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: Overcoming Barriers to PTSD Treatment Engagement

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The title of our presentation today is "Overcoming Barriers to PTSD Treatment Engagement." I'm Ron Murphy at Bowden College.

I'm Craig Rosen at the National Center for PTSD and at Stanford University.

And here's our contact information. You're welcome to email either one of us about the talk or any references we mention or any further materials related to the PTSD motivation enhancement group or any other content here.

We're going to start off with an introduction entitled "Why Do Treatments Fail?" Specifically, when PTSD treatment fails, why does it fail?

There are some common theories about why PTSD treatments fail when they fail. One is people have chronic PTSD that's unfixable because of biological changes or something about just having the disorder for a long time. Another reason, patients just are not ready for treatment. The third reason, from a treatment outcome research approach, is that we're still trying to find the right treatment.

Now, true or not, you can't really do much about these reasons for treatment failure.

We're going to talk about treatment failure reasons you can do something about. These reasons are all related to treatment engagement, and specifically, barriers to treatment engagement. So the rest of our presentation is divided into 3 sections addressing these 3 types of barriers to PTSD treatment engagement and what to do about them.

The first part of our talk; part one: Motivation to change as a PTSD therapy barrier, and Craig Rosen's going to take it from here.

When PTSD vets enter treatment they're often coming in feeling overwhelmed by problems. They are responding to all sorts of stressors and problems that they're dealing with, but they may lack insight into their own contribution to those problems. In other words, some vets may be coming in aware that they've got a problem with anger and are feeling irritable all the time and they're looking for help to stop feeling so angry, but they're also saying, "Don't you understand the world is full of dangerous, hostile, and provocative people?" They may have very little insight into what they're bringing into that problem to provoke-to elicit reactions from the people that get them into conflict.

One problem for therapists is ending up in a debate with patients about the best way to handle situations where you're giving them feedback about how they may have misperceived something as a provocation when it really wasn't. What that also may come down to is basically the therapist saying, "You're wrong." And it's one quick way to end up with a disconnect between where the client's at and where the therapist is at in terms of recognizing what's going on in terms of a problem.

So from the therapist's vantage point it's that there's a disconnect between the therapist and the patient in terms of what they see the problem is and what's going on. The therapist may end up labeling the patient as "resistant", "Not ready for change"; "This patient's ruining our beautiful treatment plan. Why won't this person get with the program?"

But the more fundamental issue is that the patient may not believe what the therapist does. The therapist is looking for how the patient's coping responses, the acquired way of reacting to things, may be an overreaction based on earlier life events. From the client's vantage point the way they're responding is a perfectly sensible way to be responding to the current situation.

So in a sense, what the patient thinks the problem is: "My wife, you know, nags me, and my friend pushes my buttons," is not what the therapist thinks the problem is, which is that the client gets easily provoked.

So, one study that we did with 240 combat veterans coming into a 60 day inpatient VA PTSD program was having them list various kinds of problems, and what we're really looking at is the problems that they might or might not have. And these are really 2 kinds of problems, either things they were wondering if this is a problem; in other words they're coming into treatment not sure if that it's a problem but suspecting it might be; or it's a problem that they don't seem to think is a problem but other people around them keep bothering them about. So these are problems which they're not sure is a problem or not, or other people are giving them feedback that it's a problem, and they think these other people have some misconceptions.

This next slide shows the proportion of patients who listed these various things that might have problems. So they put them in their own words. We then put them into categories.

So half the patients were coming into a residential PTSD treatment program; that they're coming in for 2 months of PTSD treatment, taking 2 months out of their lives to get treated for PTSD; are not sure whether anger is part of the problem. Either they're wondering about it or other people tell them they've got an anger problem and they don't see it.

Some, really a third of them, are not really sure whether isolation, distrust, the way they handle conflicts…whether those things are problems. Another 15-25% are not sure whether or not showing feelings or having feelings or being on guard…whether those are good things or bad things.

So, what's striking is, even though patients are coming in for PTSD treatment, a lot of what a therapist would say are typical symptoms of PTSD, the person who is having those symptoms may or may not recognize this as a problem. They may think that this is a normal way to respond to a threatening world.

What's critical in working with people is having, really, a readiness for change view of PTSD. And what we mean by that is, that individuals are at different levels of awareness or readiness to change for specific problems. So someone may come into treatment saying, "I know I've got nightmares and I'm eager for the pill that's going to fix that. I'm not sure whether being distrustful is a good thing or a bad thing."

Different interventions are needed for people at each stage to move to the next stage. Having a readiness for change view means not broadly labeling that a patient is in denial, resistant, or not ready to change, but rather some inventorying, What things is this person more ready to work on, what things is

this person less ready to work on, and how do we help bring them along for the things that they haven't really recognized as a problem?

So one framework for thinking about readiness for change is the "stages of change" models developed by Jim Prochaska and Carla DiClemente. And that model posits that people can be at one of five stages for any given problem.

For the Pre-Contemplation stage, which means literally the "not even thinking about it yet" stage, someone's not considering whether or not to change. They're almost asking themselves, sort of, "What problem?" So you may have vets who spend a lot of time by themselves and they don't think isolation's a problem. They think it's part of how I am and it's a good survival skill.

So the intervention for somebody who really doesn't even have a problem on his or her radar yet, is some basic education. So for someone who doesn't see isolation as a problem it may be really striking for them to find out that that's actually a symptom of PTSD, that's actually a way of coping that's associated with having a disorder, and that while it works in the short-term, that being isolated and away from other people may be one of the things which contributes to being depressed, or lonely, or being overwhelmed when they've got problems to deal with; being short of other people to turn to for help. So really, the intervention there may be just putting some basic education and putting some facts out there for people to know more about what they're dealing with.

Another stage someone can be at is a Contemplation stage; the "thinking about it" stage, where they are thinking about something as a potential problem but they haven't yet made a decision whether they need to change or not. So someone may be aware that they're more distrustful than other people are and aware that sometimes that costs them something but also thinking: Well there's other times where it really protects me. So someone hasn't made a decision about whether or not they need to change.

Interventions to help someone at that kind of stage are weighing pros and cons of, "What is it gaining you or costing you to behave this way?" Also some comparison to norm: "Is what I'm doing typical for most people? Is it different from what most other people do?" Those are tools to help somebody make the decision whether or not they need to change.

For people at Preparation stage, this is where people have recognized the problem and started to take some steps but not yet developed into a regular routine. One way of thinking about it is all the people who've joined the health club and have gone a couple of times but are not yet into any regular exercise routine and may or may not still be there 2 months later.

Here the questions people are wrestling with are, "Can I change? Is it possible for me to really do this?" Part of the intervention is really instilling hope in the sense that this is really possible. Interventions which help with that are: giving people education about therapy and how it works, and the fact that it can really produce results. And what's particularly powerful is modeling by peers and seeing that other people who are coming from where we have come from have made gains in this way.

An Action stage is the easiest stage to work with people. This is where people are actively working to change and really just need some coaching. And at that point you can help people with practice and role-play homework. That's the easiest spot to work with people.

The last stage is the Maintenance stage-- continuing that behavior change. You know, as we know, that the norm is that most people have to quit smoking several times before it actually sticks, or people often lose weight and regain it, and there the issue is how do I keep changing?

And I think that brings up the importance of 2 kinds of interventions. One is continuing support. So, for example, the continued attendance at NAA helps people remain sober even after they've become sober, and the second is lifestyle change, where you really are changing the contingencies in your life. So again,

back to the example of substance use, how you really change so the people you're socializing with are not the people who were your drinking buddies. You really need to have a new group of friends to maintain sobriety.

One question this raises is: Well how can someone be unaware of a serious problem? How can somebody be in a Pre-Contemplation stage or still mulling it Contemplation stage with something which is really a very severe problem? And there are really 3 broad kinds of answers.

One is the issue of what is normal from the client's perspective. Second is roadblocks to admitting a problem to yourself, and the last, roadblocks to admitting a problem to other people.

So one question is: What is normal for patients or for us? What is our own idea of what normal is? Vets may be coming in with norms that they've had from their childhood, from their military combat experience, their post-military norms of what normal is. So if someone has grown up in an abusive household, escaped that household by going into the military to then serve in a war zone, then comes back after the military "hanging" with a pretty rough-and-tumble crowd, their idea of how you handle conflict isn't that you talk things out. Their norm is you either get into peoples' face or you back down.

So people are coming in with…often with, "That's all I know." Often the reason they're coping with things poorly is that they haven't really had exposure to adaptive coping models for that kind of problem.

People may also come in where they're assuming that the kinds of things that work for other people won't work for them; that they're in a low-power position. We use the "getting in the house" metaphor where you go around and you climb to the second story and climb in through the open window, not being aware that the front door's unlocked-you could've just walked in the front door. So I think particularly for folks like Vietnam vets, who had the experience of being really disrespected and ostracized when they came back from the war, they may not realize that people are open to them and supportive to them. They're so used to being shunned that they don't actually recognize that the front door is open to them.

Other reasons why PTSD patients in particular may be unaware of the need to change is that the trauma symptoms or the responses feel "right" as appropriate responses to regarding safety. So people keep doing things that work in the short term, even if they don't work in the long term. So, if my spouse starts to get on me to do something and I begin to feel anxious and upset, then I go off in my garage and isolate for 2 hours and I feel better. The isolating works in the short term. It feels right."

An example of "trauma-based perceptions of safety" is when "I'm aware that I walk in the shopping mall and I see danger where other people don't" and that's because the average guy is stupid. I'm more aware than the other person is; that it really is dangerous.

So in addition to having a different sense of what's normal, what normal behavior is, vets may have roadblocks to admitting problems to themselves. By not admitting a problem, that's one way of avoiding fears. Having to label this problem and confront it is scary. There is some literature suggesting that cardiac patients with PTSD are less good at self-care because taking my pills means reminding myself I've got a heart attack.

A second factor is internal stereotype; these are cognitions about what having a problem is. That it means "I'm weak". That it means "I'm stupid. I'm crazy; a failure". Vets may be very eager to avoid thinking of themselves as a crazy Vietnam vet or labeling themselves as an alcoholic because of the baggage that those labels carry.

Another factor may be survivor guilt, feeling that' "Because I've done terrible things, or because I've survived when more deserving people died, I don't deserve to get better." And lastly, that complying with treatment means that I have to admit the problem to myself. For me to get help means that I have to

acknowledge a problem. And again, there's all this guilt and shame around admitting that there's a problem.

Vets may also encounter important roadblocks admitting a problem to other people. There's fear of rejection or shame and guilt. There's fear of being judged by the people as damaged or weak. And there may be realistic concerns about their job status, confidentiality, what's their partner's reaction going to be.

Concerns about admitting problems to others are particularly salient for folks who are on active duty or recently returned from active duty or in professions like firefighters, where you're judged by your peers in terms of, "Are you the person I can trust to watch my back?" And if you have to admit to having any kind of problem, that you're struggling at all, that you're not managing well, that really raises questions about whether other people can trust you.

So there are some realistic concerns about if other people know about this, is this going to be a career-ending thing for me, for people to know that I'm struggling, that I'm not perfect, that I'm not bulletproof.

So what are some of the implications in terms of treatment failure of the Stages of Change Approach? Our take is that treatment failure is often due to a therapist or program misreading patients' stage of change for a particular problem, and then mismatching interventions to their stage of change, in other words, going on as though people are ready for an Action stage when they're really not there yet.

So the implications for outcome of mismatching interventions to where people are at is that people exit treatment unconvinced that their old ways of coping and thinking are maladaptive. They don't see a need to use new coping skills so they may not be doing the homework or assignments or other things that they're given because they really don't think they're useful. They return to their trauma-based old coping and their post-treatment adjustment is not as good.

Reverse of that: If patients are convinced that the way they're responding to post-treatment stressors is an overreaction arising from the past and is not a perfect way to respond but is really a part of the problem, they'll cope differently or seek help. But again, readiness to change varies for different PTSD-related symptoms and problems. So it's helpful to get started with people on the things they're most motivated to change but then use the motivational approaches to bring them along on the things that they have not really recognized or embraced as being a problem they need to work on.

So what I now want to talk about is how we address motivation to change in PTSD treatment. The general approach is informed by the Motivational Interviewing process; really pioneered by Bill Miller and Steven Rollnick for helping people deal with substance abuse problems. We've taken that approach and expanded it to really bring it in as a brief group therapy, a PTSD motivation enhancement group, which takes those principles but does it in a group format and really applies it to PTSD.

The PTSD motivation enhancement group is a 4-session group; four 90 minute sessions, focusing on the use of decision-making skills to help patients recognize the need to change unacknowledged PTSD-related problems. We'll refer to these as "blindsiders." They're problems that can trip you up because you're not aware of them and not dealing with them.

The first session; "Rationale and Review," really reviews the purpose, the procedures, and the values of the group and helps patients get started with identifying some possibly unacknowledged problems; what we call "might have" problems.

In running the PME group it's really important to provide a solid rationale to patients of why it's important they step back and take a look at problems that they are not yet aware of or be open to the idea that there are problems that they may have that are not yet on their radar.

A key part of this is really encouraging peer response and having this be as much peer-to-peer inter-reaction as possible. One of the principles of motivational interviewing is getting the therapist out of the

role of being the expert who is the know-it-all, but rather the person who is just facilitating the client in making their own decisions.

So similarly, it's avoiding a very paternalistic medical model. One of the core principles of motivational interviewing, as for therapy in general, is really based on a position of empathy. It makes perfect sense to me that if you've been managing this way for 20, 30 years and this is part of what you think has helped you survive, and you're not sure that you want to change that yet. But let me put some information out there and then you can make your own decision.

One of the core components of the group is Form #1, or the Problem Identification Form, and this is really a list which… clients keep their own list of 4 kinds of problems; 4 categories of problems.

One of these is "Problems I definitely have." Some clients may come in saying, "I know I have nightmares and I know I have problems with alcohol. Even though I'm not drinking now, I know that that's something I need to worry about. That's on my definitely have list". Those are problems that they're ready to engage dealing with right away.

A second category, over at the far-right column, is "Problems I don't have." These are problems that I don't think I have and nobody else thinks I have either. So; I don't smoke. I don't do drugs. These are not problems I have.

Then there are 2 types of "Might Have" problems: One is "Problems that I'm wondering if I have," being unsure in my own mind whether this is a problem or not. So I may have been thinking that feeling guilty was a perfectly normal deserved response for terrible things that I've done, but now I'm wondering, after 20 years if the guilt hasn't gone away maybe I really am feeling too guilty, or I may be wondering whether being "on guard" is a good thing or a bad thing.

Then there's "Problems that I might have that are problems which other people perceive and which I disagree with." So other people say that "I'm cold and unfeeling, but I don't feel that way at all. I don't know why they get that perception." And other people say that I have problems with authority, whereas I think I've just had a string of jerks for bosses. These are problems that you put in the "might have" column and we'll tell clients, "You don't have to agree that this is a problem to put in the might have column. In fact if you agreed it was a problem, it wouldn't be here. This is going to be a forum for you to take a look and make up your own mind about this without anybody else telling you what to think."

So, really, the goal of the problem area review group as a whole; this motivation enhancement group, is to decide if these "might have" problems are actually problems they have. To either make the decision: Is this a "might have" problem, something that needs to go into my "definitely do have" column and I need to confront this and deal with it? Or, is it something that can go in the "don't have" column and I really can spare my energy and focus on other things? Group participants then use decision-making tools reviewed in the next 3 sessions to either move these "might haves" to the "definitely have" or "don't have" column.

One recent addition to this group and to the first session is a brief educational component on the rationale of having an openness toward the ideas about needing to change. And the way we frame this is that an attitude that can be very helpful when you're facing a difficult situation or problem, is to step back and ask yourself, "Is there something that I'm doing or something that I'm bringing to this situation that's actually making the problem worse?" To be open to the idea… open to the possibility that there might be something that I'm bringing to what's going on that's making the problem worse. Whether… either …what that opens people up to is: 1. Considering the possibility that their past experience is having them respond to a problem that really is not the best way to fix it. And Secondly, it kind of opens the idea that if I'm… If there's something that I'm bringing to this problem that's making it worse, that it's also… I also have the power to do something else to make it better.

So one of the tools that we give people is a self-taught checklist for continuing progress after treatment. This is basically a set of statements or questions that people can use to ask themselves whether they are sizing up a problem in a way which is not as helpful as it could be.

So, ask yourself, “There might be something about the way I’m looking at the situation because of my past experience, rather than the situation itself, that’s causing some difficulties.” To remind yourself to look for blindsiders: A way or act or think that I don’t think are a problem but really are tripping me up.

To remind yourself I have to consider what other people say when they give me feedback about my behavior or my way of thinking, that I’m so used to shutting that out and telling them they’re wrong, I need to step back and think about whether there’s actually some truth to what they’re telling me; something useful I want to use.

And perhaps most importantly, reminding yourself that you’re responsible for handling situations that are difficult, upsetting, or get me angry, even if other people are pushing my buttons; that even if other people are responsible for causing the problem, I have choices about how I want to respond to it.

And what’s important in the whole mind-set of doing this is that we’re empowering people. We’re not coming in as an outsider, telling somebody, “You’re seeing this wrong.”, because that just gets people defensive and that isn’t very helpful. Rather, we’re giving people tools to ask themselves to invite… “Am I missing something here?” So if you’re asking yourself if you’re missing something here, that’s very different than having someone else come in as the expert therapist and tell you that you’re wrong.

Following that first session, there are 3 additional sessions that really give people decision-making tools to help them make decisions about whether these “might have” problems are really problems they need to deal with or issues that they can put aside as problems they really don’t have.

Session 2 is fairly straightforward involving pros and cons or decision balance techniques to help patients decide about the need to change specific behaviors. So for example, if someone has recognized being the person who’s sort of always in charge as something that other people…having to be the one who’s always right and always in charge and always running things is something that other people see as a problem, that person can then lay out, “How is this working for me? What is being a take-charge guy help me? But as…are there ways that are also costing me? Is it alienating people? Is it cutting me off from some people? What are the plusses and minuses of this behavior?”

Session 3 is a normative comparison, or comparison to the average guy, in which patients compare their behavior to age-appropriate norms. And session 4 is one that identifies roadblocks or individual cognitive or emotional factors that may get in the way of their considering changing problems.

The comparison to the average guy problem is really a way of having people reassess, “Is what I do typical? Is what I do different from the way most other people do?” What’s important is to have this work in a way where it’s not the therapist saying, “Am I matching the therapist idea of what’s normal, but rather my own idea of normal; something that makes sense for my own peers?”

So we’ll use Form #3 to…and get the group to get some consensus on some benchmarks, to think of a person who’s your age, your gender-but not a combat vet, to think what is that average person like? Where does that person live? How many children does that person have? What kind of car does that person drive? And then we’ll identify potential problem behaviors and say, “How much does a person do that?” So for example, how much does the average person drink-in a day or in a week? And sort of a frequency or how much of a certain behavior someone’s doing.

At the other extreme, then we’ll say, “Think about as a group what does somebody who has an extreme drinking problem, what is a severe alcoholic doing? What behavior is that person doing? How often? How

much is that person drinking?" It'll also have benchmarks for well…how about somebody who's got, not the world's worst drinking problem, but a moderate drinking problem. What is that person doing?

We'll go through this process on really 3 dimensions. One is the things a person is doing or the frequency or how much they're doing this behavior; what kinds of consequences this person is having, what kinds of problems it's causing for them; and third is that the purpose or the…why are they doing this?

To give a more concrete example of how the Comparison to Average Guy approach works, let's use the example of hypervigilance or being "on guard". So we might work with a group to come up with, "What are things that the average person does to feel safe, and how often do they do them?" They might generate a list of things like: A person checks locks before they go to bed. Maybe they put some lights outside their house. They've upgraded the locks on their front door. Various things that the average person might do to feel more safe and how often they do these things.

Then, at the other end, we'll have a group discussion of "Well, what does somebody who has a real problem with feeling safe, who never feels safe, is preoccupied with it constantly-what is that person doing?" Well that person's rechecking the locks constantly. Every time this person wakes up at night, they wake up every half hour or hour rechecking the locks. When they wake up from a nightmare, they're patrolling the perimeter and staying out of bed for a couple of hours. What kinds of behaviors is this person doing to feel safe?

And then we'll come up with a benchmark of "How about somebody with a moderate problem? What's that person doing? Well, maybe that person checks locks twice a night. Maybe they only wake up once and go check the locks and then they go back to bed and are back asleep within a half an hour.

So we'll come up with some distinct behavioral benchmarks; whether you're the average person, whether you have a moderate problem, or extreme problem. This gives the client tools for seeing where they fall on that continuum, without somebody else telling them where they are. But they can use these benchmarks to make their own decisions.

So in addition to how often they'll do something, we'll have what kinds of consequences does somebody have from this behavior, and also why are they doing it. Is this something which is a matter of choice? Do I do these things to make me feel even more secure, but I basically already do feel secure and I could do it or not, or for the person with an extreme problem: It's a matter of survival, life or death. I have no choice but to do all these things.

The fourth session really focuses on identifying roadblocks or perceptions that people have that are going to get in the way of their recognizing a need to change. We'll basically use the group to come up with some kinds of typical roadblocks, but then have people really think about what are their personal roadblocks; which of these potential roadblocks really apply to them and get in the way of their acknowledging problem areas. And we can think of roadblocks in 3 kinds of areas.

There are roadblocks to admitting a problem to yourself. We discussed earlier the fears or concerns or perceptions that may get in the way of admitting to yourself you have a problem. There are roadblocks to admitting a problem to others and there are other reasons why people might be ambivalent about the need to change. In general there may be things that get in the way of changing or of understanding whether or not they need to make changes.

In session 4 we'll, as a group, really talk in detail about what are some of the roadblocks that really keep people from changing. One of the first things we'll talk about is stereotypes; if there's a certain label that carries certain baggage with it. So that the idea of having a mental health problem, for example, carries a lot of stigma with it because it means you're crazy. So we'll talk about how not everybody who needs counseling looks like somebody from "One Flew Out of the Cuckoo's Nest." We'll talk about what is the baggage that comes along with saying that you have an alcohol problem. Does this mean that you're a

falling down, skid row drunk, or is it possible to be somebody who is working and holding down a job and raising a family but still, you could also have an alcohol problem? So what are some of the stereotypes that get in the way of acknowledging problems because the label or baggage doesn't really fit the full range of people who might have that kind of problem?

One of the most poignant discussions will be talking as a group about what kinds of fears would get in the way of acknowledging having problems. Some people might have a fear of failure; that if I acknowledge this as a problem, it's going to give me one more thing to screw up at because I don't really think I can change it.

People may also have a fear of success. I really identify what I need to do different and its not just that other people are causing these problems, but that really there's something that I need to do different. Well now I don't have an excuse. Well, what if my family starts to get used to my spending more time with them? Does that mean I can still run away when I get anxious, or are they going to insist I be there?

Another domain is cognitive distortions or ways of not seeing things clearly. And we'll talk about, because we're human, we're not really wired to keep an open mind. We tend to jump to conclusions and we tend to simplify things. So I may think if I don't have the most severe drug problem I've ever seen, then I don't really have a drug problem. I'm not as bad off as that guy is. So it's all-or-nothing thinking.

Or again, there may be externalizing or internalizing biases, where I think that other people provoke me. That's the reason I have an anger problem. It's not my problem; it's that other people provoke me. Where I'm externalizing blame rather than looking at both sides of it.

Another set of roadblocks really has to do with shame and guilt, and these can be particularly huge issues for people who are new to coming into treatment, for whom the whole idea of acknowledging that they're having any difficulties is really a new notion. So there's, again, a lot of shame or stigma around the idea of needing counseling or needing help, or people may have a lot of guilt about things that they have been doing wrong or ways that they have been screwing up. It's very hard for them to take a look at what they want to do different without feeling terribly guilty about the way they've been doing things up until now. So again, we'll talk about that it's possible to take a look at what you want to do different without necessarily beating yourself up about the past.

Some other roadblocks to acknowledging problems or acknowledging a need to change--- an ethic of self-reliance, which is particularly strong among folks in the military, particularly strong among guys, and particularly strong among women who're hanging with the guys and showing that they're as tough as the guys are; the idea "I can manage everything on my own. I don't need input from anybody else. I'm doing fine. I've got to be totally strong. I can't acknowledge I've got a problem because that might mean I need somebody else's help."

PTSD avoidance symptoms are also another roadblock, where if I identify problems that bring up any trauma-related feelings or triggers or symptoms, I don't want to think about those.

Another issue, particularly for vets who are getting older, one of the roadblocks is they can't go through the normal life review process of assessing where they've been and what their life has been like because it raises emotional pain or regret and they're afraid that that's going to be overwhelming. So another of the roadblocks is not wanting to look back at your past to figure out how you want to do things differently because it's a painful look.

So by putting these kind of roadblocks on the table, by acknowledging these are the things which make it difficult to do this work and then finding ways to deal with those barriers and with those roadblocks, that's another part of how we can facilitate people taking a look at where they are, where they want to go, and what they need to change as part of the process of deciding; helping people make their own decisions about whether they need to acknowledge problems and move forward.

Now I'll shift over and have Doctor Murphy tell about some preliminary research results on this PME group and then to talk about other barriers to successful treatment outcomes. Ron Murphy: These are some early results from a VA funded randomized control trial of the PTSD motivation enhancement group; PTSDME group. The rationale for the study, as it was and is for the group, is that participants in the group hopefully will recognize more problems than they initially had coming in to therapy, and so, when they recognize more problems, more parts of treatment will seem relevant to them.

Guys who only come in…it's very common…they want the depression to go away; the nightmares. But they don't feel, as Craig addressed, that all these other things are really problems: trust, anger, isolation. So the more that they recognize those problems, the more that they will see, "Oh yeah, this part of treatment really does relate to me." The higher their perceived treatment relevance, the more likely they are to engage in treatment; primarily, basically, just to show up.

So in this randomized control trial participants were outpatients in a PTSD clinic, a VA PTSD clinic. Now the program…the treatment program they were involved in is a 12 -month program. They went to a different group four sessions per month every month for 12 months. In this study the patients were randomized to either receive the PTSDME group in the second month of their year-long participation in the treatment program or they got the regular group that month, which was PTSD education II.

We followed guys; we have lots of different measures; we followed guys for 12 months and what we want to talk about today is to just briefly mention some early results on the attendance. If you look at the graph; basically the red line is the participants who got the PTSDME group and the control group is in yellow. And what we found, and the statistical analyses bear this out, is that about month 7-9, it looks like patients who got PTSDME group showed up for about 10% more sessions. Toward the very end of the program there's lots of dropout for both groups.

But this is at least encouraging for us to show that, you know, just having this one brief group, 5 or 6 months earlier, seems to have impact on them. We have lots of other measures we're going to assess and analyze also but at least it looks like we might be getting them to show up to treatment more.

Okay, the second part of our talk is about treatment beliefs as PTSD therapy barriers.

There are different types of treatment beliefs. The first type is treatment fears. There are lots of different types of treatment fears that someone might have coming into therapy. They might have concerns about coercion, fears about being stigmatized, what's the therapist going to do, am I going to go crazy; lots of different things. And we do know that fear of treatment is related to under consumption of treatment services, in areas other than PTSD anyway. It's the Kushner and Sher reference.

Now we know, that PTSD vets are already known for their issues of mistrust and also concerns about coercion and deception, particularly related to their reasons for deployment, whether it's going to Vietnam and "What are we doing there?" What was I doing there?" And vets from Iraq and Afghanistan; many have concerns about the validity of the mission. Now many don't, and this is, you know, a hot topic in the news, obviously, but this would be particularly an issue for someone who came back saying, "What was I doing over there giving up my life back home?" So for recent vets anyway, but certainly for Vietnam vets, a big issue, especially if it's a government-based treatment program. They used to say, you know, you're getting treatment from the same company that dropped you off in the jungle 25 years ago. So, now they know that already and, you know, they have issues--it's important to bring them up.

The second type of treatment beliefs are treatment expectancies. These are very important. Two main types. Outcome Expectancy: What's the patient's belief that therapy is going to lead to improvement? The next one is Process Expectancy: What's the belief that the patient can actually do what's necessary or tolerate what's necessary to fully participate in therapy. These are very important to assess early on and are rarely done…rarely done.

Now the third type of treatment expectancy is the credibility of treatment. Does it make sense? Do the techniques and the rationale for what they're going to do here in this program, do they make sense to me? This is…all patients think this.

Patient role expectancies: Patients don't often know what's the role of the patient. Often it comes from medical model: Just sit there and someone does something to you and you get better now. Are they supposed to be passive? Active? How is the therapist supposed to act? Are they supposed to be warm? Am I going to lay on a couch and have someone who looks like Sigmund Freud behind there? I think it's important to remember that a lot of people have not been to therapy, have not heard about therapy, and they get most of their notions about therapy from TV and movies: "Analyze This", Billy Crystal's character, Doctor Malfie in "The Sopranos." These are not good examples of therapy so people are going to have concerns.

Now we do know that, again, outside of PTSD area, patient role expectancies are related to their perceptions of the therapist and to the outcome of the therapy.

A little bit more about treatment expectancies: Low self-efficacy about the ability to change can result from a number of factors including not understanding how therapy works. We do know that treatment expectancies predict treatment success in areas other than PTSD. These are important things to consider when someone comes into therapy.

And in PTSD this is a very much under-studied area. And I think in particular, we need to know-- do patients really understand how PTSD symptoms, that they're in treatment for, relate to what happened to them and how does that all relate to what's going to happen in treatment? And those connections are not often clear. We do know that non-combat PTSD dropouts rated treatment as less credible than patients who did not drop out of treatment. So, clearly, an important issue.

Addressing treatment beliefs in PTSD treatment: It's important to take time at the start of treatment to raise the issue of treatment fears and expectancies. What sorts of thoughts and beliefs do patients have about what's going to happen? About their ability to tolerate therapy; to do the therapy, about whether if they do, it if it will work.

You can do this in discussion. There are also questionnaires. In the last 5 or 10 years there have been lots of questionnaires about assessing treatment fears and treatment expectancies, and these are available.

Always it's important. Do the right thing: When someone raises concerns about therapy, listen first; correct misperceptions later. And as we're going to talk about, this relates to probably the most under-rated and critical factor in treatment success and that is therapeutic alliance.

So our third and final section here is "Therapeutic Alliance Problems as a PTSD Therapy Barrier."

Therapeutic alliance (TA) is the working relationship between a client and therapist, including patient's trust of the therapist and feeling of being understood and valued. Another way to put it is the quality of the patient-therapist teamwork; the quality of the interpersonal rapport. The most critical factor is the development of trust; established by the therapist's use of empathic listening techniques, so use of reflective listening techniques are critical for a patient to feel understood. You're going to listen no matter what their concerns and fears are. And this is important even in, and especially for, cognitive behavioral therapy.

So therapeutic alliances in PTSD: we know that outside of PTSD, therapeutic alliance is a well-established predictor of outcome across therapy types and problems. So even in studies of very specific cognitive behavioral interventions the factor that seems to predict treatment success, more than anything else, is the quality of the therapeutic alliance as rated by the patient. We do know that the strength of

therapeutic alliance in treatment reliably predicted post-treatment in childhood abuse-related PTSD, a study by Cloitre-there were actually 2 studies.

Now how do you ruin a perfectly good therapeutic alliance? There are 3 important ways you can do this. One is you can get into a control struggle with your patient. You can get in a control struggle about what the topic should be, or about how long a topic should be discussed, or whether an intervention should be done.

Another way would be when a patient raises concerns about what's going on or about something that is happening in the therapy, to just automatically reassure them or talk them out of their feeling instead of just listening.

And the third way to ruin a good therapeutic alliance is to not address 3 important factors: Race, class and gender differences in issues. Again, it's important to build trust by listening when these issues come up and not get into control struggles.

I'm going to talk a little bit about race, class, and gender in therapy; in PTSD. It's important to address racial differences between participants and therapists. One important reason for this is people have been exposed to lifelong racism, both obvious and subtle, so often, will bring into therapy what has been called in the literature a "cultural suspiciousness." And also there are culture-bound beliefs that are important to address. For example …in some cultures, for males, having strong feelings means they're going crazy.

Gender issues are very important to address. Male taboos about expressing feelings equals appearing weak, females expecting to be passive, substance abuse more shameful for women, and always with gender differences, male-female power dynamics and misperceptions about that in therapy.

Social class in therapeutic alliance: I think that we as therapists underestimate how difficult it is for people who don't share educational background to understand us. It's not that they're under-educated or we're over-educated, and so we don't realize how much our language and vocabulary, in particular our therapy and psychology jargon, is part of our everyday speech.

Another important issue: Psychological mindedness, the notion that emotions can come from past events and still control your behavior many years later. This is a little bit of an esoteric concept for a lot of people. "It happened a long time ago, you know, why would it still be bothering me? I'm over it." You know this is a basic assumption for a lot of therapists and a basic question for a lot of people.

There are also different class norms for anger, what it means to be safe, what a relationship is like. Now, what I want to put in here is another issue and that is military culture. This is particularly true for our veterans, men and women coming back from Iraq and Afghanistan, because it's so fresh in them and some of them are still in the military. Many of you are still treating people who are still in the military.

And obviously, military culture is not very touchy-feely. In addition, it's not okay to talk about your business to other people. And probably most important, something Craig discussed earlier, self-reliance: You're supposed to take care of your own problems. That's part of being a good soldier. You take care of stuff. You be resourceful. So that to go for help, this is, I think, a particularly fresh issue for all the OEF/OIF men and women.

So, how do you address therapeutic alliance in PTSD treatment? First, the most important factor is empathy. The second most important factor empathy and the third most important factor is empathy. You've got to use reflective listening. If you're doing cognitive behavioral therapy, one of the skills of a good therapist is knowing when to just stop doing the technique and step back and think about and talk about what's going on in the session. And you can directly ask about, or make it clear at the beginning that it's okay to raise issues concerning race, gender, class, effect of military. And in particular that the satisfaction with treatment is okay or dissatisfaction with you as a therapist is okay.

And one last issue: It's very important, especially with OEF and OIF veterans to use non-stigmatizing language. PTSD has more baggage for these people than for the Vietnam veterans. They will often associate PTSD with sort of long-term damage because these guys from Vietnam still have it and their lives have been ruined. So you've got to be very careful about throwing that term around. The phrase that's used a lot and you probably want to consider using more often, is post-deployment stress.

That's it for the presentation. Briefly, just to summarize, we discussed that PTSD treatment engagement is probably the most ignored treatment failure issue in the treatment field and one, though, you can do something about. That barriers to PTSD treatment engagement include patient issues, therapist issues, and alliance issues.

And finally, it's important to address early and often, patient beliefs about the need to change, about their treatment expectancies and about their feelings about the therapeutic relationship and alliance, and particularly trust. Thank you.