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# Utopia: An Integrated Stepped-Care Program for Stress Reduction

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Running Head: UTOPIA: AN INTEGRATED STEPPED-CARE PROGRAM

Utopia: An Integrated Stepped-Care Program for Stress Reduction

by

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DISSERTATION

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Department of Clinical Psychology

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presented on March 14, 2016

by

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### **Abstract**

This research culminates in a design for an integrative psychological program aimed at reducing the stress of indicated patients at an Upstate New York obstetric and gynecologist (ob/gyn) practice. The program is named Utopia. This dissertation focuses solely on program development, not program implementation. The Utopia program is based on evidence-based practices and empirically supported research regarding Mindfulness, Mindfulness Based Stress Reduction (MBSR), Interpersonal Theory (IPT), the Psycho-Oncology Consultant Model (POCM) of care, and stepped-care treatment models. The target population is patients who experience various aspects of stress due to medical and/or psychological symptomology. Patients are referred based on their scores on a program-modified stress questionnaire as well as self and/or medical personnel referral. Utopia will provide integrated psychological services for this referred target population at their ob/gyn medical practice and the program's treatment site. The program goals are to provide integrated evidence-based and empirically supported psychological services as well as to streamline efficiency and effectiveness of service delivery. Mindfulness is the philosophy of the program. Interpersonal therapy (IPT) and Mindfulness-Based Stress Reduction (MBSR) are treatment models of program psychological services. A stepped-care model is incorporated to increase efficiency and effectiveness. Scientific and contextual rationales are provided for program models, philosophy, treatments and stepped-care treatment levels. Once implemented, evaluation of the fidelity of program treatment, practices, and outcomes is a priority. Quantitative and qualitative program measures facilitate fidelity and assess desired outcomes. This program design concludes with strategies to address diversity, potential ethical dilemmas, and future considerations.

*Keywords:* Integrated, Mindfulness, Interpersonal Theory, Stepped-Care Treatment

## Utopia: An Integrated Stepped-Care Program for Stress Reduction

### **Rationale**

This program development provides an introduction to integrative program concepts and origins. The rationale for developing this program builds on the foundational information provided in the introduction, pertinent research findings regarding integrated and stand-alone treatments. In addition, the stepped-care treatment model organizes the delivery of treatment and services effectively and efficiently. The Utopia program was developed to attend to the biopsychosocial stress of female obstetric and gynecologist (ob/gyn) patients by integrating psychological providers into the ob/gyn practice. Ob/gyn and psychological practitioners will work collaboratively to identify and refer patients as well as provide direct or indirect IPT and MBSR treatment or support to stress inventoried identified patients. The goal is to reduce patient stress while increasing efficient and effective treatment service delivery through the program's stepped-care treatment model. As professional psychologists, we are educated and trained to work in a competent integrated manner with other professionals outside the traditional mental health setting (Kenkel & Peterson, 2010). We are prepared to assess, relate, and consult professionally so that the professionals and patients we work with experience an increase in access, efficiency, and effectiveness regarding assessment, treatment, and evaluation. When executed well the integration can increase the quality and quantity of prevention and intervention experienced by patients in health care settings (Kenkel & Peterson, 2010). More descriptive information follows to add depth and breadth to this brief introduction. Dissertation content and program information is reiterated throughout the proposal to increase understanding, clarity and illustration.

The American Psychological Association (APA) defines stress as a reaction to an episode

or recurring situation such as an accident, trauma, relationship, illness or death. A recent APA statistical analysis states that money, health, and relationships are the top reasons for stress in America (APA, 2015). Stress becomes clinically significant when it interferes with one's normal life and produces lasting unhealthy behaviors (APA, 2015) and impacts the psychological and physiological functioning of men, women, and children (Patterson, 1988). Increased illness, depression, anxiety, loss of work productivity, addiction, and poor interpersonal relations at home, in the community and school/workplace are examples of stress impacted functioning (APA, 2012; Patterson, 1988). This program was designed to provide integrative psychological services to patients whom indicate depression, anxiety, and/or substance use functioning that is stress related. It is important to distinguish that the target population is not individuals that exhibit depression, anxiety, and/or substance use for reasons not related to stress. The program is not designed to target individuals with severe and persistent mental illness. APA states that depressive, anxious, and substance use functioning is related to stress (APA, 2012; Patterson, 1988). This population is further discussed under the target population section.

The prevalence of stress-related issues in the medical care population increased from approximately 12% in 2000 to 25 % in 2004 (Ouimette et al., 2004; U.S. Dept. of VA, 2010). Many patients exhibit somatic presentations for stress and seek medical care rather than psychological interventions. This trend continues to be significant through 2010 (Blount, 2003; Ouimette et al, 2004; U.S. Dept. of VA, 2010). Due to shame related to stress, lack of information, negative experiences with psychological providers, as well as comfort and history with medical providers, patients rely on medical professionals to treat stress and stress related issues (Blount, A., 2003; Ouimette et al, 2004; U.S. Dept. of VA, 2010). Integrative approaches enable medical professionals to focus predominately on the physical nature of the patient's

concerns while working collaboratively with psychological professionals to comprehensively assess, diagnose, and treat the patient (Deshields & Nanna, 2010). Women tend to receive their routine medical assessments from their ob/gyn. In order to capture the target population, it is pertinent to integrate psychological services with an ob/gyn practice (Blount, 2003; Kenkel & Peterson, 2010; Ouimette et al, 2004; U.S. Dept. of VA, 2010).

This program specifically focuses on depression, anxiety and substance use behaviors that impact the normal functioning of a stressed individual. In order to measure the clinical significance of these behaviors, a modified version of the Patient Stress Questionnaire will be used. The Integrated Behavioral Health Project (IBHP) describes the Patient Stress Questionnaire as an empirically supported screening inventory widely used in medical settings (2015). This Inventory is a product of the Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder screening (GAD-7), Primary Care-Post Traumatic Stress Disorder screening (PC-PTSD) and (AUDIT) Alcohol Use Disorder Identification Test (IBHP, 2015). The Utopia program will utilize a modified version of the Patient Stress Questionnaire. A patient's stress is indicated on this questionnaire based on their responses on the PHQ-9, GAD-7 and the CAGE which assess for depression, anxiety, and substance abuse respectively (IBHP, 2015). The first difference is the use of a shorter substance use inventory, namely the CAGE, in exchange for the AUDIT which is utilized in conjunction with the DAST during the intake process. The second is the removal of the PC-PTSD. Instead PTSD is screened for by the Clinician Administered PTSD Scale (CAPS) during the intake after patients are referred. Literature research states that The CAPS, the gold standard for PTSD diagnosis, is based on the same DSM V diagnostic criterion used in structured interviewing (Blake et al., 1995; Weathers et al., 2001). Modifications allow time for administration of the inventory during the medical appointment while continuing to

provide a clinically significant preliminary picture of the patient's functioning. Use of the modified version also allows for the program to capture participants without the focus on PTSD or substance use severity at referral. This enables patients with mild presentations that need preventive experiences to be identified. More extensive assessment for stress, trauma, and substance use occurs during the intake process. It is at this point that in-depth information is used for treatment level assignment.

### **Overview of POCM, Mindfulness, MBSR, and IPT**

Literature review and program developer experience indicates that POCM, Mindfulness, IPT, and MBSR are an empirically supported integrative program model and evidence-based interventions respectively. These designations support their inclusion in the Utopia program as components and structure (Desields & Nanna, 2010; Kabat-Zinn, 1991; Weissman, Markowitz, & Klerman, 2000). The strengths, challenges and weakness of these interventions and model are discussed in this section which concludes with reasons for using them in combination for this program design.

### **Psycho-Oncology Consultant Model: Integrated Treatment Model**

All program providers seek to interact with patients in a manner that does not increase their stress but reduces it through integration. Through literature review as well as practical experiences, I chose POCM as an evidence-based and empirically supported integrative approach that interacts with patients in a stress reducing manner. Practitioners that follow this patient-centered approach understand that the physician is the patient's primary medical contact with limited time during a normal appointment (Desields & Nanna, 2010). Generally, appointments with physicians last approximately 15-20 minutes; whereas, the psychological appointment can last 50 minutes or more. Integration enables medical personnel to focus on

medical issues and then refer patients to program personnel for psychological approaches.

POCM addresses multiple biopsychosocial concerns related to overall treatment, recurrence of medical issues, advancing disease, survivorship issues as well as risks of other chronic illnesses (Desields & Nanna, 2010). This specific approach works well to address marital and family distress, coping and support problems, anger and anxiety management, medical treatment compliance issues, dying, death, and grief issues, as well as substance abuse issues (Desields & Nanna, 2010; Ouimette et al., 2004).

The goals of the POCM model are to (a) facilitate patient communication with medical providers; (b) confirm and identify psychosocial needs as they relate to patient medical needs; (c) provide interventions that connect patients with appropriate services; (d) reduce distress and symptoms; and (e) develop, maintain, and increase patient strengths, self-efficacy, coping strategies, and biopsychosocial education (Desields & Nanna, 2010). Medical personnel initiate treatment during the first session by assessing and referring based on the patient's individual needs. They provide patients with a clear description of the difference between medical services and psychological services. Medical personnel provide program personnel with a clear and thorough understanding, knowledge, and perspective regarding patient medical status. It is pertinent that personnel ascertain patient quantity and quality of support.

There are challenges to this approach. POCM originates from a traditional consultation liaison premise characterized by brief evaluations and interventions that are decided and implemented swiftly; interventions are driven by medical status, and the patient's medical diagnosis and treatment are the priorities. Psychological insight and therapeutic investment may be low (Desields & Nanna, 2010). Highly variable patients are not ideal for this approach due to limited assessment and setting. This model is used in an office or clinic setting. A patient who

needs intensive medical and psychological treatment is not a good match for this approach (Desields & Nanna, 2010).

### **Mindfulness and Mindfulness-Based Stress Reduction**

Patterson (1988) categorizes common sources of stress as biological, psychological, or social (biopsychosocial). Examples of biopsychosocial stressors are finances, mental and physical illness, interpersonal relationships, academic issues, employment, and lack of resources. Sledjeski, Speisman, and Dierker's (2008) research reinforces the correlation between stress and medical symptomology. Stress contributes to and can be a result of medical symptomology (Kabat-Zinn, 1991). Dr. Kabat-Zinn's evidence-based and empirically supported research indicates a reduction in depression and stress when mindful stress management and medical treatment are combined interventions (APA Presidential Task Force on Evidence-Based Practice, 2005; Kabat-Zinn, 1991; Novotney, 2010; U.S. Dept. of VA, 2004, U.S. Dept. of VA, 2010). This integrated mindfulness interpersonal program enables medical patients with stress related diagnoses to be addressed in a biopsychosocial comprehensive manner.

MBSR is an evidence-based program specifically developed to reduce stress of medical patients by Jon Kabat-Zinn (1991). This eight-week program provides participants with a variety of experiences that foster the acquisition of the seven Mindfulness principles. These principles are discussed in depth under the conceptualization section. Meditation, yoga, body scanning, sensory perception, and breathing techniques are among experiences used to develop a mindful practice (Kabat-Zinn, 1991). MBSR has several strengths and the program lends itself to repetition. As a result, patients are able to work on different aspects of their individual presentation by applying the same mindful principles to their specific presentation and treatment goals. The simplicity of MBSR preventive methods and treatment interventions increase

flexibility, hence, facilitating patient treatment level changes (APA Presidential Task Force on Evidence-Based Practice, 2005; Hayes, 2005). Treatment is delivered in mindfulness-based groups which increases treatment and cost effectiveness, socialization, social support, and interaction with like-minded individuals (Shapiro, Sank, Shafer, & Donovan, 1982; Yalom & Leszcz, 2005).

Mindfulness and MBSR do have weaknesses. Although mindfulness paired with another psychological approach or technique such as IPT is effective, mindfulness as a stand-alone intervention has not shown to be as effective with severe psychological impairment. In addition, the large majority of its stand-alone success with medical patients has been in group settings such as MBSR rather than in individual sessions.

### **Interpersonal Theory: Theoretical Treatment**

The stepped-care treatment component will utilize an IPT theoretical approach in therapy. Although therapeutic approaches such as cognitive behavioral therapy have been successful with depression, anxiety, and substance abuse, it is IPT's ability to address the interpersonal nature of stress, as defined by APA, which makes IPT my choice for therapeutic intervention. The use of IPT addresses issues related to role deficits, role transitions, role identity and grief often associated with stressors such as medical diagnoses and interpersonal interactions (APA, 2012; Deshields & Nanna, 2010; Kabat-Zinn, 1991; Sattler & Hoge, 2006; Weissman et al., 2000; Yalom, 1995). IPT's interpersonal theoretical approach, although developed as an individual therapy, is adaptable for interpersonal counseling in groups. IPT has undergone empirical testing under group circumstances and is used for groups targeting depression, anxiety, grief and stress (Markowitz & Weissman, 2004).

The challenge of IPT is that it is a theoretical intervention created to address

psychological issues that are significant in nature. It is not widely used in medical settings. IPT therapeutic resources provide the therapist with sample therapeutic language and statements that can be adapted and modified to match patient preventive needs and medical setting language. However, its strength, evidence-base, and empirical support are largely as an intervention used in a therapeutic setting.

### **Program Integration of POCM, Mindfulness, IPT and MBSR**

The Utopia program seeks to capitalize on the strengths of application, research evidence, and empirical support of POCM, mindfulness, IPT and MBSR as they relate to addressing stress. This is accomplished by combining elements of these approaches. POCM and Mindfulness address the integration in the medical setting. This enables patients to be identified and briefly treated through medical staff and program personnel consultation and collaboration in the medical setting. The MBSR and IPT program portion address the need for a non-medical setting approach. This approach enables groups and individual sessions to last for 50 or more minutes in length, has distance from a sterile medical setting, and utilizes a more relaxed retreat environment. MBSR provides prevention and intervention for patients with no or mild diagnosis while IPT addresses the moderate to severe presentations of stress related issues. As stated prior our target population may experience stress related to marital and family distress, coping and support problems, anger and anxiety management, medical treatment compliance issues, dying, death, and grief issues, as well as substance abuse issues. IPT was developed specifically to address these interpersonal issues (Deshields & Nanna, 2010; Markowitz & Weissman, 2004; Ouimette et al., 2004). Further discussion of IPT specifically can be found under the conceptual framework section.

POCM seeks to reduce the stress a patient encounters as they receive medical services.

This program capitalizes on this model's approach to incorporate a mindfulness philosophy to increase the reduction in patient personal stress as well as the stress associated with receiving medical and psychological services. Program services will be performed with a mindfulness philosophical approach. This same philosophy governs program provider interactions. In a recent study, the importance of provider and environmental well-being was substantiated (Bazarko, Cate, Azocar, & Kreitzer, 2013). The mindful IPT therapist working within a POCM approach enables the patient to understand how their expression of symptomology is connected to interpersonal events and circumstance. Associations between the patient's symptomology, environment, and social role are used during screening, referral, assessment, and treatment (Markowitz & Swartz, 2007; Weissman et al., 2007; Weissman et al., 2000).

Mindfulness-based practices and environments reduce stress as well as increase productivity, performance, and outcomes. For example, each patient and case will be viewed as new under the mindful principle of "Beginner's Mind." This reduces stereotypical and narrow minded evaluations and perceptions. Providers will "Let Go" of personal and professional negativity enabling them to interact with patients and providers in a positive approachable manner. A "Non-judgmental" stance provides the platform for objective assessment, treatment, and evaluation. Each of these examples contributes to a trusting, patient, and accepting environment (Bazarko et al., 2013; Kabat-Zinn, 1991). Hiring practices, program meetings, provider reviews, case meetings, and ongoing trainings assist providers with obtaining, developing, and sustaining these principles.

Psychological and medical providers are among the professionals that experience consistent high stress which may result in personal and professional burnout, absenteeism, lower productivity, lower job satisfaction, and workplace turnover. In addition, professional's stress

contributes to lower treatment outcomes (Bazarko et al., 2013). This program's mindfulness methodology will increase the effectiveness of the program team's ability to preventively and collaboratively address patient, personal, professional, and workplace stress; therefore, increasing the health of the program service delivery, treatment, and staff. Healthy professionals produce higher levels of effectiveness and efficiency in the work environment and with treatment implementation and outcomes.

### **Program Development: Research and Application**

#### **Clinical Applications**

The conceptualization and design of this program was created and revised based on the knowledge and practice I gained through academic, practicum, internship, and employment experiences. The fortitude of the program is significant. The structure, longevity, and resilience of the program, as it is mindfully developed, enabled this Utopia program to develop fortitude. I practiced integrative clinical psychology at the Glens Falls Cancer Center in NY and the Dartmouth-Hitchcock Medical Clinic located in Nashua NH. Glens Falls Cancer Center integrated psychological services within its personnel. Dartmouth-Hitchcock Medical Clinic-Nashua integrates with The Greater Nashua Mental Health Center. I draw upon these experiences and the research findings of Carlton et al. (2009) regarding the Utopia program structure, components, and guidelines that increase longevity and resilience. My beginner's mind enabled me to design a program that has already successfully navigated partial implementation, review, and revisions through a fresh open-minded lens. Antioch professors, supervisors, peers, clients and patients have contributed indirect and direct feedback to aspects of the design and development of this program. Consultation is strongly recommended during full program implementation with the goal of continuing to provide program personnel with an objective

critique of the program in action.

### **Further Research: The Four Pillars of Integrated Programs**

Carlton et al. (2009) conducted an examination of a collaborative (integrated) program. Their qualitative research resulted in an understanding of the pertinent components and guidelines for an integrated program that is empirically supported and evidence-based. Selection and cohesiveness of personnel, respectful relationships, common goals and objectives, and firm program design are named as the Four Pillars of Integrated Programs. The selection and cohesiveness of the personnel implementing the program was cited as the number one factor in success of the program. I recognize that selecting personnel committed to working under a mindfulness philosophy enables the program to incorporate individuals and providers that complement each other, therefore reducing the probability of stress in the work place. In addition, Mindfulness enables me and the practitioner to approach the development and administration of the program with patience, trust, and non-judgment.

Interviewed program participants in the Carlton et al. (2009) study named the individuals providing the programs as an essential component to the program's effectiveness. Relationships that endorse respect and investment throughout the program are another aspect. Respect was described as culturally related and inclusive. A common or interrelated vision is a third aspect presented by this study's research. Having the ability to select, hire, and work in a multidisciplinary manner with common goals, objectives, and methodology is pertinent. Mindfulness practices and interactions are respectful; hence, providing a setting for valuing culture and diversity. Clear, concise, and continual communication of program goals, objectives, and methodology in a mindful manner enables the program to work under a common and interrelated vision.

Lastly, Carlton et al. (2009) state that having a firm program design provides the necessary structure to withstand challenges and differences. Components and aspects of this program design have evolved over time and withstood the challenges of differences of settings, populations, medical diagnosis, program personnel, and resources. The following characteristics of the developer, program providers, and the program enabled the four integrative program pillars to withstand challenges and differences: including (a) communication; (b) clarity; (c) conflict resolution; (d) resilience; (e) flexibility and change; (f) appropriate power and control; (g) balance, commitment, and teamwork; (h) realistic expectations and optimism; and (i) consistent action and momentum. I exhibited all characteristics under various conditions to contribute to the integrity of the program structure. This demonstration of character enabled me to effectively assess, interpret, and modify the program to address challenges and differences. Carlton et al. confirmed that necessity of the program developer to utilize these characteristics in order for successful outcomes to continue to be achieved.

To summarize, my goal was to design a program that provides therapeutic individual and group services that address interpersonal and intrapersonal issues preventatively and collaboratively. Providing services in a stepped-care manner places patients in the most appropriate treatment level at various times and stages of treatment. Appropriate treatment level placement increases treatment compliance and commitment. Providing treatment to compliant and committed patients reduces service provider stress while increasing the effectiveness and efficiency of integrative service implementation. More information regarding the programs specific stepped-care treatment model is provided below and under the Action Step section.

### **Stepped-Care Treatment Model**

A stepped-care treatment model is chosen to further increase the efficiency and

effectiveness of treatment and costs. As the introduction describes, stepped-care treatments are least restrictive flexible models that seek to provide care in levels of severity, intensity, therapeutic interventions, and clinician qualification (Bower & Gilbody, 2005). The goal is to enable the largest number of participants to receive quality treatment in an effective, efficient, and cost conscious manner. The development of this stepped-care treatment model is based on relevant government and psychological scientific research regarding evidence-based practices of empirically supported treatments and programs for PTSD, cancer, and substance abuse (APA Presidential Task Force on Evidence-Based Practice, 2005; Bower & Gilbody, 2005; Haaga, 2000; Herbert, 2003; Society of Clinical Psychology, n.d.). The lowest treatment level addresses the needs of the largest number of patients while maintaining cost and treatment effectiveness. The other levels increase in cost and treatment effectiveness in order to address the intensity of stress related disorders presentation with a smaller quantity of patients (Bower & Gilbody, 2005; Davison, 2000; Devilly & Spence, 1999; Haaga, 2000). Specific detail regarding this program's stepped-care model is provided under the section entitled "Utopia Stepped-Care Treatment Model."

To summarize, the Utopia program is based on evidence-based practices and research regarding POCM, Mindfulness, MBSR, IPT, and Stepped-Care Treatment. It is designed as an integrated, mindfulness interpersonal therapeutic program delivered through medical practice integration and a stepped-care treatment model. IPT and Mindfulness Based Stress Reduction are the treatment approaches used by the program (APA Presidential Task Force on Evidence-Based Practice, 2005; Deshields & Nanna, 2010; Kabat-Zinn, 1991; Markowitz & Weissman, 2004; Novotney, 2010; Ouimette et al., 2004; U.S. Dept. of VA, 2004). Efficiency and effectiveness increase positive program outcomes and reduce biopsychosocial stressors (Novotney, 2010).

Therefore a POCM and a stepped-care treatment model will be implemented to maximize patient and provider stress reduction while effectively reaching the largest number of patients. Patients will receive treatment that is least restrictive and flexible through a program that attends to their individual needs related to level of severity, intensity, therapeutic interventions, and clinician qualification (Bower & Gilbody, 2005).

### **Target Population**

The primary target population is patients of an Upstate New York ob/gyn practice. These women are identified based on their response to a program-specific stress questionnaire that consists of a PHQ-9, Gad-7, and the CAGE. Patients are given this inventory at their annual appointment, 32-week gestation, 6-week postpartum, or as deemed necessary by medical or integrative program providers. Biological, psychological, and social problems contribute to and result from the stress this target population encounters. Multiple medical conditions exist when individuals with a medical, psychological, or social problem also experience additional stressor or problem area related to finances, health, or relationships (APA, 2012; Patterson, 1988). This integrative program needs to comprehensively assess, diagnose, treat, and evaluate its target population in order to ascertain if the patient meets target population criterion and level of severity (Novotney, 2010). Diagnosis, treatment, and evaluation are practitioner and patient specific under the philosophy of Mindfulness, IPT and MBSR. Detailed information from medical records, patient interviews, as well as the Life Events checklist and the Resiliency Risk and Protective Factor Checklist components of the intake battery provide program personnel with information regarding stress events, as well as patient risk and protective resources. This information is pertinent to the implementation of competent preventive and interventive methods. Further discussion of assessments is provided under the patient allocation section.

Secondarily, the program will target patients who do not presently experience biopsychosocial stressors but are at risk for succumbing to such stressors. It is imperative that program providers develop and maintain an awareness, recognition, and understanding of stress risks and protective factors. These skill sets are essential to identification, assessment, prevention, diagnosis, treatment, and evaluation of all patients (APA, 2012, Patterson, 1988). Risk factors are the characteristics of individuals or their environment that are associated with the development of maladaptive behaviors that contribute to stress. The ten major risk factors are as follows:

- (1) low birth weight
- (2) infant mortality
- (3) child mortality
- (4) teenage parenthood
- (5) arrest and incarceration
- (6) dropping out of school
- (7) teenage unemployment
- (8) teenage violent death
- (9) single-parent families
- (10) low socioeconomic status (Sattler & Hoge, 2006).

A Resiliency Risk and Protective Factor checklist is a part of the intake battery. This information coupled with the remainder of the intake battery and referral information from patient records, consultations, and interviews provide program providers with an in-depth assessment of each participant. Further discussion regarding the intake battery follows under the patient intake section.

The program also targets patients with a decrease in protective factors. Protective factors are characteristics of individuals or their environment that are associated with improving or decreasing the negative results of individual or environmental characteristics (Sattler & Hoge, 2006). Family life is the most common environment for development of protective and risk factors. The manner or dynamics of interpersonal and intrapersonal interactions in the family are the source of key risk and protective factor developmental experiences (Erikson, 1963; Sattler & Hoge, 2006). Family dynamics and the roles played in a family instrumentally increase the likelihood of children and adults developing protective factors for stress (Erikson, 1963; Sattler & Hoge, 2006).

Lastly, this program targets women with deficient, transitional, and conflicted family dynamics and roles that are detrimental and a source of stress (Weissman et al., 2000). An individual's coping mechanisms and skills, understanding about themselves and others, as well as how they view and perceive their surroundings are developed from their experiences within the family (Sattler & Hoge, 2006). This program seeks to increase program participants MSBR coping mechanisms and skills while increasing understanding about one's self in the context of intra and interpersonal contexts (Kabat-Zinn, 1991; M. Weissman et al., 2000). Patience, non-judgment, trust, acceptance, letting go, beginner's mind, and non-striving are the principle coping mechanisms and skills developed by MSBR. When appropriate, family members such as spouses, children, and significant others will gain or be denied access to program services in order to decrease risk factors and increase protective factors for our program participants.

The impact or outcome of stress on an individual is gauged by the change in an individual's functioning. Either an individual develops negative mental and/or physical reactions or they overcome or stop stress reactions (Patterson, 1988). In order to experience a positive

change in functioning, program participants need to be able to engage regularly in our program. We will target patients who are able to access our integrative resources as well as actively participate; therefore, enabling patients to develop, maintain, and sustain positive biopsychosocial outcomes.

### **An Interpersonal Framework and Mindfulness Philosophy**

This section covers in detail various key aspects of Interpersonal theory and Mindfulness. It provides historical backgrounds as well as an explanation of theoretical concepts, principles and expectations.

#### **Interpersonal Theory**

Interpersonal psychotherapy (IPT) is an evidence-based empirical-supported therapy developed over 30 years ago by Gerald L. Klerman, Myrna M. Weissman, and colleagues. IPT originates from interpersonal theories such as those developed by Adolf Meyers and Harry Stack Sullivan (Weissman et al., 2000). IPT, first used to treat depression, is a valid treatment with documented use for all ages, the depression spectrum, anxiety, as well as stress. IPT is effective for individuals, couples, and group treatment regimens (Markowitz & Swartz, 2007; Weissman et al., 2000; Weissman et al., 2007).

The IPT therapist assists the patient in understanding how she can impact the expression of her symptoms by changing the manner in which she interacts with her interpersonal environment. IPT sees diversity as significant. The therapist gathers a clear understanding of the normalities of the patient's culture as it relates to the patient's interpersonal exchanges and makes adaptations when necessary (Markowitz & Swartz, 2007; Weissman et al., 2000; Weissman et al., 2007). The IPT therapist plays the role of advocate and helps the patient to identify and normalize feelings, cope with interpersonal problems, develop independence and

confidence, and prioritize goals. Therapists listen for elements of interpersonal problem areas, elicit affect, provide psycho-education, and instill hope. The therapist is empathic, respectful, supportive, and encouraging. She assists the patient with enhancing and acquiring pertinent social skills and strives to process emotions within an interpersonal context for all problems areas (Markowitz & Swartz, 2007; Weissman et al., 2000; Weissman et al., 2007). There are four interpersonal problem areas: (a) grief, (b) role transitions, (c) interpersonal role disputes, and (d) interpersonal role deficits. These interpersonal problem areas target conflicts in relationships that cause psychological distress (Markowitz & Swartz, 2007; Weissman et al., 2000; Weissman et al., 2007).

IPT therapeutic goals and strategies provide patients with an individualized approach to reducing their stress. Stress reduction is accomplished by successfully navigating interpersonal stressors and risk factors while developing and enhancing protective factors (Kabat-Zinn, 1991; Markowitz & Swartz, 2007; Sattler & Hoge, 2006; Weissman et al., 2000; Weissman et al., 2007). The following descriptions provide information regarding some of the IPT specific therapeutic goals and strategies per problem area. The therapist's goals for the grief problem area are to assist the patient with mourning, reintroduce the patient to interests, and reconnect the patient to relationships. Therapeutic strategies include resolving grief symptomology and redefining the patient and deceased's relationship (Weissman et al., 2000; Weissman et al., 2007). The therapist's goal for the role transitions problem area is to process the emotions surrounding changing roles. These may include insecurities about the new role and lamenting the old role. Therapeutic strategies include facilitation and resolution of feelings, evaluation of benefits and losses related to the transition, and providing encouragement as the patient acquires and demonstrates mastery of new interpersonal skills associated with the new role. The therapist

also assists the patient with establishing new relationships and support relative to the patient's new role (Weissman et al., 2000; Weissman et al., 2007). Therapeutic goals for the interpersonal role dispute problem area are to identify the nature of the dispute and then develop a plan of action to resolve the dispute. Exploration of the validity of expectations and examination of the impact of miscommunications are also appropriate. One strategy is to make connections between symptomology onset and the dispute with a current significant other. A second is to assist the patient with understanding how different expectations between individuals contribute to and maintain the dispute (Weissman et al., 2000; Weissman et al., 2007). Therapeutic goals for the interpersonal deficits problem area are to reduce patient isolation tendencies and increase acquisition of healthy interpersonal relationships. Therapeutic strategies include assisting the patient with recognizing how symptomology is related to isolation and relational patterns. Strategies also include analyzing relationships for their benefits and drawbacks as well as using the therapeutic relationship as an indicator of possible maladaptive interpersonal social skills (Weissman et al., 2000; Weissman et al., 2007). My goal was to design a level of program service that addresses individual and group interpersonal issues preventatively and collaboratively to reduce stress for the patient and, when appropriate, identified significant others. IPT's clear and concise goals and strategies increase ease of implementation and consistency, hence increasing efficiency and effectiveness of therapeutic prevention and intervention. This is consistent with MBSR and enables patients to transition between levels of care with less adjustment.

### **Mindfulness Philosophy**

In an effort to provide an illustration of the seven mindfulness principles, the following is provided. According to Kabat-Zinn (1991), mindfulness is an evidenced-based and empirically

tested modality of choice when developing a treatment model related to medical conditions. Through mindfulness individuals are able to increase and access the healing nature of awareness. The seven principles of mindfulness are (a) non-judging, (b) patience, (c) beginner's mind, (d) trust, (e) non-striving, (f) acceptance and (g) letting go (Kabat-Zinn, 1991). Non-Judging is the ability to recognize, observe, and stop the judging aspects of the mind; an objective perception is the goal. Patience allows and enables situations and aspects to reveal themselves in their own time. Beginner's Mind is a view of circumstance, objects, and situations through a new lens. It deters one from habitual thought or actions (Kabat-Zinn, 1991). Trust is the state of believing in yourself, your autonomy and your initiative even when one makes mistakes or fails. Through trust one listens to their psychological and biological characteristics and states with honor. You are responsible for yourself and trust your intuition. Dr. Kabat-Zinn states that non-striving is the state of non-doing. This is exhibited when meditating or moving away from the need to achieve a specific goal. Non-striving provides a space for multiple options to present themselves. It is based on the understanding that your goals will take place on their own. Acceptance means seeing people, places, objects, and situations as they actually are in the present (Kabat-Zinn, 1991). Often acceptance is only reached after we have gone through very emotion-filled periods of denial and anger. These stages are a part of the healing process that enables you to be aware and perceive people, places, objects, and situations as they are. Letting go, a fundamental mindful practice, is the detachment from a situation, individual, or object. It is the release of control and the ability to accept things as they are (Kabat-Zinn, 1991). These seven principles guide the actions and interpretations of experiences, interpersonal, and intrapersonal that individuals encounter. Mindfulness's attention to non-judgment, patience, trust, and a beginner's mind enables non-therapeutic oriented and psychologically minded patients to participate in a

safe normalizing environment. Its universality enables it to be applied to various diagnoses, populations, and settings. As stated prior, this program uses mindfulness as its overarching philosophy. This philosophy governs program development, program provider interactions with medical providers, patients as well as theoretical and non-theoretical service delivery (Kabat-Zinn, 1991; U.S. Dept. of VA, 2004; U.S. Dept. of VA, 2010).

As discussed, the goal of this program is to successfully integrate psychological program service with an ob/gyn medical practice under the philosophy of mindfulness and the theoretical approach of IPT. Program facilitators demonstrate and foster mindful problem-solving strategies and coping techniques, designed to navigate intra and interpersonal problems (Kabat-Zinn, 1991; Patterson, 1988). Program participants are assisted with how to mindfully recognize, reduce, and eliminate sources of stress. The program seeks to develop and enhance coping mechanisms and support systems to mitigate stress. This is achieved by indirectly and directly exposing program participants to leisure and psycho-educational experiences that decrease risk factors and stress, increase the capacity to cope with stress, and build interpersonal cohesiveness (Sattler & Hoge, 2006). Developmental theorists believe that the family system is the initial source of psychological healthy traits such as trust, autonomy, and initiative (Erikson, 1963). Mindfulness incorporates and fosters these traits. The mindful presentation of these healthy traits is instrumental in stress reduction (Kabat-Zinn, 1991). Parenting is the mitigator of one's ability to acquire these traits; therefore, a goal of the program is to address prevention and intervention strategies that enable mindful parenting; hence, reducing stressful family interpersonal dynamics and increasing protective factors (Erikson, 1963; Orbuch, Parry, Chesler, Fritz, & Repetto, 2005; Winnicott, 1986).

### **Program Referral, Example, and Intake Process**

A Utopia program provider will integrate into an upstate NY ob/gyn practice. First, program providers meet with ob/gyn personnel such as practice administrative directors, providers, and nurses to discuss the best manner in which to integrate psychological services into the practice. Information regarding the benefits of integration, prevalence of psychological issues and their somatic presentation will be shared. Collaboration on the four pillars of integration (selection and cohesiveness of personnel, respectful relationships, common goals and objectives, and firm program design) will be a priority. The implementation of POCM, mindfulness, IPT and MBSR as related to the ob/gyn practice, patients, and program will be thoroughly reviewed and agreed upon. Lastly, once vital program components and philosophies are agreed upon and understood then scheduling, access to medical records, security information, computer information, office space, and written and/or oral communication are discussed and planned. All of the above are site and practice specific. Each aspect needs to be reviewed upon implementation, after one month, and annually to insure functionality and satisfaction. Issues such as where to place unused and completed questionnaires as well as who in the practice oversees questionnaire completion are pertinent to the flow of screening and work load. Some medical practices prefer appointment administrators or Certified Nurse Assistants while others require the medical provider themselves to administer and review the screening questionnaire/referral.

#### **The Referral**

After program implementation meetings the referral process is the next step in integration between medical and psychological services. These can be self-referral, medical staff referral, psychological staff referral, or criteria driven. Similar to The Glens Falls Cancer center and

Dartmouth-Hitchcock Medical Nashua Clinic/Greater Nashua Mental Health Center (GNMHC) integrated programs, the Utopia program requires a clinically significant level of stress. As stated prior, in order to assess patient levels of clinical stress the PHQ-9, GAD-7, and the CAGE are combined as the components of the brief program-specific stress inventory. Patients that indicate with scores of 14, 11, and 1 respectively on these components require more information to see if they will be referred to the program for treatment. Program providers review the stress questionnaire. If the patient indicates or is referred by other means, pertinent patient information will be obtained through review of patient records, consultation with medical and/or program staff, patient interview, or any combination these options. Program personnel meet with the patient, review the treatment component of the program, and offer to proceed to the intake portion of the program.

**Referral Example: Patient “A”.** With the goal of illustration, Patient “A” is provided as an example using a fictitious patient’s journey from medical appointment through the referral process. Two complete examples will be provided later. Patient A’s primary medical diagnosis was pregnancy. Patient A was scheduled to receive the program stress inventory at her 32-week gestational and 6-week post-partum appointments. These dates were decided upon by medical and psychological personnel and coincide with pre-existing stress inventory protocols in practice at the ob/gyn practice. The integrative stress inventory replaces the instruments used by the practice in the past. Psychological program providers reviewed her responses on the inventory and found she met clinically significant criteria for depression (score of 14) and anxiety (score of 11) on the program’s stress inventory at her 32-week appointment. Her scores designated her as an appropriate referral to the stepped-care treatment portion of the Utopia program. Further psychological services such as brief therapeutic intervention and psycho-education were

integrated with her medical treatment to address and support stress reduction. Next, program facilitators consulted with medical providers as well as accessed and reviewed patient medical records. Program providers determined that her depression and anxiety symptomology were due to marital and financial issues. These were Patient “A’s” existing biopsychosocial issues. Patient A was referred to the stepped-care treatment portion of the program outlined later in the proposal.

Integration enabled Patient A to have her needs cohesively and congruently approached. Practitioners are able to approach her case through collaboration; therefore, providing efficient, effective, and congruent services. The referral process for Patient A encompassed 30 minutes of direct and indirect medical personnel time and two hours of program personnel time. Without integration, Patient A would not have been able to receive the same comprehensive and thorough assessment, diagnosis, and brief treatment. Patient A did not have to endure the stress of explaining her presentation issue(s) to multiple practices/agencies. Each program provider interacted with her and each other in a mindful manner that increased overall stress reduction and positive outcomes (Bazarko et al., 2013; Kabat-Zinn, 1991).

### **Patient Intake**

This section covers patient allocation to MBRS and IPT stepped-care treatment. The Utopia program will maintain access to the medical records of the ob/gyn practice in order to obtain information regarding ongoing condition (symptoms and history), assessments, diagnoses, and treatments already performed. Our program personnel will review documentation to assess a fit with the program. Once given a preliminary referral, patients will participate in an initial program intake process consisting of a take-home intake battery and subsequent interview. Patients are given the take-home battery during their medical appointment to complete on their

own time without limit. The understanding is that they will return the completed questionnaire at their interview appointment during the stepped-care portion of the program site.

The program intake battery will consist of the following:

- Notice of Privacy Information and Practices
- Acknowledgement of Receipt of Privacy Practices
- Financial Policies
- Medication Guidelines and Policies
- Integrative Policies and Communication
- Client/Patient Release of Information Forms
- Personal History
- Health History
- Legal History
- DAST
- AUDIT
- Life Events Checklist
- Resiliency Risk and Protective Factor Checklists

This packet of information and/or the evaluation of the material in this packet will be shared with specific program providers as necessary. Patients will be informed of program provider access to information at the intake as well as throughout the patient's participation as needed. Standard releases and consent forms will be used for individuals and groups outside of the program (Greater Nashua Mental Health Intake Packet, 2015).

### **Screening and Assessment**

As stated prior, we will use a program-modified Patient Stress Questionnaire (that takes approximately five minutes to complete) which includes the PHQ-9, GAD-7, and the CAGE. Once identified, patients will take home and fill out the intake battery to bring with them for the clinical interview. Once interviewed, we will also administer the Clinician Administered PTSD Scale (CAPS). The CAPS, the gold standard for PTSD diagnosis, is based on the same DSM IV-TR diagnostic criterion used in structured interviewing. The CAPS takes 36 minutes to administer and assesses severity (Blake et al., 1995; Weathers et al., 2001). We will administer

the CAPS to assist with assigning program treatment levels. Current information regarding medical, past psychiatric, family psychiatric, and psychosocial histories is requested now and continually from referral sources and patients. Necessary releases will be obtained. A complete physical is required to assess physical reasons for symptomology. Drug screening results will be requested (U.S. Dept. of VA, 2011). Drug screening for family participants is strongly recommended.

Program providers will review, clarify, and augment screening and referral information during a structured clinical engagement interview with each potential patient to assess for stress levels, mental status, depression, suicide ideation, substance abuse, differential diagnoses, and level of commitment to change (American Psychiatric Association, 2000; American Psychological Association, 1999; Sommers-Flanagan, 2003). Some referrals may come with CAPS results and will be interviewed to assess for co-morbidity. Patients who meet moderate to severe diagnostic criterion will be offered information regarding the risks, benefits, and assessment procedures for pharmacological interventions (U.S. Dept. of VA, 2004; U.S. Dept. of VA, 2010). The Psychiatric Registered Nurse Practitioner (PRNP) will oversee assessment and disbursement of medication. The director, a doctoral level psychologist, will supervise and participate in this triage process.

### **Exclusionary Criterion**

Program participation is optional and not mandatory. Participants are not included if it is not their personal choice, they cannot agree to or adhere to the group agreement, they are in crisis, or they exhibit poor impulse control (Rutan et al., 2007). Some participants thrive in the group environment. People who can identify their feelings, exhibit empathy, tolerate anxiety, demonstrate a positive attitude toward change and helping others, and are motivated to

participate in therapy are ideal for group therapy. Some participants may need to initiate individual treatment first. Patients who need time to learn to express themselves and interact appropriately in a group setting will benefit from individual therapy first (Rutan et al., 2007).

### **Severity and Treatment Level Allocation**

Patient stress severity determines initial treatment level allocation. Severity is dictated by triage results. Severity and level placement are based on CAPS results, co-morbidity, and clinical judgment. CAPS severity designations are as follows: asymptomatic = (0-19), mild = (20-39), moderate = (40-59), and severest = (60+; Weathers et al., 2001).

### **Monitoring and Adjustment**

In order to monitor program participants for clinical and evaluative reasons clinical staff will alternate weekly between administering the program stress inventory to monitor stress symptoms and the SF-36 to monitor aspects of their social and health related quality of life (Terhakopian, et al., 2008; U.S. Dept. of VA, 2010). Due to the somatic presentation of stress the SF-36 was chosen. The SF-36, the short form of the Medical Outcomes Study (MOS), is commonly used in health settings. The Client Satisfaction Questionnaire (CSQ-8) will be administered every four weeks to assess the patient's quality of experience with the overall program. Instruments were chosen based on application to diagnostic and treatment characteristics, in addition to brevity, cost effectiveness, validity, and efficiency (Client Satisfaction Questionnaire, n.d.; Herbert, 2003; Lambert & Hawkins, 2004; Najavits, 2002; Shapiro, 2009; U.S. Dept. of VA, 2004, U.S. Dept. of VA, 2010; Ware, Jr., n.d.) .

Every four weeks, the program team will review clinician observations, program stress inventory, SF-36, and CSQ-8 results, and released collateral information. Patients whose observations and assessments indicate a reduction in symptomology, an increase in quality of life

and program satisfaction will be recommended to move to a lower level of treatment. Patients that experience an increase in symptomology will be recommended to a higher level. At the 8th week, patients who experience no change will be recommended to a higher level. At the 12<sup>th</sup> week, patients who are unable to show treatment progress will be referred for a full mental health and physical evaluation. Level changes will be team recommended, director approved, and collaboratively decided between patient and clinical staff treatment provider.

### **Program Treatment Teams and Levels**

The stepped-care treatment team consists of one doctoral-level psychologist, two masters-level mental health clinicians, and a PRNP. Although generally medical personnel do not provide direct care at this junction, consistent communication is maintained with the patient's medical professional regarding progress and necessary medical and psychological recommendations and updates.

Utilizing a hierarchy of professionals facilitates the ability of the program to provide services in a cost-effective manner based on preparation, salary, and experience. A consultant is needed to offer an objective analysis of the program from its inception. Objective analysis can be achieved by ongoing observations, assessments, and evaluations as viewed through his or her organizational and cultural expertise.

Each of the three treatment levels implements an evidence-based guided treatment. Treatment includes: (a) psycho-education, (b) coping and interpersonal skills acquisition, and (c) stress reduction. Individual therapy is implemented on levels two and three. Treatment may be provided through homogeneous groups based on condition and gender. The number and type of groups per level is contingent upon patient allocation. Patients are strongly urged to increase social support, strengthen family relationships, and engage in positive community involvement

(Koenen, Stellman, J., Stellman, S., & Sommer, Jr., 2003; U.S. Dept. of VA, 2004, U.S. Dept. of VA, 2010).

In an effort to develop, expand, and enhance methods for patient acquisition and maintenance of mindful strategies and IPT approaches, the Utopia program will deliver the largest amount of prevention and interventions through groups. Yalom (1995) continues to provide evidence-based support for group therapeutic experiences and practices. He empirically supports the need for group therapeutic experiences that address the comprehensive needs of clients and patients dealing with stress related issues. Targeting subgroups enables us to potentially develop a homogenous treatment regime specific to medical condition, age, or relational status (i.e., married, divorced, single). Homogeneous group members experience faster reduction of symptoms; a stronger connection to and support from the group; and increased investment in the group process (Yalom & Leszcz, 2005). Psycho-education of homogeneous groups increases normalization, self-understanding, and self-acceptance (Swartz et al., 2007; U.S. Dept. of VA, 2004; U.S. Dept of VA, 2010). Further description of program groups will follow in this section under each level description.

Although individual sessions and appointments will be available, the majority of patients will receive treatment in a group setting, therefore, ample accommodations for groups are a necessity. One option for the setting of this program is a rural/suburban gentleman's working farm. The farm has a house with space for large and small groups, workshops, and offices. There is a large barn with accommodations for exercise and applied psychological experiences that require a martial arts studio, dance studio, or art studio. Although the Utopia program will not provide these services, the Utopia program supports the exploration and participation in biopsychosocial activities for program participants such as applied therapeutic experiences (e.g.,

art and movement therapy), functional athletic training, group activities, and workshops through use of their facility. Each level's flexibility in program interventions enables patients to move to and from levels at specific clinically significantly appropriate times. Examples are provided under the Case Example section of this dissertation.

### **Level One: Mindfulness-Based Stress Reduction Group**

The first level of our program is a weekly co-facilitated Mindfulness-Based Stress Reduction group. An eight-week MBSR protocol is followed. Groups are facilitated by a PRNP and a masters-level clinician. This level is recommended for asymptomatic patients, mild severity patients, and moderate severity patients with low therapeutic engagement. The program's MBSR-related exercises increase mindfulness, problem solving, and non-striving goal acquisition. Patients will be encouraged to use adjunctive classes that connect with curriculum such as yoga, tai-chi, and meditation (Kabat-Zinn, 1991). The PRNP will assist with monitoring and facilitate treatment groups and work collaboratively with a masters-level clinician to increase effectiveness and continuity of treatment content between levels. In addition, clinical contact with patients ensures administration of assessments, observation of patients and group dynamics, and facilitation of level changes.

### **Level Two: Individual therapy**

The second level of the Utopia program is IPT individual therapy facilitated mainly by masters-level clinicians. This level is recommended for patients with moderate severity. This IPT individual therapy will be tailored to the patient's specific psychological needs based on assessment and evaluation. It incorporates prolonged recognition and management of stress and stress related symptoms, recognition of role and grief problem areas, relapse prevention, and titrated termination in addition to the prior mentioned interventions in the conceptualization

section of the proposal (Weissman et al., 2000; Weissman et al., 2007). These individuals will enter level one as soon as clinically appropriate: refer to monitoring and adjustment.

### **Level Three: Group and Individual Therapy**

The third level of our program is individual and group therapy offered by a doctoral-level clinician. This level is recommended for patients with the highest severity. The Level Three group will follow a modified eight-week MBSR protocol. It will be designed specifically for severe stress reactions. Stress reduction and IPT therapy interventions are the major therapy components (Kabat-Zinn, 1991; Weissman et al., 2000; Weissman et al., 2007). These individuals will enter Level Two as soon as clinically appropriate: refer to monitoring and adjustment.

## **Co-occurrence with Substance Abuse**

### **Identification, Assessment, and Treatment**

Najavits (2004) states that patients with co-occurring substance abuse and stress are more likely to exhibit destructive behavior and experience family, legal, health and occupational issues. This sub-group has a higher propensity for multiple co-occurring disorders, uses more than the average physical and mental health services, and experiences lower program success. Addressing the needs of this sub-group is critically important due to implications regarding safety, complexity of treatment, as well as cost and time-effectiveness (Lambert & Hawkins, 2004; Najavits, 2002; Najavits, 2004). Screening and assessment information such as the DAST, AUDIT, and CAGE will be continually used to assess for substance abuse (Sommers-Flanagan, 2003; U.S. Dept. of VA, 2004). Upon initial diagnosis, immediate assessment of patient and contextual safety will occur. The doctoral level clinician will offer a modified “Seeking Safety” therapeutic group specifically for these patients. The group will provide 25 possible IPT and/or

Mindfulness-based sessions where substance abuse, stress, and medical conditions are concurrently addressed (Hayes, 2009; Najavits, 2004).

### **Evaluation, Funding, and Resources**

#### **Evaluation**

As described above, the Utopia program is designed so that it can be evaluated throughout treatment. We will use Kellogg's logic model to evaluate implementation fidelity and overall effectiveness of our stepped-care model. This model provides guidelines for formative evaluation of implementation fidelity and summative evaluation of the overall effectiveness of the program (W.K. Kellogg Foundation, 2005). Program providers execute evaluations under director supervision of the doctoral level psychologist by using the qualitative methods and quantitative assessments within the structure of the program (Herbert, 2003; Lambert & Hawkins, 2004). Formative evaluation is based on the assessments, patient allocation, monitoring, and modifications made to aspects of treatment implementation. Implementation fidelity is contingent upon program teams' satisfaction, program and treatment critique, and addressing professional and personal challenges (Najavits, 2002). Adherence and uniformity of treatment delivery is achieved through the following: extensive training in MBSR protocol, supervision provided by doctoral level clinicians, practice and program meetings, and uniformed assessments. In addition, the Utopia program will offer training, information, and ongoing collaborative support specific to the needs of group facilitators, individual therapeutic providers, primary care personnel, and referral sources (Herbert, 2003; Lambert & Hawkins, 2004). Implementation of these and all policies and procedures will be done under the four pillars of collaboration and mindfulness. The commonality of providers operating under an IPT therapy and mindfulness approach increases uniformity and reduces stress.

Summative evaluation assesses the program goals, resources, development, treatment, and evaluation activities, costs (outputs), outcomes, and program impact (W.K. Kellogg Foundation, 2005). A focus group will be developed to gain a qualitative perspective of summative areas. Patients who prematurely terminate will be measured by his or her last stress inventory, SF-36, and CSQ-8 results; and clinical observation. Patients who complete the program will be given a CSQ-8 and CAPS to accompany data regarding their progression of stress inventory, SF-36, and CSQ-8 results. These results will be reviewed in conjunction with clinical observations, focus group input program costs, center impact, and efficiency. A doctoral level clinical psychologist will be hired to provide consultant services. This objective resource will provide integral feedback and contributions to the evaluation process and overall program outcomes.

### **Funding and Resources**

The program will apply for a grant through the Office of Planning Research and Evaluation. This is an Office of the Administration for Children & Families. Grants such as the Child Support Enforcement Community Healthy Marriage Initiative are available to pilot programs such as the one developed by this study. In addition, program personnel will apply for funds provided through the Affordable Care Act. This federal initiative ensures 10 essential services. Most relevant are those related mental health services and addiction treatment. The program will utilize other public and private grants and philanthropic endeavors to provide financial resources. The use of evidence-based and/or empirically supported program material as well as literature labeled Gold standard services increases grant and funding access.

### **Completed Action Steps**

Although this program will not be implemented at this time, there are specific action

steps that I completed in order to further support and exhibit aspects of the program's implementation. First, I met with Dr. Selma Nemer, who agreed to consult with me regarding the program's development and execution. Dr. Nemer is a licensed Clinical Psychologist who is MBSR trained by Dr. Jon Kabat-Zinn and is the founder of One Roof Holistic Health Center in Saratoga Springs, NY. She practices individual therapy as well as facilitates the center's MBSR program with two other associates. Second, the program developer provides two additional examples of journeys that patients would have experienced as they travel through the Utopia program.

### **Consultation**

I received consultation from Dr. Selma Nemer regarding the contents, design, possible implementation, and feasibility of this program. We reviewed my education, professional background, and experiences extensively. Dr. Nemer reviewed the contents of the Utopia program on her own and through our conversation. She was concise in her response stating that she saw no flaws in the program development. We shared theoretical approaches to program development, therapy, and in general. I asked several questions regarding how her practice implements some of the approaches incorporated in this program. Dr. Nemer discussed her knowledge and expertise with MBSR, Interpersonal theory, as well as how psychological therapy integrates into cancer care as in the case of POCM. Dr. Nemer continues to successfully direct and facilitate a MBSR program that has spanned two decades. She sees clients individually whom participate in her MBSR group, some concurrently and some not. Although Dr. Nemer does not institute a formal stepped-care treatment, she endorses the structure, premise, efficiency, and cost effective benefits of its use. Dr. Nemer agreed with the design, content, development, and feasibility of this program. As with her own program, she only noted funding as a possible

issue. I shared with her Dartmouth-Hitchcock Medical Clinic–Nashua’s example of funding. The clinic contracts with Dr. Cynthia Whitaker for integrated hours. I also shared this programs financial resource, the federal grant discussed in the Funding and Resource section. She was pleased with the information and took the reference to use. Dr. Nemer stated that she would be pleased to further consult once the program was initiated. In response to her feedback I have added a second federal grant to the Funding and Resource section.

### **Case Examples**

The following case examples are related to past patients. Patient demographics and treatment information are modified for their privacy and to enhance illustration of possible program implementation. As demonstrated by Patient A, all cases start with a referral based on their score on a 5-minute program stress inventory. If appropriate, cases are recommended to progress to the stepped-care treatment portion of the program. Patients bring their finished take home intake battery to a clinical interview scheduled at the stepped-care program site. After the 1 to 1.5-hour clinical interview, they will take the 30-60 minute CAPS. Patients are assigned to a treatment level based on severity. Severity is based on CAPS results, co-morbidity, and clinical judgment. CAPS severity designations are as follows: asymptomatic = (0-19), mild = (20-39), moderate = (40-59), and severest = (60+). The impact of stress is mitigated by an individual’s coping strategies, as well as the presence of stress protective factors and lack of risk factors. Intrapersonal factors such as psychological and biological states as well as interpersonal factors such as family and peer relations are mitigators of stress (Patterson, 1988).

Interviewers look for indication of parental style, psychopathology, and relational approach that impacted the development of the patient. Exposure to these risk factors and protective factors are important to consider when assessing, diagnosing, treating, and evaluating

a patient with complex presenting problems. Inclusion of these elements, as well as their impact on the stress our patients experience, increases the accuracy of patient diagnosis, treatment plan development, treatment, and evaluation (Hastings & Singh, 2010; Sattler & Hoge, 2006; Sawyer et al., 2009)

In addition interviewers look for low birth rate, teenage parenthood, criminal and violence exposure; unemployment and lack of academic progression; and lower socio-economical status which are risk factors that have the greatest negative impact on biopsychosocial development. Reducing exposure and prevalence of stress related risk factors; increasing available resources, and promoting a non-violent environment are protective factors that increase stress resistance and resiliency (Sattler & Hoge, 2006). Resiliency is the ability for individuals and families to cope and bounce back from risk factors and stressors despite significant stress or adversity. Resiliency is achieved through a complex interplay between characteristics of the individual and their environment (Sattler & Hoge, 2006; Stewart, Reid, & Mangham, 1997).

**Case One: Sharon.** Sharon was a patient who entered the program as the result of her scores on the stress inventory at her annual ob/gyn appointment. Review of the stress inventory indicated both depression and anxiety. Program personnel met with her at the practice to review her stress inventory and discuss therapeutic options. Sharon was resistant to therapy, stating that she participated unsuccessfully throughout her life. She stated that she had to do something since the grief she experienced was impacting her marriage. One month earlier, the day after her wedding, her mother passed away from cancer. Sharon stated that she missed her mother's calls, laughter, singing, and support. She was concerned about the quality of care she provided her mother while she was ill, especially, toward the end of her mother's life. Sharon reported an

increase in anxious symptomology despite her efforts to process her grief. Sharon, a musician and composer, knew her stress had worsened when her grief stifled her ability to compose a song in memory of her mother. She recognized that she was detached from performing and creating music. Sharon stated that her anxiety increased the longer she was unable to create the song. She feared that she would cross a point where she would never be able to compose music again.

Sharon also expressed concern regarding the negative impact her grief may have upon her new marriage. She feared she was not “living up to her wifely duties.” Sharon felt that she was unable to fully contribute to their relationship due to her emotional state. She was worried that Steve, her husband, might reach a point where he would get tired of supporting her emotionally. Sharon reported feeling guilty because Steve turned down offers for employment to stay with her while she cared for her mother. A third issue arose during the course of treatment. Sharon expressed frustration and anger over her relationship with her maternal aunt. Her aunt made the process of closing her mother’s estate difficult. She negatively engaged Sharon with the intent to argue and cause a conflict between the two. These interactions increased Sharon’s symptomology.

Sharon scored an 18 and 21 respectively on the depression and anxiety portions of the Stress Inventory. She did not indicate on the substance abuse portion. Sharon was referred to the stepped-care treatment portion of the program. These scores place Sharon’s depression and anxiety in the moderate to severe range. Therefore, the second (individual therapy) and third (individual therapy coupled with group therapy) steps were suggested to Sharon as possible therapeutic modes of intervention. Sharon made an appointment at the program site to be interviewed and take the CAPS described under the patient intake section of this document. This information coupled with the take home intake battery enabled program personnel as well as

Sharon to assess and understand what the most appropriate placement would be based on intake information.

Sharon's intake battery and clinical interview confirmed the depression and anxiety diagnosis. As stated prior, severity and level placement are based on CAPS results, co-morbidity, and clinical judgment. Sharon has co-morbidity by meeting the criterion for both depression and anxiety. She is also an Adult Child of an Alcoholic (ACOA). Her CAP score was a 45. Clinical judgment factors in Sharon's ability to exhibit a decrease in symptomology while participating in the intake process. She was less anxious and stated that her depression had started to "lift." Just knowing she had an appointment increased healthier sleep behavior and appetite. Her response to therapeutic experiences, her psychological mindedness, coupled with the results of her intake battery, placed her on the second level. Sharon's resiliency was a significant benefit.

Although Sharon had several risk factors for stress, her protective factors and resiliency reduced the severity of her overall assessment. Sharon was parented by an inconsistent and aggressive parental style. Her father was an alcoholic and her mother exhibited both depression and anxiety. These factors negatively impacted Sharon's development. Sharon was a low birth weight baby who was exposed to crime and violence. Although her parents worked, unemployment and lack of academic progression contributed to their lower socio-economic status.

As aggressive as her mother was in her parenting style, she tried to reduce Sharon's exposure and prevalence of stress-related risk factors, increased the families available resources while promoting a non-violent environment therefore developing Sharon's ability to increase stress resistance and resiliency (Sattler & Hoge, 2006). Sharon's mom divorced her father and made sure the family was active members of Al-anon. She fostered and nurtured Sharon's music

abilities and skills from toddlerhood. Sharon was placed in private school to enable her to have a classroom experience that focused on her individual educational needs. Sharon developed a strong work ethic and financial awareness that has kept her out of debt and thriving. Sharon maintained healthy relationships with her brothers and uncle. She also developed and maintained a healthy relationship with her father.

Sharon participated in Step Two of the treatment program. She received IPT individual therapy facilitated by a masters-level clinician for six months. Throughout therapy, Sharon's therapist implemented IPT therapeutic interventions in a mindful manner. In addition, the therapist identified, reinforced, and developed protective factors for stress and resiliency while decreasing risk factors. Grief was Sharon's primary IPT problem area. She expressed her grief through depressive and anxious symptomology. Weissman et al. (2007) state that anxiety is commonly co-morbid with depression. Sharon received psycho education regarding grief, depression, anxiety, as well as chronic and terminal illness during the initial sessions and as needed throughout therapy. Role transition was a secondary IPT problem area due to her transition from girlfriend to wife. Sharon lacked the coping mechanisms needed to deal with the different responsibilities, expectations, and changes she encountered in her new role as wife. Onset and maintenance of mood symptomology are important to the conceptualization of role transitions (Weissman et al., 2007). Later in therapy, interpersonal role dispute was an IPT problem area. This was chosen due to the conflict that arose between Sharon and her aunt when she assumed the role of head matriarch when her mother died. Weissman et al. (2007) state that role disputes commonly occur when individuals are transitioning from one role to another. This conflict was highly emotionally charged and exhibited during family functions and when Sharon tried to resolve issues regarding her mother's estate.

Sharon's primary concern was having a place, outside of her marriage, where she could process her grief. The Utopia program provided Sharon with a therapeutically trusting environment where she could actively mourn and process her grief. One of the strategies mentioned for this problem area was to redefine the patient's relationship with the deceased (Weissman et al., 2000; Weissman et al., 2007). This was mainly achieved through discussing and normalizing the feelings Sharon experienced. Emotions were elicited through the sharing of anecdotal accounts of her relationship with her mother as she journeyed from diagnosis to death. Non-judgement of emotions and anecdotal details increased Sharon's comfort with sharing. Encouraging Sharon to use her psychological insightfulness, strong communication skills, and spirituality assisted her in moving through the grieving process and built trust in herself and the therapeutic process. The non-striving approach to her grieving processes reduced her anxiety.

Her therapist explored how Sharon's depression and anxiety about the care she provided might have stemmed from the distant relationship they maintained since her childhood. She stated that, "Although I loved my mother I often felt as if I walked on eggshells around her." Psycho-education was provided about how people's priorities and perspectives change when they are chronically and terminally ill. They "let go" of many things that would have bothered them in the past. IPT informed discussion helped Sharon to redefine her interpersonal relationship with her mother. She realized that her mother may not have been the same person after she became ill and knew she was dying—a transformation that her mother may not have had the words, strength, or opportunity to explain. As she continued to process anecdotal scenarios, Sharon felt she was less encumbered by her grief. Shortly into the intermediate phase, Sharon had composed a song in remembrance of mother. Although she continued to process her grief throughout therapy, this was a pertinent milestone for Sharon. Sharon recognized

significant movement in her mourning. She no longer felt that her expression of grief permeated and controlled her. She approached situations inside and outside therapy with a beginner's mind.

Sharon actually experienced two role transitions: (a) from youngest adult female to head matriarch and (b) from girlfriend to wife. The later was the transition that caused the most conflict in her current interpersonal life. The goal was to process her insecurities about being a wife. One of the strategies mentioned prior for this problem area is to provide encouragement as the patient acquires and demonstrates mastery of new interpersonal skills associated with the role (Weissman et al., 2000; Weissman et al., 2007). Sharon felt that she and Steve were prevented from functioning as a typical newly married couple due to her grief and were therefore unable to develop a communication style that enabled them to deal with emotionally laden topics.

After addressing her grief issues, Sharon felt like she was able to express other emotions other than grief in her household. However, communication issues maintained the symptomology associated with her new role as wife. Therapeutic interventions suggested that Sharon take cues from all of the relationships she encountered. She can use them to decide how she wanted, and didn't want, to be as a wife and to use these relationships for Sharon and Steve to find their own dance, one unique to their interpersonal styles and needs. Encouragement was provided as Sharon acquired and demonstrated new methods of communication with Steve. Role-play and developed scripts were used to assist her with confronting him about issues in their marriage. Sharon started with less emotionally laden topics such as caring for their pets and then moved to topics like collecting rent and sending demo tapes to producers and agencies. Sharon's effective communication skills increased with each conversation, therefore allowing her to settle into a matrimonial role that was comfortable and authentic. Sharon was no longer a girlfriend living an independent life. She found the communication style she needed to enable

her to interact as a part of a couple, a team, regardless of the emotional content of the issues they faced.

The majority of Sharon's family welcomed her into the new role as head matriarch. Sharon's maternal aunt did not accept Sharon as head matriarch; therefore, an interpersonal role dispute arose. The goal was to identify the nature of the dispute and develop a plan of action to resolve the dispute. One of the strategies mentioned prior for this problem area is to assist Sharon in understanding how different expectations between her and her aunt contributed to and maintained the dispute (Weissman et al., 2000; Weissman et al., 2007). Sharon's depression and anxiety escalated due to her aunt's negativity. Sharon stated that her aunt purposely called to argue with her. Her aunt called her frequently requesting to be allowed to go through her mother's house alone prior to selling it. Each phone call increased in toxicity.

Sharon came to understand that her aunt needed to be validated as a person of worth in the family. Sharon acknowledged that her aunt could feel slanted and angry. Although Sharon didn't believe that her aunt deserved the role of head matriarch, she saw value in changing the way they interacted. Through patience and acceptance Sharon was able to soften her approach to her aunt. Sharon sent her aunt a card with the intent of connecting with her. Then she worked on changing her role in their arguments. Sharon also started to ask her aunt what she thought about various aspects of the estate. This allowed her aunt to feel needed and valued. Within a month, their caustic relationship had moved to a more positive place.

Clinical staff alternated weekly between administering the program stress inventory which monitored stress symptoms and the SF-36 which monitored aspects of her social and health-related quality of life. These results were shared with Sharon and assisted in showing her progress which reduced her level of anxiety. The Client Satisfaction Questionnaire (CSQ-8) was

administered every four weeks to assess Sharon's quality of experience with the overall program. Initially, Sharon's trust level for unfamiliar program personnel was low and her overall satisfaction was moderate. Her trust and satisfaction with the program increased over time. Sharon stated that the supportive non-stressful therapy sessions helped her to face and change interpersonal behaviors that contributed to her problem areas and she reported that she felt less defensive and anxious with each session.

Every four weeks, the program team reviewed her clinician's observations, program stress inventories, SF-36, and CSQ-8 results. For several months, observations and assessments indicate a reduction in symptomology as well as an increase in quality of life and program satisfaction. Program communication through inventories, meetings, and therapy enabled Sharon to work through her frustration with her therapeutic progress. She stated that she wanted to quit therapy several times but her therapeutic relationship with program personnel made her stick with it. With that said, after six months, her level of severity reduced to enable her clinician to recommend she move to a lower level of treatment. Sharon successfully participated in 8 weeks of the MBSR course. She further learned how to incorporate mindfulness practices such as meditation and yoga as well as mindfulness principles into her life. Sharon left treatment with an ability to navigate and control her anxiety. Her depression was no longer clinically significant and her grief was manageable. She gained the necessary skills and abilities to utilize old and new interpersonal resources in a mindful manner to continue increasing her quality of satisfaction with life.

**Case Two: Ruthann.** Ruthann was a patient who suffered from stage-three cancer of the Labia. Ruthann was referred to the program by her ob/gyn during an inpatient stay. Ruthann's initial referral provided inadequate information regarding her mental status. The referral stated

the she was distressed yet exhibited incongruent affect. The medical staff made their own interpretation of Ruthann's response to her diagnosis, treatment, and her husband. As part of her discharge plan Ruthann was asked to make an appointment to see the Utopia program personnel at her ob/gyn practice.

Ruthann came in for an appointment with program personnel at the office a week after being discharged from the hospital. She was given the stress inventory and scored a 28 on the PHQ-9, a 10 on the GAD-7, and did not indicate on the CAGE. Program personnel met with Ruthann to review her results. Ruthann's score place her presentation of depression in the severe range. Therefore, the third (individual therapy coupled with group therapy) level was suggested to Ruthann as a possibility. At this time she revealed that she experienced distress due to her husband's announcement during her inpatient stay of his plan to file for a divorce at the completion of her treatment. He stated he was overwhelmed by the responsibility of being the sole caregiver for her elderly father, Ruthann, and their household. Ruthann's 24-year-old daughter lived at home and refused to contribute to maintenance of the household.

Ruthann had a strong spirituality and faith. She appropriately recognized the severity of her diagnosis and the implications of her husband's decision to divorce her. She chose to approach these issues from a place of faith, strength, and cautious optimism. Due to the site, stage, and type of her cancer, Ruthann participated in an aggressive chemo and radiation therapy treatment regime. Several physical and mental side effects resulted from this aggressive treatment. Ruthann experienced fatigue, nausea, and loss of appetite. She lost about thirty pounds and felt extremely weak. The side effects coupled with her diagnosis decreased her desire and ability to maintain sexual relations with her husband. Ruthann decided to remain with her husband and work on their relational issues. Ruthann was referred to the stepped-care portion of

the program.

After completing the take-home intake battery, Ruthann participated in a clinical interview at the program site. She then took the CAPS. Due to the complexity of Ruthann's issues, couples therapy was suggested as an adjunctive therapeutic intervention to individual and group therapy. Ruthann's husband also completed the intake battery, clinical interview, and CAPS administration. Ruthann's intake battery and clinical interview indicated a depression diagnosis. Ruthann's husband's battery did not reveal a diagnosis. His lack of distress was noted. Ruthann's case was assessed as co-morbid by meeting the criterion for both depression as well as the medical severity of her cancer. Her CAP score was a 60. Clinical judgment factored in Ruthann's ability to navigate her medical diagnosis and treatment while maintaining a family and household. It was difficult to tease out where the side effects of her treatment/ cancer ended and psychological and interpersonal impairment started. It was all linked together. Although Ruthann did not experience developmental risk factors for stress, situational stress exposed her to many risk factors. She had lost her ability to work and utilize the education she received. Ruthann's income was reduced by medical bills moving her from an upper-middle class to a low socio-economic status. Depression, grief, and stress have reduced parenting and family interpersonal relationships to hostility, denial, and contempt. Protectively, Ruthann increased resources by taking advantage of programs and philanthropies in the area. Ruthann consistently promoted a non-violent environment and hoped that couples therapy would support and contribute to that end. Her resiliency was an example and a motivation for the family.

Ruthann participated in Level Three of the treatment program. Due to Ruthann's severity, psychological mindedness, lack of substance abuse diagnosis, and resources it was decided that Ruthann participated in the MBSR group facilitated by a doctoral-level clinician. She received

IPT individual therapy and couples therapy facilitated by a doctoral-level clinician as well. Constant communication was maintained with Ruthann's medical personnel. At medical personnel, program personnel, and Ruthann's request, the primary focus of their couples therapy was loss of physical intimacy due to Ruthann's medical status and treatment plan. Medical treatment and personnel strictly prohibited physical sexual interaction of any kind for Ruthann for four to six weeks and vaginally until further notice.

It was difficult to assess Ruthann's primary problem area since her diagnosis and interpersonal issues were interrelated. Grief was determined to be her primary IPT problem area because it was the overarching issue related to her diagnosis and interpersonal issues. From the start of therapy, the terminal possibility of her cancer was real. Ruthann saw her cancer as ending her role as wife and mother because she could no longer execute tasks, responsibilities, and facets of these roles. She expressed her grief through depressive symptomology. Ruthann received psychoeducation regarding grief, depression, anxiety, as well as chronic and terminal illness during the initial sessions and as needed throughout therapy. Role transition was a secondary IPT problem area due to her transition from wife and mother to terminal patient. Ruthann's children distanced themselves from her and increased their independence. Both children were over the age of 18 and stopped relying on her for parental guidance. Her relationship with her children was roommate-like.

Ruthann's primary concern was her marital relations. The therapist assisted Ruthann in understanding the importance of processing grief to enable her to have the emotional stability to navigate her relationships. The Utopia program provided Ruthann with a therapeutically trusting environment where she could actively mourn and process her grief. One of the strategies mentioned for this problem area was to redefine the patient's relationship with the deceased

(Weissman et al., 2000; Weissman et al., 2007). The “deceased” in this case was Ruthann. This was mainly achieved through discussing and normalizing the feelings Ruthann experienced regarding her cancer, treatment, and possible death. Psychoeducation as well as processing treatment and death scenarios enabled Ruthann to confront her grief. Patience, non-judgement, acceptance, and letting go of preconceived notions were the focus of therapeutic sessions. Ruthann depended on protective factors such as spirituality, strong parental relationships, and stable childhood development to assist her in moving through the grieving process and building trust in her medical journey. As Ruthann let go of the expectation of holding onto her past roles of mother and wife and focused on her medical treatment and developing survivorship, her depression lifted. However, when her depression lifted, she wanted to return to her past roles as mother and wife. This is when the therapeutic focus changed to staying in the moment and savoring the lack of depressive symptomology.

Another goal was to process her insecurities about reducing her involvement as wife and mother. One of the strategies mentioned prior for this problem area is to provide encouragement as the patient acquires and demonstrates mastery of new interpersonal skills associated with the role (Weissman et al., 2000; Weissman et al., 2007). IPT informed discussions helped Ruthann to redefine her interpersonal relationship with her husband and children. Through couples therapy, it was stressed that Ruthann cannot execute the same aspects of her past role as wife and mother. New ways of communicating and interacting were discussed and implemented. Ruthann was a very “hands on” mother and wife. Therapy enabled Ruthann to guide her children in situations through verbal communication and roleplaying rather than physically resolving and executing parenting. Non-physical intimacy was supported and explored during couples therapy while the mental and physical damages of physical intimacy were emphasized.

Clinical staff alternated weekly between administering the program stress inventory to monitor stress symptoms and the SF-36 to monitor aspects of their social and health related quality of life. Initially, these results were shared with Ruthann and her husband individually and collectively to show their progress. A negative interpersonal dynamic developed between the two. Within three weeks, Ruthann revealed to medical personnel that the couple were engaging in physical sexual interactions. Ruthann knew that all program personnel might have access to her information and would work collaboratively to address her needs. The programs' multilevel approach provided Ruthann with several qualified, safe, and trustworthy program personnel to interact with. This provided the ongoing support she needed to disclose.

Immediately a family crisis intervention was conducted regarding the possible abusive nature of their sexual relationship. During the course of the last three weeks, Ruthann's husband had continued to request and initiate sexual relations with her despite the mental and physical consequences to her recovery and health. Under the guidance of program supervision, a safety plan was developed for Ruthann in case he forced himself upon her. Her daughter was engaged in accompanying and supporting her mother in reporting his behavior to the police and family court. Ruthann's husband moved out, her safety plan was revised to include a safe place to go in case of his return. Ruthann dropped all criminal charges, withdrew her family court claim, and her husband was removed from the program due to exclusion criterion for safety and stress.

The Client Satisfaction Questionnaire (CSQ-8) was administered every four weeks to assess Ruthann's quality of experience with the overall program. Although Ruthann acquired stress-reducing coping skills through the MBSR group, her medical and interpersonal situations made her stress ongoing. After sixteen weeks, the program team reviews of her clinician's observations, program stress inventories, SF-36, and CSQ-8 results indicated she could move to

Level Two (individual therapy). Ruthann continued to participate in individual therapy. She continued to utilize the skills and abilities she learned from the MBSR group to enhance her daily life and actively participation in individual therapy. Ruthann focused on her ability to navigate the physical and mental distress related to her treatment and diagnosis. IPT interventions (e.g., increasing her ability to cope with the grief of her martial distress and diagnosis, increasing her problem solving skills, and advocating for herself) increased Ruthann's ability to navigate her treatment and diagnosis. She demonstrated significant positive ability to communicate with interpersonal sources of stress. Interventions provided the foundation for her children's active participation in her cancer treatment and family life. There was significant reduction in the negative impact of her cancer and treatment on each individual and the family as a whole. Sessions with her children and services for her father were included as support for Ruthann and reduction of stress. For example, after Ruthann was released from the hospital, home care for her father was initiated within three days of a phone call from program providers.

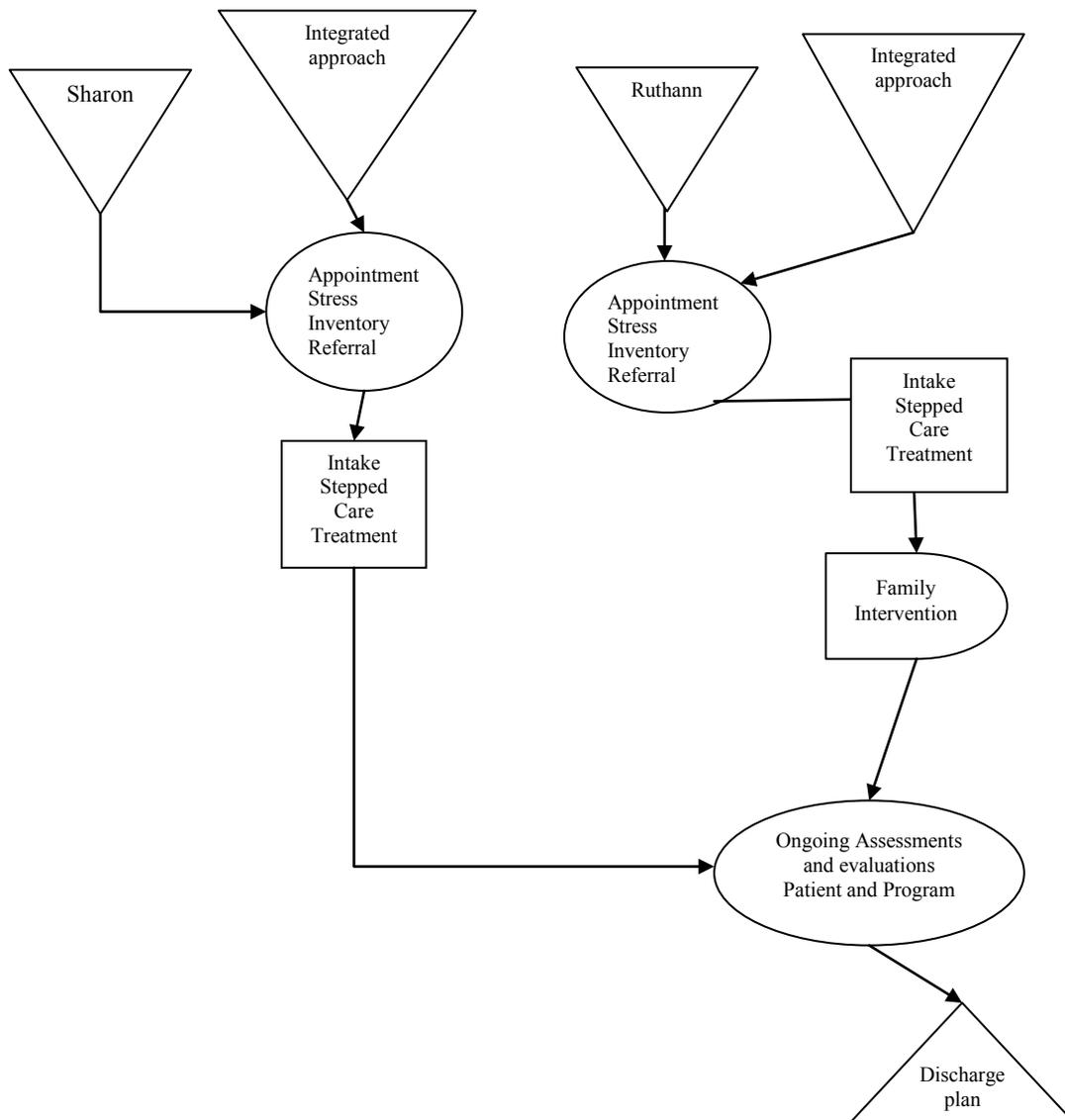
Ruthann finished individual therapy and is now in remission. She transferred to Level One and uses the MBSR group to reinforce mindfulness skills and abilities. Ruthann can apply MBSR and IPT skills to all areas of her life. Ruthann has returned to work, attends her ob/gyn appointments regularly, maintains healthy family relationships, and has a life with normal manageable levels of stress. Her progress and ability to sustain her mental and physical health continues to be monitored by medical and Utopia program personnel at the ob/gyn practice.

### **Case Examples Summary**

In both these case examples, the program met the patient at their level of severity and provided appropriate prevention and interventions specific to their therapeutic and medical needs. The Utopia program enabled the patient to address multiple diagnoses simultaneously

while reducing their level of stress and expression of symptomology. Integrated evidence-based and empirically supported psychological services were provided and delivery of services was streamlined, efficient, and effective. Program personnel recognized each patient’s risk and protective factors, and diverse characteristics. The program is tailored to address interpersonal problems while reinforcing and developing patient-specific stress protective factors and resilience. Patients experience satisfaction with therapy while therapy is administered in a cost-effective and efficient manner. Figure 1 provides a visual diagram of case examples’ program progression.

**Figure 1. Case Treatment Flow Chart**



## **Diversity and Ethical Dilemmas**

### **Diversity**

The Mindfulness philosophy provides attention to diversity that is woven throughout the program and its evaluation. Mindfulness principles of acceptance, trust, patience, beginner's mind, and non-judgment are all essential characteristics necessary to work effectively with diversity (APA, 2003; Kabat-Zinn, 1991; Roysircar-Sodowsky & Kuo, 2001). An ethno-motivational interviewing philosophy will govern providers' ability to meet each program participant where they are at based on their individual diversity characteristics such as race, socioeconomic status, gender, and sexual orientation to name a few (Swartz et al., 2007). Specifically, relevance to the overall delivery of program groups (i.e., how to implement theoretical approach, professional demeanor), clients presenting issue, relevance to accuracy of assessment, relevance to individual treatment (i.e., preventions, interventions, and follow-up treatment plans) will be extensively considered. Treatment specific issues may be interpreters, amount and appropriateness of family involvement, financial assistance, and religious/spiritual consideration. When implemented, the plan is to locate this program in Saratoga, New York. Saratoga is a medium-suburban area in New York of approximately 27,000 residents. Per capita personal income is just about \$37,000 (\$3,000 less than the country's average). There is a mix between impoverished, mid-class, and affluent families in Saratoga. The Utopia program is designed to meet the needs of individuals and families from mixed socio-economic levels through professional preparation, mindfulness, and an ethno-motivational interviewing approach.

### **Ethical Dilemmas**

Conflicts regarding case conceptualization, difference in interpretation, and confidentiality between program personnel as well as between program personnel and medical

providers are potential ethical dilemmas. Individual program providers may conceptualize a patient's severity based on risk and protective factors, clinical interview, and the intake battery differently. Although clinical and professional interpretation of these aspects may seem subjective at times, if handled inappropriately, patients can experience a delay in services and or triangulation between professionals. This leads to an increase in stress, decreasing trust, and experiencing psychological distress, if not harm. In an attempt to demonstrate understanding of differences in expectations, the program provides a resolution that avoids or minimizes harm (APA, 2010 para 1.03, 3.04). A doctoral-level clinician, outside of the dispute, will review the patient's collective information and make a designation. Doctoral clinicians are trained in ethics and how to effectively and competently handle ethical disputes (Kenkel & Peterson, 2010).

Patients are informed that their information is available for review by program personnel and their consultants. This will be a part of their informed consent. Clear and concise information regarding ethical responsibilities pertaining to diagnosis, treatment, and confidential practices will be written and provided to referrals sources, patients and families (APA, 2010). Pertinent professional ethics codes will appear on all informed consent forms, posted at the site, and verbally expressed continually throughout personnel trainings and program delivery.

Professional psychology programs, such as Antioch University, New England prepare their students to face the challenges of working in an integrated manner. For over 30 years programs like Antioch New England pride themselves on educating psychologist to obtain competencies in relationship, assessment, intervention, diversity, research/Evaluation, management/supervision, and consultation/education (Kenkel & Petterson, 2010). The integrated psychologist draws upon the knowledge, skills, and attitude gained in these areas through practical experience, classroom education, and programs milestones such as qualifying exams

and dissertation to not only develop integrated programs but to lead them. The longevity, breadth, and depth of our profession are indicative of our capabilities as long standing leaders of the integrated field. At one time we were pioneers, now we are leaders amongst other professions, such as the medical field, that now support and prepare their students to work collaboratively in the millennium (Kenkel & Petterson, 2010).

### **Future Considerations**

In general, this program can be used as a model for treatment for several other medical service providers such as in family practice, pediatrics, and cardiac care. It can also be modified to include applied therapeutic approaches such as equine, art, music and dance therapy. The treatment setting can also be urban, rural, or suburban. The Utopia program is a private-sector based program but it can move into public and/or governmental establishments like public housing, VA's, or colleges. The target populations can be modified based on gender, age, and marital status to name a few. This program's efficiency, effectiveness, and cost saving is in alignment with a universal health care system and the initiatives of APA. Therefore, various program implementations can increase access to empirically-supported treatments delivered through evidence-based integrated practices to all populations.

This program could have significant results if implemented with veterinarians. Whether for residential pets, farm animals, or a combination of the two, the health and well being of animals impact the individuals who own them. Animal illness and death can cause stress related to each IPT problem area. Financial and interpersonal stress accompanies the decisions regarding when and why to treat or euthanize animals.

This program could be implemented in an educational setting. Psychologists would work integratively with teachers, staff, and administration to identify and refer students that need stress

reduction. Adolescence is a stressful life stage and transitional period that is compounded with intrapersonal, interpersonal, and community stressors. As if this normative period were not challenging enough, certain populations face added obstacles. The program could enhance the ability of each adolescent to cope with stress by increasing attention regulation, social-emotional awareness, body awareness, and interpersonal skills through mindfulness training (Association for Mindfulness in Education, 2009).

On a larger scale, this program could be implemented to address the needs of a small village. Clinical psychologists could lead an integrated team that addresses the concerns of a small village with their medical, educational, and animal needs. There are villages that gain their livelihoods through hunting extinct animals. This program could enable clinical psychologist to assist a village with the stress of transitioning from these practices and developing a new source of livelihood. Domestic as well as foreign townships and villages suffer from issues related to livelihood and poverty. This program can be implemented to reach the needs of men, women, and children stressed by lack of resources and options as well as the impact of poverty on their lives.

## References

- American Psychiatric Association. (2000). *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (IV-TR.)*. Washington, DC: American Psychiatric Association.
- American Psychological Association. (1999). *Standards for educational and psychological testing*. Washington DC: American Educational Research Association.
- American Psychological Association, Presidential Task Force on Evidence-Based Practice. (2005). Policy Statement on Evidence-Based Practice. Retrieved from <http://www.apa.org/practice/resource/evidence/evidence-based-statement.pdf>
- Association For Mindfulness in Education. (2009). Association for Mindfulness in Education. *Association for Mindfulness in Education*. Retrieved June 21, 2010, from <http://www.mindfuleducation.org/>
- APA. (2003). Guidelines for multicultural psychotherapy proficiency for psychologist: Implications for Education and Training, Research and Clinical Practice. *American Psychologist*, 58, 377-402.
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271-285.
- APA. (2012). Stress in America: Our Health at Risk. Mind/Body Health: For a Healthy Mind and Body, Talk to a Psychologist, 1-78.
- APA. (2010). Ethical Principles of Psychologists and Code of Conduct. *American Psychological Association*. professional, . Retrieved August 7, 2011, from <http://www.apa.org/ethics/code/index.aspx>
- APA. (2015). Stress Definition. *American Psychological Association*. Retrieved

July 26, 2015, from <http://www.apa.org/topics/stress/>

- Bazarko, D., Cate, R. A., Azocar, F., & Kreitzer, M. J. (2013). The Impact of an Innovative Mindfulness-Based Stress Reduction Program on the Health and Well-Being of Nurses Employed in a Corporate Setting. *Journal of Workplace Behavioral Health, 28*(2), 107–133. doi:10.1080/15555240.2013.779518
- Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a Clinician-Administered PTSD Scale. *Journal of Traumatic Stress, 8*(1), 75-90-90.
- Blount, A., (2003) Integrated Primary Care: Organizing the Evidence. *Families, Systems & Health: 21*, 121-134
- Bower, P., & Gilbody, S. (2005). Stepped-care in psychological therapies: access, effectiveness and efficiency. *The British Journal of Psychiatry, 186*(1), 11 -17.  
doi:10.1192/bjp.186.1.11
- Carlton, E., Whiting, J., Bradford, K., Dyk, P., Vail, A. (2009) Defining Factors of Successful University –Community Collaborations: An Exploration of One Healthy Marriage Project, *Family Relations: Interdisciplinary Journal or Applied Family Studies, 58*, 28-40.
- Client Satisfaction Questionnaire (CSQ-8). (n.d). . Retrieved August 4, 2011, from [http://apntoolkit.mcmaster.ca/index.php?option=com\\_content&view=article&id=94:client-satisfaction-questionnaire-csq-8&catid=38:patient-satisfaction&Itemid=56](http://apntoolkit.mcmaster.ca/index.php?option=com_content&view=article&id=94:client-satisfaction-questionnaire-csq-8&catid=38:patient-satisfaction&Itemid=56)
- Davison, G. C. (2000). Stepped-care: Doing more with less? *Journal of Consulting and Clinical Psychology, 68*(4), 580-585. doi:10.1037//0022-006X.68.4.580
- Deshields, T. L., & Nanna, S. K. (2010). Providing Care for the “Whole Patient” in the Cancer Setting: The Psycho-Oncology Consultation Model of Patient Care. *Journal of Clinical*

- Psychology in Medical Settings*, 17(3), 249–257. doi:10.1007/s10880-010-9208-1
- Devilly, G., & Spence, S. H. (1999). The Relative Efficacy and Treatment Distress of EMDR and a Cognitive- Behavior Trauma Treatment Protocol in the Amelioration of Posttraumatic Stress Disorder. *Journal of Anxiety Disorders*, 13(1-2), 131-157.
- Erikson, E. H. (1963). *Childhood and Society* (2nd ed.). New York and London: W.W. Norton & Company Inc.
- Greater Nashua Mental Health Center, 2015, Intake Packet List
- Haaga, D. A. F. (2000). Introduction to the Special Section on Stepped-Care Models in Psychotherapy. *Journal of Consulting and Clinical Psychology*, 68(4), 547-548
- Hastings, R. P., & Singh, N. N. (2010). Mindfulness, Children, and Families. *Journal of Child and Family Studies*, 19(2), 131–132. doi:10.1007/s10826-010-9357-8
- Hayes, S. (2009). Association for Contextual Behavioral Science. *Acceptance & Commitment Therapy (ACT)*. Organization, . Retrieved August 4, 2011, from <http://contextualpsychology.org/>
- Hayes, Steven. (2005). *Get out of your mind & into your life: the new acceptance & commitment therapy*. Oakland CA: New Harbinger Publications.
- Herbert, J. D. (2003). The Science and Practice of Empirically Supported Treatments. *Behavior Modification*, 27(3), 412-430.
- Integrated Behavioral Health Project (2015). *Website on Integrated Behavioral Health Screening Tools for Primary Care*, . Retrieved July 15, 2015, from <http://www.ibhp.org/uploads/file/ScreeningTool%20Mandy.pdf>
- Kabat-Zinn, J., & University of Massachusetts Medical Center/Worcester. (1991). *Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and*

- illness*. New York, N.Y.: Pub. by Dell Pub. a division of Bantam Doubleday Dell Pub. Group.
- Kenkel M.B., & Peterson, R.L. (2010) *Competency-Based Education for Professional Psychology*. Washington, DC: American Psychological Association
- Koenen, K. C., Stellman, J. M., Stellman, S. D., & Sommer, J. F., Jr. (2003). Risk Factors for Course of Posttraumatic Stress Disorder Among Vietnam Veterans: A 14-Year Follow-Up of American Legionnaires. *Journal of Consulting and Clinical Psychology, 71*(6), 980-986. doi:10.1037/0022-006X.71.6.980
- Lambert, M. J., & Hawkins, E. J. (2004). Measuring Outcome in Professional Practice: Considerations in Selecting and Using Brief Outcome Instruments. *Professional Psychology: Research and Practice, 35*(5), 492-499.
- Markowitz, J. C., & Weissman, M. M. (2004). Interpersonal psychotherapy: principles and applications. *World Psychiatry, 3*(3), 136–139.
- Markowitz, J. C., & Swartz, H. A. (2007). Case formulation in interpersonal psychotherapy of depression. In *Handbook of psychotherapy case formulation* (2nd ed.). New York: Guilford Press.
- Najavits, L. (2002). Clinicians' views on treating posttraumatic stress disorder and substance use disorder. *Journal of Substance Abuse Treatment, 22*(2), 79-85.
- Najavits, L. (2004). Treatment of Posttraumatic Stress Disorder and Substance Abuse. *Alcoholism Treatment Quarterly, 22*(1), 43-62. doi:10.1300/J020v22n01\_04
- Novotney, A. (2010). Integrated care is nothing new for these psychologist. *Monitor on Psychology, 41*(1)40.
- Orbuch, T., Parry, C., Chesler, M., Fritz, J., & Repetto, P. (2005). Parent-Child Relationships

- and Quality of Life: Resilience Among Childhood Cancer Survivors. *Family Relations*, 54(April), 171–183.
- Ouimette, P., Cronkite, R., Henson, B. R., Prins, A., Gima, K., & Moos, R. H. (2004). Posttraumatic stress disorder and health status among female and male medical patients. | Mendeley. *Journal of Traumatic Stress*, 17(1), 1-9. doi:0894-9867/04/0200-0001/1
- Patterson, J. M. (1988). Families experiencing stress: I. The Family Adjustment and Adaptation Response Model: II. Applying the FAAR Model to health-related issues for intervention and research. *Family Systems Medicine*, 6(2), 202–237. doi:10.1037/h0089739
- Roysircar-Sodowsky, G., & Kuo, P. Y. (2001). Determining cultural validity of personality assessment: Some guidelines. D. Pope-Davis & H. Coleman (Eds.), *The intersection of race, class, & gender: Implications for multicultural counseling* (pp. 213-239). Thousand Oaks, CA: SAGE.
- Rutan, J. S., Stone, W. N., & Shay, J. J. (2007). *Psychodynamic group therapy* (4th ed.). New York and London: Guilford Press.
- Sattler, J. M., & Hoge, R. D. (2006). *Assessment of children: behavioral, social, and clinical foundations* (5th ed.). San Diego: J.M. Sattler.
- Sawyer Cohen, J. A., & Semple, R. J. (2009). Mindful Parenting: A Call for Research. *Journal of Child and Family Studies*, 19(2), 145–151. doi:10.1007/s10826-009-9285-7
- Schwab, W., Marth, C., & Bergant, A. M. (2012). Post-traumatic Stress Disorder Post Partum: The Impact of Birth on the Prevalence of Post-traumatic Stress Disorder (PTSD) in Multiparous Women. *Geburtshilfe Und Frauenheilkunde*, 72(1), 56–63. doi:10.1055/s-0031-1280408
- Shapiro, J., Sank, L. I., Shaffer, C. S., & Donovan, D. C. (1982). Cost effectiveness of individual

- vs. group cognitive behavior therapy for problems of depression and anxiety in an HMO population. *Journal Of Clinical Psychology*, 38(3), 674-677.
- Shapiro, J. P. (2009). Integrating outcome research and clinical reasoning in psychotherapy planning. *Professional Psychology: Research and Practice*, 40(1), 46-53.  
doi:10.1037/a0012596
- Sledjeski, E. M., Speisman, B., & Dierker, L. C. (2008). Does number of lifetime traumas explain the relationship between PTSD and chronic medical conditions? Answers from the National Comorbidity Survey-Replication (NCS-R). *Journal of Behavioral Medicine*, 31(4), 341–349. doi:10.1007/s10865-008-9158-3
- Society of Clinical Psychology. (n.d.). Society of Clinical Psychology. *Website on Research-Supported Psychological Treatments*. Organization, Retrieved July 22, 2011, from <http://www.psychology.sunysb.edu/eklonsky-/division12/index..html>
- Sommers-Flanagan, J. (2003). *Clinical interviewing* (3rd ed.). New York: Wiley.
- Stein, M. B., McQuaid, J. R., Pedrelli, P., Lenox, R., & McCahill, M. E. (2000). Posttraumatic stress disorder in the primary care medical setting. *General hospital psychiatry*, 22(4), 261-269.
- Stewart, M., Reid, G., & Mangham, C. (1997). Fostering Children's Resilience. *Journal of Pediatric Nursing*, 12(1), 21–31.
- Swartz, H. A., Zuckoff, A., Grote, N. K., Spielvogel, H. N., Bledsoe, S. E., Shear, M. K., & Frank, E. (2007). Engaging depressed patients in psychotherapy: Integrating techniques from motivational interviewing and ethnographic interviewing to improve treatment participation. *Professional Psychology: Research and Practice*, 38(4), 430-439.  
doi:10.1037/0735-7028.38.4.430

- Terhakopian, A., Sinaii, N., Engel, C. C., Schnurr, P. P., & Hoge, C. W. (2008). Estimating population prevalence of posttraumatic stress disorder: An example using the PTSD checklist. *Journal of Traumatic Stress, 21*(3), 290-300. doi:10.1002/jts.20341
- U.S. Dept. of VA. (2004). *Iraq war clinical guide. 2* (2nd ed.). National Center for PTSD. Retrieved from <http://www.ptsd.va.gov/index.asp>
- U.S. Dept. of VA. (2010). Va/DoD clinical practice guideline for management of post-traumatic stress: VA/DoD evidence-based practice. Version 2.0. *Mental Health*. Retrieved July 23, 2011, from <http://www.mentalhealth.va.gov/>
- U.S. Dept. of VA. (2011). National Center for PTSD. *United States Department of Veterans Affairs*. Retrieved July 22, 2011, from <http://www.ptsd.va.gov/index.asp>
- Ware, Jr., J. (n.d.). The SF Community - SF-36® Health Survey Update. *SF-36. research*, . Retrieved August 4, 2011, from <http://www.sf-36.org/tools/sf36.shtml>
- Weathers, F. W., Keane, T. M., & Davidson, J. R. T. (2001). Clinician-administered PTSD scale: A review of the first ten years of research. *Depression and Anxiety, 13*(3), 132-156. doi:10.1002/da.1029
- Weissman, M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York: BasicBooks.
- Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2007). *Clinician's quick guide to interpersonal psychotherapy*. Oxford; New York: Oxford University Press.
- Winnicott, D. W. (1986). Transitional Objects and Transitional Phenomena: A Study of the First Not-Me Possession. In *Essential Papers on Object Relations* (pp. 254–271). New York and London: New York University Press.
- W.K. Kellogg Foundation. (2005). *W.K. Kellogg Foundation evaluation handbook W.K. Kellogg*

*Foundation logic model development guide*. Battle Creek, Michigan: W.K. Kellogg Foundation.

Yalom, I. D. (1995). *Theory and practice of group psychotherapy* (4th ed.). New York: Basic Book.

Yalom, I. D., & Leszcz, M. (2005). *Theory and practice of group psychotherapy* (5th ed.). New York: Basic Book.