Adapting a family-involved intervention to increase initiation and completion of evidenced-based psychotherapy for posttraumatic stress disorder

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ADAPT
DURHAM CENTER OF INNOVATION TO ACCELERATE DISCOVERY AND PRACTICE TRANSFORMATION

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Poll

How often do you work with family members of Veterans?

- **All the time**
- **Some of the time**
- **Rarely**
- **Never**

Poll

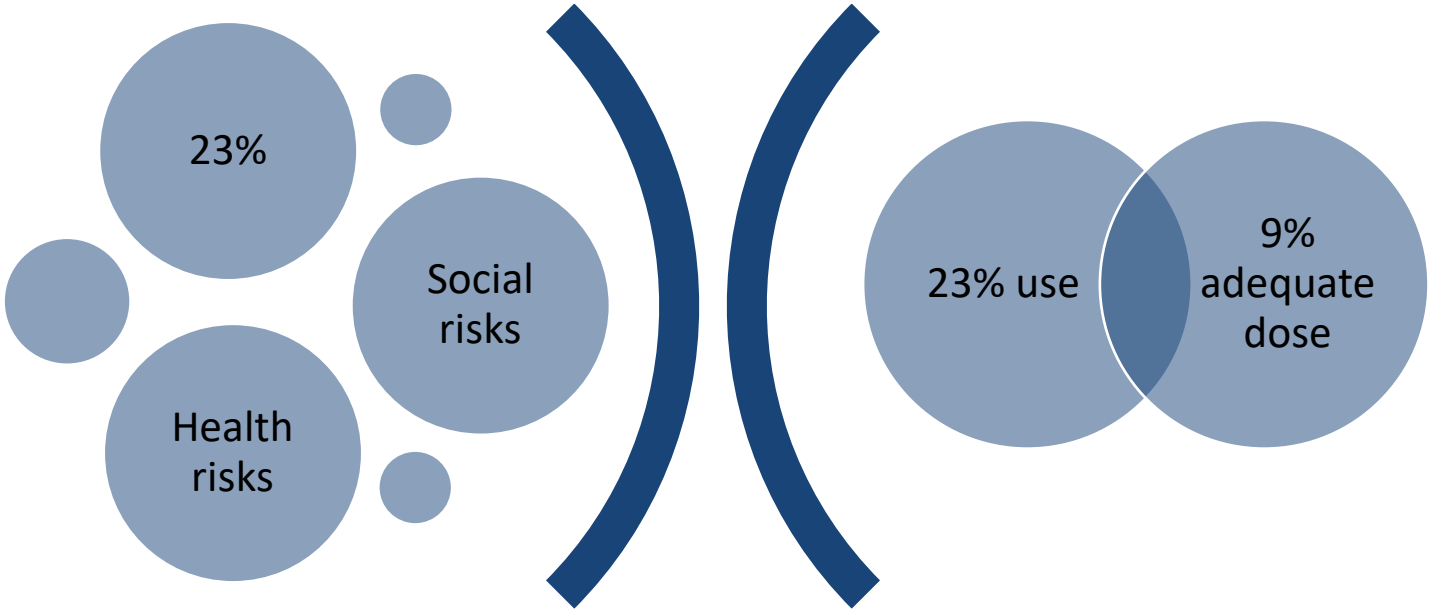
How comfortable do you feel working with family members of Veterans?

- **Very comfortable**
- **Somewhat comfortable**
- **Not at all comfortable**

Overview

- **Background**
- Rationale
- Intervention adaptation process
- Feedback about adapted intervention
- Conclusions and next steps

Background

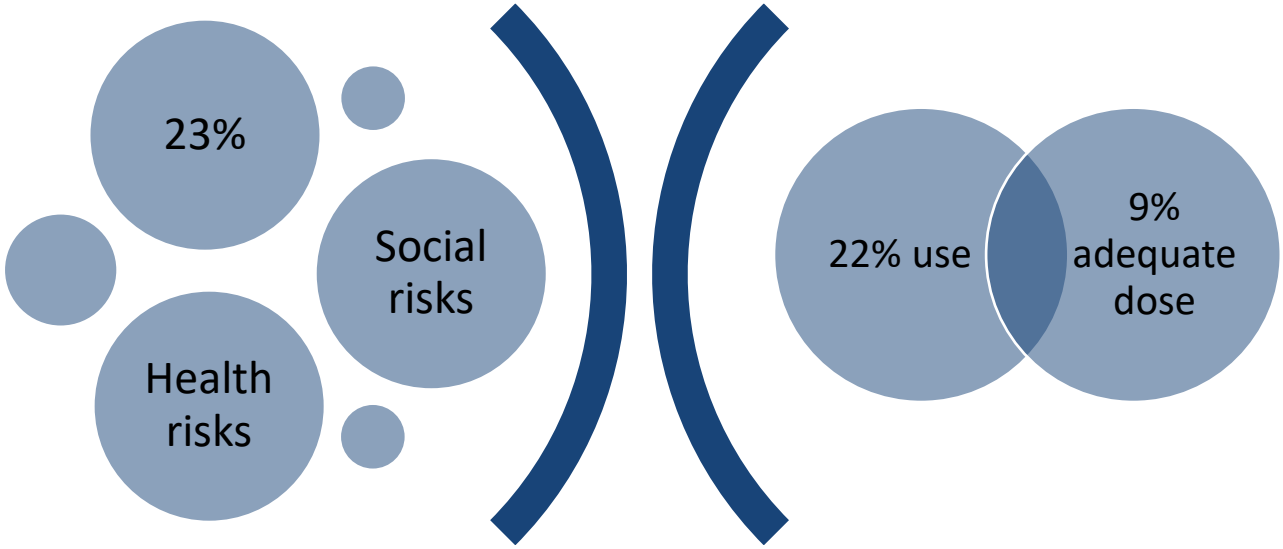


PTSD is prevalent and impedes function

Low use of evidenced-based psychotherapies (EBPs) for PTSDs

Fulton et al, 2015, Maguen et al, 2019, Erbes et al, 2011, Sayers et al, 2010

Background



PTSD is prevalent and impedes function

Low use of evidenced-based psychotherapies (EBPs) for PTSDs

Might support from family members increase use of effective therapies?

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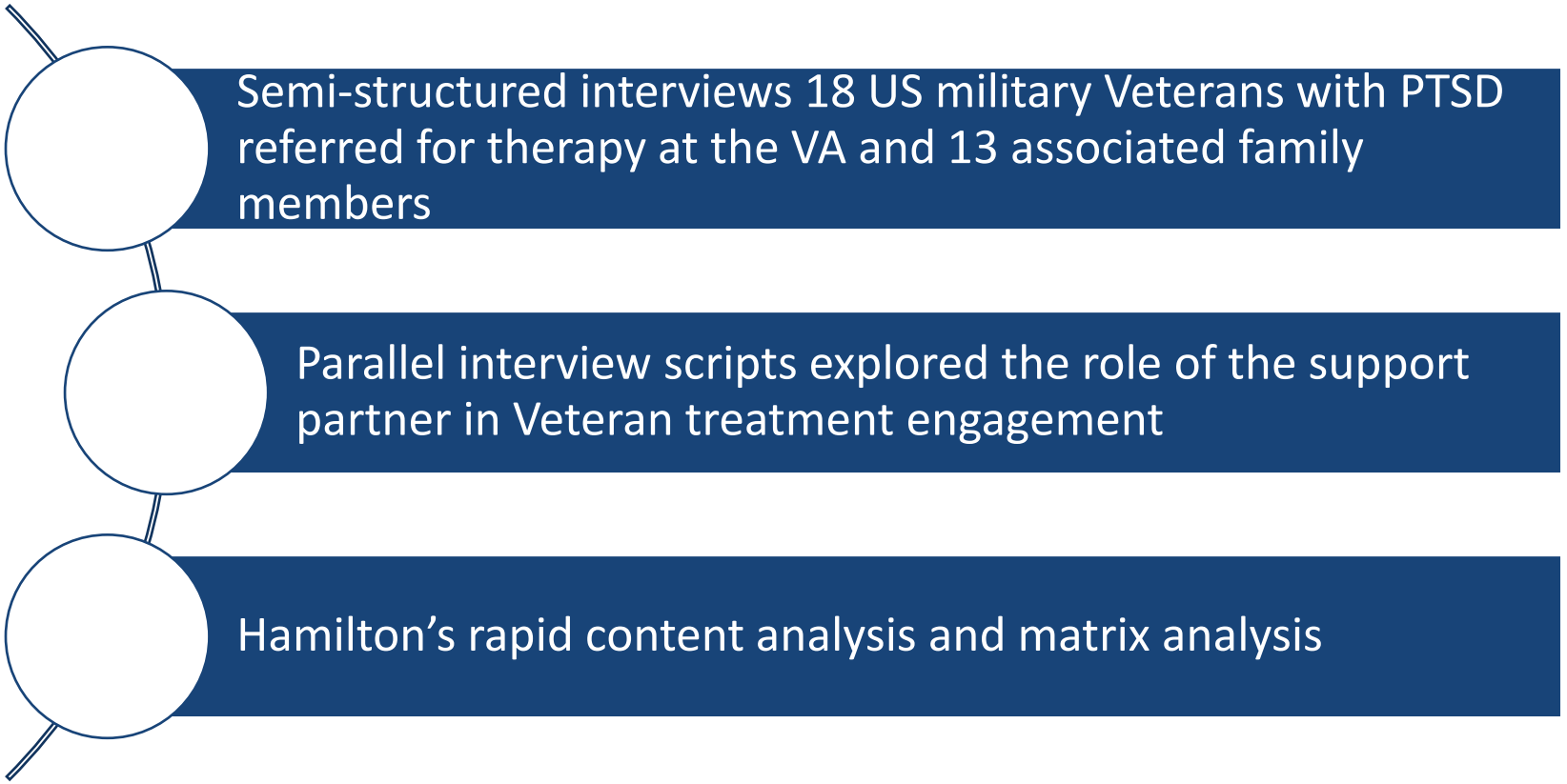
Rationale

- **Positive and empathetic family interactions may:**
  - Increase feelings of safety for individuals with PTSD
  - Enhance a Veteran's willingness to engage in treatment
  - Reinforce treatment gains
- **Contact between family and providers is associated with early treatment commitment, despite the patient's own treatment attitudes**
- **Formative qualitative work (unpublished)**

Meis et al, 2015; Meis et al, 2014, Charuvastra & Cloitre, 2008; Price et al, 2013

Formative treatment development work



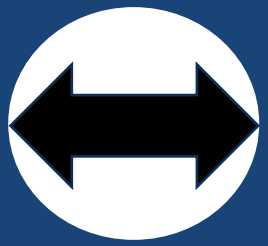
Shepherd-Banigan et al, 2022, submitted
Shepherd-Banigan et al, 2022, R&R at Psychological Services

Formative treatment development work

Research questions

- How do families influence why and when individuals with PTSD seek therapy?
- How do family members engage with the individual with PTSD who is seeking therapy?
- Do these interactions help or hinder the therapy process?

Formative treatment development work



Family member involvement in PTSD therapy a dynamic, bi-directional process

Veterans and family members made treatment decisions together—shared family goal

Positive family member attitudes towards therapy were important for Veteran enthusiasm towards treatment

Non-judgmental conversations about PTSD/treatment promoted emotional safety

CONCLUSIONS

Shepherd-Banigan et al, 2022, R&R
Images from Noun Project and Adobe Stock

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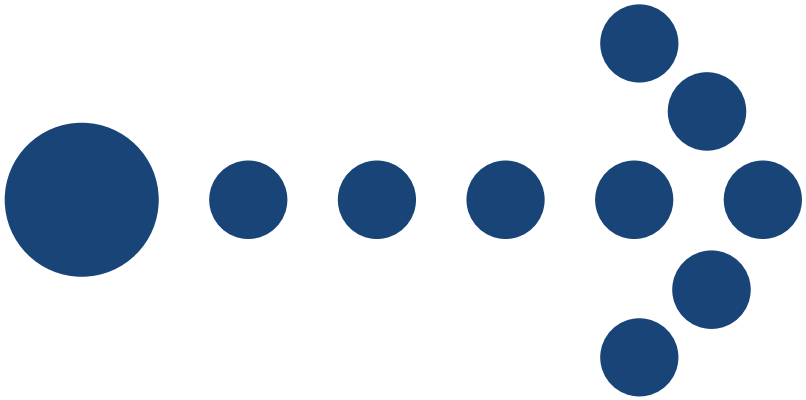
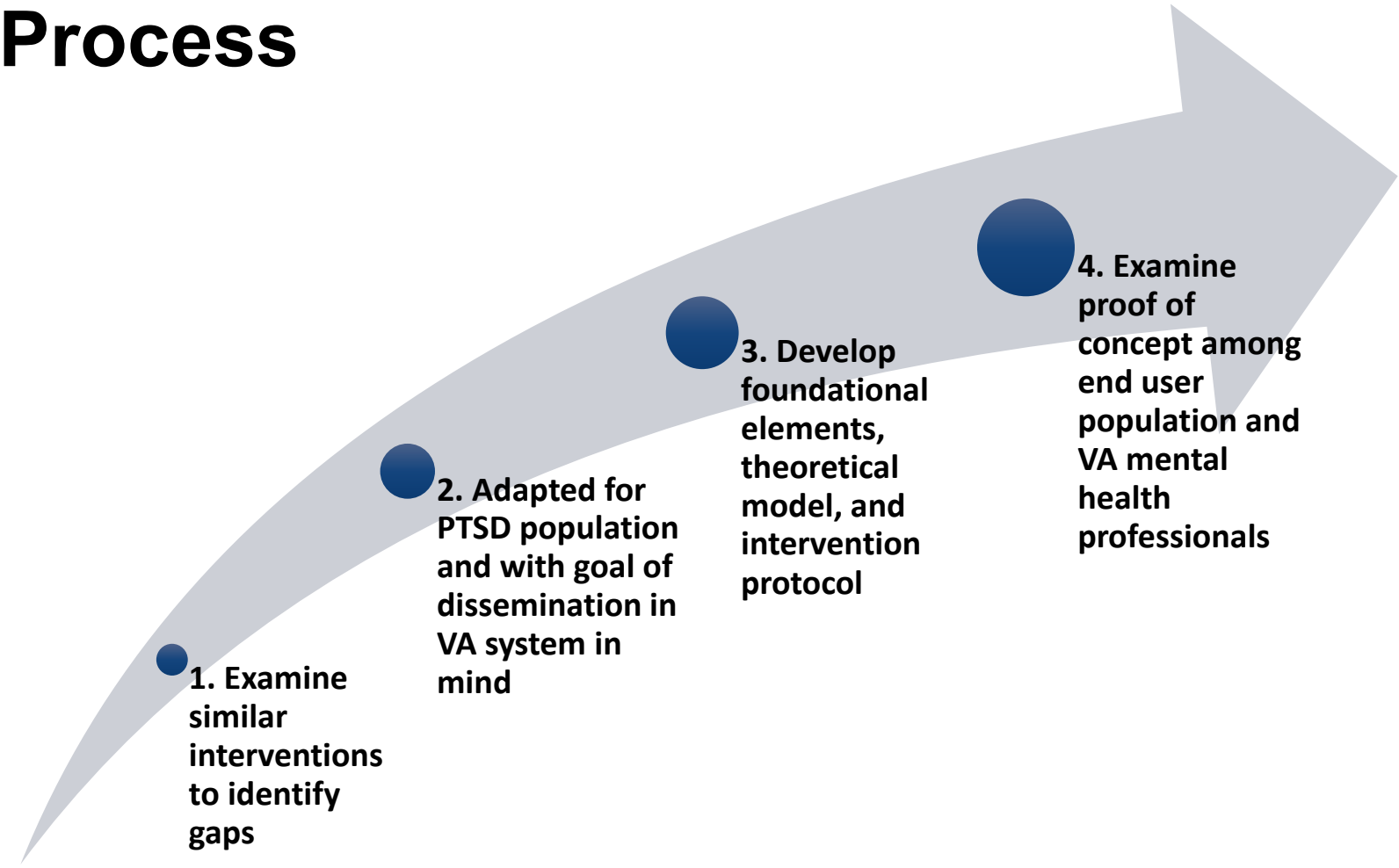
Purpose

Develop an adjunct intervention leveraging social support to increase Veteran initiation and adherence to PTSD EBPs



Process


1. Examine similar interventions to identify gaps
2. Adapted for PTSD population and with goal of dissemination in VA system in mind
3. Develop foundational elements, theoretical model, and intervention protocol
4. Examine proof of concept among end user population and VA mental health professionals

1. Process

- **Chose REORDER intervention as starting point**
  - Population: Veterans with serious mental illness and support partner (SP)
  - Goal: To engage SP in mental health treatment team
  - Structure
    - *Phase 1 (Veteran only), Phase 2 (SP only)*
    - *6 sessions*
    - *Sessions lasted 45-60 minutes*
    - *Sessions occurred while Veteran in treatment*
    - *Separate sessions for Veteran and SP*
  - Treatment strategies included shared decision-making, motivational interviewing, psychoeducation

1. Process

- **Examine similar interventions to identify gaps**
  - Literature review of family-involved interventions for mental illness – lots of great work by Sherman, Monson, MacDonald, Meis, Thompson-Hollands and others
    - *Examined structure, treatment strategies, goals, and target population*

2. Process

- **Adapt for PTSD population and with goal of dissemination in VA system in mind**
  - Adaptation process guided by Framework for Adaptations and Modification (FRAME) (Wiltsey Stirman et al, 2019)
    - *Systematically track and describe modifications*

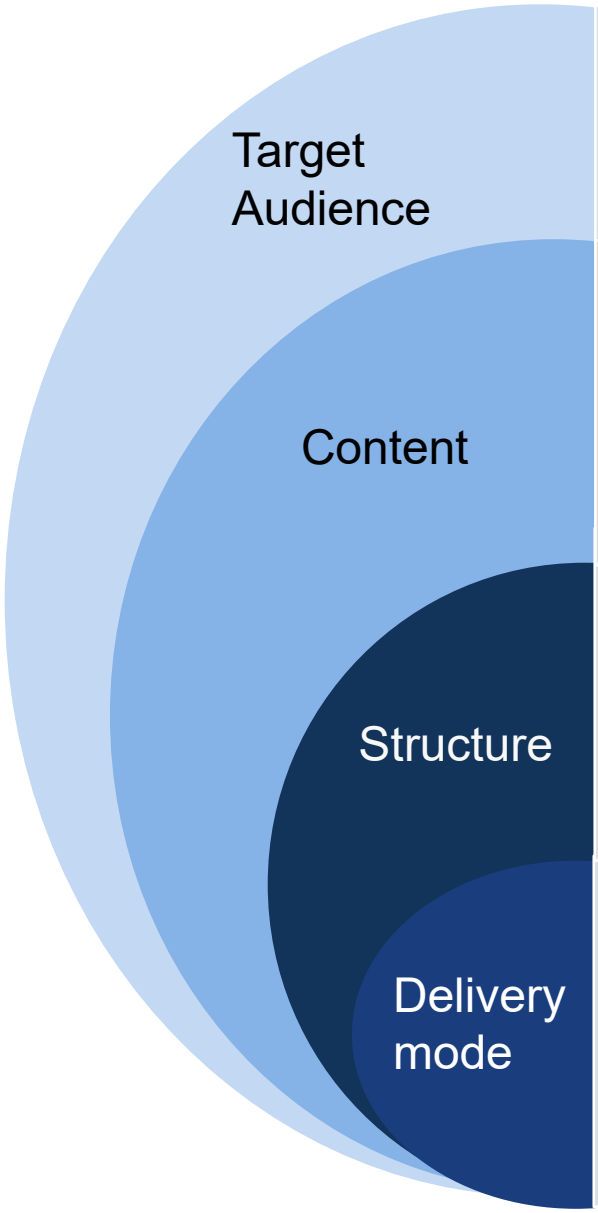
Framework for Adaptations and Modification

Timing	• When did modification occur within implementation process?
Purposefulness	• Was modification planned or unplanned?
Decision-maker	• Was the decision to modify made by treatment developer, researcher, administrator, or other?
What is modified	• What is modified (e.g. content of the intervention, delivery modality, or training and evaluation of the intervention)?
Level of modification	• What is the target for the modification (e.g. the individual, a patient population, a clinic, an organization)?
Nature of modification	• What is comprised of the adaptation (e.g. removing aspects of an intervention, changing the spacing of the modifications, adding content)?
Fidelity consistent modifications	• Was the modification consistent or inconsistent to fidelity of original intervention?
Rationale/purpose of modification	• What was the rational for the modification (e.g., to improve fit of the intervention for a particular group or culture, reduce costliness of the intervention)?

Wiltsey Stirman, S., A.A. Baumann, and C.J. Miller, *The FRAME: an expanded framework for reporting adaptations and modifications to evidence-based interventions.* Implement Sci, 2019. **14**(1): p. 58.

2. Process

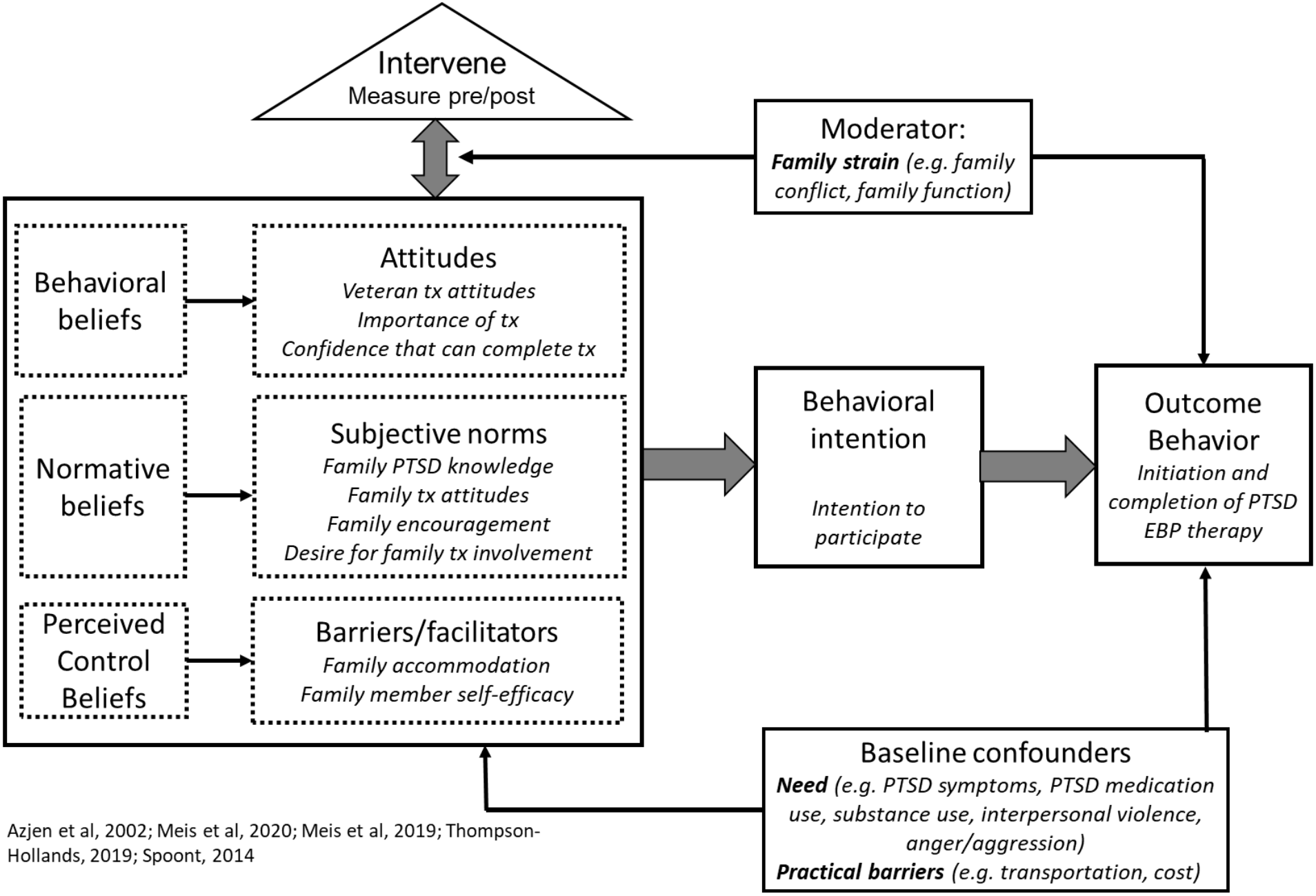
- **Adapt for PTSD population and with goal of dissemination in VA system in mind**
  - Made changes to REORDER via modification categories in FRAME
  - Changes informed by:
    - *Literature review*
    - *Qualitative interviews with Veterans and family members*
    - *Input from Durham VA clinicians*
    - *Input from advisory board, input from Durham VA Veteran engagement research panel*
  - New intervention is called FAMILIAR (Family Support in Mental Health Recovery)



	REORDER	FAMILIAR
Target Audience	• Veterans with serious mental illness and SP • Goal to engage SP in mental health treatment team	• Veterans with PTSD and a support partner (SP) • Goal to engage Veteran in PTSD evidenced-based program (EBP)
Content	• Veteran directed; focused on Veteran recovery goals • Treatment strategies included shared decision-making, motivational interviewing, psychoeducation • Phase 1 (Veteran only), Phase 2 (SP only)	• Veteran directed; focused on Veteran therapy engagement • Same treatment strategies as REORDER • Phase 1 (Veteran only), Phase 2 (both) • Phase 3 booster session once treatment started (both)
Structure	• 6 sessions • Sessions last 45-60 minutes • Sessions occur while Veteran in treatment • Separate sessions Veteran and SP	• 3-4 sessions • Sessions last 60-75 minutes • Phases 1 and 2 occur prior to Veteran treatment and phase 3 occurs once Veteran has started treatment • Separate and conjoint sessions
Delivery mode	• Clinic–based service offered by trained mental health provider • Virtual sessions available for SP	• Clinic–based service offered by trained mental health provider in PTSD specialty clinic • Delivery is adaptable (virtual or in-person for Veteran and/or SP)

3. Process

- **Adaptation lead to theoretical model, foundational elements, and intervention protocol**
  - Theoretical model developed by PI
  - Intervention protocol developed for new intervention by social worker-trained interventionist
  - Reviewed by intervention development committee



Azjen et al, 2002; Meis et al, 2020; Meis et al, 2019; Thompson-Hollands, 2019; Spoont, 2014

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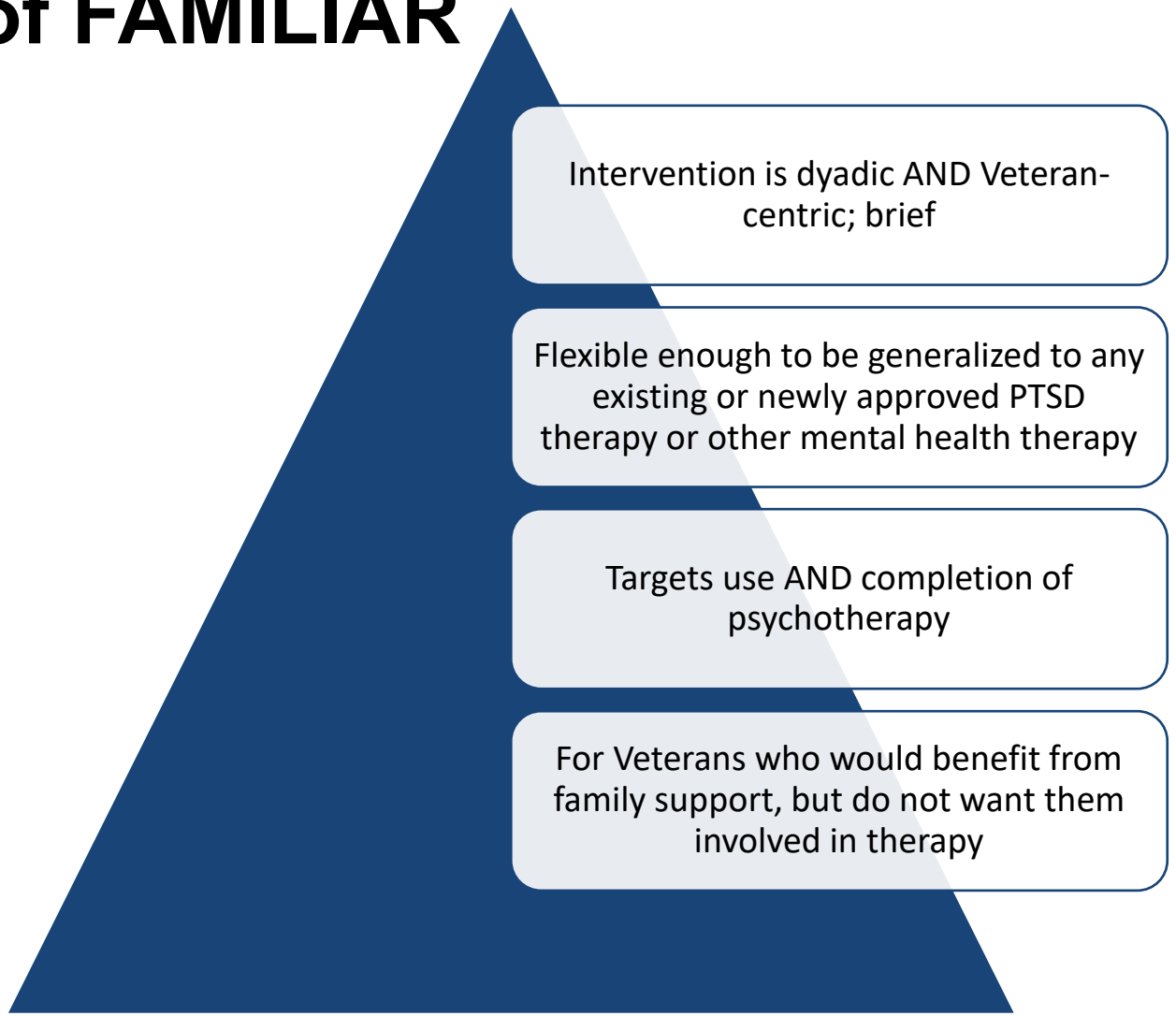
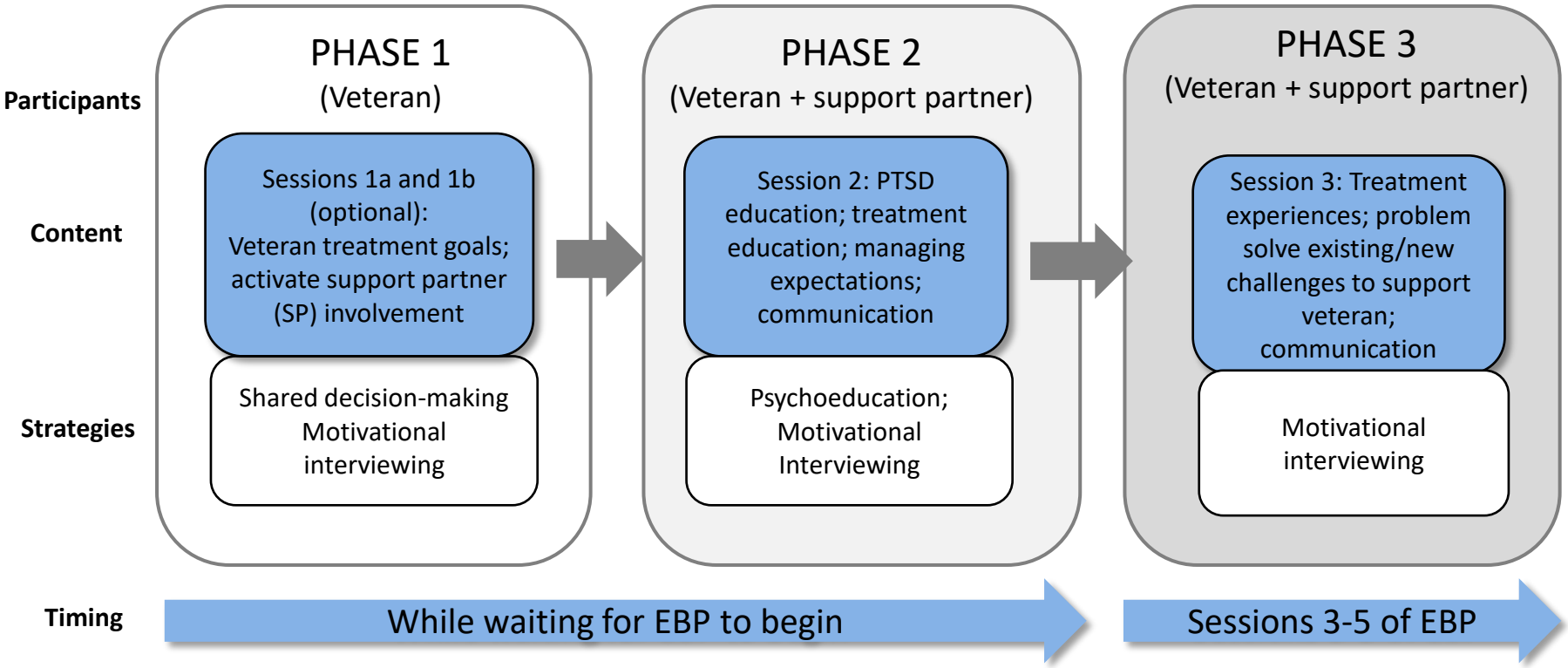
Foundation and distinguishing features of FAMILIAR



4. Process

- **Examine proof of concept**
  - Deliver intervention to 15 dyads (single group)
    - *Veterans with PTSD who were referred to PTSD EBP and a support partner*
    - *Collected quantitative assessments corresponding with conceptual model (analysis ongoing)*
    - *Conducted qualitative exit interviews (preliminary results)*
  - Qualitative interviews with VA mental health clinicians and leaders across VA system
  - Descriptive statistics of pilot sample

Session plan



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Selected baseline statistics of pilot sample

Baseline statistics	Completed FAMILIAR (n=16)	Did not complete FAMILIAR (n=8)
PCL score, mean (SD)	46.8 (14.2)	54.5 (9.2)
PTSD medication use, n (%)	11 (69%)	8 (100%)
McMaster general family functioning score (cutoff for poor functioning)*	11 (69%)	5 (62%)

*score of 2 or more indicates family functioning

Descriptive statistics of pilot sample

16/24

Completed FAMILIAR intervention (all enrollees)

20/24

Initiated at least one EBP session after FAMILIAR

11/24

Completed at least 8 EBP sessions within 6 months after FAMILIAR

Findings from Veteran Exit Interviews

Behavioral Beliefs: Many Veterans found the intervention helpful for including their SP in their care.

Interventionist helped Veterans and support partner communicate better about PTSD

Normative Beliefs: Veterans felt the education was helpful for their SP's understanding of their PTSD and treatment

Behavioral Beliefs: Some Veterans had trouble distinguishing intervention and clinical care

Perceived Behavioral Control: A few Veterans felt efficacy of intervention was lower because of wait lists/scheduling challenges/availability of EBP

Other factors: Challenges with marital conflict and Veteran anger affected intervention experience

Veterans with history of MST struggled with engaging spousal support partners in their care

Findings from Support Partner Exit Interviews

Normative Beliefs: Education components helped many SPs understand their Veteran's PTSD and choose communication and strategies to support them

Interventionist helped Veterans and support partner communicate better about PTSD

Behavioral Intention: Several SPs felt the intervention increased their intention to provide support to their Veteran around their PTSD and treatment

Other Factors: Most SPs valued the dyadic sessions for facilitating communication with their Veteran

Normative Beliefs: A few SPs felt the intervention was not helpful for them or their Vet

Other factors: Challenges with marital conflict and Veteran anger affected intervention experience

Some SPs did not understand the goals of the intervention; some conflated the intervention with the evaluation data collection.

Exit interviews- “What was useful to you about the intervention?”

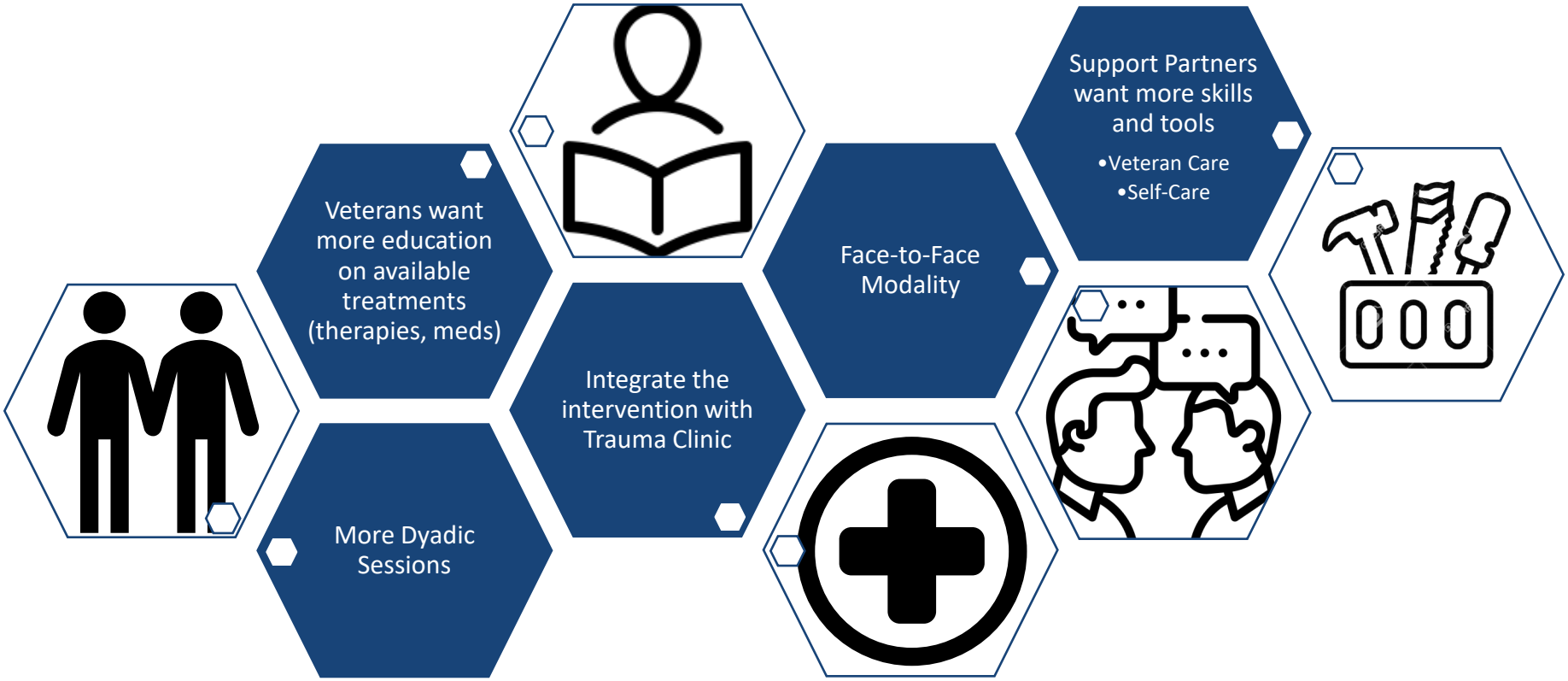
“I learned I shouldn’t hold stuff in like I was taught to do” – V1

“[Interventionist] got stuff rolling, so after the sessions we could continue talking about it” – V2

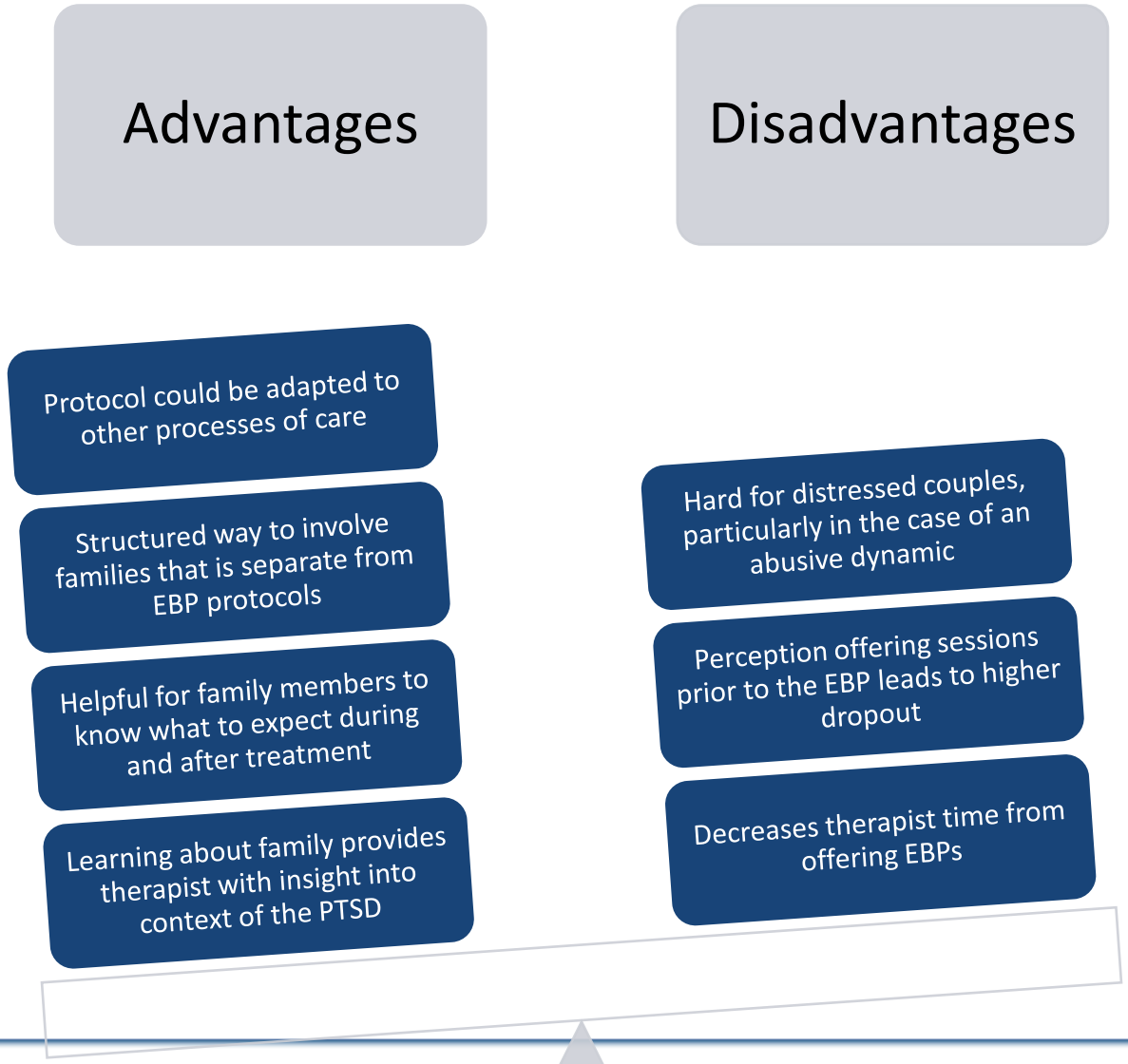
“[the intervention] showed me this isn’t my fault” – V3

“We have had our disagreements, which is normal; he is part of my family. Now I can read him... I can tell if he needs to chill out a little bit.” – SP1

Exit interviews- “What would you change?” “What would you add?”



Select themes from provider interviews



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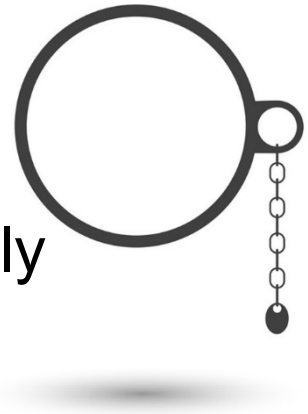
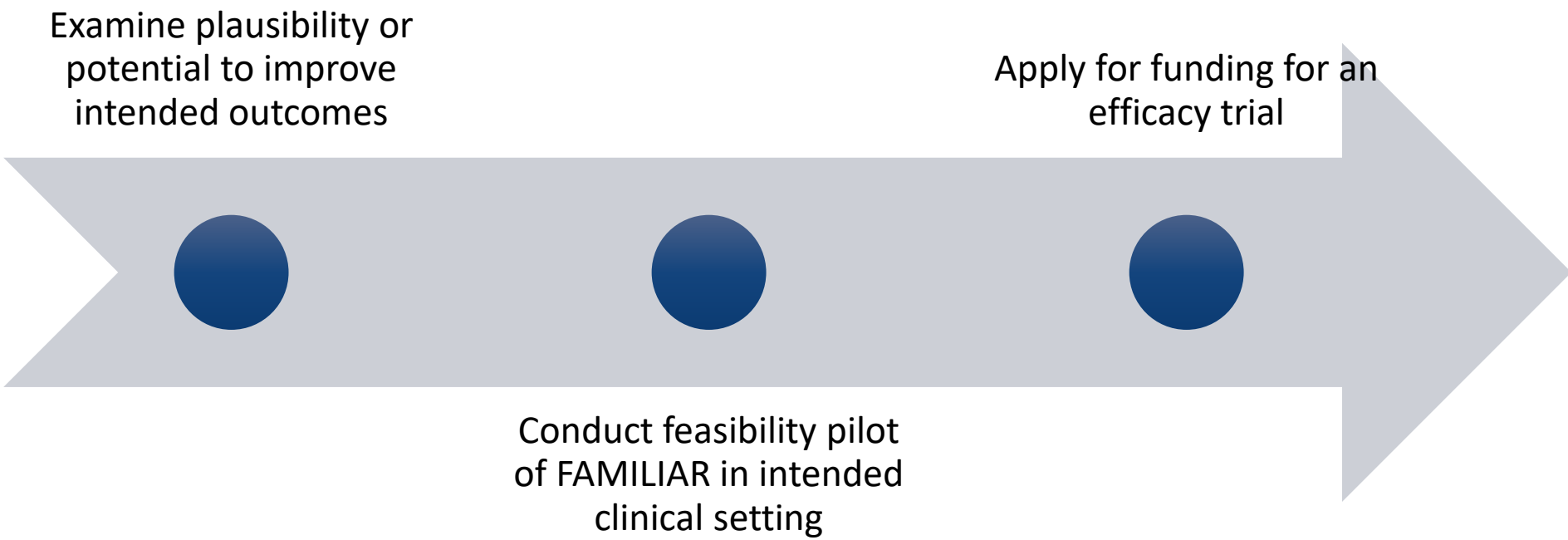
Conclusions



- FAMILIAR was acceptable to Veterans and family members
  - Most dyads who enrolled, completed FAMILIAR
- Providers recognized challenges of offering new family-involved intervention, but discussed many benefits
- Offers unique aspects to other interventions
  - Dyad focused
  - Not part of EBP protocol—offers Veteran privacy in their treatment
  - Flexible protocol that could be adapted for other conditions

Next steps


Examine plausibility or potential to improve intended outcomes
Conduct feasibility pilot of FAMILIAR in intended clinical setting
Apply for funding for an efficacy trial

Acknowledgements

Advisory Board Members and Others Who Provided Input

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Other findings presented here are under review

Q&A

I am looking forward to your questions and having a robust discussion!

As we go through the Q&A, I'd love to ask you some questions as well. Please add any thoughts that you have into the chat!

1. What benefits do see to involving family members in mental health services for Veterans?

2. What information or evidence do you need to increase your ability to involve family members in mental health services for Veterans?

3. What do you think is the most important thing for researchers like me who are interested in family services work in VA to know?

Thank you

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