# Readiness to Change in PTSD Treatment 6
## Written Video Transcript

That's nice to see. We also got a lot of consumer satisfaction data. We use something that we call the consumer satisfaction survey. It's an evaluation of did they like the group, did they find it useful as well as what components they found useful and also some educational questions in terms of did they understand [00:00.20.00] what the heck we were talking about. Okay? So understanding [00:26] and process, ratings of helpfulness and then these are—we had a smaller group of about 128 patients who completed this. The patients loved this group. I mean, I don't think it's because we did anything [00:00.40.00] brilliant. We fell on something that they seemed to respond to. And so I'll show you some numbers for this. Average guy group, they like a little less. They like it but they like it a little less than some of the other groups. And they didn't quite—about half of them said something that was pretty much right on in terms of what was the actual concept [00:01.00.00] behind this group. And if you look at the numbers, on a one to five scale, the mode was five for pros and cons and roadblocks for component type analysis. Compare to the average guy, a little bit lower here, modal response of four. And then for whether other group members' participation helped, you know, trying to get at more [00:01.20.00] process measures. A little bit about the leaders, group's purpose clear. Mode response five on all this in high numbers. Can I go back just one second? I'm going to end in about two minutes and allow ten minutes for questions. I hope that I have an accurate reading of the time. [00:01.40.00] On the paper, the research I referred to earlier it's all being—it's all submitted for review and a second time for some of the papers unfortunately. One of the reviewers said, you know, "Maybe there's a real positive bias that these guys want to tell you, you know, how great the group is." Now I don't know if they worked with the guys I worked with. [00:02.00.00] They are more than happy to tell us that things are not working, right, us agents of the government. Right? So I, I kind of believe that we did something right here. I believe that we've done something right and that they like it both in terms of the content and, as I made reference to earlier, the style. We have other research, [00:02.20.00] actually have a paper submitted where we found differences in ethnicity and service connection on readiness to change, on the might have stuff. We've got to do more work on instrument validation, predictors of outcome. We have some data started to analyze. We've got data for what they said within the group and then what they reported for symptoms three months after treatment. [00:02.40.00] My general goal is to empirically validate the PTSD motivation enhancement group and to meet all those criteria, you know, manuals, treatment adherence, all that kind of stuff. And we're about half way there I think. Summary and conclusions, well basically the relationship between readiness to change, PTSD and treatment outcome [00:03.00.00] is an untested hypothesis. We don't know for sure that your ambivalence about problems correlates with your difficulties later on when we ask you about PTSD symptoms. Now, we've tried to analyze some of that data. And as you're probably aware, if not [00:03.20.00] you need to be aware, you can not ask guys

on disability if they're feeling bad. Okay? So, one of the great emphases I'm going to talk a little bit about it the next, the randomized control trial we're going to run on the PTSD ME group, you can't just give out PCL's, PTSD symptom checklists anymore. If you really want [00:03.40.00] to try to get some significant results. You've got to look at other things and you've got to be creative. What people are starting to look at is quality of life. Are you just generally doing bad, are you, you know, getting along better with people? And try to keep it out of the domain of PTSD symptoms because most of the patients, if you work with inpatient combat veterans, under tremendous pressures—I don't blame them. [00:04.00.00] Some of them I blame. But for the most part, you know, we've really set up a system that makes it very difficult for them to get—to report being better. And a lot of them had problems for a long time and it's going to be very difficult for them just to snap back to a full time job. And they feel desperate about money, I think for the most part I believe that. So, it's very difficult [00:04.20.00] to do this. But in any case I want you to know that, you know, the data really is not there yet. And a lot of things I'm presenting to you are really an untested theoretical hypothesis. And of course we need a randomized control study of the PTSD motivation enhancement group. And we are planning that. And again, like I said, [00:04.40.00] the difficulty is you just can't give out the old PTSD measures if you have, like if you have an anxiety group or depression group, you know, give out the (Beck) or the, something and then look for pre post changes. When there's disability involved you're really in a lot of trouble. So, a lot of our problem solving has had to be around what are we going to ask them, what [00:05.00.00] are we going to ask them? Now to address some of these theoretical hypothesis I talked to you about it's very important if you're going to use this model that you measure how guys are using components in the treatment program that you're doing this in. One of the things I meant to say earlier, I would—this is not proposed as a stand alone treatment. The PTST motivation [00:05.20.00] enhancement group is an adjunct to ongoing treatment. I would never do this alone. So, if you're going to study its effects, as we're going to, one of the things we're going to do is we're going to find measures of people's participation in treatment. How many homeworks they're doing, how many three columns they're doing, you know, things like that. We're going to get clinician [00:05.40.00] ratings of how patients are participating in treatment. And this will be very important to make that tie between if you're more ambivalent you're not going to use treatment as much, you don't use treatment as much, you're going to do more poorly to make those theoretical ties here. [00:06.00.00] I do think that these findings are suggesting that we continue to apply this model. It may have tremendous benefit. I am going to take great pains to try to continue to get data that supports the model, especially on the effectiveness of the motivation group. And you need randomized controls to do that. [00:06.20.00] We've got some encouraging pre post data as I showed you. But you really need to have randomized controls. And we need to have some other measures of participation related to ambivalence and more well-validated measures. But I think Bill Miller has been advocating—a very important thing to do would be to look at Bill Miller's book [00:06.40.00] the Miller enrollment book, Motivational Interviewing. You don't have to buy any of this stuff. But if you want to have a good handle on how to deal with patients having difficulty with your therapy—notice I'm not saying resistant—then buy this book. Very, very helpful and practical, called Motivational Interviewing. I think the new version's coming out [00:07.00.00]

next winter, this coming winter. We have time for some questions? First of all, last of all, please I have manuals. If you want copies of the manuscripts that we've submitted and are waiting for reviews on, involving that data, you want the forms, call me, [00:07.20.00] e-mail me. I'd be more than happy to talk with you and send you whatever you want. Okay? And then I have a website that has a lot of—part of it's a clearinghouse for information on motivation to change, mostly in trauma but some other areas too as well as some of my own stuff and my colleagues is up on that website. So, do you have that on your last sheet there? [00:07.40.00] Anyway it's up here. I welcome you to call me or e-mail me anytime, I'd be more than happy to talk with you. Okay so we have time for some questions I think. Yes sir? Get to that microphone.

Hi. Given that the intervention is [00:08.00.00] based on motivational interviewing and that model in turn was developed for, I think, alcoholics I'm surprised that the substance abuse was one of the few areas that showed no improvement. Do you have any hypotheses about that?

Well yeah. When we get guys, [00:08.20.00] especially Vietnam veterans, it's been 30 years since combat—right, is it 30 or more now, right—a lot of guys (got to be) between 65 and 70—and then 30 years of substance abuse. So, if they get to us that means they're not dead basically. And what we found [00:08.40.00] is that there's a lot of—there's like three groups. Basically guys still using, guys who are completely sober, right—I mean they've had to be because they're not like the other group, which is dead. Okay?

The silver group, the silver group wouldn't have showed up as the people that everybody else says [00:09.00.00] I have a drinking problem?

Part of it is that they—some of those guys, and I've tried to address this after this, is some guys who have a serious drinking problem will put it as a don't have or say, you know, maybe I do. But that's because they were unclear about what we meant. If they've been sober for 20 years but are clearly an alcoholic or addict, they don't know what we mean [00:09.20.00] by have it or don't. And sometimes they don't either. So, I think that's what that reflects. And you've got guys who are newly sober—because the other issue, which is a problem, too many guys think, "Hey I've been sober for two months, this is great. This is great." And I think one of the problems, if the guys are moving to the right hand column, [00:09.40.00] they're just feeling too good. Because it's the first time in their life they've gotten over anger, they haven't struck anybody in a week. Right, they have not strangled their roommate. And they feel real good. And they feel like they've kind of, "Hey I took care of that. I'm going to be okay." Because especially the inpatient program you know, they're in a very protected, [00:10.00.00] supportive environment all the time. And I think they overestimate what benefits. And I think that's the other part that I'm worried about. These guys are clean and sober, don't have. Don't have it, I'll be okay. Of course they, you know—and I think that's true for all of us. A lot of times we think we've got something beat until we're exposed to the cue again, [00:10.20.00] right. So, I think that would be my response to that. It's what I think about when you ask that. Other questions or thoughts if we have time? I know it's a long presentation. Maybe Ned? Yeah.

Yes. Where do you get the norms [00:10.40.00] for the so called average guy behaviors?

Well there's the ideal of what I'm going to do, which is someday get all sources of information I can from whatever polls have been taken on norms for things like how many times the average guy checks his locks at night, how many times the average guy buys flowers for his wife. Now all this stuff, I'm going to have [00:11.00.00] a big book that we bring into the group for norms. It's not available. The census data is not that helpful. I even looked at the census data. What we do is, like I explained before a little bit, is we use the group to generate a range of norms. And I will tell you, except for marijuana, I have never doubted—from my own judgment [00:11.20.00] which may be a problem, but I usually have a coleader, so that can help—what the norm generated was. It's certainly an area, Ned, that we want to improve by getting more numbers. But there's also a tremendous benefit to getting the patients to think about it and for us to discuss it. And I hate to lose that by just having a list. I think there's some advantages [00:11.40.00] by having the group discussion about it and by setting up the range and it depends kind of thing too, so. We're going to try to do some different things other than the group comparison. A question in back?

My specialty is addiction treatment. And how do you handle the addiction piece and the PTSD piece [00:12.00.00] concurrently when it manifests in the group? Like somebody is coming in that obviously is continuing to drink excessively. How do you manage that?

You mean when a patient says well I'll stop drinking when you fix my PTSD symptoms? That kind of thing?

Well something like that, yeah.

Well, you have to basically—if I'm [00:12.20.00] following you, you treat them as just overall, you know, different problems that a patient has and not identifying them as a PTSD patient who's got these other things. And I think the general approach here you want to start to do, I've done this in other settings, is this is really for anything, for anybody. [00:12.40.00] So, just tell us the different kind of problems. Be real specific, real sort of real life, what is it that you're struggling with or been told is a problem and take each one separate. Take each one separate and use the group modules. And they should be putting as might haves, if it's a PTSD patient with a might have for alcohol—I mean it doesn't matter what the primary [00:13.00.00] diagnosis or what the patient believes is the problem. All right? Does that make sense, am I answering your question?

Yeah, Well I was wondering, do you refer them for concurrent treatment of the problem or do you sometimes refer them for addiction treatment or?

I guess you should ask [00:13.20.00] the programs now, just because I'm not sure what they're doing. We usually kept our guys—unless they were using, right? Now if they're actively using we started to have more debates right before I left about, well, you know this is a problem we can't discharge him for that problem. And there were pros and cons

to that view, right. A lot of issues now in substance abuse treatment about whether you [00:13.40.00] discharge someone because of the problem they're coming into you for. But I think you can't provide a safe environment though. But there are other pros and cons. But if they did use we would discharge them but bring them back right away. All right, so it looked like we're booting them for using, they'd be back in a week. That was one way it was handled. I'm not—you know, I don't know how they're [00:14.00.00] doing it now. And in New Orleans there tends to be a little more—because as an outpatient a little more acceptance of ongoing use, as long as it's not problematic. But if it is problematic people get stopped in the PTSD stuff and given treatment.

I see.

But the relapse itself does not automatically boot them out of the PTSD treatment.

Okay. Thank you.

[00:14.20.00] Okay, I don't know if we have—I'm sorry we're out of time. So, thank you very much for your patience over all this time here.

Thank you. On behalf of the National Center for PTSD and our director Fred (Guzman) and EES I want to again thank Ron for his time and effort [00:14.40.00] and graciousness to come all the way from New Orleans to be with us today and for an outstanding presentation. Thank you so much.

Thank you very much.

And I would like all of you to look forward to more courses that are coming your way specific to your ongoing training in the area of PTSD. [00:15.00.00] And EES has promised us more courses, so we're very much looking forward to presenting those to you. And thank you for being here today.

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