going to relapse around being hostile to everybody. That's what the return of symptoms is where it's going to come. Another patient said "very mean" as a "might have," [00:11.20.00] but had endorsed anger—I'm sorry, let me go back, going to go back to that previous slide. Temperamental and then my favorite example. We had a patient come in to the motivation group when we were doing it here at (Menlo). Every day he'd come into the motivation group. We ran it at night. And, [00:11.40.00] well, we didn't know if he was going to be discharged. He was getting in fights. He was getting so revved up during the day, getting into arguments. And so of course as we got into motivation group what's he putting down for a "might have?" "Over reactive." "People tell me I'm over reactive all the time. I don't know what they're talking about." So, finally, by the end of group he sort of [00:12.00.00] was starting to get, make connections



that maybe his response was a little bit overreactive. And I think that's a great phrase to use with the patients. Because I don't think they see it as overreactive. Weapons and hypervigilance, patients see as two different things in terms of what you need to change. And we've worked with patients who a father and his ten year old son carried like [00:12.20.00] holstered guns around the house, in the house, you know, while they were watching TV or cooking, so. And of course, you know, you might think I've got a problem with relationships. But your current relationship, it ain't your fault, right? Finally I want to tell you about another study we did. We examined various beliefs about [00:12.40.00] personal change among vets about the discharge from a one year PTSD outpatient program. Now, they're about to discharge. Now, these results I'm going to show you do not reflect at all on this program. This is a wonderful program. All right, this is a great outpatient PTSD program and I've been doing the motivation group with them. I want to look a little—I'm going to tell you about a little [00:13.00.00] questionnaire we gave out for patients about to go out and in three months get questionnaires about post treatment outcome, right. We had 20 inpatients—outpatients within one or two months of discharge. There were seven statements that we asked patients to "strongly disagree," to [00:13.20.00] "strongly agree," seven point scale. I'm going to tell you about three of the statements that are most relevant to readiness to change. "I have to consider what other people say when they give me feedback about my behavior and beliefs," that should be. There's a lot of people disagreeing with this statement, about to leave your program. [00:13.40.00] Do you want them to be thinking liking this? Now, a little better news here is that when we asked them to agree or disagree whether it was "important to consider the positive and negatives about my behavior or way of thinking," a lot of them agreed with this. I was pleased to see that. I was pleased to see that. [00:14.00.00] Now, these are patients who had not had the motivation group. These are—not had the group. So that's good to see. However, "I am responsible for handling situations that are difficult, upsetting, or get me angry." Well, a lot of patients agree. That's nice. But you've got, [00:14.20.00] what, maybe 36% of the patients disagreeing with that. So, who are you worried about after treatment? This is where the ambivalence and lack of awareness and responsibility. These are the people who are going to show up as doing poorly on your—in your research studies of post treatment outcome. It's going to be these patients, [00:14.40.00] along with the ones who don't go to outpatient therapy or take their meds and stuff like that. But in terms of some variance we like to think we're explaining or trying to explain that's the group you're worried about.

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