Evidence-Based PSYCHOTHERAPIES

10th Edition

Transforming EBP Training

Spring 2019

Welcome

The Evidence-Based Psychotherapy (EBP) Training Program welcomes you to the 10th edition of our *Transforming EBP Training* newsletter. Our EBP training programs are indeed undergoing significant transformations.

The articles in this edition provide an overview of our latest developments and next steps.

The Role of Working Alliance in Evidence-Based Psychotherapy for Depression

Mandy Kumpula, Ph.D.

Working alliance, or therapeutic alliance, is one of the most frequently investigated and cited predictors of psychotherapy outcome (see Fluckiger et al., 2018 for a review of previous research). Working alliance is identified as a "common factor" in the success of psychotherapy across treatment approaches and modalities. Despite agreement on the importance of the alliance within the research literature, the mechanisms through which working alliance impacts treatment outcome are not clearly understood. One claim is that when a strong working alliance is established between a patient and therapist, the patient may experience the relationship as therapeutic regardless of other interventions. An alternative hypothesis is that working alliance interacts with other aspects of interventions to influence treatment outcome. Thus, we know that alliance is important but do not yet fully understand its precise role in successful psychotherapy.

Another important consideration is understanding how working alliance is defined. Commonly, alliance is viewed as the relationship or bond between a therapist and a patient. While the affective bond between therapist and patient is one factor of alliance, current conceptualizations of alliance identify three distinct but related features: 1) agreement between patient and therapist on the goals of therapy; 2) the patient's agreement with the therapist that the tasks of the therapy will address the problems the patient brings to treatment, and 3) the quality of the interpersonal bond between the patient and the therapist (Horvath & Greenberg, 1989). Research suggests that the three aspects of working alliance may have differential effects on the success or outcome of therapy (Hatcher & Gillaspy, 2006), highlighting the importance of conceptualizing alliance beyond a single construct.

Understanding the role of working alliance in evidence-based psychotherapy (EBP) is important for a multitude of reasons. Importantly, there continue to be misconceptions that manualized approaches to psychotherapy do not emphasize the therapeutic alliance, or that the structured nature of treatment interferes with forming a strong alliance. Additionally, some claims assert that evidence-based psychotherapies are not more advantageous than other approaches to treatment because the alliance, most usually thought of as the therapist-patient relationship, is the key element driving therapy outcome.

To better understand the role of working alliance in EBPs for depression, the Evidence-Based Psychotherapy Training Program examined how different fac-

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ets of working alliance, measured by the Working Alliance Inventory-SR (Hatcher & Gillaspy, 2006), impacted change in depression symptoms among 3,233 Veterans engaged in Acceptance and Commitment Therapy for depression (ACT-D), Cognitive Behavioral Therapy for Depression (CBT-D) or Interpersonal Psychotherapy for Depression (IPT) while therapists were in consultation as part of their VA EBP Training. Depression symptoms were assessed via the Beck Depression Inventory – II (BDI-II). Both the BDI-II and WAI-SR were administered at the start of treatment (session 1), mid-treatment (typically on or around session 7) and at the end of treatment (typically on or around session 11). Results showed that all aspects of working alliance (i.e., Bond, Goal, and Task) increased over the course of treatment, with the Task subscale of the WAI-SR showing the most sizeable increase over time. Additionally, Bond had the highest alliance scores at all 3 timepoints, relative to Goal and Task, indicating that Veterans reported a strong affective bond with their therapists throughout treatment. Bond, Goal, and Task dimensions of working alliance were all associated with improvement in depression symptoms, with the Task dimension demonstrating the strongest associations with improvement in depression over time. This finding suggests that a Veteran's agreement that the tasks of the therapy will address the problems the Veteran brings to treatment is an especially important determinant of treatment success.

These findings have important implications for clinicians providing ACT-D, CBT-D, and IPT to Veterans. Notably, a key to effective treatment may center on the therapist's ability to help the Veteran understand how specific tasks of therapy will lead to achieving therapeutic goals. Ensuring Veterans have full understanding of the treatment rationale and linking the rationale to the Veteran's specific goals are important steps to facilitate this aspect of working alliance. Further, if treatment gains are not being seen as would be expected, it may be beneficial to examine, in order of relative importance 1) Whether the Veteran is able to identify how the tasks of therapy will help achieve their specific goals; 2) Whether there is mutual understanding of therapeutic goals; 3) Whether there has been a rupture to the Veteran-therapist bond that requires repair. Regular administration of the WAI-SR may be helpful to measure and facilitate discussion of these factors.

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> *— Claire Gibson, Ph.D., SST National Trainer and Consultant*

Finally, the present results may also serve to address barriers to EBP implementation related to beliefs or misunderstandings of the value and role of the therapeutic alliance in manualized therapies. Providers who are skeptical or non-supportive of EBPs may benefit from understanding that EBPs are associated with development of a strong affective bond and that the structure and rationale of EBP delivery are well aligned with the importance of task and goal alliance in predicting treatment success.

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Implementing Social Skills Training on an Inpatient Mental Health Unit

Clare M. Gibson, PhD

Social Skills Training for Serious Mental Illness (SST) is an evidence-based intervention which aims to improve social functioning through behavioral strategies such as role-plays, modeling and ample positive reinforcement. SST helps Veterans build interpersonal skills, enhance overall self-efficacy, improve psychosocial functioning—all considerations for many of the Veterans I work with including (and sometimes especially) the Veterans I provide services for on an acute inpatient mental health unit. I started an SST group on our inpatient unit because of the known value of this group for Veterans and the desire to increase the availability of evidence-based interventions for Veterans on the inpatient unit. In addition, there was interest from the psychology trainees working on the inpatient unit in learning an evidence-based intervention

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for SMI such as SST, so this became an additional training opportunity to provide for supervisees. I would like to share some observations about the experience implementing SST on the inpatient mental health unit and how the intervention was delivered to maximize benefits for the Veterans.

It should be noted that this initiative is consistent with the Inpatient Mental Health Services Handbook, which emphasizes providing recovery-oriented care for Veterans, and the Inpatient Recovery Services Toolkit, which recommends implementing evidence-based interventions on inpatient mental health units. Additionally, The Uniform Mental Health Services in VA Medical Centers guidelines (2008) require that SST is available to Veterans with serious mental illness who would benefit from the SST intervention.

Fortunately, the SST Training Program provides guidance on implementing SST on inpatient units on their website (VISN 5 MIRECC website). The archived slide presentation was a useful resource to refer to when starting the group. An important part of the implementation plan was to ensure that the unit staff are involved in the process. Staff are educated about SST and ways SST might be useful for the Veterans. They are included in discussions about what social skills may be most helpful for the Veterans on the unit at that time. Additionally, handouts of the skills are provided to staff to promote practicing the skills outside of group and further educate staff about the group content. The unit staff are also invited to attend if interested.

I will discuss some considerations that arose when implementing the group. For one, the length of stay for some Veterans could potentially make completion of an outside practice assignment challenging (which is a component of an SST group). Regardless, we still assign an outside practice assignment and encourage thinking of ways to practice the skill outside of group and ideally even on the unit (e.g., making a request of staff). Staff can also help to reinforce practicing the skill outside of group. A second consideration is the heterogeneity on the unit and thus in our groups. Since the groups on the inpatient unit are open, all Veterans are encouraged to attend. SST is well suited to meet diverse needs as each Veteran has the opportunity to collaborate with the group facilitator(s) in designing personalized roleplays to practice in group and personalized practice assignments to complete outside of group. A third consideration of doing an SST group on an inpatient unit is that there are often competing clinical needs and other distractions that occur during group (e.g., staff bringing a Veteran medication that they are scheduled to take). It is important for SST group facilitators to remain flexible and open and it has been helpful to have the structure of SST to quickly reengage the Veterans in meaningful therapeutic work when such distractions happen.

In choosing the group curriculum, I have found that in addition to the basic skills (e.g., listening to others, making requests, expressing positive feelings, and expressing unpleasant feelings), other skills that are particularly helpful include the health maintenance (e.g., talking to a doctor about medication side effects) and assertiveness skills (e.g., asking for help). Some Veterans in the inpatient SST groups have noted that these topics are relevant to their current course of treatment and that improving these skills was immediately beneficial; for example, one Veteran shared that she was experiencing stress related to getting her needs met at home where she would be returning after her discharge from the hospital. The Veteran specifically practiced making a request of her roommate and shared it was helpful to have the opportunity to practice having this conversation.

I have indeed noticed many benefits since starting the group. SST is not focused on symptoms or diagnosis but rather interpersonal skills, community inclusion and relationships. Veterans on the inpatient unit appreciate the opportunity to focus on building relation-

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ships and refining their communication skills. As noted, SST provides positive reinforcement and is strengths-based. Veterans welcome the collegial and supportive atmosphere. The welcomed experience may promote Veterans practicing the skills outside of the group room-maybe even following-up with an SST group or mental health treatment once discharged to outpatient care. Education about opportunities to participate in SST and other outpatient options are provided in the group. Lastly, the psychology trainees have shared that they appreciate the opportunity to learn an evidence-based intervention for SMI, as well as learning about how to thoughtfully implement an intervention in this setting.

I look forward to providing recovery-oriented and evidence-based care for Veterans across the continuum of care. To learn more about SST, including how to provide SST on an inpatient unit, please visit the VISN 5 MIRECC website. VA staff interested in learning how to provide SST can contact their VISN's SST Regional Master Trainer, the SST Program Manager, Elizabeth Gilbert, Ph.D. at Elizabeth.Gilbert@va.gov, or the SST Program Coordinator, Laché Wilkins at Lache.Wilkins@va.gov, to learn about training opportunities.

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Dr. Clare Gibson is a National Trainer and Consultant for Social Skills Training as part of the VA Psychosocial Rehabilitation Training Program at the VISN 5 Mental Illness Research and Education Clinical Center (MIRECC). She also provides training for psychology trainees at the VA Maryland Health Care System. Dr. Gibson's professional interests are in psychosocial treatments for SMI, integrating recovery into mental healthcare systems and self-care for mental health professionals. She can be contacted at Clare.Gibson@va.gov.

The EBP F2F Strategic Meeting Report

The National EBP Training Program held our second Face-to-Face Strategic Planning meeting on Feb 26-28, 2019 at the VA Mid-Atlantic Mental Illness Research, Education and Clinical Center (MIRECC) in Durham, NC. During this meeting, we reviewed highlights from our 2017-2018 Strategic Action Plans, celebrated program accomplishments, discussed current priorities and new initiatives, and began to develop a revised action plan based on our top three areas of focus for the next year:

- **Communicate Value**
- **Assess Training Processes and Increase Efficiencies**
- **Operationalize Implementation**

Throughout the meeting, we discussed elements and activities that we want to "preserve", "achieve", "avoid", and "eliminate/retire." We fine-tuned this list during a focused "action planning" brainstorming session at the end of the meeting. Although we had developed a very ambitious "achieve" list, we were successful in determining ways that we can reduce redundancies and non- value-added activities such as the collection of measures that don't predict outcomes of interest or activities that are no longer relevant or central to our mission.

We plan to maintain our momentum by continuing to discuss priorities and action items as a group. Our next steps involve developing an **EBP Communications Plan** geared towards communicating our value to leaders, providers, and Veterans; **gathering data on our current training processes** from start to finish with the ultimate goal of centralizing key training elements across programs and increasing efficiencies; and **re-balancing our training efforts** with new priorities that emphasize post-training implementation and sustainability.

If you have any questions about the February 2019 Face-to-Face Meeting please contact Dr. Kristin Powell at Kristin.Powell@va.gov

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Perspectives: What in the world is a psychiatrist doing in the EBP newsletter?

Roy M. Stein, MD

The long and winding road that led me to your newsletter began at an addiction medicine conference in 1998 with a presentation on motivational enhancement therapy (MET), one of three interventions in Project MATCH, a multicenter (and largest to date) trial evaluating psychosocial treatments for alcohol dependence. The concepts underlying motivational interviewing (MI) resonated with my psychotherapy background and clinical experience as a VA addiction psychiatrist. Project MATCH's finding that a four-session MET intervention was as efficacious as 12 sessions of CBT or twelve-step facilitation of course drew the attention of policymakers in and out of VA. My interest was piqued, and I welcomed the opportunity to become a subject in a study, "Evaluating Methods for Motivational Enhancement Education" (EMMEE) by Bill Miller and colleagues at the University of New Mexico. As a research subject I had the good fortune to receive training by Drs. Miller, Carolina Yahne, and Theresa Moyers, and to be randomized to receive coaching on recordings by Dr. Moyers. EMMEE and subsequent work by Miller et al influenced the MI training approach employed by VA to this day. The EMMEE experience propelled me to incorporate MI as a central element of substance use disorders treatment at Durham, and to teach it to Duke psychiatry residents and medical students. Subsequent attendance at an MI Training-of-New-Trainers resulted in membership in the Motivational Interviewing Network of Trainers (MINT). For 8 years I practiced and taught MI in local settings, but efforts to provide intensive MI training for VA clinicians were stalled by administrative barriers. This all changed in 2011, when MI became the focus of a national EBP rollout. To get the ball rolling, program leadership put out a call for VA personnel who were already MINT members to serve as the initial cadre of trainers and consultants. I jumped on board and haven't looked back.

I've benefited tremendously, personally and professionally, from participation in the MI/MET initiative. I've enjoyed a stimulating, collegial community of trainers and consultants, and the intimate connection gained through coaching frontline clinicians treating Veterans from White River Junction, VT to Big Spring, TX. Connecting with colleagues from around the globe at MINT Forums in North America and Europe has heightened my appreciation of VA's unique commitment to advancing evidence-based practice through the intensive training and sustained consultation we are privileged to provide. Few if any organizations around the world have committed the level of time and resources for staff development in psychotherapies like MI.

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My one source of disappointment has been the sparse representation of my psychiatric colleagues as learners, consultants, or trainers in this initiative. In 8 years with the program, I've had only one physician consultee. I suspect this is more a reflection of the intense clinical pressures on VA psychiatrists' time than a lack of interest on their part. With institutional support I believe we would see much more participation. Veterans would benefit from increased engagement of VA psychiatrists in EBP's in several ways: (1) Recruitment/retention. A large proportion of US psychiatry residents receive clinical training in VHA. Most budding psychiatrists want to learn and practice modern, effective psychotherapies; doing so is a core competency in psychiatric residency training. VA's EBP focus is a major draw for trainees in psychology, social work, and other MH disciplines to commit to careers in VA. The opportunity to learn and practice evidence-based psychotherapies would similarly attract talented, graduating residents to pursue careers in service to Veterans. (2) Service delivery: The reality is that for many Veterans with severe and/or chronic mental illness, their psychiatrist is their sole MH clinician. And for the Veteran who does engage in time-limited psy-

chotherapeutic interventions, the psychiatrist remains as the one clinician with whom he or she has a sustained relationship, often lasting years or even decades. Although appointments may be spaced months apart, visits typically include both medication management and psychotherapy. The benefit of these interactions could be enhanced through targeted research, leading to tailored evidence-based interventions. (3) The evolution of evidence-based mental health care in VA would be enriched by cross-talk between psychiatrists and fellow disciplines. The evidence on which we base our treatments necessarily evolves, as does the whole undertaking of delivering evidence-based medicine or health care – that is, our quest to determine how best to integrate research evidence with Veteran-centric, shared decision-making to arrive at the right plan for each individual. Our various disciplines have much to learn from each other in this enterprise. Sharp distinctions between biological and psychological interventions are obsolete, and we're way past the time when living and practicing in silos is an acceptable way of doing business. I hope for many more fruitful intersections as we head further on down the road.

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"The soldier above all others prays for peace, for it is the soldier who must suffer and bear the deepest wounds and scars of war."
— General Douglas MacArthur

"True heroism is remarkably sober, very undramatic. It is not the urge to surpass all others at whatever cost, but the urge to serve others at whatever cost."
— Arthur Ashe, Athlete

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