Adapting an evidence based group therapy protocol to address access issues in a VA mental health outpatient clinic

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Learning Objectives

• Demonstrate how to implement a transdiagnostic Group Behavioral Therapy for Anxiety in a Mental Health Outpatient Clinic

• Discuss how to overcome barriers to patient access and limited provider resources by adapting a group therapy treatment protocol

• Discuss how to measure and compare effectiveness, once a treatment protocol is adapted to meet patient demand

• Discuss limitations and alternatives to adapting evidence based treatment protocols
Why a Transdiagnostic CBT Group for Anxiety?

• Patients with a wide variety of anxiety disorders present to Mental Health Outpatient Services (MHOS) for treatment (Espejo et al., 2015)
  • Social Anxiety Disorder (7%), Panic Disorder (2 – 3%), Generalized Anxiety Disorder (2.9%), Unspecified Anxiety Disorder, PTSD (3.5%), Obsessive Compulsive Disorder (1.2%) (as cited in DSM-5, 2013)
• Feasibility of providing group or individual for each type of anxiety disorder that presents in the clinic
  • No role outs for EBP’s for PD, GAD, SAD, or other anxiety disorders (Espejo et al., 2015)
  • Group CPT for PTSD (Chard, Resick, Monson, Kattar, 2009)
  • Cognitive-Behavioral Group Therapy for Social Anxiety (CBGT; Turk, Heimberg, Magee, 2008)
  • Mastery of Anxiety and Panic (Barlow & Craske, 2007)
  • Cognitive-Behavioral Therapy for Generalized Anxiety Disorder (Dugas & Robichaud, 2007)
  • Group Delivered Cognitive/Exposure Therapy for PTSD (Castillo et al., 2016)
• Transdiagnostic approach performed equally well vs. specific approaches in an RCT (Norton & Barrera, 2012)
Why a Transdiagnostic CBT Group for Anxiety Continued

- Group improves access, evidence of effectiveness, efficient use of resources (Espejo et al., 2015; Norton 2012)
- May be more commonalities than differences across disorders and treatments for anxiety
  - e.g., distorted perception of threat (difference between disorders is the type of threat) and avoidance (Espejo et al., 2015; Norton & Barrera, 2012)
  - “Miss the forest for the trees.”
- Universality and Group Cohesion (Yalom, 2005)
Group Cognitive Behavioral Therapy for Anxiety (Norton, 2012)

- 12 session evidence based transdiagnostic CBT group therapy for anxiety protocol
- Recovery Oriented
- Recent pilot study by Espejo, et al. (2015) showed to be effective in a VA Mental Health Outpatient Clinic
- Pretreatment Individual Assessment
  - Assess appropriateness
  - Psychoeducation and Group Overview
  - Develop Trigger Response Hierarchy
- Group Overview
  - S.1 – S.2: Psychoeducation and monitoring anxiety
  - S.2 – S.3: Cognitive Restructuring
  - S.4 – S.9: In-session and Homework Exposure
Cognitive Restructuring

- Trigger
- Automatic Thoughts
- Thinking Errors
  - Overestimation
  - Catastrophizing
  - Maladaptive
- Disputing Questions
- Rational Response
Exposure – “Facing your fears”

• In-session exposure
  • Therapist pre-session review of patient trigger response hierarchies for potential in-session exposures

• Types of exposure exercises
  • In-Vivo exposures (difficult in group, typically for homework)
  • Simulated Exposures
    • Interoceptive Exposures
    • Role-Play Exposures
      • Development of Socializing Techniques (Yalom, 2005)
  • Imaginal Exposures
  • Pre-exposure Cognitive Restructuring
  • Behavioral Goals and SUDS ratings
  • Conduct Exposure
  • Debrief
## Outcomes

<table>
<thead>
<tr>
<th>Referrals (source – MHOS Providers and MHOS orientation group)</th>
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<tbody>
<tr>
<td>73 Referrals</td>
</tr>
<tr>
<td><strong>47 did not engage or referred</strong></td>
</tr>
<tr>
<td>• 10 referred to other treatment</td>
</tr>
<tr>
<td>• 17 No show/cancel or did not return call</td>
</tr>
<tr>
<td>• 20 no longer interested</td>
</tr>
<tr>
<td><strong>26 engaged or partially engaged</strong></td>
</tr>
<tr>
<td>• 9 completers</td>
</tr>
<tr>
<td>• 12 dropped out</td>
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<tr>
<td>• 5 in process</td>
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</tbody>
</table>
Outcomes - 1st round by protocol

*BAI = 0 – 7 minimal, 8 – 15 mild, 16 – 25 moderate, 26 – 63 severe (Oei & McAlinden, 2014)
*PHQ-9 = 1 – 4 none, 5 – 9 mild, 10 – 14 moderate, 15 – 19 moderately severe, 20 – 27 severe (Kroenke & Spitzer, 2002)
Access and Adaptations

• Followed protocol for the first round of treatment
• Started to back up on referrals
• Cohort caused at least a 3 month wait
• Adaptations to improve access
  • Entry point every 6 weeks
  • Integrate “advance” cognitive restructuring
  • Instead of cohorts, integrated groups of “seniors” and “freshman”
  • S.1 – S.6: Psychoeducation and Cognitive Restructuring
  • S.7 – S.12: Exposure
  • Freshman engage in psychoeducation and cognitive restructuring, while seniors engage in exposure
• Potential Therapeutic Factors (Yalom, 2005)
  • Instillation of Hope
  • Imparting Information
  • Imitative Behaviors
Adapted Outcomes

- BAI
- PHQ-9
Adapted vs. Protocol Outcomes

Adapted

Protocol

For Adapted Protocol:

BAI

PHQ-9

Pre Post

Pre Post

For Protocol:

BAI

PHQ-9

Pre Post
Combined Outcomes

- BAI
- PHQ-9

Graph showing pre and post outcomes for BAI and PHQ-9 scales.
Concerns & Future Directions

- Continued assessment and tracking
  - MBC MH initiative switch to GAD 7
- No true comparison group yet (all “freshman” dropped out on first attempt)
  - Group Cohesiveness? (Yalom, 2005)
- Adding another group(s)
  - Cohort or combined groups
- S.1 – S.6 all cognitive restructuring and switch to Exposure S.7 – S.12 (no “advance” cognitive restructuring)
- Balancing the potential for treatment drift with access demands
- Pretreatment group instead of individual pretreatment assessment
Comments and Questions
References

References


