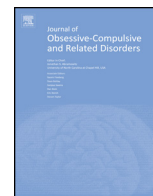




ELSEVIER

Contents lists available at ScienceDirect

## Journal of Obsessive-Compulsive and Related Disorders

journal homepage: [www.elsevier.com/locate/jocrd](http://www.elsevier.com/locate/jocrd)

## Clinical report

## The progress cascading model: A scalable model for teaching and mentoring graduate trainees in exposure therapy

Amanda M. Balkhi<sup>a,b,\*</sup>, Adam M. Reid<sup>a,b,1</sup>, Andrew G. Guzick<sup>a,b</sup>, Gary R. Geffken<sup>a,b,c</sup>, Joseph P.H. McNamara<sup>a,d</sup><sup>a</sup> Division of Medical Psychology, Department of Psychiatry, College of Medicine, University of Florida, 8491 NW 39th Avenue, Gainesville, FL 32606, USA<sup>b</sup> Department of Clinical and Health Psychology, College of Public Health and Health Professions, University of Florida, P.O. Box 100165, Gainesville, FL 32610-0165, USA<sup>c</sup> Department of Pediatrics, College of Medicine, University of Florida, P.O. Box 100296, Gainesville, FL 32610-0296, USA<sup>d</sup> Department of Psychology, College of Liberal Arts and Sciences, University of Florida, P.O. Box 112250, Gainesville, FL 32611-2250, USA

## ARTICLE INFO

## Article history:

Received 22 September 2015

Received in revised form

20 February 2016

Accepted 29 February 2016

Available online 2 March 2016

## Keywords:

Graduate training

Exposure therapy

Anxiety disorders

Psychotherapy competency

## ABSTRACT

Little has been written as to how clinicians in specialty treatment clinics go about training unlicensed trainees to work with patients with OCD. The University of Florida's OCD (UF OCD) treatment and training program was founded over 20 years ago by Drs. Wayne Goodman and Gary Geffken and has reported treatment response rates above the national average. The success of the program is largely due to a continued emphasis on trainee development through a progressive cascading model of mentorship. Using this competency based model, the UF OCD program focuses on skill acquisition and competency based evaluation through mentoring, collaboration, and co-therapy with clinicians and other trainees. Trainee satisfaction with this model was assessed using qualitative and questionnaire based feedback from trainees whom had completed at least one semester within the training program. Most trainees felt competent in implementing exposure therapy and were satisfied following their training within the program, reporting particular benefit from the co-therapy approach. Recommendations for implementation of this model in graduate training clinics are discussed.

© 2016 Elsevier Inc. All rights reserved.

## 1. Introduction

Obsessive-compulsive disorder (OCD) is a severely distressing condition in which people experience disturbing, intrusive thoughts and engage in compulsive behaviors to alleviate the anxiety caused by obsessive thoughts. When left untreated, OCD rarely remits (Keller et al., 1992; Pine, Cohen, Gurley, Brook, & Ma, 1998; Rapee, Schniering, & Hudson, 2009) and causes substantial burden to the individual (Mendlowicz & Stein, 2000; Piacentini, Bergman, Keller, & McCracken, 2003), their close relationships (e.g., Cooper, 1996; Stewart et al., 2011), and society (Greenberg et al., 1999). Cognitive-Behavioral Therapy with Exposure and Response Prevention (CBT-ERP) is the most-empirically supported psychotherapeutic treatment for pediatric and adult OCD (e.g.,

Franklin et al., 2015; Ponniah, Magiati, & Hollon, 2013) and is recommended as the psychotherapeutic treatment of choice for this disorder (e.g., American Psychiatric Association, 2011; Connolly & Bernstein, 2007). Exposure and response prevention (ERP) is the key ingredient in CBT-ERP (Abramowitz, Deacon, & Whiteside, 2012; Ponniah et al., 2013) and challenges the patient to systematically face feared stimuli for prolonged periods until the patient habituates to the internal experience of anxiety, learns corrective information about their fears, or is able to tolerate the fear without anxiety-reducing behaviors (Foa & Kozak, 1986; Craske et al., 2008). Despite being a challenging treatment, CBT-ERP can generally result in notable improvements in just a few weeks and is often preferred by patients and their families (Lewin, McGuire, Murphy, & Storch, 2014; Patel & Simpson, 2010).

Unfortunately, exposure therapy is highly under-utilized by community providers in the United States and abroad (Becker, Zayfert, & Anderson, 2004; Böhm & Külz, 2008; Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010; Freiheit, Vye, Swan, & Cady, 2004; Schwartz, Schlegl, Kuel, & Volderholzer, 2013). When ERP is used by community therapists, it is often combined with theoretically incompatible techniques (e.g., arousal reduction strategies; Hipol

\* Corresponding author at: Division of Medical Psychology, Department of Psychiatry, College of Medicine, University of Florida, 8491 NW 39th Avenue, Gainesville, FL 32606, USA.

E-mail address: [Amanda.M.Roberts@ufl.edu](mailto:Amanda.M.Roberts@ufl.edu) (A.M. Balkhi).

<sup>1</sup> Present address: Harvard Medical School, Department Of Psychiatry, 401 Park Drive, 2 West Room 305, Boston, MA 02215, USA.

& Deacon, 2013) or delivered in a less intense format for the patient (e.g., taking breaks between exposures; Deacon, Lickel, Farrell, Kemp, & Hipol, 2013b) or for the therapist (e.g., assigning exposures for homework rather than in-session; Hipol & Deacon, 2013). These deviations in delivery can be detrimental to treatment outcome (Abramowitz, Franklin, & Foa, 2002; Armfield, 2008).

Emerging research suggests that a lack of training may account for the poor dissemination of ERP. While many therapists hold strong unsupported negative attitudes and beliefs towards exposure (e.g., it could exacerbate symptoms), practitioners with more training in these techniques rarely hold such biases (Deacon et al., 2013a; Harned, Dimeff, Woodcock, & Contreras, 2014; Reid, 2016, in press). Therapists with training in exposure-based techniques may have other characteristics that leave them more likely to use ERP, such as more knowledge about exposure therapy (Harned et al., 2014), less anxiety and disgust sensitivity (Reid, 2016, in press), and more self-efficacy in exposure delivery (Harned et al., 2014). These findings suggest that more training in exposure-based techniques is required to disseminate best practices in exposure therapy.

The well-documented need to educate clinicians in best practices has led to the encouragement of graduate schools to provide ample opportunity for novice therapists to learn CBT-ERP during their initial graduate training (Klepac et al., 2012). In support of this recommendation, empirically supported training models for CBT-ERP that emphasize exposure therapy need to be developed so that they can be adopted by training sites. These models should be flexible, easily implemented, and respond to the unique factors that negatively impact CBT-ERP delivery, such as negative attitudes and beliefs about exposures. Research and dissemination of these training models will help improve the general lack of training in exposure-based techniques reported by most community therapists (Becker et al., 2004; Hipol & Deacon, 2013; Russell & Silver, 2007; Van Minnen, Hendriks, & Olf, 2010).

### 1.1. Graduate clinical training

Despite clinical training being a well-established cornerstone of practice-oriented programs (e.g. clinical psychology, mental health counseling) and the need to disseminate ERP in graduate programs, few if any, use an articulated model of clinical training (Weissman et al., 2006). Most instead suggest that mastery of ERP and other evidence based treatments is best developed from a triad of manual based education, workshop based practice, and ongoing supervision built on a foundation of basic therapeutic skills (e.g. reflection, open ended questions) and experience (Bennett-Levy, McManus, Westling, & Fennell, 2009; Stoltenberg, 2005; Sholomskas et al., 2005). However, in the instruction of CBT-ERP this approach to clinical training can be limiting, as it characterizes CBT-ERP as an “advanced” skill when it can be effectively taught to beginning trainees. Early engagement in the delivery of CBT-ERP maximizes the time spent building positive attitudes and beliefs about exposure and has potentially positive impacts on dissemination of this highly effective treatment (Beidas & Kendall, 2010; Klepac et al., 2012).

In order to support beginning trainees in CBT-ERP, creating a training environment with continuous, structured supervision that is focused on patient progress while also being tailored to the trainee's developmental level is important (Hilsenroth et al., 2002; Stoltenberg, 2005). Structured, collaborative, and high feedback environments in both individual and group supervision have been consistently related to patient satisfaction and therapeutic alliance (Freitas, 2002; Hilsenroth et al., 2002; Linton, 2003; Riva & Cornish, 1995, 2008). This relationship is especially true for live supervision (where a supervisor watches in real time and interjects

as needed), which while perceived as more disruptive and incongruent by patients, leads to higher levels of therapeutic alliance among trainee therapists and patients than the traditional taped or remote supervision (Freitas, 2002, Bennett-Levy, McManus, Westling & Fennell, 2009). To the best of the authors' knowledge, there has yet to be a model of clinical training that integrates the frequency and flexibility of live supervision with the depth of modeling and structured feedback required to teach foundational and CBT-ERP specific skills while at the same time having the scalability to work equally well in small and large clinics. Given this, the authors propose a competency based model of supervision and clinical experience based on the model used within the University of Florida Obsessive Compulsive Disorder Program.

## 2. The proposed model

### 2.1. The university of Florida obsessive compulsive disorder program

The program for study and treatment of OCD in the Department of Psychiatry at the University of Florida (UF) was created by Wayne Goodman, M.D. and Gary Geffken, Ph.D., beginning in the early 1990s. Drs. Goodman and Geffken recognized the limited treatment opportunities for individuals with OCD in north central Florida. In the early days of the program, efforts were focused on patient treatment and clinical teaching of trainees in psychiatry and practice-oriented disciplines of psychology (e.g. Clinical and Health Psychology, School Psychology) who saw patients with OCD across the lifespan on a weekly basis in the clinic; however, increasing demand from patients with refractory OCD necessitated the development of an intensive daily outpatient treatment option modeled after existing intensive CBT for OCD programs (Abramowitz, Foa, & Franklin, 2003; Hiss, Foa, & Kozak, 1994; Storch et al., 2008). This three week, daily therapy program led to the development of a team approach to treatment in which each patient was paired with a group of skilled and training clinicians who kept in daily contact in order to communicate treatment progress and flexibly provide CBT-ERP to the quickly growing patient base.

The UF program quickly became a treatment center for patients with OCD and other related disorders, drawing patients from across the United States, as well as internationally. Current directors, Drs. Geffken and McNamara have continued to foster connections within other training programs at UF and currently have active trainee involvement from Clinical and Health, Counseling, and School Psychology programs, Counselor Education, medical school and residency programs. This has led to a substantial increase in the number of trainees who received training in CBT-ERP and have actively participated in service delivery. Currently the UF OCD program employs seven faculty and six post-doctoral associates and trains an average of 15–20 masters or pre-doctoral level trainees per semester in addition to two to five medical students and residents on monthly rotations seeing patients in both the intensive and once weekly treatment programs.

### 2.2. The progressive cascading model

The growth and expansion of the UF OCD program paired with the frequent rotation of trainees on variable schedules (from one month to five year placements within the program) required the development of a mentorship and training system that allowed for rapid trainee development with little to no interruption of patient care. Also important to this system was recognition of an OCD treatment skill set that was respectful of but not contingent on the level of the trainee (e.g. practicum student, intern, post-doctoral associates) within the clinic's administrative hierarchy. This was important because while advanced trainees traditionally have

Download English Version:

<https://daneshyari.com/en/article/912186>

Download Persian Version:

<https://daneshyari.com/article/912186>

[Daneshyari.com](https://daneshyari.com)