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BRIEF CLINICAL REPORT

Patient experiences with group behavioural activation in a partial hospital program

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Abstract

Background: Behavioural activation (BA) is an evidence-based treatment for depression that has been primarily delivered in individual out-patient treatment. Prior research supports a positive participant experience in individual therapy; however, less is known about the patient experience in group therapy, which is common in acute psychiatric settings.

Aims: The present study examined the patient experience of Brief Behavioral Activation Treatment for Depression (BATD) delivered in group acute psychiatric treatment.

Method: We used thematic analysis to extract themes from feedback surveys administered as part of quality improvement practice at a partial hospital program. Survey questions explored what patients learned, liked, disliked and thought could be improved in the BATD groups. Three individuals independently coded survey responses and collaboratively developed categories and themes.

Results: Themes included several helpful content areas (e.g. value-driven activities, increasing motivation, goal setting, activity scheduling, cognitive behavioural model, self-monitoring) and learning methods (e.g. group format, experiential exercises, worksheets). Patients also identified unhelpful content (e.g. specific focus on depression and listing activities by mood). There was mixed feedback regarding the repetition of material and balance of lecture *versus* group participation.

Conclusion: Overall, these findings suggest a mostly positive patient experience of group-delivered BATD and support the acceptability of group-delivered BATD as a component of short-term intensive treatment.

Keywords: behavioural activation; group psychotherapy; qualitative methods

Introduction

Behavioural activation (BA) is a treatment for depression that aims to expand an individual's contact with rewarding experiences (Hershenberg and Goldstein, 2019). A meta-analysis (Ekers *et al.*, 2014) supports BA for reducing depressive symptoms, with comparable effect sizes across delivery modes (individual, group, self-help). BA, and specifically Brief Behavioral Activation Treatment for Depression (BATD), is an appealing intervention for in-patient and partial hospital programs, given the high prevalence of depression in these settings. However, to our knowledge, no studies have examined group-delivered BA or BATD in acute psychiatric settings.

Most of the BA protocols for group settings mirror individual treatment manuals. For example, existing group BA protocols are generally structured with weekly sessions with the same group of participants for several weeks. This is very different from the structure of treatment in acute

psychiatric settings, where stays are short in duration and the composition of groups changes daily. In addition, patients are often not able to attend groups in a specified sequence.

To address the unique needs of acute psychiatric programs, we developed new group treatment protocols for BATD based on the manual by Lejuez *et al.* (2011). We retained core elements of BATD, including psychoeducation, self-monitoring, values-assessment and activity scheduling. Based on clinical expertise of clinicians working in acute psychiatric settings, we also considered the unique demands of our specific cognitive behavioural therapy (CBT)-based partial hospital program. For example, because individuals attending these groups also attend other CBT-based groups, efforts were made to incorporate BATD within the over-arching CBT model. In developing these protocols, we strove to create a set of groups that could be flexibly implemented in a wide variety of settings. Each group stands alone and is designed to have therapeutic value independent of participation in other group sessions, while also building on possible attendance at previous groups. In addition, these protocols incorporated research findings which recommend emphasizing value-driven activities.

The aim of the current study was to examine the acceptability of group-delivered BATD in a partial hospital program. Specifically, we sought to understand the experiences of group members regarding what they learned, liked and disliked about the group sessions. We used thematic content analysis to extract themes from feedback surveys administered as part of ongoing quality improvement. Based on prior qualitative studies of individual BA (Finning *et al.*, 2017), we expected patients to find BATD generally helpful. We did not have *a priori* expectations about which aspects of the group protocol patients would find helpful or unhelpful.

Method

Treatment setting and BATD protocols

We obtained patient feedback on the BATD group protocols at McLean Hospital's Behavioral Health Partial Hospital Program (BHP).

We developed four distinct 50-minute BATD groups: (1) '*What is it?*' (offered twice per week), (2) '*Practice*', (3) '*Weekend Preparation*' and (4) '*Weekend Review*'. The full group protocols and hand-outs are available upon request from the corresponding author. The '*What is it?*' group provided an overview of the treatment rationale and components. Additionally, patients identified and planned one value-driven activity. The '*Practice*' group experientially demonstrated the practice of BATD and taught individuals to set specific, achievable goals, as well as strategies to overcome barriers to activation. The '*Weekend Preparation*' group provided a brief conceptual overview of BATD and value-driven activity, and taught patients how to monitor activity and pair it with a mood rating. Group leaders also worked with patients to brainstorm patient values and potential ideas to increase activity. During the group, patients scheduled value-driven activity into their weekend schedule. Finally, in the '*Weekend Review*' group, patients discussed their experiences regarding their scheduled goals from the weekend. Additionally, group leaders reviewed the rationale behind engaging in behaviours despite one's mood, taught patients how to use data from self-monitoring to plan their next schedule, and reviewed strategies to overcome barriers to activation.

The series of groups could be taken in any order, as each group underscored the basic principles of BA. All patients participating in a BATD group were eligible to participate in the current study. Responses were collected across 23 BATD groups delivered from March to April of 2019 as part of a quality improvement initiative. In total, 130 anonymous responses were obtained. Due the anonymity of survey responses, it is possible that some patients completed the survey more than once.

Data collection was limited to the last few minutes of each group; thus, we were unable to collect demographic and clinical information. Prior research from this partial hospital

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indicates that the patient population is mostly White (85%) and approximately half female (52%). Most patients present for treatment in the context of a major depressive episode (~75% either in a full episode or partial remission). The most common diagnoses at admission are major depressive disorder (57%), generalized anxiety disorder (42%), social anxiety disorder (35%) and bipolar disorder (25%).

Measures

At the completion of each BATD group, patients were asked to complete a brief survey about their experience consisting of four items: (1) In a few sentences, briefly summarize what you learned in today's group, (2) What about this group did you find helpful?, (3) What about this group *was not* helpful? and (4) Is there anything else we can do differently to improve this group moving forward?

Coders

There were three coders. A.T.S. and K.C. were doctoral students in clinical psychology and L.T. was an undergraduate research assistant. A.T.S. is experienced in developing treatment protocols for BA, has conducted research in this area, and is experienced in delivering BATD. K.C. is experienced in delivering BATD. L.T. had no prior experience with BATD.

Analysis plan

Qualitative analysis was conducted using the principles of thematic analysis. All survey responses were coded by A.T.S., K.C. and L.T. A.T.S. and L.T. separately created an initial code list and then collaborated to create the initial codebook. The three coders adapted the codebook from a close read of a subset of ten surveys. Team members then separately used the codebook to analyse the first question of the remaining surveys and to confer about their suggested codes; they repeated this process with question 2 and determined they had identified the full range of relevant codes for questions 3 and 4. The team used the resulting codebook for a portion of the remaining surveys, resolving discrepancies through consensus and then coded all of the remaining surveys. Discrepancies were discussed until consensus was reached. Throughout the coding process, the team adjusted the codebook to reflect emergent data from the patient responses.

Results

Table 1 shows the three over-arching themes in patients' feedback about the groups: (1) helpful, (2) unhelpful and (3) mixed feedback (lack of consensus). Within each of these themes, responses generally addressed either BATD group content or the implementation/learning methods of said content. Sample quotations for each theme are provided in Table 1.

Discussion

We examined patient perceptions of group-delivered BATD in a partial hospital program. Patients perceived the core elements from the original BATD protocol (Lejuez *et al.*, 2001) as helpful, including values-driven activities, activity scheduling and self-monitoring. Consistent with prior qualitative findings from individual BA (Finning *et al.*, 2017), patients found setting realistic goals helpful. These findings provide preliminary evidence that the adapted protocol sufficiently conveyed critical aspects of BATD to patients.

Subthemes emerged that were not identified in prior qualitative analyses of BA (Finning *et al.*, 2017). Unique themes included the importance of value-driven activity and understanding that

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Table 1. Summary of themes and representative quotations

Main theme	Subthemes	Example quotations
Helpful content	The importance of value-driven activities	– *It's best to choose activities that are important to you – i.e. in support of your values and goals* – *Doing important activities that contribute to your values creates happiness*
	How BATD can be useful for increasing motivation	– *Action precedes motivation* – *I learned that there are times you need to initiate behaviours even if you do not feel motivated. By doing so, you will increase your motivation, which in turn makes you feel better and have more positive thoughts about yourself*
	How to set effective goals	– *SMART goal setting technique* [was helpful] – *I learned to break down activities that I enjoy or have to do into smaller more manageable pieces*
	The importance and utility of structure and activity scheduling	– [I learned] *How to structure my time/schedule wisely enough to strike a positive or 'feel good' reaction* – [I learned] *How critical it is to be flexible/forgiving about the schedule you establish - to take 'failures' as opportunities to learn about what works*
	The relationship between thoughts, feelings and behaviours	– *Behaviours are a catalyst for how you think/feel. Even if you don't feel like doing something, it may be helpful to do it because it may change the way you feel* – *We learned that our behaviuors influence our feelings and thoughts and vice versa*
	The utility of self-monitoring and reflection	– *Using the prior weekend's activities as a learning tool for future weekend planning* [was helpful] – [I learned] *The concept of self-monitoring to realize/recognize what and when makes me happy/what is important to me*
Helpful learning methods	Group format	– *Sharing our ideas with the group and getting feedback and suggestions* [was helpful] – *I found it helpful that other people had similar difficulties that I've encountered*
	Participation in experiential group activities intended to demonstrate BATD concepts	– *Learned that my fatigue went down after the activity with the class. ACTION → MOTIVATION* – *The exercise in which we had to get up and engage with others in the session* [was helpful]
	Worksheet for integrated activity planning	– *The practice exercise where we thought about something we are going to do this weekend* [was helpful] – *The breakdown of BA*[TD] *and explanation of each step* [was helpful]
Unhelpful	Focus on depression	– [Unhelpful because] *It's only based on depression* – [Suggestion on what to do differently:] *Maybe different groups for different problems but on the same skills*
	Listing activities by mood	– *It wasn't helpful to talk about activities that make one more/less depressed*
Mixed feedback	Repetition of material	– *I found it helpful that he reviewed what BA*[TD] *was. I always forget things* – [It was unhelpful] *How repetitive it was about what BA*[TD] *was, it was a bit tedious*
	Balance of lecture *versus* group participation	– *The mix between lecture and active participation* [was helpful] – *Too much talking by clinician/not involving group enough* [was unhelpful]

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'action precedes motivation'. The emphasis on values is unique to BATD, explaining why this theme did not emerge in qualitative reviews of BA protocols (Lejuez *et al.*, 2001). These two subthemes were among the most consistently identified helpful concepts on patient surveys. One aspect of our protocol that differed from the published manual was the inclusion of psychoeducation on the CBT model. This was designed to integrate BATD concepts into the overall CBT-dominant framework of the program. Patient feedback supported integrating BATD into a discussion of CBT principles.

Consistent with Finning *et al.* (2017), patients generally reported they found completing worksheets and practising skills helpful. However, some patients in both studies found it aversive to focus on aspects of behaviour that relate to negative mood. It is possible that patients are uncomfortable engaging in exercises that require approaching negative mood. It is also possible that these patients already spend a substantial amount of time engaging with activities associated with negative mood states. It may be beneficial to replace this exercise with practising concrete, change-oriented BATD skills.

Patients also identified that the group format was helpful in learning BATD skills. To our knowledge, there are no prior qualitative studies that have examined patient experiences with BATD in a group format. Patients reported enhanced perceptions of community support, shared experience and self-exploration, even in this setting where group membership was not consistent.

Several patients identified that the groups' focus on depression as unhelpful. Although three-quarters of patients are admitted within the context of a depressive episode, many do not meet criteria for a current major depressive episode or have co-morbid diagnoses that they identify as more distressing than their depression symptoms. Group leaders might highlight the benefits of BATD for non-depressed patients by emphasizing overlapping symptoms and behaviours across common psychiatric disorders and including examples that extend beyond depression.

With regard to group structure, patients expressed differing opinions about the proportion of group time allocated to lecturing *versus* group participation. Some patients benefited from listening to group leaders, while others preferred to hear from other group members. This may reflect that patients have different learning styles. A balanced approach is advisable in order to maximize benefits to patients with varied learning styles.

Our study has several limitations. Feedback was collected immediately following each group. While initial patient perceptions are important, it is unclear how perceptions change over a course of treatment. Surveys were short and limited in scope. Interview data would have allowed for richer extraction of themes. Finally, while we provide information on the demographic and clinical composition of the patients in the partial hospitalization program, we did not collect this information for participants who filled out the survey. The lack of demographic data limits our ability to determine the generalizability of these findings to other groups of patients.

Patients in hospital settings receive intensive care for brief periods of time; existing BATD group protocols require regular weekly attendance and thus do not fit well into the hospital model of care. This study suggests that an adapted BATD protocol can provide patients with an understanding of core concepts and clear examples of how to put these skills into practice, even when groups are not attended regularly over a period of weeks. Patient feedback suggests that patients find BATD helpful. BATD groups should continue to emphasize value-driven activity and how these concepts influence motivation.

Supplementary material. To view supplementary material for this article, please visit https://doi.org/10.1017/S1352465820000569

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References

Ekers, D., Webster, L., Van Straten, A., Cuijpers, P., Richards, D., & Gilbody, S. (2014). Behavioural activation for depression: an update of meta-analysis of effectiveness and subgroup analysis. *PLoS ONE*, *9*, e100100. https://doi.org/10.1371/journal.pone.0100100

Finning, K., Richards, D. A., Moore, L., Ekers, D., McMillan, D., Farrand, P. A., O'Mahen, H. A., Watkins, E. R., Wright, K. A., Fletcher, E., Rhodes, S., Woodhouse, R., & Wray, F. (2017). Cost and outcome of behavioural activation versus cognitive behavioural therapy for depression (COBRA): a qualitative process evaluation. *BMJ Open*, *7*, e014161. https://doi.org/10.1136/bmjopen-2016-014161

Hershenberg, R., & Goldstein, S. (2019, October 12). *Behavioral Activation for Depression*. Society of Clinical Psychology. https://www.div12.org/treatment/behavioral-activation-for-depression/

Lejuez, C. W., Hopko, D. R., Acierno, R., Daughters, S. B., & Pagoto, S. L. (2011). Ten year revision of the brief behavioral activation treatment for depression: revised treatment manual. *Behavior Modification*, *35*, 111–161. https://doi.org/10.1177/0145445510390929

Lejuez, C. W., Hopko, D. R., & Hopko, S. D. (2001). A brief behavioral activation treatment for depression: treatment manual. *Behavior Modification*, *25*, 255–286. https://doi.org/10.1177/0145445501252005

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