National Center for PTSD
Posttraumatic Stress Disorder
U.S. Department of Veterans Affairs
National Center for PTSD
ADVANCING SCIENCE AND PROMOTING UNDERSTANDING OF TRAUMATIC STRESS
www.ptsd.va.gov

PTSD 101 Course

Transcript for: Increasing the Effectiveness of Evidence-Based Treatments for PTSD

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This presentation will be on ways to increase your effectiveness while using evidence-based treatments for posttraumatic stress disorder.

Hello. I'm Kate Chard and I'm the Director of the PTSD and Anxiety Disorders division at the Cincinnati VA Medical Center. What I would like to do today is talk with you about difficult situations or scenarios you might run into when you are trying to implement evidence-based treatments in your practice. So, I think one of the things I'd like to focus on are things you may have already found as troublesome or things you haven't stumbled upon that may get in your way and maybe provide some answers for you on how to address those situations.

By way of introduction, we know that research has shown that cognitive-behavioral therapies, especially prolonged exposure and cognitive processing therapy, have consistently been found to be effective treatments for PTSD. We now even have numerous practice guidelines that confirm the effectiveness of CBT treatments including the Institute of Medicine Report, the VA/DoD Guidelines, and the ISTSS Guidelines, all of which unanimously endorse cognitive-behavioral interventions for the treatment of PTSD.

After viewing this presentation, you should be able to do at least three things. The first is to understand the limitations of evidence-based therapies for the treatment of PTSD. You should also be able to identify and address potential treatment-interfering behaviors that might get in the way of doing evidence-based practice. Then finally, we want to help you develop strategies for managing some of the complex cases that you'll be working with when you work with individuals who have a PTSD diagnosis.

So first, let's start with some of the limitations. Why don't we discuss assessing people who are appropriate or not appropriate for evidence-based practice in the diagnosis of PTSD?

One of the first things we can do to enhance our use of evidence-based practice is to use an assessment. Assessments give us a number of things, but first off, they give us a comprehensive view of the patient beyond the PTSD symptoms. So we can look at depression. We can look at their hopefulness and other positive psychology variables. We can look at their motivation to actually participate in care. We can also look at levels of anger, pain, traumatic brain injury, or other medical complications that may get in the way of doing an active trauma treatment at this time.

Second, assessments help us identify problem areas at the start of treatment, so things that might get in the way—treatment-interfering behaviors—but also things that we might want to tweak in the manual to help us do that evidence-based treatment. For example, if that person has a learning disability. Third, assessments help us track improvement during the therapy. Sometimes it's difficult for the individual to identify ways that they're improving. Now by using standardized assessment measures, we can show them objective gains on things that they've changed in their life that can actually help motivate them to continue on in the therapy. Fourth, assessments can help us isolate areas that need more intervention. Sometimes it can be difficult to see the very specific areas where someone may be stuck and not making the gains. For example, some of the avoidance symptoms may be very obvious because they are not going places or doing things they used to enjoy, but it may be even more difficult to identify some of the arousal symptoms that perhaps they're not mentioning to you because they are not doing the things they used to do.

Finally, we can use assessments to determine if the therapy is effective. We can then identify whether the person has actually reached a good maximum level of improvement. We can also see if maybe they are avoiding. Maybe they are not getting the gains out of the treatment that we were hoping for and we can discuss with them whether they want to continue to stay in that therapy or if perhaps switching to an alternate treatment would be a better idea for that individual at that time.

Why don't we focus on some specific areas of assessment that can be very helpful in your practice in order to get a full well-rounded view of the individual you are working with. So, four areas I'd like to talk about today include medical, psychological, substance use, and motivation.

We know that individuals come to us often with very complex histories and medical is just as important as any of the psychological issues you may be dealing with. You may want to look into their chart and also do a full psychological and psychosocial history that includes medical conditions that could impact care. For example, if you have someone that has seizures that have not been diagnosed or treated, eating disorders that have pretty severe complications, and any other acute medical diagnosis that would interfere with your individual's ability to come to sessions and do all of their practice assignments outside of the therapy relationship, these are things that could become treatment interfering. Another example would be someone who has a disability that would not allow them to go and do some of the prolonged exposure in vivo assignments. We would want to know ahead of time what limitations they have so that we can tweak the therapy in a way that will still make it the most effective it can be for them.

Another area that is gaining a lot of attention with our recent conflicts in Iraq and Afghanistan is traumatic brain injury. We do know that their levels of traumatic brain injury, and depending upon the individual's level of injury, the impact on their ability to do an evidence-based therapy can vary. It's important that you have a neuropsychologist and, if necessary, a neurology team work up the patient to find out where are their strengths, and where perhaps are their limitations. These therapies have been shown to be effective with mild traumatic brain injury in small pilot studies, and over time we'll learn more information about other types of traumatic brain injury.

Another important area to evaluate is medication use. Many individuals are helped by the use of sleeping medications and antidepressants, but we also find that many individuals go through trauma treatments with no add-on medications at all. One thing to definitely consider is the use of pain or anxiety medications which can become treatment interfering, especially if they are taken at such a level at which the individual is not able to process their emotions or even focus on the cognitive restructuring that you are doing. We have found that it's very effective for you to work collaboratively with any medication prescribers to inform the prescribers of the type of therapy that you are doing and to help make sure that the medical care they're getting is not interfering with the psychological care that you would like to offer.

The next area for us to look at is the psychological evaluation. We know that many individuals with a diagnosis of PTSD have a comorbid psychological disorder in another area. The first I'd like to talk about

is bipolar. If someone's in a bipolar manic episode it can be difficult for them to focus on getting their practice assignments completed or even focusing on their session. At that point, it might be good to get a medication consult to get the bipolar mania under control before we start the active trauma treatment.

The next area would be schizophrenia. Many people with schizophrenic disorders have had very successful treatment using evidence-based practices. But, at times, it can be important to go ahead and use medications to control some of the delusions or hallucinations that again can be interfering in the treatment. A good work-up that identifies whether the delusions or hallucinations are an add-on to a depressive or PTSD diagnosis or actually part of a schizophrenic disorder would be very important.

Third, we need to establish whether the suicidal intention that someone has is different from suicidal ideation that they may have. Many of our posttraumatic stress disorder patients have thoughts about suicidality or even homicidality at some time or another. This is very different, though, from the full intent to harm themselves or someone else. Using some of the gold standard suicide assessment measures, we can determine if the individual is ready for active trauma treatment or perhaps we need to address some of these intentional thoughts using some coping skill building.

Fourth is dissociation. Many individuals with dissociative disorders have a very hard time paying attention to trauma-related material and even practice assignments that we may ask them to do outside of session. The first thing we want to do is establish whether the individual has a history of dissociating. The second thing we want to do is ask them if they have control over their dissociation and if they can control it during the therapy session and during practice assignments. You might be surprised by the number of people who tell us that they actually do have more control over it than they thought, they just had never been asked that question before. If they do not have control over their dissociation, this would be a great time to consider some of our great skill building therapies, like dialectical behavior therapy or stress inoculation training.

Finally, we need to assess for personality disorders. While much of the research on posttraumatic stress disorder has shown that individuals with a comorbid personality disorder still do very well in these active trauma treatments, some individuals may find that their personality skill deficits get in the way of their ability to do well in these therapies. What we can do with them is provide a lot of structure and be very consistent, but if it really looks like those personality disorders are going to get in the way of the trauma treatment, again, going back to skill therapies that give them the skills and coping mechanisms to handle talking about the traumatic material can be very helpful.

The next area to consider is substance use in your evaluation. The first thing we may want to look at is how motivated an individual is to decrease or quit using whatever substances they are using to avoid feeling their feelings or thinking about the traumatic event. We know that some people are very motivated to stop using and are very likely to cut down, and others may have a more difficult time. One of the things that may make it difficult is withdrawal concerns. If the use has become so high that if they stop using or even cut back they are going to have severe symptoms, we'd probably want to consider having them go through some type of detoxification treatment prior to starting active trauma treatment. In many cases though, our individuals are self-medicating. They are using the substances to avoid feeling their feelings or thinking about the traumatic event. Much research has shown that using substances while undergoing active trauma treatments is not a no-win situation. If we asked them not to use before, during, or after session, or before, during, or after their practice assignments, what we have found is that their substance use decreases over time during the trauma treatment and, in fact, often is completely gone by the time they are done with the treatment protocol.

The next area we want to evaluate is motivation, and the first part of motivation we want to look at is the individual's desire to change. We know that trauma therapies can be difficult and a person has to really want to change in order to get them motivated to go through that therapy. So, we also at that same time need to look at how motivated they are to go through a change in therapy structure. If someone has been

in a different type of therapy, if they have been in therapy before you, it may feel awkward to them to go through an evidence-based psychotherapy. So it's important to them to a), understand what the therapy will be like and b), make sure they are motivated to do the work that will be required.

Another area of motivation we need to look at is how motivated they are to attend weekly, and sometimes even biweekly, sessions. This could take a lot of time out of their day or their week, especially when we ask them to complete out-of-session practice assignments as well. This is where giving a good explanation of the therapy and helping them understand how they can benefit from the therapy will ensure that they'll be willing to meet the obligations required for the treatment.

In summary, it is very important that we assess for and address comorbid psychological disorders. That should not preclude us from using evidence-based psychotherapies with individuals who have multiple diagnoses. In fact, we can often use the evidence-based treatment manuals as they're written. Or we may make alterations as suggested by the treatment protocols, such as focusing on the symptoms related to the other disorder. For example, focusing on stuck points related to their substance use.

What we just covered were some of the areas of evaluation that we find important. Certainly a thorough evaluation that includes all parts of history, psychosocial functioning, family history, etc., would be just as important as well. What I would like to do now though, is switch to treatment-interfering behaviors that might get in the way of doing evidence-based practice.

Because we are dealing with people with PTSD and one of the main symptoms of PTSD is avoidance, we know that avoidance behaviors can be one of the biggest ways that individuals will interfere in their own care. One of the things that you are going to often see is individuals who don't show up for appointments or give late cancellations calling 5 minutes before or even 15 minutes into their session. Another thing they may be is late to the appointment, where they have all sorts of excuses or problems that they ran into that cause them to be a few minutes or even 45 minutes late for their appointments. Next, we'll find that some people don't complete their assignments at all or only complete part of their assignments, sometimes offering excuses such as, "I didn't have time," or "competing things got in the way," but often sometimes just saying, "I didn't do it." or "I didn't feel like doing it."

Another area of avoidance is intellectualizing. These are the individuals who almost become an analyst of their own problems, where instead of allowing themselves to feel their feelings or focus on their cognitions, they become a distant dictionary about what's really happening inside their head. Another area to look at is people with the "crisis of the week." They come in with different crises each week—that may even have the same flavor—but are very critical to them and they feel like it is the most pressing thing that needs to be talked about that day in session. Similar to "crisis of the week" are people come in with storytelling; these are individuals who always seem like they need to convince you about what happened in great detail. I often find that these are individuals who perhaps haven't felt listened to in the past, and they feel like they have to get the whole story across so that you'll understand and believe their side of the story.

There are several things you can do to manage avoidance both before you actually start the trauma treatment and once you are already in the therapy. The first thing you can do is provide an education about the therapy to the individual. This includes how long they're going to be in therapy, what will be asked of them, what will be the responsibility of the therapist, and what we can expect from the therapy. Along with this is explaining, and if need be, reiterating the rationale for the treatment to them, both at the beginning and any time they start to waver during therapy. What this means is focusing on why we're doing what we're doing and how it explicitly works. Finally, we can use motivational enhancement techniques prior to even starting therapy so we can find out where they are really struggling with their lives. Is it they're not going out? Is it they're not taking time to be with their grandchild? And we can revisit these reasons at any time during the therapy to keep them motivated and on course.

In working with individuals who have problems with motivation, I often find that I have to pause in the session and regroup and ask them several questions in order to get them motivated back into the psychotherapy. In this case, I was working with a 60-year old Vietnam combat Veteran who had expressed original interest in doing prolonged exposure, but he was not doing any of the in vivo exposures outside of session and he was not one to go into any detail in his imaginal exposures in session.

So, the first thing I did is I asked him his memory of the rationale for the treatment. And once I established that he had a very good understanding of the rationale, I moved into asking him what he wanted from the treatment, what he was hoping to gain from the therapy. He responded that he wanted to be able to spend more time with his grandson, spend more time with his wife, be able to go out in public without having fear of having flashbacks or feeling like he was going crazy. When I asked him what his life would look like without PTSD, he paused. At first, he said he couldn't imagine it. But after a little bit of reflection, he realized his goal would be to be able to go to little league games with his grandson, but more importantly, to take him to professional baseball games where his grandson could see the athletes in action.

We were then able to tailor the in vivo exposures to things that directly apply to being able to get out and do things that would allow him to reach his goals of being in public with his grandson. So, the first imaginal exposure that we did in session, he was more motivated to talk with me about his traumas and then in the in vivo exposures, we actually had him sitting in his car at the little league park watching his grandson's game for thirty minutes and then leaving and coming back the following game and trying to do that again. We found that anchoring him to something that was very very important and not just focusing on removing PTSD symptoms was the trick to get him more motivated and more willing to fight through his avoidance.

Some things that we can do actually in the protocol is to start off by setting an agenda with each and every session. We can remind the individual the things that we're hoping to cover that day and ask them if they have anything they would like to add to the agenda. By being collaborative in setting the agenda, the individual would be more likely to stay adherent to the agenda, and also feel like they're part of setting up the stage for the therapy, which allows for them to have time to talk about whatever's on their mind. The last thing we can do is stay in the protocol. Sometimes it can be tempting to deviate from the therapy if the person brings up something that's new or novel or different. But what we know is this can lead the therapy astray and actually increase avoidance behaviors.

As I mentioned earlier, it's important to assess for individuals with personality disorders, but we also know that individuals with personality disorders may need special care when going through evidence-based treatments. One of the first things that we can do is make sure we've been very clear in explaining the rationale and providing an overview of the protocol, because adding this structure can help waylay any concerns they have about not being able to predict or control what's going on in their life. The next thing we can do is we can use the treatment to address interfering behaviors. For example, in prolonged exposure we can stay focused on the imaginal exposure and keep bringing them back to the exposures instead of focusing on other things they may be bringing in to talk about. In CPT we can focus on the ABC sheets and actually use the ABC sheets to focus on the issues in their life and help them see that using these sheets can be an effective way to manage the chaos that may be happening around them.

Another thing we can do to help people who have personality disorders in therapy is build coping skills prior to the treatment. Definitely, this is not necessary all of the time and many individuals with personality disorders do beautifully in evidence-based treatments with no prior care; but as I stated earlier, dialectical behavior therapy sessions that build coping skills can be a nice way to give them an alternative way to respond when they're feeling more internal stress from their trauma. Finally, it's important to be aware of your own impact because we know many individuals will be looking for cases where you cannot be trusted or to be counted on, it's important that you're on time, that you are prepared, and you do what you

say you're going to do in each session. This is another way to make sure that you stay on track in following the protocol.

In addition to some of the avoidance behaviors that can be difficult to manage in a therapy sessions, many of the people who we work with will bring very problematic issues to the sessions that may be more difficult to manage without looking at outside supervision.

Some of the potential difficult issue areas that I have encountered during my trainings include religiosity, traumatic brain injury, perpetration, and no improvement or limited improvement as you go through the therapy. I'd like to address each of these in turn.

One area that can often get in the way in therapy is rigid religious beliefs. It can be very daunting when someone comes at you with very dogmatic statements about their religion and about their beliefs or disbeliefs in God. The first thing you can do is to stay in the model. Often prolonged exposure and cognitive processing therapy have suggestions for how to handle extreme or exaggerated concepts about a person's faith. How do we handle that? By being Socratic. Have them explain their beliefs to you, their rationale behind their beliefs, and look for holes in the arguments that they're making. The goal here is not to become argumentative, not to engage in a philosophical banter about the Bible, the Koran, or the Torah, or any other religious document, and not to convince them or tell them your interpretation. But, like with any other belief that's become over-exaggerated, over-generalized, and over-encompassing, is make sure they're looking at all of the logic behind holding that belief and all of the evidence against that belief.

One way to work through strong religiosity beliefs is to maintain your Socratic questioning while listening to the strong beliefs being held by the individual. I once worked with a 26-year-old female rape survivor who stated that God was punishing her for the rape and that she should not have had sex even though the rape was not volitional on her part. She came from a very religious family, had never told anyone about the rape until therapy and had not dated after the rape occurred in college. Her reason for coming to therapy was that she wanted a family and she wanted children, and she didn't see any way that would happen with her current unwillingness to date. When she mentioned to me that God was punishing her for the rape, I asked her if she believed that the rape was her fault, and she said yes, the rape was her fault and that God was unwilling to forgive her for having sex. The next question I asked her was if that was true for everyone who had a rape happen to them and that they were all to blame for sex if they were raped. Her response was very strong and she stated, "No, definitely not. Women should not be blamed for their rape and men should not be blamed if they are raped." But, that this only applied to her. I then queried if that's how she believed in her God. That her God had rules for some people but not for others and they were applied discriminately depending upon the person.

She puzzled over that over the entire week and then came back the following week and she said, "I believe in a fair God so it really doesn't make sense that I believe that God would have some rules for me and some rules for others." I think the important part of this interaction was that I did not begin to fight with her about her beliefs in God. I did not begin to put my beliefs on top of hers or push her to change her beliefs. I just asked simple questions about what she believed and began looking how erroneous the thinking was when you try to apply that to everyone who was in a similar situation to her. By staying calm, and trying not to get into philosophical arguments, we can often help people get through their religious stuck points or areas where they're being punished and help them move towards a more balanced and healthy view.

Many individuals have suffered traumatic brain injury both in the context of their traumatic event or in their daily life, perhaps even as a combat Veteran. One of the things that we know is that the VA and the Department of Defense Consensus Conference has recommended both PE and cognitive processing therapy for the treatment of mild TBI comorbid to PTSD. We also know that individual presentation will vary depending upon where the damage occurred, so it is important that we understand what are the

limitations of the individual we are working with. For example, we may need to vary the protocol depending on whether the person has an auditory or a visual learning deficit and both the PE and CPT manuals have suggestions for how to handle these types of limitations in learning.

Both in PE and CPT, repetition may be needed. It may be important to tell their story over and over. It may also be important for them to do their cognitive challenging of their new thoughts over and over. Finally, it can be very important to involve other disciplines. Many individuals with traumatic brain injury have problems with pain, speech, they may need occupational therapy, or even some type of physical therapy. By involving these other disciplines, you can create a multidisciplinary approach that can help build up strengths in many areas that will help remove or even remediate the PTSD symptoms.

One area that many therapists call me about is perpetration. Often, an individual becomes stuck in the details of an event saying to themselves, “It's my fault,” when they actually did do something that turned out badly. This becomes very easy to mislead a therapist with, and they will miss the core underlying issue or the over-generalized belief which is really, “I am bad.”

One of the things that we can do is we can help them look beyond the event—help them understand that perhaps they did do a bad thing, but that does not mean they are a bad person. We can do this though our cognitive challenging in CPT, but we can also do this through some gentle questioning after an exposure. Even if someone did do something bad, even if they did do something intentionally, it is important to examine the context that may have impacted the decision making at the time to help them understand that they are not a bad person and they may have done this only in response to a context that felt very out of control.

One example of working with someone who is struggling with their thoughts about perpetration was a 24-year-old combat Veteran I worked with who served in Iraq. He killed a man as the gentleman was approaching the security check point, because he got out of his car even though he was asked to remain in the car with his hands on the steering wheel. As the gentleman was getting out of the car, the Veteran couldn’t tell whether he was armed or not, whether he was pulling a weapon out of the car. And he shot and killed the Iraqi civilian. When he came to therapy, this young combat Veteran stated, “It’s my fault he’s dead.” And then he indicated that no one can change that and, therefore, his life is ruined. Instead of challenging the idea that it was his fault that the Iraqi civilian was dead, I asked him what it meant to him underneath that, that this gentleman was dead. His response was, “I am a bad person and I will always be a bad person for having done this, and there is no way I can have a normal life.” It was much easier to challenge the belief of, “I am bad, I will not have a normal life, I cannot be forgiven,” instead of challenging, “It’s my fault,” because, indeed, the death, on one level, was his fault for having shot at him. We were then able to look at whether he had done many things well in his life. Was he a good person in many of the areas in his life? Was he a kind brother? A good son? Was he actually quite good to his fiancé’? And he was able to see that yes, he was a good person and even a good soldier. The second thing we looked at is the context. What was the man in the car supposed to do? As it turns out, the man was getting instructions from an Iraqi translator telling him to remain in the car with his hands on the steering wheel. And he chose to ignore them. So even though the soldier did shoot and kill him, he had orders that if anyone approached a security check point and got out of their car and acted in a suspicious manner, he was supposed to shoot. We were able to look at the context and look at his orders and look at the reason for those orders of retaining safety and security on the base. By doing that the Veteran was able to realize, although he did kill this individual, there was a very different context and it didn’t mean that he was a bad person in total.

A final area that people often have concern with is, “What if my individual is making no improvement or limited improvement as we are going through the therapy?” The first thing I do is I evaluate their commitment: Are they coming to therapy? Are they doing their out-of-session practice? Are they still motivated for the therapy? And what do their assessments look like when I give them weekly assessments for their PTSD symptoms?

If I see they have very little commitment, I question whether it is a good idea to continue in the therapy. The other thing that I do is I revisit the treatment rationale:

All right, are you really invested in this therapy? Do you understand why we are doing this therapy? Did I not explain something well? Can I explain it better?

Another issue that can come up when we see lack of improvement is a competing agenda. Sometimes people have a disability status that they are worried about maintaining or keeping or maybe they are being redeployed and they see their symptoms as actually beneficial to “being a good soldier,” so to speak. What we need to do is evaluate whether their agenda is actually getting in the way of their ability to do the work and whether this is a good time for them to be doing the therapy.

A final thing to consider is an alternative treatment. We find that if you actually carry someone through the treatment and they are not doing any of the work outside of the therapy, they can end up walking away from the treatments saying the treatment failed them or they personally were a failure or the therapist was a failure; all of which are pretty bad things for them to be thinking about their experience. It might be better to do a good job in matching the treatment to the individual where they are, and if this means changing the therapy in midstream, that can often be your best course of action.

Why don't we take a minute now to talk about some of the frequently asked questions that I hear when I am doing some of my training workshops?

Question: How do I know if my client is ready for trauma-focused therapy?

Answer: Well this is one of the main reasons we try to do assessments on every individual before we start therapy. By using standardized assessments along with a good clinical interview, you can identify the individual's strengths and also areas that may be limitations to being able to do a good solid trauma therapy. So some of the things we are going to look for are solid coping skills and a good social support network. If the individual does not seem to have much in terms of coping skills and it looks like doing any discussion about the traumatic material, whether directly or indirectly, would be painful to the point of incapacitating them or causing significant disruption in their daily life, we might want to consider building coping skills using some of the good evidence-based coping skill building treatments we have out there.

Question: Can I combine treatments? Like can I put PE and CPT together?

Answer: At this point we know that in terms of the research, the treatments have been found to be effective when you actually follow the manual and you do not add or take away from the protocols. There is some research pending looking at combining key aspects of the two, but we do not know if that is effective or not. While you are working with these individuals and while you are trying out these therapies we strongly suggest that you actually use the manuals as they are written. But, if you run into a situation where you wonder if the manual is actually right for your individual or if you are having difficulty staying in the model, that’s when we would suggest getting consultation before combining therapies.

Question: Can evidence-based practices work for moderate or severe TBI? I feel like I can’t get a solid answer on that.

Answer: That’s a great question. While we do have some preliminary evidence that both CPT and PE work with individuals who have mild traumatic brain injury, there is less data to support their use with moderate or severe. I can say at this point I do know that there are preliminary case studies and some small pilot studies that have come out that do have information suggesting that the two manuals are effective with traumatic brain injury. I suggest, though, that you focus more on the exact symptom disruption instead of just the label of moderate or severe. So, focusing on whether the individual has problems with their verbal memory, their visual memory, or maybe even just being able to read clearly

and understand the concepts on the page. If you focus on those then you can actually make the alterations that the manuals outline that will be most effective for that particular person.

Question: What do I do if I have a situation that is not covered in the manual? Where else can I look?

Answer: You raised a great point. Obviously, there is a lot of information in the front of both the CPT and the PE manuals that would be very helpful for informing you about difficult cases or questions you may have where the situation does not seem to fall right in the manual. But there are a couple other things you can do.

The first thing is to go to the ptsd.va.gov website where there are significant resources both for family members, therapists, and for patients that you might want to use in your clinical work. The next option is online trainings. There are quite a few online training resources that you can go to, both as a VA practitioner but also as a private practitioner in the community, that can give you more education about how to handle difficult scenarios. I also suggest going and looking at the dissemination team consultants. So we know that both of these therapies are being disseminated throughout VA and through the Department of Defense, and you can contact some of the experts and talk to them about how would they handle difficult scenarios using their treatment protocols. And finally, I can never undersell the importance of peer consultation. If you have someone else in your clinic who is doing the same therapy, don't forget to ask them about the situation you are dealing with and see if they have suggestions for how to best handle it.

In conclusion, there are a couple key points that I hope you have taken away from our talk today. First of all, evidence-based practices in the treatment of PTSD do not work for all people all the time. But, there are certain techniques that you can perform before and during the treatment to increase the likelihood of successful implementation.

First, a thorough assessment can help us understand any limitations or difficult areas that we might want to address during the therapy. Second, by using motivational enhancement we can ensure a strong buy-in to the treatment. Third, by explaining the rationale, we can make sure the individual is committed to doing what they need to do to perform the therapy successfully. And finally, we can use consultation when we need to for those difficult situations that arise. Don't forget you've got teams of experts out there and websites that you can go to if you ever have a problem with it that makes you think that you might need to deviate from the protocol. Sometimes there's actually an answer that someone can help you with in keeping on track with the protocol before you feel like you need to leave.

I wish you the best of luck in using evidence-based care. Thank you.