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Cognitive and Behavioral Practice 22 (2015) 468-480

Cognitive and Behavioral Practice

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Behavioral Activation Between Acute Inpatient and Outpatient Psychiatry: Description of a Protocol and a Pilot Feasibility Study

Fredrik Folke, *Uppsala University, and Centre for Clinical Research, Dalarna, Falun, Sweden*
Timo Hursti, *Uppsala University*
Stefan Tungström and Per Söderberg, *Center for Clinical Research, Dalarna, Sweden*
Lisa Ekselius, *Uppsala University*
Jonathan W. Kanter, *University of Washington*

Gaps in the continuity of care between acute inpatient and outpatient psychiatric services are common and potentially detrimental for service users. In this paper we provide the rationale for and description of a 12-session behavioral activation intervention for acute inpatients with depression and comorbid psychiatric disorders. The intervention was tailored to be initiated during acute inpatient care and to continue after discharge into outpatient services. We also describe a small pilot investigation (N = 13) of the intervention's preliminary feasibility. Treatment retention, self-ratings, and participants' adherence to treatment principles indicate preliminary feasibility of behavioral activation in this complex context. Self-rated activation and avoidance improved during the intervention. The value of a parsimonious inpatient therapy that can bridge the gap between services is discussed along with the limitations of this study.

The period after discharge from around-the-clock acute psychiatric inpatient services to less frequent community outpatient follow-up is associated with increased risk for suicide (Qin & Nordentoft, 2005), noncompliance, relapse, and rehospitalization (Walker, MinorSchork, Bloch, & Esinhart, 1996). Engaging inpatients in outpatient treatment programs before discharge has been found to increase adherence to outpatient services (Boyer, McAlpine, Pottick, & Olfson, 2000). However, serious gaps in the continuity of care have been recurrently reported (Adair et al., 2003) and many patients receive no immediate or much delayed outpatient aftercare (Boyer et al., 2000).

Psychological treatments for inpatients are not readily available on acute inpatient units (Mullen, 2009). When such treatments are available, they rarely span over the critical transition period between inpatient and outpatient services. The lack of psychological services in acute inpatient settings is perhaps explained by complicating features of the ward milieu such as short and unpredictable admission lengths, diverse and preliminary diagnoses, high symptom severity, behavioral disturbance, lack of relevant staff training, and occasional staff skepticism towards psychotherapy (Curran, Lawson, Houghton, & Gournay, 2007; Mullen, 2009). Research indicates that cognitive and behavioral therapies (CBTs) can be successfully adapted for inpatients with depression (Cuijpers et al., 2011) as well as mixed diagnostic groups (Durrant, Clarke, Tolland, & Wilson, 2007; Lynch, Berry, & Sirey, 2011; Veltro et al., 2008). The research is however preliminary and the magnitude of psychotherapy effects may be smaller than the ones observed in other contexts (Cuijpers et al., 2011). The effectiveness of CBTs for depressed inpatients has been argued to improve if outpatient sessions are scheduled after discharge as it ensures consolidation of skills learned during admission (Stuart, Wright, Thase, & Beck, 1997; Thase & Wright, 1991). There is promising data from inpatient depression trials where CBTs start during inpatient treatment and continue after discharge (Miller, Bishop, Norman, & Keitner, 1985; Miller, Norman, & Keitner, 1989; Scott, 1992; Whisman, Miller, Norman, & Keitner, 1991).

Behavioral activation (BA) has been proposed to be particularly well suited to deal with the challenges of the inpatient milieu (Curran, Lawson, Houghton, & Gournay, 2007). We will highlight a few arguments for this and for why we believe it could serve as a treatment to bridge the gap between inpatient and outpatient services. First, data from a large clinical trial (Dimidjian et al., 2006) suggested that BA was more effective than cognitive therapy (CT) in the acute treatment of severe depression. BA was also equally effective to pharmacotherapy and evidenced superior retention. In a reanalysis of the data, Coffman and

[1] Video patients/clients are portrayed by actors.

Keywords: continuity of care; acute; inpatient; behavioral activation

colleagues (2007) found that BA did not evidence the same nonresponse pattern as did CT for a subset of patients with functional impairment, problems in the primary support group, and severe depression.

Second, Hopko and colleagues (2003) reported that their brief protocol Behavioral Activation Treatment for Depression (BATD; Lejuez et al., 2001) evidenced significantly larger improvements from baseline to posttreatment in depression compared to supportive therapy. In another recent open trial BA was implemented as a nurse-driven milieu therapy called Behavioral Activation Communication (BAC; Gollan et al., in press) on an acute ward. Inpatients in the BAC milieu demonstrated significantly greater changes in self-reported positive affect and activation from admission to discharge compared to a nonrandomized control group.

Third, BA has been proposed to be easier to learn than the extensive CT package (Jacobson et al., 1996). Actually, data do suggest that BA can be learned and effectively executed by nontherapists after only 5 days of training (Ekers, Richards, McMillan, Bland, & Gilbody, 2011). The parsimonious nature of BA is of particular value for the inpatient context as the majority of staff involved in such treatment is nontherapists. Finally, BA also appears well suited to deal with the heterogeneous inpatient population with diverse and preliminary diagnoses. Successful adaptations of BA have been reported for a wide variety of diagnoses and populations (Dimidjian, Barrera, Martell, Munoz, & Lewinsohn, 2011).

In summary, BA is an efficacious, easy-to-learn, parsimonious therapy that can be successfully adapted to both a variety of diagnoses as well as treatment contexts. This has led us and others to conclude that BA is plausible therapy for further evaluation in inpatient settings and, we assert, a promising therapy to bridge the gap in the transition from inpatient to outpatient care.

The Present Study

In this pilot study we sought to adapt a BA protocol to bridge the gap in the transition from inpatient to outpatient care for acutely admitted patients with depression and other psychiatric comorbid disorders. The primary aim of the pilot study was to examine the intervention's feasibility and to provide empirical data from the treatment process (i.e., activation, avoidance, homework adherence, working alliance) as BA is implemented between inpatient and outpatient services. A secondary aim was to report the uncontrolled outcomes and investigate possible relations between outcomes and treatment process variables.

The BA Model

BA has its roots in early behavioral models of depression (Ferster, 1973; Lewinsohn, 1974). The models assert the role of decreased levels of positive reinforcement and increased aversive control for understanding depression and pleasant activity scheduling as a primary treatment strategy. Contemporary BA arose in the 1990s and it exists in two different widespread versions: BA developed by the late Jacobson and colleagues (Jacobson, Martell, & Dimidjian, 2001; Martell, Dimidjian, & Herman–Dunn, 2010) and BATD (Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011). They share many features but they also differ in content, emphasis, complexity, and structure (Kanter et al., 2010). BATD provides a simple structure with fewer components and greater emphasis on formal values assessment. BA, on the other hand, relies more on the therapist's ability to conduct ideographic functional analysis and to structure therapy accordingly. The model used in our study was based on the synthesis of the two versions, developed by Kanter, Busch, and Rush (2009). It capitalizes on the simplicity and structure of BATD while it retains BA's emphasis on ideographic functional analysis.

Overview of the Adapted BA Protocol

The first author produced a therapist manual and patient workbook with input from one of the authors (J. W. Kanter). An overview of the BA protocol is outlined in Figure 1.

General Adaptations

The complex treatment context required some adaptations of therapy structure and content. First, inpatient diagnoses are often preliminary as admission to acute psychiatric wards is reserved for persons with severe, and often unusual, symptoms and pronounced behavioral disturbance. The manual thus had to address a wide range of problems beyond the scope of typical major depression. As a result, patient materials used the term *depression* interchangeably with other words that denote emotional problems. Exposure techniques were added to the protocol based on our clinical observation that anxiety and avoidance is highly common in the inpatient population. We consider exposure a logical extension of BA given that both approaches are rooted in the behavioral tradition, apply a similar functional understanding of avoidance, and foster approach behaviors to counter avoidance. The kinship between BA and exposure therapy has been noted by other researchers (Jacobson et al., 2001; Kanter et al., 2010) and the two have been integrated before (Chu, Colognori, Weissman, & Bannon, 2009). We also encouraged therapists to be flexible regarding session length and amount of content covered each session given many inpatients' hampered ability to focus attention. Instead of specifying the exact content of each session, we defined three phases of therapy (i.e., early, middle, and late phases). Sessions were scheduled twice a week whenever possible to increase the amount of support during the critical time period and to work intensively on achieving behavior change. The protocol also needed to take into account that wards are artificial milieus with few similarities to patients'