



## Readiness to Change in PTSD Treatment 1 Written Video Transcript

Welcome, everyone. We're very pleased to have you with us here today. And on behalf of the National Center for Post Traumatic Stress Disorder, and EES, Employee Educational System, [00:03.20.00] I'd like to welcome you to the third in our series of ongoing courses specific to post-traumatic stress disorder. Today's speaker is Dr. Ron Murphy, who received his Ph.D. in clinical psychology from SUNY Binghamton. He did his internship at the Brockton VA in Massachusetts, [00:03.40.00] followed by post-doc training at the Center for Alcohol and Addiction Studies at Boston University. Then he came to the National Center for Post Traumatic Stress Disorder and was with us here at Menlo Park for eight years. During that time he was involved in a variety of clinical and research activities, [00:04.00.00] most specific to substance abuse, focus group treatment and motivation for change in the context of PTSD. And it's to that topic that he'll be addressing today. Currently he's an assistant professor of psychology at (Dillard) University in New Orleans, and I'm very pleased [00:04.20.00] and very happy to welcome Dr. Ron Murphy. Thank you.

Okay. Okay. Well, good afternoon everyone. It's very much a pleasure for me to be here today [00:04.40.00] and come back to Palo Alto and Menlo Park. Very privileged to be asked to speak with you also today. Unfortunately, we're still in the shadow of events of two weeks ago to the day now and I think our hearts go out to everyone, victims and families, and to all people who were affected by this tragedy. [00:05.00.00] Some people to thank. I have a long list of collaborators, too long to list, that I'm grateful for their help in doing the work that I'm going to talk to you about today. I do want to thank Fred (Gussman), of Menlo Park, for his support in the work I did here and also Carolyn (Thompson) and Madelyn (Udo) at New Orleans [00:05.20.00] VA. They've been supporting my work there. There'll be three parts to the presentation I'm going to give to you today. One will be sort of clinical and theoretical basis of a PTSD readiness to change model, then some research findings related to that and then finally some clinical applications. [00:05.40.00] And I'll make time between those breaks, between those sessions for questions if that's okay. Okay, let me just mention first PTSD, of course is a set of symptoms induced by a traumatic event only, we're only too familiar with I think in the last two weeks. [00:06.00.00] The main symptom categories of course are re-experiencing symptoms, things like nightmares, intrusive thoughts, avoidance symptoms, avoidance of any reminders of the trauma, isolation, emotional numbing also and finally arousal symptoms, anger, irritability, in particular hypervigilance, [00:06.20.00] startle reaction, also. Okay, so, part one, clinical and theoretical basis for a PTSD readiness to change model. All right, let's look at PTSD treatment outcome first. This is where we need to start. What's the good news? [00:06.40.00] The good news is that controlled studies tend to show that cognitive behavioral therapies are effective for PTSD and in particular the review by (Sherman) in '98, there are others also. You can look at the



empirical guidelines by [6:53] I think also talk about that. Now, of course, [00:07.00.00] there is the bad news. And the bad news is that some studies show this poor treatment outcome for combat veterans with PTSD. Now (Fontina and Rosenhack) is the most infamous study, but it's not the only one, it is not the only one. There are at least two others but like I said, they're the most infamous at this point. [00:07.20.00] So, I think that the question we need to ask then is that PTSD treatment it appears to work but sometimes it's not working. So, the question is, if it can work, what's preventing it from working? That there must be something preventing it from working. Now, there are some [00:07.40.00] common attributions or theories about why it does not work when therapy does not work, okay. First of all, the most common one, more recently in the last ten years, theories about permanent biological changes. And then more commonly just the length of disorder, that people have had it [00:08.00.00] for a long time, especially the Vietnam veterans. Inadequate treatment, you know, there's different camps that propose different treatments, that support different treatments. So, sometimes if a therapy doesn't work they talk about, well, you know, "they didn't use our treatment. They used the other team's treatment and it didn't work." And there's some general [00:08.20.00] criticism of therapy. The other issue, of course, is disability compensation. Is it because of the great threat that veterans feel to their income from disability compensation? They're either not going to report that they're doing better or—I think this happens a lot—they really will not engage in treatment [00:08.40.00] because they don't want to be seen as getting better. So, they don't get the benefits from treatment. Of course another important factor is lots of co-morbid problems. They can be severe, substance abuse and depression most particularly. Okay, there's another possibility I want to [00:09.00.00] talk to you about today. What if veterans are not practicing new coping skills because they are not aware of or convinced of the need to change? And if they don't practice the new coping skills for that reason then they're not going to have good post-treatment outcome and that's going to show up in the treatment outcome studies like (Fontina and Rosenhap) [00:09.20.00] and the others that I mentioned, okay. So, what if this is true? Now where does this come from? I'm going to tell you a little bit about some of my clinical experiences where, where I and my colleagues started to think about these issues about not being convinced of the need to change. And of course, one of the things if you work [00:09.40.00] with combat veterans, especially in inpatient units, they tend to question the need to change their defensive approach to life. By defensive I mean trust issues, hypervigilance, physically being on guard, isolation. You know, a lot of our guys are out in a bunker somewhere, whether it's in, [00:10.00.00] you know, in their cellar in downtown San Francisco or out in the woods in Oregon or whatever. We've got a lot of guys like that. But, you know, they will argue about why that's okay. And if you work with these guys you hear that a lot. You hear that a lot. The other thing, unfortunately—and I have been guilty [00:10.20.00] of this—is I put debating in there, but basically arguing with your patients about why they should look at things a different way or act a different way. And I know that you cannot argue someone out of a psychiatric symptom, okay? And even though I know that, and I know many of my colleagues do that, we often tend to get lost in debates and arguments about— [00:10.40.00] with our patients about, you know, why they should look at the world a different way. And this has occurred a lot. I'm going to call it the messy roommate



situation. We have patients walk out of an anger control group, go up to their room immediately, and their roommate has done something like left food on the floor, something they had asked him not to do a thousand times [00:11.00.00] a day, right? And there's a big blowup and people maybe get kicked out or something hairy happens. And if you talk to the guy who just left the anger control group, you know, "What happened?" He's not going to say, "Geez, I dropped my tools or I didn't use my skills." You're going to get a pretty good argument about why. [00:11.20.00] "I've been telling him. I've been telling him. He's known, what are you supposed to do when people don't listen to you?" And I think that this unfortunately happens a lot. So, in terms of just clinical experience, these are the things that influence some of us to start to think about the need to change in a different way. [00:11.40.00] And I think, unfortunately, what patients think the problem is, is not what therapists think the problem is. And patients will come to us and they want to stop being angry. But then will say, "You know the world's a very hostile, dangerous, and provocative place. I mean I've seen what it can be like." [00:12.00.00] And so, they will defend their general cognitive approach to the world but then say, "But look, I don't want to be angry anymore." And I hope you can see the conflict in these two statements. Another common one is patients wanting treatment for depression. They're lonely but are mystified [00:12.20.00] why you want them to work through problems with their roommates. And that's not an easy conversation. You start to say, "Well, let me tell you why. Of course you've got to understand that, you know, building relationships and assertiveness and expression of feelings is going to in the end make you less depressed and you're going to connect—" You know, "What are you talking about? Just get me less depressed, less lonely so I can go back out to the bunker, [00:12.40.00] okay?" And I think that very much underestimated is that patients don't believe what we tend to believe, at least many therapists, that present day trauma-based coping responses, trauma symptoms, are overreactions to current situations [00:13.00.00] based on earlier life events. And this is how we approach our patients. I don't think they believe this. I don't think they believe it even after lengthy treatment, even after a lengthy period of treatment. Okay, now what happens when our patients don't do what we want [00:13.20.00] them to do? People get a little bummed out because their beautiful treatment plans are ruined that we spend a lot of time on, right? And then unfortunately what we've done is something that the alcohol field has done and drug addiction field is we call patients "resistant." We call them not ready for treatment. [00:13.40.00] We call them narcissistic if they're men. And you know what we call them if they're women, what? Borderline, right? (axis two) basically is a diagnosis for people who annoy us or don't do what we want them to do, right? Or the most famous [00:14.00.00] phrase that I'm hopefully going to talk you out of ever using again is, "in denial," okay. Clearly, we need a more scientific approach to why patients don't change than these sort of old fashioned terms none of which come from clinical psychology, okay? The [00:14.20.00] best articulated and most widely used model is the trans-theoretical model of (Prochaska and Diclemente) and their colleagues, in particular I'm going to talk about the stages of change component of their model, okay? Bill Miller has developed a motivational interviewing approach [00:14.40.00] and that is more well known for the practical applications of a readiness to change model, and very helpful, very helpful. These models have been applied initially to smoking and



alcohol but now they're applied to health behaviors, battered women. Christopher Murphy is doing tremendous work applying this model to male [00:15.00.00] batterers who, you know, you think it's tough working with PTSD guys. And also I've seen a recent paper on eating disorders where this model's applied to eating disorders. (Can be applied to a lot of different things. Okay, what are some of the basic assumptions of this model? First of all, that individuals are at different levels of awareness or readiness [00:15.20.00] to change. There is no room here for "not ready to change." Everybody's ready to change. Everybody's ready to change, there are just different levels. The second critical component to this model, the second critical assumption, is that for each stage of change—and I'm going to go to the specific model in a second or [00:15.40.00] at least my version of it—only specific interventions help people move up to the next stage. Other interventions don't work with somebody who's at this stage. It's a particular type of intervention. And we're going to talk about and hopefully you'll see why these things are going to drop out of your vocabulary [00:16.00.00] after today. Okay, five general stages. The way that I have looked at this—and I have also modified this for PTSD—I've emphasized one part of the model that (Prochaska) talked about which is that at each stage people have a certain [00:16.20.00] cognitive set or, I think most helpfully, clinically to think about they have a question that is unanswered. They have a question that is unanswered. So—and you can be at different levels of stage, different levels of readiness to change or different stages of change for different problems. By the way this applies to all of us. You do not to have any severe psychopathology or brain damage, [00:16.40.00] which some of us have anyway, but to be at different levels of readiness to change particular things. Okay, all of us have some things we're at precontemplation on, others we're contemplators on. I'll talk a little bit more about that. The bottom level here is precontemplation where the person does not think [00:17.00.00] they have a problem. It could be alcohol. I'm going to talk about anger or isolation, hypervigilance. They say, "Hey, what problem?" This is the unanswered question. For people at this stage the best intervention is general education. And for the PTSD guys you want to talk with them about PTSD, okay? [00:17.20.00] Even if it's just, and particularly if it's just a specific problem like isolation or some hypervigilance or having 600 automatic weapons in the house, okay, and other weapons you can't buy in those Army-Navy Stores. "What's the problem?" Education about what [00:17.40.00] PTSD, what it involves. Now, when you apply that intervention what you hope for is that you get people bumped up to the next stage which is contemplation stage. All you want people to do after your education intervention is to say, "Huh, based on what you're saying, I wonder if I have a problem?" Or as I [00:18.00.00] have it here, "Do I need to change?" So, if you get people to this stage, or sometimes people come into treatment at this stage, the things that are most helpful for people—and again all of us the things we're contemplators on, pros and cons, very powerful. We're always weighing the pros and cons. And I [00:18.20.00] think that you want to stay away from notions of—some notions of psychopathology as a lot of this is sort of normal cognitive process and a lot of our behavior is based on the pros outweigh the cons. Now, you may not have a clear picture of the pros and cons but you're operating on some comparison. The other thing, and one of the real [00:18.40.00] great things about Bill Miller's work, was to bring in this comparison, norm comparison component to treatment. What he would do is he would advertise for people who were—



who felt they were being unjustly accused of being alcoholics. He did a study and some clinical work. That's who he would advertise for. [00:19.00.00] He didn't want the people who thought they had alcohol problems. Brought them in, took all kinds of data, quantity, frequency of drinking, blood levels, liver function tests, neuropsych tests. Of course he takes all this information, puts it on one side of the page. What does he put on the other side of the page? The norms. This is very [00:19.20.00] powerful information to see where you compare to the rest of society on some particular behavior. So, this is important to do for people in contemplation. If you can get people to believe that they need to change the next step of course is preparation stage. I've emphasized a component here [00:19.40.00] of "can I change?" There's another way to emphasize that. And I think a lot of people become convinced that they need to change but are not sure that they can change. There's a couple of reasons for that. They don't know what therapy is. And therapy, people don't understand therapy is not what you see on Oprah or in Analyze This [00:20.00.00] or in The Sopranos. Right, Dr. (Malfey)? Terrible, terrible examples of therapy. And so, patients don't know how therapy works so, how can I change? The other important issue here is modeling by peers, an exposure to successful peers. People in preparation [00:20.20.00] stage eat that up. They find it very powerful. And now, as I talk a little bit more about how this model works, somebody lower on the levels of change here, you expose them to peers, they don't buy it. You see this with—you work with substance abusers, you send them to an AA meeting or NA meeting, if they're not in preparation stage what do they say? [00:20.40.00] "Oh those people, I'm not anything like them." Right? Or, "God, they're so sick." But that same person, if they're in preparation stage, finds it a very warm and healing experience. People in action stage, how do I change? This is where homework and roleplays are the most effective. [00:21.00.00] Keep in mind what I'm trying to say is that earlier on that stuff is not going to work as well. You need someone to be in this stage. And then, maintenance stage after that. So, again, the things I'm trying to emphasize with this model are that interventions work best, and only specific ones, [00:21.20.00] at different stages here, okay.

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