

Accelerated Unified Protocol for Transdiagnostic Treatment of Anxiety Disorders in a VHA System

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Background: Veterans often present with multiple co-occurring mental health disorders, such as anxiety and depression, posing significant treatment challenges. Veterans are at increased risk for suicide, and anxiety and mood disorders are associated with increased suicide attempts and death by suicide. The Unified Protocol (UP) is a transdiagnostic cognitive behavioral therapy (CBT) intervention that addresses underlying emotional experiences (ie, negative affect and emotional distress) present in anxiety, depressive, and emotional disorders. UP uses interventions that can also be found in other CBT protocols, including motivational enhancement, mindful awareness, cognitive reframing, and exposure strategies. As a transdiagnostic intervention, UP can address anxiety, mood, emotional disorders, and other co-occurring disorders within the same treatment. Few veterans who could benefit from high-quality CBT interventions, such as UP, can access them.

Observations: The Veterans Affairs Pacific Islands Health Care System (VAPIHCS) created the Intensive Virtual Evidence-

Based Psychotherapy Team for Anxiety With or Without Co-Occurring Depression program to deliver transdiagnostic UP with an accelerated model of service delivery (≥ 3 therapy sessions weekly). The program increased access to and completion of CBT for patients at VAPIHCS. By delivering UP in a massed or accelerated format (≥ 4 sessions weekly), the program provided an empirical solution that increased access to UP. It consists of 3 main components: (1) individual massed UP therapy (4 sessions weekly); (2) whole health and wellness classes (4 group sessions weekly); and (3) individual health coaching (1 session weekly). A total of 87.5% of participants completed all 16 UP therapy sessions the first year. Patients reported reduced anxiety, depression, suicidal ideation, and substance use risk with improvements in psychological flexibility and quality of life.

Conclusions: Virtual massed UP was found to be feasible, acceptable, effective, and to have high retention rates and patient satisfaction in a diverse veteran population with anxiety and other emotional disorders.

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Cognitive behavioral therapy (CBT) is supported as an effective treatment for depression by clinical practice guidelines from the US Department of Veterans Affairs (VA) and US Department of Defense.¹⁻³ Despite research supporting the use of evidence-based CBT for anxiety, mood, and emotional disorders, patient access to these interventions is limited.⁴ One barrier to CBT for anxiety, mood, and emotional disorders is the traditional use of single-disorder protocols (SDPs) to separately treat each disorder (eg, major depression, generalized anxiety disorder, panic disorder).

Use of SDPs places a high burden on clinicians, requiring them to learn and competently implement multiple different manualized interventions for each anxiety, mood, or emotional disorder encountered in practice.⁴ It is common for individuals who present with an anxiety, mood, or emotional disorder to experience co-occurring disorders.⁵ Traditional SDP-based CBT may require multiple SDPs to address co-occurring disorders, extending time in treatment and increasing training burden. There is evidence that even when an SDP is used, co-occurring difficulties may decrease in intensity.⁶ Thus,

evidence-based CBT for 1 presenting concern may positively affect co-occurring difficulties that are not the primary treatment target.⁶

Unified Protocol (UP) is a transdiagnostic CBT intervention for anxiety and mood disorders. UP targets emotional experiences (eg, negative affect and emotional distress) that are present in multiple anxiety, depression, and emotional disorders. UP is organized into 8 modules and uses interventions present in other CBT SDPs, such as teaching objective assessment methods to clients, motivational enhancement and goal setting, emotion psychoeducation, mindful awareness, cognitive reframing, and exposure principles as mechanisms of change (Table 1).⁴ UP is an ideal intervention for addressing a number of anxiety, mood, and emotional disorders as well as addressing co-occurring disorders within the same course of treatment.

UP has been compared to SDPs; studies illustrate that UP is equivalent to SDPs at the end of treatment and at 6 months posttreatment.^{4,7} Additionally, patients who received UP experienced symptom reduction for multiple co-occurring disorders.⁷ Furthermore, patients were less

TABLE 1. Unified Protocol Treatment Components

Session(s)	Focus	Module
1	Assessment	1: Motivation
2	Goals and motivation	1: Motivation
3–4	Emotion psychoeducation	2: Emotions
5–6	Mindful emotion awareness	3: Mindfulness
7–8	Cognitive flexibility	4: Cognitive flexibility
9–10	Countering emotional behaviors	5: Countering emotional behaviors
11	Understanding and confronting physical sensations	6: Physical sensations
12–15	Emotion exposures	7: Emotion exposures
16	Wrap-up and final review	8: Celebration and relapse prevention

likely to drop out of UP when compared with SDPs.⁴

Studies have reported positive impacts on affective disorders with UP. A 2019 meta-analysis found significant reductions in depression and anxiety-related disorders.⁸ Additionally, UP has been shown to be effective when delivered in person and via telehealth.^{9,10} UP has also been successfully used in veterans.¹¹ While traditional models of UP (1-2 sessions weekly) have a lower dropout rate than SDPs, UP and CBT dropout rates still leave room for improvement.¹²⁻¹⁴ Specifically, rates of attrition from SDP CBT and transdiagnostic CBT protocols range from 9% to 35%, and dropout reduces the likelihood of attaining a full therapeutic dose of any course of CBT. Notably, accelerated delivery of CBT (ie, ≥ 3 sessions/wk) has been shown to reduce risk of dropout.^{14,15}

Veterans are at increased risk for suicide, and anxiety and mood disorders are associated with increased risk of suicide attempt and death.^{16,17} Very few veterans who could benefit from high-quality CBT interventions, whether SDP or UP, are able to access them. Only 6.3% of veterans received ≥ 1 session of an evidence-based CBT SDP for posttraumatic stress disorder (PTSD) at 6 clinics evaluated in 2010.¹⁸

We identified 2 strategies to increase access to and completion of an evidence-based CBT course. First, the use of transdiagnostic UP instead of SDPs reduced burden on therapists and allowed them to address presenting

and co-occurring disorders within the same course of care. Second, the use of an accelerated model of service delivery reduced dropout risk. Training clinicians to deliver UP is efficient and cost-effective, considering clinicians use core strategies that can be tailored and flexibly applied to a range of emotional difficulties. Thus, implementing UP may decrease barriers to receiving an optimal dose of an evidence-based CBT delivered with fidelity in a time- and cost-efficient manner.⁴ Two studies have found no evidence of differences in outcomes between UP and SDPs, suggesting that training and supervising clinicians in a single transdiagnostic UP intervention may prepare them to treat heterogeneous and co-occurring anxiety, mood, and emotional disorders with less burden than learning multiple SDPs.^{7,19}

Delivering UP in an accelerated or massed format (≥ 4 sessions/wk) instead of the traditional spaced model (1 session/wk) has empirical support but has not been widely implemented. This approach, sometimes referred to as a UP-intensive outpatient program (UP-IOP) or UP-intensive outpatient track (UP-IOT), has been shown to be feasible, acceptable, and effective, with increased completion rates compared with traditional UP delivery (1-2 sessions/wk).²⁰⁻²²

Ragsdale et al describe a 2-week IOP with multiple treatment tracks, including a general track.²⁰ The general track includes massed UP and additional standard services, including case management, wellness services,

TABLE 2. Patient Demographics (N = 42)

	Results
Age, mean (IQR), y	46.9 (25-76)
Sex, No. (%)	
Male	28 (67)
Female	14 (33)
Race, No. (%)	
White	14 (33)
Black/African American	6 (14)
Asian/Pacific Islander	14 (33)
Other/Mixed	6 (14)
Prefer not to answer	2 (5)
Ethnicity, No. (%)	
Hispanic	5 (12)
Non-Hispanic	36 (86)
Prefer not to answer	1 (2)

family services, and a single session effective behaviors group. Additional augmentation services are available when clinically indicated (eg, repetitive transcranial magnetic stimulation, transcranial direct current stimulation, psychoeducation, motivational interviewing, relapse prevention). In other words, this was an UP-IOP.²⁰

Thompson-Brenner et al described a successful implementation of massed UP applied in intensive treatment settings, such as residential and day-hospital programs, for eating disorders. Patients reported improvements in 3 UP targets: experiential avoidance, mindfulness, and anxiety.²¹ Watkins et al evaluated a 2-week IOP using CBT for comorbid substance use and mental health disorders, including prolonged exposure, UP, and relapse prevention for substance use disorders. Participants were post-9/11 veterans and active-duty personnel. Results indicated that UP reduced PTSD and depressive symptoms following treatment. Furthermore, the retention rate (91%) was higher than retention in outpatient treatment (39%-65%), supporting the IOP model as a strategy to reduce dropout.²²

Massed psychotherapy has been extended to IOP programs for PTSD treatment within the Veterans Health Administration (VHA). Yamokoski et al found that patients who completed an IOP that included massed CBT for PTSD had high retention, high satisfaction, and significant reduction in self-reported co-occurring depression symptoms. The authors also found that this model of care could be implemented and

sustained within a VHA facility using minimal staffing resources.²³

The UP-IOP models described by Ragsdale et al and Watkins et al included massed UP as the primary evidence-based practice (EBP) with adjunctive groups (eg, wellness and educational groups and access to complementary interventions such as mindfulness and yoga); they found that adding these groups increased retention and patient-reported satisfaction (ie, UP-IOP).^{20,22} The addition of wellness education alongside a primary EBP aligns with the VHA focus on whole health well-being and wellness. This includes understanding factors that motivate a patient toward health and well-being, providing health education, and offering access to complementary interventions such as mindfulness.²⁴

Dryden et al described the whole health transformation within VHA as a proactive approach to addressing both employee and patient wellness. Their research found that the whole health model promoted well-being in patients and staff and these improvements were sustained during the COVID-19 pandemic. Dryden et al also noted that virtual technologies facilitated continued whole health implementation.²⁵

The literature illustrates that (1) massed UP can be delivered with complementary education and wellness offerings that may increase retention and satisfaction by enriching treatment (eg, delivering UP-IOP); (2) whole health, including wellness education and complementary interventions (eg, mindfulness, motivational enhancement), promotes well-being in patients and clinicians; and (3) whole health education and complementary interventions can be delivered virtually.

IVET

Health Care Need

Veterans Affairs Pacific Islands Health Care System (VAPIHCS) provides medical services to veterans in the Hawaiian Islands, American Samoa, Guam, and Saipan spanning nearly 4000 miles across the Pacific Ocean. Prior to implementation of this program, veterans who received care at VAPIHCS had little to no access to UP in outpatient settings and no access to UP in residential settings. Access to UP depended

TABLE 3. Intensive Virtual Evidence-Based Psychotherapy Team for Anxiety Program Outcomes (N = 42)

Outcome measure	Session 1 (mean)	Final session (mean)	P value
GAD-7	13.6	8.3	< .001 ^a
PHQ-9	14.6	9.7	< .001 ^a
PHQ-9 item 9 ^b	0.4	0.2	.002 ^a
AAQ-II	33.2	42.6	< .001 ^a
Use-BAM	0.7	0.6	.61
Risk-BAM	11.6	8.6	< .001 ^a
Protective-BAM	11.1	11.7	.32
Q-LES-Q-SF	38.4	46.0	< .001 ^a

Abbreviations: AAQ-II, Acceptance and Action Questionnaire-II; BAM, Brief Addiction Monitoring; GAD-7, Generalized Anxiety Disorder 7-item scale; PHQ-9, Patient Health Questionnaire 9-item scale; Q-LES-Q-SF, Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form.

^aStatistically significant, paired sample *t* test.

^bItem 9 evaluates suicidal ideation or self-injury.

on the presence of a therapist trained in UP within a given clinic and was geographically limited to the location of the UP-trained therapist. The limited outpatient access to UP was restricted to the traditional UP delivery model (eg, about 1 session/wk); thus, there was no access to accelerated UP for veterans served at VAPIHCS. In the fiscal year prior to implementation of the massed UP program, > 1000 VAPIHCS veterans had been diagnosed with obsessive-compulsive related disorder or anxiety. A massed-UP program with weekly rolling admissions would support access to UP for more veterans over 12 months, and the virtual treatment modality would reduce barriers for diverse and underserved veterans, making care more equitable and inclusive.

Successful implementation and sustainment of an EBP prompted the establishment of this UP program. In 2022, VAPIHCS launched the Intensive Virtual Evidence-Based Psychotherapy Team (iVET) for treatment of PTSD. This clinic and associated EBP project demonstrated that massed (≥ 3 individual sessions/wk) of prolonged exposure (PE) therapy, delivered virtually to a geographically diverse veteran population with PTSD, resulted in significant reductions in PTSD, depression, and anxiety symptoms and substance use risk factors, with very high retention rates. The iVET for PTSD program was feasible, acceptable, and effective, with

veterans reporting significant improvement in quality of life and high satisfaction with their mental health services.¹⁵ Given the known benefits of transdiagnostic UP treatment (vs SDPs), the need for accelerated UP, and success with accelerated PE, our goal was to spread the EBP of massed (≥ 3 sessions/wk) virtual psychotherapy to other presenting problems (eg, anxiety disorders with or without co-occurring unipolar depression) using transdiagnostic UP.

Program Description

The program implemented within outpatient mental health services at VAPIHCS was iVET for the treatment of anxiety with or without co-occurring depression. The program model consists of an accelerated course of UP and whole health education provided via VA Video Connect (VVC), the VA video telehealth platform. iVET is a 2- to 4-week program and consists of 3 parts: (1) massed individual UP for transdiagnostic treatment of anxiety and co-occurring depression, (2) group whole health and wellness classes, and (3) individual health coaching to address personal wellness goals. Programming is offered over 10-hour days to increase access across multiple time zones, especially to allow participation from Guam and Saipan.

When a patient is referred to iVET, the first contact is a video (or telephone) appointment with a registered nurse (RN) for a screening session. The screening session is designed to provide education about the program (including interventions, time commitment, and resources required for participation). Following education, the RN completes a safety screening, including screening for suicidal ideation and risk, as well as intimate partner violence risk. If urgent safety concerns are present, a licensed social worker or psychologist joins the screening to complete further risk assessment and address any safety concerns.

Following screening, patients are scheduled for a VVC telehealth intake with a licensed therapist (social worker or psychologist) to complete a diagnostic interview. Patients are sent a secure link to complete a measurement-based care (MBC) battery of self-report measures, including assessments of demographics, anxiety symptoms, depression symptoms, substance use, psychological flexibility, quality of life, and satisfaction with

mental health care. The results of the diagnostic interview and self-report measures are discussed with the patient during the intake session to plan next steps and support shared decision-making. This initial VVC intake not only allows for fit assessment but also serves to troubleshoot technical difficulties with the virtual platforms.

Notably, there are minimal exclusion criteria for participation in iVET. These include active unmanaged psychosis or manic symptoms, recent suicidal crises (attempt within 8 weeks), active nonsuicidal self-injury (within 8 weeks), and moderate to severe cognitive impairment. Following intake, patients are scheduled to begin their course of care with iVET. Upon completion of intake, patients receive program materials for individual and group classes and are told they will receive email links for all VVC telehealth appointments. Patients are admitted to the iVET on a rolling basis, thereby increasing access compared with closed group and/or cohort models of care.

Patients receiving iVET attend 2 to 4 telehealth appointments daily and complete exercises between sessions. The primary iVET for Anxiety program EBP intervention is a massed or accelerated individual course of UP, which includes 8 primary components: assessment, goals and motivation, understanding emotions, mindful emotion awareness, cognitive flexibility, countering emotional behaviors, understanding and confronting physical sensations, and emotional exposures. UP is delivered in 4 to 8 individual sessions weekly (60-90 minutes each), allowing completion of the full UP protocol with fidelity in 2 to 4 weeks. In addition to primary EBP intervention, patients participate in 4 group sessions weekly (50 minutes each) of a whole health and wellness education class and have access to 1 individual health coaching session weekly (30-60 minutes) to set wellness goals and receive coaching. During iVET, patients are invited to complete MBC batteries of self-report measures assessing anxiety symptoms, depression symptoms, substance use, psychological flexibility, quality of life, and satisfaction with mental health care at sessions 1, 5, 9, 13, and the final UP session. Following discharge from the iVET, patients are offered 1-, 3-, and 6-month individual postdischarge check-up

sessions with a therapist, during which they are invited to complete MBC measures and review relapse prevention and maintenance of treatment gains. Likewise, patients are offered 1-, 3-, and 6-month individual postdischarge check-up sessions with an RN focused on maintaining wellness gains.

The iVET for Anxiety staff has 3 therapists (psychologists or social workers) and 1 RN. Additionally, the iVET for Anxiety is supported by a program manager and a program support assistant who support 2 programs total (the iVET for Anxiety plus another mental health program). The primary cost of the program is staff salary. Additional resources included computer equipment for staff and supplies (eg, printed materials for patients and office supplies). Due to the virtual environment of care, iVET staff telework and do not require physical space within VAPIHCS.

Outcomes

Veterans receiving iVET for Anxiety are invited to complete MBC multiple times, including pretreatment, during UP treatment (sessions 1, 5, 9, 13, and the final session), and posttreatment (1, 3, and 6 months). MBC measures include self-reported demographics; a 2-item measure of satisfaction with mental health services; the Acceptance and Action Questionnaire II,²⁶ the Brief Addiction Monitor-Intensive Outpatient Program,²⁷ the Generalized Anxiety Disorder-7,²⁸ the Patient Health Questionnaire (PHQ-9),²⁹ and the Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form.³⁰

Forty-two veterans completed the iVET for Anxiety program, with a retention rate of 87.5% completing ≥ 16 sessions of massed UP (Table 2). Veterans reported reduced anxiety ($P < .001$), depression ($P < .001$), and substance use risk ($P < .001$). Veterans experienced improved acceptance of emotional experiences ($P < .001$) and quality of life ($P < .001$), based on paired sample *t* tests comparing session 1 vs final session scores on the self-reported measures. Veterans also reported high satisfaction with mental health care in iVET for Anxiety.

Veterans experienced reduced thoughts of death or suicidal ideation (SI) based on responses to item 9 of PHQ-9. When SI was categorically analyzed (presence vs absence)

using PHQ-9 item 9, there was an association observed between absence of SI and completion of a course of massed UP that does not appear to be due to chance, ($X^2 [1, N = 42] = 3.94; P = .047$). In addition, veterans who completed the program showed a significant decrease in SI severity measured continuously (range, 0-3) on PHQ-9 item 9 ($P < .05$) (Table 3).

Future Directions

The aim of this program is to see sustained patient outcomes as iVET continues to serve more veterans. Another line of inquiry is longer-term follow-up, given that long-term follow-up was not addressed in this project. We also hope that the accelerated model of care can be applied to treatment of other presenting concerns (eg, relationship difficulties, insomnia). Expansion of accelerated mental health treatment into other federal and non-federal health care settings is another area worthy of future inquiry. Exploration of staff satisfaction and burnout related to providing accelerated UP is another important future direction. Relatedly, assessment of the staff burden to learn 1 transdiagnostic EBP vs learning multiple SDPs is another future direction. Likewise, exploration of institutional benefits of investment in transdiagnostic training, supervision, and consultation for UP vs multiple SDPs may be important. These areas could also result in insightful, beneficial evidence of the effectiveness of massed UP to add to the existing literature.

CONCLUSIONS

UP for transdiagnostic treatment of anxiety, depressive, and emotional disorders has demonstrated reduced suffering and improved functioning and is supported by multiple clinical practice guidelines.¹⁻⁴ Federal practitioners are positioned to improve access to this intervention, thereby reducing pain and improving lives. Indeed, it is crucial to envision a future state in which access to UP for a range of anxiety and depressive disorders is improved and broad, retention rates are dramatically improved, and clinicians providing UP do not experience the high burden and burnout associated with needing to learn and implement a variety of SDPs. Development of these programs, or similar tracks within existing programs,

that provide massed or accelerated UP for transdiagnostic treatment of a range of anxiety and depressive disorders with virtual delivery options, is imperative to advance improved care for patients and clinicians.

Federal health care settings treating patients with anxiety and depression, such as those within the US Department of Defense, Indian Health Services, Bureau of Prisons, and VHA, are positioned to implement programs like iVET. Moreover, at the institutional level, investment in training and supervision in the transdiagnostic UP as opposed to multiple SDPs warrants consideration. We believe this model of care has great merit and foresee a future where all patients seeking treatment for anxiety and depression have the option to complete an accelerated or massed course of transdiagnostic care with UP if they so desire. Our experiences with iVET illustrate the feasibility, acceptability, and sustainability of such programs without requiring substantial staffing and financial resources.

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Disclaimer

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Ethics and consent

Veteran participation in iVET was voluntary and optional. Participants engaged in routine informed consent practices utilized for all veterans receiving mental health care at VAPIHCS. The development of iVET was an Evidence Based Practice (EBP) Council approved project at VAPIHCS and, as such, it is not considered research and is exempt from Institutional Review Board review. The project was approved by the council on December 26, 2023, and Chief of Staff on December 29, 2023. The project final report was submitted to the EBP Council on February 28, 2025, and the project remains in the sustainment phase.

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