A PROVIDER'S GUIDE TO

BRIEF COGNITIVE BEHAVIORAL THERAPY

south central
mirecc
Mental Illness Research, Education
and Clinical Center

Jeffrey A. Cully, Ph.D.

Darius B. Dawson, Ph.D.

Joshua Hamer, Ph.D.

Andra Teten Tharp, Ph.D.

THE BRIEF CBT MANUAL

This manual is designed for mental health practitioners who want to establish a solid foundation of cognitive behavioral therapy (CBT) skills. Concepts contained in the manual detail the basic steps needed to provide CBT ("Practicing CBT 101") with the intent that users will feel increasingly comfortable administering CBT. The manual is not designed for advanced CBT practitioners.

Instructional material in this program is designed to be used within the context of a psychotherapy supervisory relationship to ensure appropriate application of the training materials and timely feedback, which are viewed as critical to the development of CBT skills.

The content of this manual is a compilation of foundational works on CBT, such as Judith Beck's (2011) *Cognitive Therapy: Basics and Beyond,* with the addition of key skills needed for developing CBT providers. The information is condensed and packaged to be highly applicable for use in a brief therapy model and to aid in rapid training.

TABLE OF CONTENTS

ESSENTIAL PSYCHOTHERAPY SKILLS

Module 1: Introduction to Brief Cognitive Behavioral Therapy (bCBT)
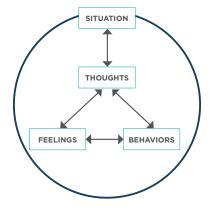
OBJECTIVES
- To understand CBT and the process of brief CBT
- To identify key treatment considerations and problems most suitable for brief CBT
- To learn how to assess the patient's suitability for brief CBT

What is Brief CBT, and Why Does It Require Specific Treatment Considerations?

CBT combines cognitive and behavioral therapies and has strong empirical support for treating mood, sleep, chronic pain, and anxiety disorders (Hoffman & Otto, 2017; Lepping et al., 2017; Shatkin, 2018). The basic premise of CBT is that emotions are difficult to change directly, so CBT targets emotions by changing thoughts and behaviors that are contributing to the distressing emotions.

Figure 1.1. Cognitive Behavioral Model

This training manual is focused on second-generation **CBT** (Beckian Cognitive Therapy), which focuses on using cognitive restructuring and relaxation techniques to influence behavior change. From this perspective, we may understand situational feelings as influencing thought patterns, behavioral responses, and long-lasting emotional states.

CBT builds a set of skills that enables individuals to

1. Identify how situations influence thoughts and behaviors
2. Become aware of the connection between thoughts, behaviors, and emotions
3. Improve emotional states by changing unhelpful thinking styles and behaviors linked to negative emotional sates.

The process of CBT skill acquisition is collaborative. Skill acquisition and homework assignments are what set CBT apart from "talk therapies" and nondirective therapies. Time in session should be used to help the patient obtain skills to address the presenting problem and not simply to discuss the issue with the patient or offer advice. Identifying and *changing* unhelpful thoughts and behaviors sets CBT apart from third-wave therapies such as acceptance and commitment therapy, mindfulness-based therapies, and dialectical behavior therapy.

Brief CBT is the compression of CBT material and reduction of the average 12-20 sessions into four to eight sessions. In brief CBT the concentration is on specific treatments for a limited number of the patient's problems. Specificity of the treatment is required because of the limited number of sessions. Additionally, the patient is asked to be diligent in using extra reading materials and homework to assist in his or her therapeutic growth.

Brief CBT can range in duration from patient to patient and provider to provider. The exact length of treatment will be determined by a host of factors involving the provider, patient, and treatment setting. Although variability exists, the table below shows an example session-by-session outline. You are encouraged to think flexibly in determining length of treatment. As indicated in the table, you are not expected to rigidly adhere to a "set schedule" of progress or topics but rather should be flexible and adaptive in approaching brief CBT applications. Time-limited therapy may offer additional incentives for patients and providers to work efficiently and effectively. For example, it is often helpful to work within a "session-limited framework" in which the patient receives four-to-six sessions of "active" treatment, followed by one or more follow-up sessions that occur at increasing intervals after the active-treatment phase (e.g., two weeks posttreatment with an additional booster four weeks after that).
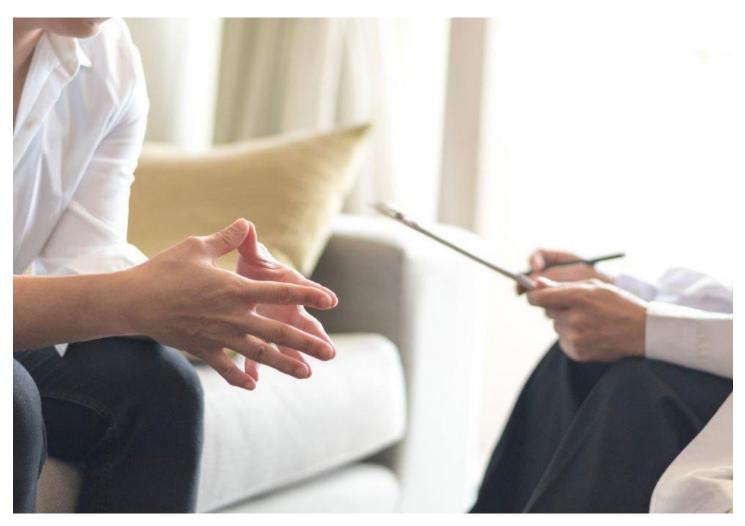
Table 1.1 Potential Brief CBT Session Structure

Session	Session Content	Possible Modules
Session 1	Orient the Patient to CBT Assess Patient Concerns Set Initial Treatment Plan/Goals	Module 4: Case Conceptualization Module 5: Cultural Considerations Module 6: Using Technology Module 7: Orienting the Patient Module 8: Goal Setting
Session 2	Assess Patient Concerns (cont'd). Set Initial Goals (cont'd) Or Begin Intervention Techniques.	Module 4: Case Conceptualization Module 8: Goal Setting Technique Modules 11-16: Unhelpful Thoughts, Behavioral Activation, Problem Solving, Relaxation, Exposure
Session 3	Begin/Continue Intervention Techniques	Technique Modules 11-16
Session 4	Continue Intervention Techniques. Re-assess Goals/Treatment Plan	Technique Modules 11-16 Module 4: Case Conceptualization Module 5: Cultural Considerations Module 8: Goal Setting
Session 5	Continue/Refine Intervention Techniques.	Technique Modules 11-16
Session 6	Continue Intervention Techniques.	Technique Modules 11-16
Session 7	Continue Intervention Techniques.	Technique Modules 11-16
Session 8	End Treatment and Help Patient to Maintain Changes.	Module 18: Ending Treatment and Maintaining Changes

When? Indications/Contraindications

Certain problems are more appropriate for brief CBT than others. The following table summarizes problems that may and may not be conducive to brief CBT. Problems amenable to brief CBT include, but are not limited to, adjustment, anxiety, and depressive disorders. Therapy also may be useful for problems that target specific symptoms (e.g., depressive thinking) or lifestyle changes (e.g., problem solving, relaxation), whether or not these issues are part of a formal psychiatric diagnosis.

Brief CBT is particularly useful in a primary care setting for patients with anxiety and depression associated with a medical condition. Because these individuals often face acute rather than chronic mental health issues and have many coping strategies already

in place, brief CBT can be used to enhance adjustment. Issues that may be addressed in primary care with brief CBT include, but are not limited to, diet, exercise, sleep, pain, medication compliance, mental health issues associated with a medical condition, and coping with a chronic illness or new diagnosis (Cully et al., 2017).

Other problems may not be suitable for the use of brief CBT or may complicate a straightforward application of brief CBT. Axis II disorders, such as Borderline Personality Disorder or Antisocial Personality Disorder, are not typically appropriate for a shortened therapeutic experience, because of the pervasive social, psychological, and relational problems individuals with these disorders experience. Patients exhibiting comorbid conditions also may not be appropriate because the presence of a second issue may impede progress in therapy. For example, an individual with substance dependence secondary to major depression may not be appropriate because substance use requires a higher level of care and more comprehensive treatment than is available in a brief format. However, brief CBT could be used with Axis II and comorbid concerns in dealing with specific negative behaviors or in conjunction with more intensive treatment.

Table 1.2 Examples of Suitable and Unsuitable Problems for Brief CBT

Problem	Brief CBT?
Anxiety	Yes
Depression	Yes
Assertiveness	Yes
Diet	Yes
Exercise	Yes
Social Isolation	Yes
Specific Phobia	Maybe
Panic Disorder	Yes
Grief/Bereavement	Yes
New Diagnosis of Chronic	Yes
Obstructive Pulmonary	Yes
Disease	Yes
Coping with	No
Chemotherapy	No
Caregiver Burden	Maybe

Problem	Brief CBT?
Alcohol Dependence	Maybe
Paranoid Personality	Maybe
Disorder Crisis	No
Intervention	Yes
Chronic Posttraumatic	Yes
Stress Disorder	Yes
Divorce	Yes
Somatoform Disorder	Yes
Sleep	Maybe
Pain	Yes
Health Anxiety	Maybe
Treatment Adherence	Yes
Motivational Engagement	Yes
Schizophrenia	Maybe

How? (Instructions/Handouts)

PROVIDER CONSIDERATIONS

It is important to be adequately skilled to evoke change in a patient's life in a short time. You should periodically assess and seek supervision/consultation regarding your capabilities in the process and content of brief CBT.

The following are general provider skills and abilities required for brief CBT:

- Capability to establish a strong working relationship quickly
- Thorough knowledge of the treatments used
- Ability to integrate and use treatment manuals
- Thorough and quick assessment of patient concerns
- Skill in structuring sessions and homework material to address problems
- Skill in presenting material clearly and concisely with specific examples for each patient issue
- Provider interpersonal/personality variables: ability to be assertive, directive, nonjudgmental and collaborative

ASSESSING THE PATIENT

It is necessary to collaboratively engage patients appropriate for brief CBT versus traditional CBT or other types of therapy. Below are important points to consider in selecting patients for brief CBT. This assessment should precede the treatment phase. It may be based on the intake assessment, input from the referral source, or a review of the medical chart.

Highlight 1.1 Things to Consider in Evaluating Patients for Brief CBT

1. **Strong Motivation to Change**
   a. Increased distress is often associated with increased motivation to change.
   b. Positive treatment expectancies (e.g., knowledge of CBT and perceived benefits of treatment) are associated with improved outcomes. Alternatively, the patient does not have negative self-thoughts that might impede progress or change (e.g., "Seeking care means I am crazy"; "Nothing I will do can change things").
   c. Patients who have clear goals for treatment are good candidates.

2. **Time Commitment**
   a. Patient is willing to devote the time needed for weekly or biweekly sessions.
   b. Patient is willing to devote energy to out-of-session work (e.g., homework).

3. **Life Stressors and Social Support**
   a. Too many life stressors may lead to unfocused work and/or frequent "crisis-management" interventions.
   b. Patients supported by family and friends are more likely to benefit.

4. **Cognitive Functioning and Educational Level**
   a. Independent homework assignments and reading materials may require adjustment according to patients' cognitive status and educational level.
   b. Patients able to work independently are more likely to carry out between-session work.
   c. Patients who are psychologically minded are more likely to benefit from short-term therapy.

5. **Severity of Psychopathology**
   a. Patients with comorbid psychopathology may be more difficult to treat in short-term therapy. In addition, some conditions such as substance abuse or serious mental illness require focused and more intensive interventions.
   b. Patients with an Axis II diagnosis are also less likely to benefit from short-term CBT. Long-standing interpersonal issues often require longer treatment durations.

SUPPLEMENTAL READINGS

Beck, J.S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford Press; Chapter 1.

Bond, F.W. & Dryden, W. (2002). *Handbook of brief cognitive behavioral therapy.* San Francisco: Wiley.

Cully, J., Stanley, M., Petersen, N., Hundt, N., Kauth, M., Naik, A., Sorocco, K., Sansgiry, S., Zeno, D., & Kunik, M. (2017). Delivery of Brief Cognitive Behavioral Therapy for Medically Ill Patients in Primary Care: A pragmatic randomized clinical trial. *Journal of General Internal Medicine, 32*(9), 1014–1024.

Hofmann, S., & Otto, M. (2017). *Cognitive behavioral therapy for social anxiety disorder : Evidence-based and disorder specific treatment techniques.* Routledge.

Lepping, P., Whittington, R., Sambhi, R., Lane, S., Poole, R., Leucht, S., Cuijpers, P., Mccabe, R., & Waheed, W. (2017). Clinical relevance of findings in trials of CBT for depression. *European Psychiatry, 45,* 207–211.

Shatkin, J. (2018). 14.2 Sleep hygiene and CBT for insomnia (CBT-I). *Journal of the American Academy of Child & Adolescent Psychiatry, 57*(10), S21–S21.

Module 2: Using Supervision

OBJECTIVES

- To discuss the importance of supervision/consultation in CBT training
- To provide information on how to use clinical supervision and consultation in CBT training
- To outline various models of supervision/consultation in CBT training
- To provide tips on selecting a supervisor/consultant

Introduction

Knowledge about psychotherapy can be broken down into two broad domains, 1) knowledge of concepts and 2) knowledge of how to apply concepts. Information contained in this manual will provide you with basic knowledge of CBT concepts and attempt to provide you with practical tips on how to use these concepts. However, because the provision of CBT is highly variable, depending on the provider, patient, and treatment setting, applications of CBT will need to be customized and practiced in real-world settings. This manual is, therefore, only the first step toward CBT competency. Supervision and consultation are two methods to advance CBT practice skills through routine feedback and interaction with a knowledgeable CBT provider who can serve as a trainer/consultant.

What is Supervision, and Why Is It Important to CBT?

Supervision is designed to a) foster the supervisee's development and b) ensure patient welfare and safety by monitoring patient care. Supervision is NOT therapy; although supervision may involve an exploration of a provider's personal experiences, such a focus is restricted to issues that influence the provider's professional work (see following table.)

Table 2.1 Goals and Focus of Supervision

For the Supervisee	• Provides provider performance feedback • Provides guidance and acquisition of alternative viewpoints • Contributes to the process of forming a provider's identity • Serves as a secure base to explore applications and therapeutic principles

For the Patient	• Ensures that patients receive acceptable care
	  » Providers do no harm
	  » Providers possess sufficient skills
	  » Those who lack skills are provided with remediation

SUPERVISION VERSUS CONSULTATION

There is a difference between supervision and consultation. Whereas supervision involves the direct oversight of clinical cases over a period of time (often involving evaluation of the provider), consultation refers to a relationship designed to assist in professional development that does not involve formal oversight of clinical cases and may or may not continue over time. In essence, consultation involves a growth-oriented discussion of cases or issues without oversight or evaluation.

<u>When? (Indications/Contraindications)</u>

Ideally, supervision or consultation occurs on a regular basis. Typically, for providers learning CBT, supervision/consultation should occur every week or every other week. Monthly consultation meetings may be appropriate for licensed practitioners in a more advanced stage of psychotherapy training. Supervision and/or consultation may also augment workshop-based training, with the workshop building initial skills and consultation/supervision helping the provider to deliver high-quality care during real-world applications.

<u>How? (Instructions/Handouts)</u>

The following table outlines the most common formats for supervision. The usefulness of each procedure will be determined by the goals of supervision and the supervisee's level of training and developmental needs. Exposure to multiple training modalities is seen as most effective.
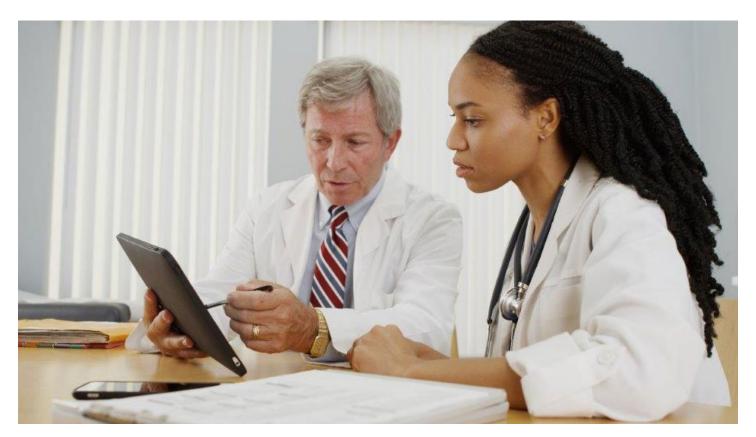
Table 2.2 Common Formats for Supervision

Format	Description	Advantages	Disadvantages
Verbal Report	Providers verbally report the details of a given therapy session, or case, to the supervisor.	• Less threatening to providers • Allows free-flowing discussion between provider and supervisor	• Subject to provider recollection (errors and omissions) • Limited ability for supervisors to monitor and provide feedback on the "process" of therapy
Process Notes	Providers write down and recount issues identified in session along with their own personal reactions and feelings encountered in the session.	• Less threatening to providers • Provide a more detailed recount of the session (compared with verbal report alone) • Begin to identify provider issues during session (process)	• Subject to provider focus and recollection • Limited ability to monitor and provide feedback on the process of therapy
Audio/Video Recording	Actual sessions are audio or video recorded and reviewed in supervision.	• Provides access to objective and process content of sessions • Serves as an excellent learning tool	• Can be intimidating to providers (and sometimes to patients) • Logistical issues – specific informed consent for patients, availability of equipment
Live Supervision	The supervisor is in the room (connected through audio/visual technology) with the supervisee and patient or watching through a double-sided window. The supervisor does not engage in direct therapy, but instead the supervisee consults with the supervisor in the presence of the patient.	• Provides the supervisor with real-time evidence of supervisee's clinical skills development • Allows the supervisee to enhance therapeutic approaches and/or learn alternative approaches in real-time with a patient	• Possibility of missing nonverbal cues during the consulting encounter if connected by telephone. • Possibility of novice providers being threatened or anxious • Possibility of patient discomfort with this approach. • Possibility of reduction in credibility of novice provider with patients if the intent for this modality is not adequately explained at the outset
Group Supervision	Multiple providers interact with supervisor in group format.	• Provides provider-to-provider learning • Uses all the above techniques in addition to group format	• Less individual emphasis, not as much time for each individual

SELECTING A SUPERVISOR / CONSULTANT

The following are characteristics to seek out in selecting a CBT supervisor or consultant:

1. CBT knowledge and practice experience

   • Ideally, CBT supervisors and consultants have received formal training in CBT and use CBT in their daily clinical practice.

2. Availability

   • For those first learning how to apply CBT, it is highly recommended that you identify supervisors/consultants who are available for weekly or bi-weekly meetings that involve anywhere from 30 to 60 minutes per meeting. The actual length of meetings can be determined by the number of cases being reviewed.

   • Consider logistical issues in scheduling. Would the supervisor/consultant be available for in-person or telephone sessions (in-person is more effective)? Consider proximity, travel, and availability of resources (e.g., audio/video recording).

3. Experience with a patient population similar to those you will be serving, as well as considering experience with brief or longer-term therapy.

SUPPLEMENTAL READINGS

Bernard, J. M. & Goodyear, R.K. (2004). *Fundamentals of clinical supervision* (3rd ed.). New York: Pearson.

Liese, B.S. & Beck, J.S. (1997). Cognitive therapy supervision. In Watkins, C.E. (Ed). *Handbook of psychotherapy supervision*. New York: Wiley; pp114-133.

Module 3: Therapeutic Skills in Brief CBT

OBJECTIVES

- To better understand the need for a strong therapeutic relationship in brief CBT
- To understand the factors associated with a strong therapeutic relationship
- To learn strategies for developing rapport and maximizing nonspecific factors

What are Therapeutic Skills, and Why Are They Important to CBT?

CBT is structured and goal-directed. The context is supportive, and the techniques are paired with a collaborative therapeutic stance. Therapeutic skills refer to the relationship components of therapy (e.g., rapport, installation of hope, trust, collaboration) and are comparable with treatment-specific skills that refer to the technical aspects of the psychotherapy orientation (e.g., the actual techniques such as guided imagery, thought challenging, etc.). Therapeutic skills are common within all psychotherapies and serve as the foundation for patient improvement. Refer to intervention techniques unique to the type of therapy being provided (e.g., CBT, psychodynamic, interpersonal). Studies show that therapeutic skills are responsible for a large percentage of the change associated with psychotherapy treatments.

When? (Indications/Contraindications)

Therapeutic skills are critical during the early stages and important at all phases of treatment. Strong therapeutic skills aid in engaging and retaining patients in psychotherapy and also strengthen the technical components of treatment. Patients who perceive the therapeutic relationship to be collaborative, safe, and trusting are in a better position to obtain benefit from the treatment, will likely be less resistant and more open to exploration and change. As treatment progresses, the therapeutic relationship should become stronger, allowing the provider and patient to gradually move into more complex and meaningful therapeutic issues.

How? (Instructions/Handouts)

Borrowing from person-centered therapy, this module focuses on four factors (Figure 3.1) important to the development of a strong therapeutic relationship. These factors are empathy, genuineness, and positive regard. These concepts are defined and discussed and represent general characteristics that all providers should attain in working with patients. Following a discussion of these principles, active listening is introduced as a technique to better attain a solid therapeutic relationship.

EMPATHY (VALIDATING THE PATIENT'S EXPERIENCE)

Empathy is the ability to understand experiences from another person's point of view. Empathy is an important part of building rapport and facilitates feelings of trust and mutual respect between the patient and provider. It is impossible for a provider to be knowledgeable about every patient's unique background. Empathy, which at its core

consists of asking questions in a respectfully curious manner and expressing emotional understanding of the answers received, is a solid first step towards understanding patients' unique life background. Additional reading about cultural differences may facilitate more informed questions and better prepare the provider for additional questions and/or rapport development.

Showing empathy to patients helps to validate their experiences. Being critical, even subtly, of what patients are sharing in therapy often makes them feel judged and unwilling to disclose additional information. Use validating responses to show empathy towards a patient. Validating responses are simply statements of understanding of your patient's viewpoint. Validating responses usually entails the provider's describing what the provider heard the patient say, in a nonjudgmental manner.

Figure 3.1 Developing a Strong Therapeutic Relationship

EMPATHY
(Validating the Patients' Experience)

GENUINENESS
(Being Authentic)

POSITIVE REGARD
(Respect)

ACTIVE LISTENING

STRONG THERAPEUTIC RELATIONSHIP

GENUINENESS

Genuineness is the ability to be authentic and free of deceit or judgment. You can be professional and express who you are at the same time. Genuineness helps build rapport and solidify a therapeutic relationship by allowing the patient to view the provider as a human being. Patients often assess the genuineness of the provider for credible feedback about progress in their functioning.

Genuineness consists of a wide variety of concepts ranging from nonverbal behaviors to overt statements. Examples of factors related to genuineness include:

Supporting nonverbal behavior: Providers should be aware of their own nonverbal behaviors like keeping eye contact, giving a patient your full attention like substitute such as for like keeping eye contact, giving a patient your full attention, and nodding in agreement or understanding. It's important that these nonverbal behaviors match what is going on in the conversation, so as not to seem unnatural or inauthentic.

Role behavior: CBT providers encourage patients to be active and empowered and subsequently attempt to facilitate this development through their behaviors in therapy. Providers that stress their authority in and between sessions with patients can cause a patient to feel inferior or intimidated. It is important to remember that the therapeutic relationship is one of partnership and the provider and patient work together to alleviate concerns, fears, and problems in the patient's life.

Congruence: Making sure that your words, nonverbal behavior, and feelings match each other is referred to as congruence. Not demonstrating congruence of your feelings and thoughts can become confusing or misleading to a patient.

Spontaneity: This concept deals with the way the provider speaks and the timeliness of responses. Responses and feedback provided "in the moment" are more valuable than feedback provided at a later time. Patients are more likely to receive spontaneous messages as genuine.

POSITIVE REGARD

Positive regard simply means showing all patients the respect they deserve. It's essential to show patients that they are valued and that what they have to say is important. Patients who feel that their thoughts and feelings are acknowledged and understood often share more and feel more connected to the provider and the therapeutic process.

Communicating positive regard may be harder than it seems, especially if you hold some negative beliefs about the person you are trying to help. Sharing any negative feelings or beliefs about your patients with your supervisor or consultant can be an excellent method to ensure that you develop and demonstrate genuine positive regard toward your patients.

Commitment to the patient means that you are dedicated to working with patients on whatever issues they are bringing to therapy. This includes being on time, avoiding canceling patients' appointments, and using all efforts to help patients work through these issues.

Having a nonjudgmental attitude towards the thoughts, feelings, and actions of the patient is essential. It is possible to accept and understand a perspective without necessarily agreeing with it.

Displaying warmth towards patients is a vital part of building rapport. Warmth can be displayed through tone of voice, facial expressions and body postures, or the thoughtfulness of your responses.

The following section addresses the concept of active listening. Active listening is a useful technique to communicate the nonspecific factors of empathy, genuineness, and positive regard.

ACTIVE LISTENING

Listening to your patients is the foundation of all therapeutic approaches. Listening is made up of three steps: receiving a message, processing it, and sending it back. Providers should attempt to remain open to all messages from their patients (both verbal and nonverbal) and attempt to process as many messages as possible.

Clarification: Since we all speak from our own frame of reference, messages we send to others may not be received in the way we intend. Clarification is a useful and necessary tool for all providers. Clarification can be used to help simplify a message that is being sent by patients or to help confirm the accuracy of what providers think they have understood.

In-Session Example 3.1

Patient	I just do not feel like trying any more.
Provider:	**Tell me more about what you mean.**
Patient:	I just feel like giving up
Provider:	**Do you mean giving up on your goal to complete college; or are you referring to something different, like giving up on life and possibly harming yourself?**
Patient:	I am not referring to suicide, if that is what you mean; but I am feeling really depressed. Each day seems like such a struggle, and I often just feel like staying in bed. When I said "give up," I guess I was referring to not wanting to face all the struggles I face in life … my school work, financial problems, relationship problems, etc.

Notice that the clarifying statement and question helped the provider and patient to more fully explore her feelings and thoughts. Given this new information, the provider is in a better position to explore the patient's concerns and to set up targeted efforts and strategies for treatment.

Paraphrasing and Reflection: These techniques involve restating the patient's main thoughts in a different way or reflecting back the emotions the patient is currently experiencing to gain depth or clarification.

In-Session Example 3.2

Patient:	Since my fiancé's death, I feel like every day is a struggle; and I often question whether my life will ever get better. I just miss him so much that I think about him constantly. I don't know what to do, but the pain is getting to be too much.
Provider:	**You are really struggling to feel better, and much of your pain comes from the grief and loss you feel from losing your fiancé. You may even be questioning whether or not this pain will subside because it is getting unmanageable.**
Patient:	Yes, that is correct. I do not want you to think that I think only about the pain of losing him. The pain I feel comes from my intense feelings of loss, but this pain is also because I miss all the things he meant to me and the joy he brought to my life. I am really struggling because I do not want to let go of him, but holding on hurts so much.

In this example of paraphrasing, the provider gives back to the patient what he or she heard, which allows the patient to hear her own words and react with a more detailed response. The use of paraphrasing in this example facilitated a deeper understanding of the issue but also conveyed to the patient a feeling of being heard and understood.

Listening for Themes and Summary Statements: Often, patients express thoughts, feelings and behaviors that become thematic across situations. Although novice providers may initially have difficulties identifying this thematic content, repetition over time (e.g., across sessions) usually helps to create a clearer picture of the salient therapeutic issues that require attention or focus. With experience, providers become more effective and efficient at identifying thematic content.

Once identified, thematic content can be a very powerful mechanism to influence treatment outcomes. Summarization is the technique that brings thematic content into the purview of the patient. Summarization is a condensed phrasing of the patient's responses over a specific period of time (e.g., across the session, since the outset of treatment, since the onset of his/her current difficulties.) You should rephrase the themes, and repeat them back to the patient for clarification.

BARRIERS AND CHALLENGES TO BUILDING AN EFFECTIVE THERAPEUTIC RELATIONSHIP

Setting limits in an empathetic manner is an essential tool for new providers. Many new providers desire to "make it all better," in that they may coddle and console the patient and are distracted from working on deeper issues. A provider can create a holding environment through empathetic words and active listening. A holding environment is a setting in which the patient feels like he or she is being heard and that he or she is in a safe and secure place to voice thoughts and feelings without judgment.

Moving from rapport and relationship building to assessment and goal setting can be challenging. When provider and patient are "on the same page," this transition appears

seamless. Often, however, patients and providers are not speaking the same language. For example, a provider may feel most comfortable when tackling a certain issue first; whereas a patient may wish to focus on a different problem first. When the provider and patient are not in congruence regarding goals, the move between rapport building and goal setting is strained. To overcome this issue, providers are encouraged to use motivational interviewing strategies (see Rollnick, Butler, and Mason – Chapters 3, 4, and 5). Primary techniques involve listening to the patient, following the patient's lead and/or motivation, and setting collaborative and mutually agreed-upon goals. A vital aspect to transitioning from rapport to goal setting involves assessing the importance, confidence, and readiness of the patient about specific treatment goals (see Goal Setting, Module 8).

SUPPLEMENTAL READINGS

Beck, J.S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford Press; Chapter 2.

Cormier, L. S., Nurius, P., & Osborn, C. J. (2017). *Interviewing and change strategies for helpers.* Boston, MA: Cengage Learning; Chapters 3, 4, 5, and 7.

Rollnick, S., Butler, C., & Mason, P. (1999). Chapters 3, 4, and 5. *In Health behavior change: A guide for practitioners.* New York: Churchill Livingstone.

Module 4: Case Conceptualization and Treatment Planning

OBJECTIVES

- To better understand the role of case conceptualization in cognitive behavioral therapy.
- To develop specific case conceptualization skills, including:
  a. Assessing patient concerns/difficulties
  b. Establishing a treatment plan (goal setting)
  c. Identifying treatment obstacles

<u>What Are Case Conceptualization and Treatment Planning,
and Why Are They Important in Brief CBT?</u>

Case conceptualization is a framework used to 1) understand patients and their current problems, 2) inform treatment and intervention techniques and 3) serve as a foundation to assess patient change/progress. Case conceptualization also aids in establishing rapport and a sense of hope for patients.

Case conceptualization is vital to effective treatment and represents a defining characteristic of expert providers. Using these skills, providers are better able to define a treatment plan using intervention techniques that provide the best opportunities for change. This focused and informed approach provides the roadmap for both patients and providers and should include a foundation for assessing change/progress using measurement-based care principles. Case conceptualization (Figure 4.1) is particularly important for short-term therapy, as it serves to focus both the patient and clinician on the salient issues to avoid ancillary problems that often serve as distractions to core goals.
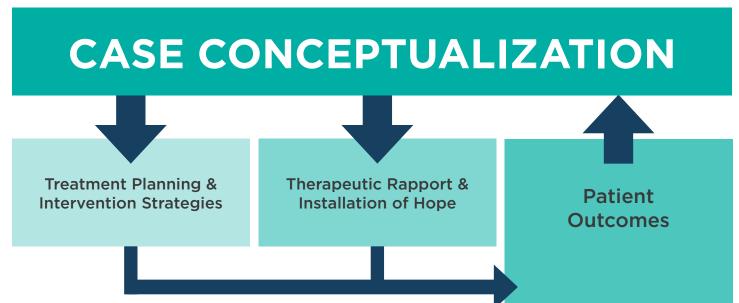
Figure 4.1 Case Conceptualization

CASE CONCEPTUALIZATION

Treatment Planning & Intervention Strategies

Therapeutic Rapport & Installation of Hope

Patient Outcomes

When? (Indications / Contraindications)

- To better should begin during the first session and become increasingly refined as treatment progresses.

- An assessment of current difficulties and the creation of a problem list should occur during the first session.

- A treatment plan (including treatment goals) should be addressed early in treatment (sessions 1, 2). Early conceptualization and treatment planning may require modification as additional information becomes available.

- Treatment plans and goals should be routinely revisited to ensure that the patient is improving and agrees with the flow of the therapeutic work.

How? (Instructions/Handouts)

1. CASE CONCEPTUALIZATION STEP 1: Assessing Patient Concerns/Difficulties

The patient's presenting concerns and current functioning can be assessed in a number of different ways. The following section outlines several possible avenues for identifying problems/concerns.

A) Using established <u>self-report symptom inventories.</u> A common practice in CBT involves the use of self-report symptom measures to assess baseline functioning as well as therapeutic progress. Frequently used measures for depression and anxiety include the Beck Depression Inventory – Second Edition, Patient Health Questionnaire-9 (depression), Geriatric Depression Scale, Beck Anxiety Inventory, and Generalized Anxiety Disorder 7-item scale.

Self-report measures are often completed by patients while in the waiting room and evaluated by the clinician during the session. Often self-report measures can serve as a routine agenda item during CBT sessions and highlight important improvements and/or continuing symptoms. Information obtained from these self-report inventories can also provide insight into the way the patient thinks and behaves and factors that might be important areas of need and will inform treatment progress and treatment continuation/discontinuation.

B) <u>Problem lists.</u> These are a common and useful strategy for identifying the psychological, social, occupational, and financial difficulties faced by patients. Providers who use problem lists typically elicit a list of five to 10 difficulties from the patient during the first part of session 1. Problems are best identified using open-ended questions (e.g., "What brings you to this clinic?" "What issues would you like to focus on in our work together?"). Problems are best described in terms of symptom frequency (How often does the symptom occur?), intensity (How mild or severe is it?) and functional impact (What influence does the symptom have on daily functioning or general distress?).

Some patients may describe their difficulties or goals in vague or abstract ways, such as, "I want to improve my life," or I want to be happy again." Problems and subsequent goals are best described in specific terms to maintain clinical focus. For example, specific problems are listed in the following table.

Table 4.1 Problem List Example

Problem	Frequency	Severity	Impact
Social Isolation	Stay at home six of seven days	Limited social contacts: moderate-to-severe isolation	Highly distressing; socially debilitating; estranged family/friends
Pain	Experience pain each hour	Pain intensity is high, 7 out of 10, when present	Pain leading to decreased activity level, inability to work
Feelings of Worthlessness	Occur three of seven days	Very intense when present; sometimes involve suicidal thoughts	Highly distressing; influence work, social, and intimate relationships
Fatigue	Occurs almost constantly	Not intense but troublesome	Decreased activity level, frequent naps, inability to complete daily tasks

C) <u>Assessing cognitions.</u> Within the CBT model, it is often helpful to examine the patient's thoughts, especially how the patient perceives them. A commonly used, structured way to examine these factors is to assess (ask questions related to) how the patients perceives themselves. For example, a patient might self-describe as incapable, not useful, or a burden. They may generally perceive others to be critical or hard to please. And their view of the future might be largely pessimistic and involve beliefs that the future will include only more losses and disappointments (see also Thought Records in Modules 11 and 12).

D) <u>Assessing behaviors and precipitating situations.</u> Precipitating situations are events, behaviors, thoughts, or emotions that activate, trigger, or compound patient difficulties.

The Antecedents, Behavior, Consequences (ABC) Model is a model for examining behavior (symptoms) in a larger context. It postulates that behaviors are largely determined by antecedents (events that precede behavior/thoughts/mood) and consequences (events that follow the behavior/thoughts/mood).

The ABC model (see worksheet at the end of this module) is used in a functional assessment. It follows the premise that behavior (B) is shaped by antecedents (A) and consequences (C). The antecedent occurs before a behavior and may be a trigger for a particular reaction in the patient. Behavior is any activity (even a thought or feeling) that the patient exhibits in response to an antecedent. Consequences are events that occur after the behavior and direct the patient to either continue or discontinue the behavior.

Two kinds of consequences are examined in a functional assessment: short-term and long-term consequences.

A) <u>Antecedents</u>: Antecedents, or events that occur before a behavior, typically elicit emotional and physiological responses. Antecedents may be affective (an emotion), somatic (a physiological response), behavioral (an act), or cognitive (a thought). They are also subject to contextual (situational) and relational (interpersonal) factors. For example, patients who report depressed mood (emotion) may feel bad when they are alone at home late at night (contextual antecedent) or better when they are around family (relational antecedent). Alternatively, they may feel depressed by thinking, "I will always be alone" (cognitive antecedent). It's important to remember that antecedents can both increase and decrease a particular behavior.

   To help your patiens identify antecedents, teach them to pinpoint conditions that affect their behavior.

In-Session Example 4.1

"What were you feeling right before you did that?" (Affective)

"What happens to you physically before this happens? Do you feel sick?" (Somatic)

"How do you normally act right before this happens?" (Behavioral)

"What thoughts go through your mind before this happens?" (Cognitive)

"Where and when does this usually happen?" (Contextual)

"Do you do this with everyone, or just when you are around certain people?" (Relational)

B) <u>Behaviors</u>: A behavior is anything the patient does, feels, or thinks immediately following the antecedent. Each behavior that your patient displays could potentially include an affective component (feelings or moods), a somatic component (bodily sensations such as rapid heartbeat or stomachache), a behavioral component (what a patient does or doesn't do), and a cognitive component (thoughts or beliefs).

C) <u>Consequences</u>: Consequences are categorized as being either positive or negative. Positive consequences increase the chances that a behavior will be repeated through the experience of something pleasant or the removal of something negative (e.g., do not have to do a chore). Negative consequences decrease the occurrence of a behavior, either by the presence of something noxious (e.g., being yelled at) or the absence of something desired (e.g., a child being grounded from watching TV). Patients tend to repeat behaviors that result in something positive or the removal of something negative.

   <u>Identifying Consequences</u>. Similarly to identifying antecedents, when you and a patient are attempting to identify the consequences of a certain behavior, it is important to explore all components of each consequence.

In-Session Example 4.2

"How do you feel immediately after this occurs?" (Affective)

"Do you have any bodily sensations after this happens, like trembling?" (Somatic)

"How do you react after this behavior occurs? (Behavioral)

"What do you think about after this happens?" (Cognitive)

"Are you in a different place when this behavior ends?" (Contextual)

"Are there any people who make this behavior worse? Make it better?" (Relational)

When completing a functional assessment, examine both short- and long-term consequences. Short-term consequences tend to be behavioral reinforcers, while long-term consequences tend to be negative outcomes. In the case of addiction, the short-term consequence of using a substance is intoxication, or escape from a negative mood; the long-term consequence may be legal trouble, family problems, or a hangover. Understanding the positive and negative consequences of a behavior for a patient helps design the timing and nature of intervention. For example, in the case above, an intervention would need to follow a noxious antecedent to offset the negative mood it causes. Treating the negative mood would then decrease the need for escape through substance use. A variety of questions may be used to elucidate a short-term consequence:

In-Session Example 4.3

"Does this behavior get you attention in some way?"

"What good things happen as a result of this behavior?"

"Does this help you in some way?"

"Do you feel a certain 'rush' from doing this?"

"Does this behavior help you avoid something you don't want to do?"

2. CASE CONCEPTUALIZATION STEP 2: Clinical Hypotheses and Treatment Plan

Establishing focused clinical hypotheses based upon the information obtained in Case Conceptualization Step #1 serves to direct intervention options and possible treatment techniques. These hypotheses may require adaptation as new information becomes available during treatment. Clinical hypotheses can either be used exclusively by the provider or can be shared with patients. Generally, sharing this information improves trust and communication between patient and provider.

A focused clinical hypothesis for a person with depression might be as follows:
"Since your retirement, you have experienced many life transitions and numerous losses (e.g., financial, social, functional). Your thoughts, which used to be largely positive and ambitious, are now negative and pessimistic; and you appear to be fearful of the future. In

reaction to your mood and negative thoughts, you have reduced the number of your activities; and you have begun to withdraw from your family."

The end result of case conceptualization is formation of a treatment plan, an agreed-upon strategy between patient and provider that gives direction to the therapeutic process. A treatment plan should include a presentation of the causes of the patient's current difficulties (e.g., cognitive and behavioral factors creating symptoms or difficulties) and a specific plan. When presenting the plan, actively involve the patient and incorporate his or her feedback.

In-Session Example 4.4

Example: "In the brief amount of time we have spent together, it appears that we have identified some thoughts and behaviors that are likely contributing to your current difficulties. In particular, your view of yourself and your future are quite negative; and you have stopped doing many things that used to bring you pleasure. My recommendation would be to further explore your thoughts and see if we can find a more balanced view of your current difficulties. I would also like to talk with you more about re-engaging in activities you used to find pleasurable. What do you think about these targets for therapy?"

3. CASE CONCEPTUALIZATION STEP 3: Identifying Possible Treatment Obstacles

It is not uncommon for patients to simply agree with recommendations from their provider. However, it is important to identify potential obstacles to treatment early on to avoid setbacks or treatment failures. Asking for frequent feedback from the patient helps to reduce over-compliance and serves to include the patient in a collaborative and active treatment approach. As part of this collaborative venture, it is important to ask patients whether they see any potential obstacles to treatment. Barriers might include logistic difficulties (financial, travel), personal beliefs (concerns about stigma, effectiveness of treatment) or interpersonal issues (family not supportive of therapy).

Highlight 4.1

Tips for Using Case Conceptualization in Brief Therapy

- Case conceptualization in brief CBT is much the same as with longer forms of treatment, with the following exceptions:
  - » Brief therapy leaves little room for delays in case formulation.
  - » The time constraints of brief therapy must be considered in all treatment/ goal- setting endeavors. Treatment goals should be reasonable, measurable and as simple as possible.
  - » Because of limited time, the focus of treatment in brief CBT also generally limits the depth of cognitive interventions. For example, it is quite frequent to address automatic thoughts and intermediate beliefs as foci of treatment, while addressing core beliefs is often difficult. If core beliefs are addressed, this usually occurs indirectly through more surface-level intervention techniques or at a time when the patient is particularly ready for such work.

Homework Assignment Examples

1. Think about our agreed-upon treatment plan, and consider any adjustments it might need.
2. Make a list of any obstacles to therapy that may arise.

SUPPLEMENTAL READINGS

Beck, J.S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford Press; Chapter 3, 4, 5
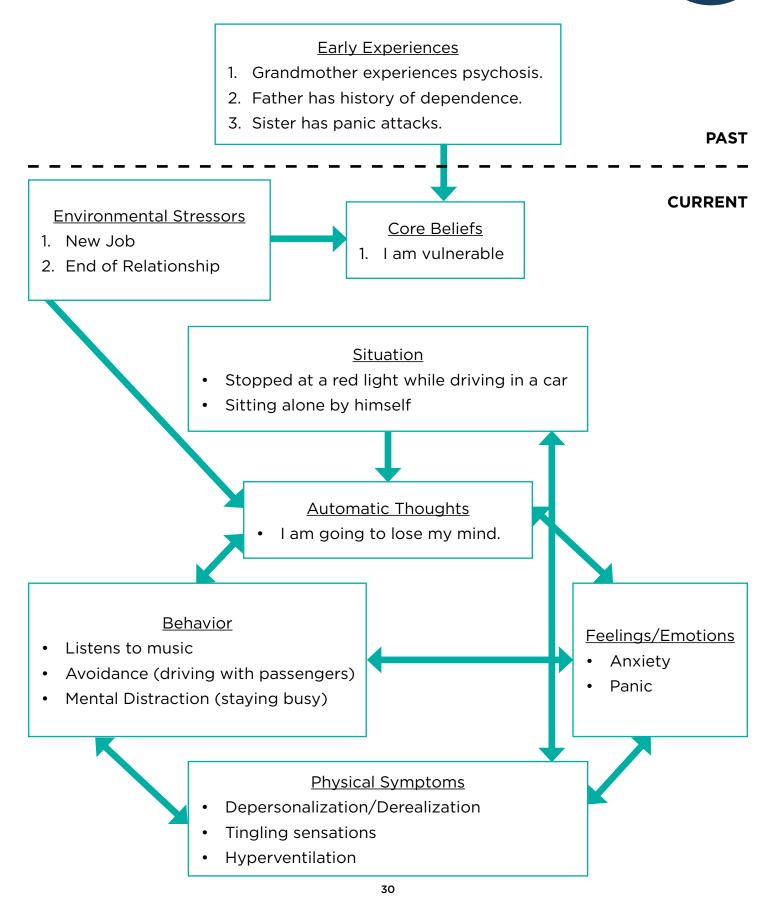
Cormier, L. S., Nurius, P., & Osborn, C. J. (2017). *Interviewing and change strategies for helpers.* Boston, MA: Cengage Learning; Chapter 6.

Persons, J.B. & Tompkins, M.A. Cognitive-behavioral case formulation. In Ells T. (Ed.). *Handbook of psychotherapy and case formulation.* New York: Guilford Press, pp. 314-339.

Example Case Conceptualization

Early Experiences

1. Grandmother experiences psychosis.
2. Father has history of dependence.
3. Sister has panic attacks.

PAST

CURRENT

Environmental Stressors

1. New Job
2. End of Relationship

Core Beliefs

1. I am vulnerable

Situation

- Stopped at a red light while driving in a car
- Sitting alone by himself

Automatic Thoughts

- I am going to lose my mind.

Behavior

- Listens to music
- Avoidance (driving with passengers)
- Mental Distraction (staying busy)

Feelings/Emotions

- Anxiety
- Panic

Physical Symptoms

- Depersonalization/Derealization
- Tingling sensations
- Hyperventilation

Functional Assessment: ABC's

Antecedents (What happened before?)	Behaviors (What did you do?)	Short-Term Consequence (What was the result one second, one hour following behavior?)	Long-Term Consequences (What were the lasting results?)

Module 5: Cultural Considerations in Therapy

OBJECTIVES

- To understand the importance of patients' cultural backgrounds and experiences in brief CBT
- To learn how to assess and integrate patients' culture into psychotherapy

<u>What Is Culture, and Why Is It Important in Brief CBT?</u>

Culture defines individuals' specific "ways of being" that are shaped by the intersection of their identity and their lived experiences. Culture influences our behaviors and impacts our lifestyle choices, which is why it is an important factor in psychotherapy and therapeutic relationships. Not only should providers become aware of patients' unique cultures, but they should also consider their own culture to form genuine and effective therapeutic relationships.

Cultural recognition and appreciation begin with an understanding of an individual's race, age, and gender; however, culture goes much deeper. Although two individuals may have similar physical identifiers of culture, past experiences and unseen forms of culture can create differences. For example, two Mexican American men may look the same and even be in the same age group. However, they may have grown up with different religions, in different socioeconomic groups, one with a single father and the other with two parents and his grandmother living in the home. Table 5.1 is an inexhaustive list of cultural identifiers that influence an individual's culture.
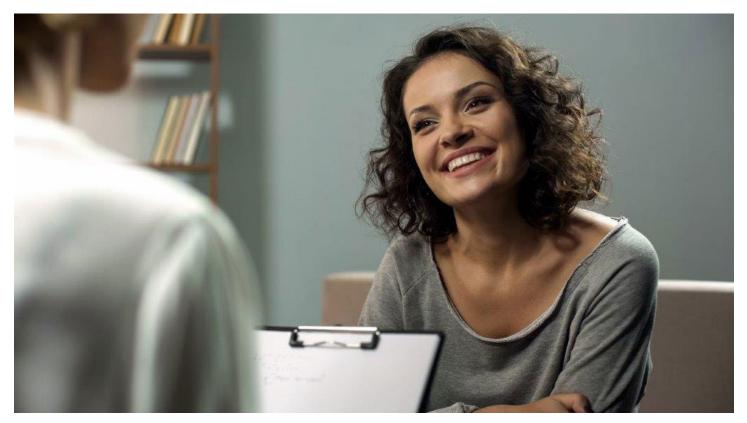
Table 5.1. Types of Cultural Identifiers

Cultural Identifier	Definition	Select Examples
Race	Human constructed classifications of major divisions of people based on biology and physical characteristics, often skin color, facial features, and hair type	White, Black, Asian, Native Hawaiian/ Pacific Islander, American Indian/ Alaska Native
Ethnicity	Classification of major divisions of people based on cultural traditions and nationality, often a combination of ancestry and customs	African American, Italian American, Latinx/Hispanic, Native American, Mexican American
Nationality	The status of belonging to a nation, typically defined by origin of birth or citizenship	American, Mexican, Chinese, Ethiopian, German, Indian
Age/ Generation	Classification of a group of people in the same birth cohort displaying similar values, due to shared global experiences	Generation Z, Millennials, Generation X, Baby Boomers
Sex	Assignment of gender based on external genitalia	Male, Female, Intersex
Gender	Human constructed classifications of people based on social constructs related to biological sex, masculinity, and femininity; can differ from gender assigned at birth	Man, Woman, Transgender, Non-binary or Gender Non-Conforming, Genderqueer/Gender fluid
Sexual Orientation	Describes romantic or sexual attraction towards others	Heterosexual/Straight, Homosexual: Gay & Lesbian, Bisexual, Queer, Asexual, Pansexual
Socio-economic Status	Classification of social standing measured by level of education, income, and occupation that results in access to resources	Upper Class, Upper-Middle Class, Middle Class, Working Class, Lower Class
Religion	Belief in a personal god or gods, associated with a system of faith and worship	Christianity, Islam, Judaism, Hinduism, Buddhism, Nonreligiousness
Disability	A physical or mental condition that limits a person's movements, senses, or activities, both visible and invisible	Blindness, Deafness, Autism Spectrum Disorders, Dementia, Traumatic Brain Injury, Physical Impairments, Chronic Pain, Mental Illness
Language	Distinct methods of communication used by groups or communities of people	English, Hindi, Arabic, Mandarin, Spanish, Zulu, American Sign Language, Braille
Residence	Current and historical location or status of an individual's main place of dwelling or home.	Urban, Rural, Homeless, Suburban, Affordable Housing, Temporary Housing

DEVELOPMENT OF CULTURAL IDENTITY

Many models explain how culture develops over time. These models explain how individuals interpret their identity through interactions with others, and their basis is often minority or majority status. For example, an integrated model of cultural/racial development from Hoffman and Hoffman (2006) is included, which depicts various stages of development and how these stages interact with others' development (found in Table 5.2). You and your patient may be at different stages of the model, which may impact the conceptualization of your respective cultures, how culture influences the therapeutic interaction, and how culture influences the interpretation of stressors and symptoms. The Hoffman and Hoffman model emphasizes the importance of recognizing minority and majority status when considering culture. Use this model to guide conceptualization of culture and, more importantly, to consider cultural stages as part of the overall therapeutic process. The Hoffman and Hoffman model provides one example, but you may wish to use other cultural models in your practice, such as:

• Black American Racial Identity by William Cross (1991)

• White Racial Identity Model by Janet Helms (1990)

• Stages of Acculturation by John W. Berry (2005)

• Filipino American Racial Identity Model by Kevin Nadal (2011)

Table 5.2 Integrated Model of Cultural/Racial Development (Hoffman & Hoffman, 2006)

Stage I. Conformity (All)	
Everyone "conforms" to the majority society to emulate the way the majority acts, speaks, dresses, and believes, because the majority is perceived as positive.	
Stage II.	
Minority Group	**Majority Group**
<u>Dissonance</u> The minority group realizes that its race or gender may preclude it from the benefits of the majority group. It begins to see that racism and sexism may be impacting it.	<u>Acceptance</u> The majority group can diminish comments or actions that indicate racism or sexism is alive. It feels the minority should be more like it or dismiss the effects of minority status.
Stage III.	
<u>Immersion</u> Due to the effects of racism and sexism, members of minority groups begin to feel negative emotions towards the majority group.	<u>Resistance</u> Members of majority group may feel that racism and sexism do not exist and can express beliefs about "reverse racism" or "reverse sexism."
Stage IV.	
<u>Emersion</u> Anger towards the majority group causes minorities to associate only with the group they belong to, avoiding contact with the majority.	<u>Retreat</u> When the majority group's assumptions about minorities are proven false, it may feel guilt and shame about how difficult life is for minorities. It may also feel frustration towards other members of its own group who do not agree.
Stage V.	
<u>Internalization</u> Minority groups realize that there are negative qualities about their own people and that not all members of the majority group are the enemy. They begin to see that racism and sexism can be fought against.	<u>Emergence</u> Members of the majority start to understand their privilege and how it continues to benefit them.
Stage VI. Integrative Awareness (All)	
Both majority and minority group members positively identify their own cultural/racial identity and acknowledge other aspects of both their own and others' identities.	

CULTURE AND PSYCHOTHERAPY

The goal of culturally competent psychotherapy is to ensure that patients' experiences and culture are considered when providing care. Optimal care is achieved when both the provider and patient are collaborative in the treatment. Appropriate consideration of patients' backgrounds and experiences results in patients' feeling heard and understood, creating a safe space for patients to express themselves. Acknowledging your patient's culture provides an opportunity to fully understand the patient and conveys a level of openness that encourages discussion and exploration of other factors important in the psychotherapy process.

Traditional CBT and Western models of psychotherapy typically have not considered or accounted for ethnic and cultural values and beliefs of patients. Historically, minority patients have high dropout rates, due to various challenges to care, such as:

1. Psychotherapy can feel "foreign" to non-Western or underrepresented groups because emotional expression and discussing personal experiences may conflict with certain values. For example, some groups view expressing emotions as weak or unstable. Also, some may view discussing themselves as rude or insensitive to others.

2. Inflexible use of manualized treatments can feel impersonal and too formal for patients, limiting the possibility for patients to feel like a collaborative partner in their care. Manualized treatments are developed to be efficacious and are typically not created to be culturally sensitive.

3. When mismatch between the provider and patient's gender, race, age, etc. are not appropriately acknowledged, it can limit patients' comfort in expressing themselves.

When? (Indications/Contraindications)
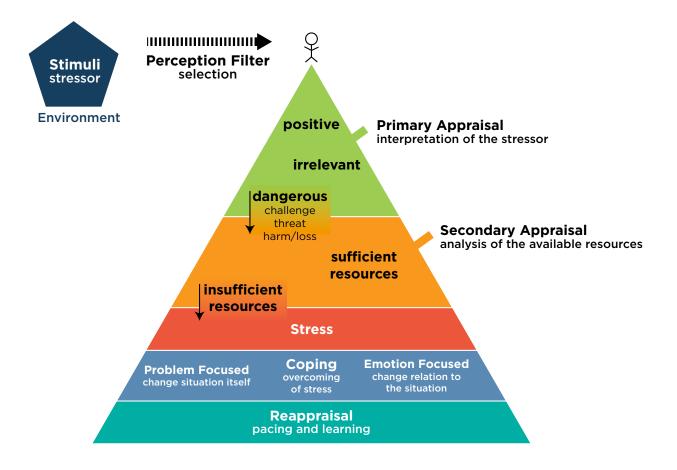
You should be aware of your patients' and your own cultural identity. Given the importance of the therapeutic relationship in psychotherapy, it is critical to not only communicate and model nonspecific factors (e.g., warmth, genuineness) but also consider culture and factors of diversity as a process that occurs initially and throughout the therapy process.

IMPACT OF CULTURE ON MENTAL HEALTH

Look to minimize any negative outcomes associated with the intersection of culture and mental health. The Transactional Model of Stress and Coping (Figure 5.1.) describes how patients react or appraise stressful situations or triggering events and, subsequently, how they seek to cope with those stressors, based on their initial appraisal. Patients appraise situations through their own cultural lens, based on their own past experiences of coping and the experiences of others close to them. In addition, stressors and triggering events can be cultural in nature. For example, experiencing discrimination at work or receiving a life-altering medical diagnosis or physical/mental disability impacts both our culture and our mental health. If you are aware and accepting of cultural differences when assessing and treating mental health issues, you will be better informed and in tune with your patients' needs.

Figure 5.1: The Transactional Model of Stress and Coping
(Folkman, Lazarus, Gruen, & DeLongis, 1986)

EVALUATION OF PATIENTS' CULTURE

Although providers are experts in mental health and mental health treatment, patients are experts of their own identity and life experiences. To provide treatment, providers should understand and be willing to explore each patient's lived experiences. Do not assume that culture will always play a role in patients' psychopathology. Provide your patients with the opportunity to hypothesize how aspects of their culture may play a role. Examples of how to begin these conversations are provided below. Important to note: the patients may be clear as to how culture influences their symptoms, ongoing stressors, or presenting concerns. Therefore, understanding patients' experiences may be more helpful for the provider than the patient.

EVALUATION OF PROVIDER'S CULTURE

In addition to cultural considerations of the patient, consider your own cultural experiences. All individuals have unique experiences and backgrounds that may differ from another's. Evaluating your own cultural experiences and past behaviors will inform ways in which you may interact with patients of different backgrounds. Personal experiences contribute to explicit and implicit biases, which impact how individuals interact with others.

PATIENT AND PROVIDER INTERACTION

The interaction of two cultures often leads to cultural differences. Under ideal circumstances, cultural differences create opportunities for individuals to learn about others' cultures, highlight commonalities among shared cultural experiences, and develop awareness of differing experiences. However, cultural differences can also lead to negative experiences and outcomes, such as discrimination, stereotypes, and injustice. Providers and patients bring their own lived experiences to the therapeutic relationship, but it is imperative to model behaviors that attend to cultural differences. This may be the first time your patient is introduced to the concept of cultural difference and, thus, negative outcomes can be directed towards you. Just as patients can be negatively impacted by not acknowledging culture, you as a provider can be discriminated or stereotyped.

Both you and your patient may experience discrimination. Discrimination is the mistreatment of individuals based on societal or personal views of an aspect of their culture being inferior. Discrimination can be direct, such as overt racism and sexism, or indirect, such as microaggressions. Microaggressions are intentional or unintentional slights or behaviors directed towards others that indicate social inferiority, hostility, or derogation. For example, a teacher telling parents of an African American student that she is so articulate and well mannered may be an unintentional microaggression. Even though the teacher is trying to compliment the student, the teacher may be making a microaggression because of the underlying societal stereotype that African American students would present otherwise. Both providers and patients should attend to the possibility of microaggressions and discuss any occurrences as much as possible in the moment. Awareness of explicit and implicit biases presented in Table 5.3 can help prevent microaggressions and discrimination from occurring.
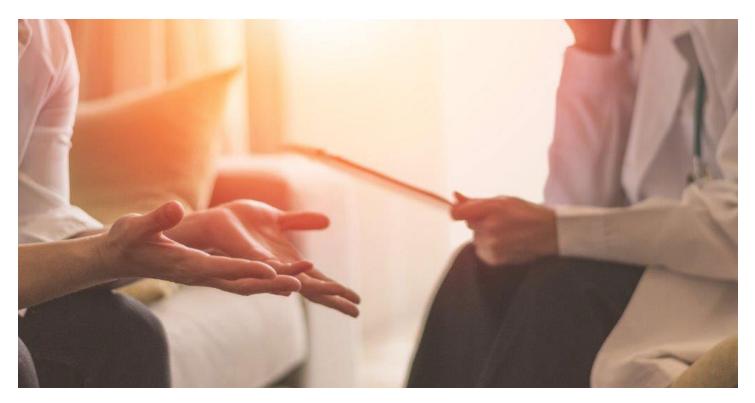
Table 5.3 Biases

Explicit Bias Definition: Attitudes and beliefs we have about a person or group on a conscious level. Individuals are aware of this bias and express it directly.	Implicit Bias Definition: Attitudes and beliefs we have about a person or group on an unconscious level. Individuals are unaware of this bias and express it subconsciously.
General Examples:	
• A boss choosing not to interview an applicant after seeing the applicant's dreadlocks. The boss feels that dreadlocks indicate he will not be a good employee or fit in with the company's culture. • A male patient choosing not to work with any female providers because he assumes they are all judgmental, incompetent, and unhelpful.	• Assuming a woman working in a hospital is a nurse instead of a doctor. • A White individual asking a Latinx individual where he was born, because she assumes most Latinx individuals are not U.S. citizens.
Examples in Psychotherapy:	
• A female provider choosing to refer a transgender patient to her LGBT colleague, because she assumes she would not be able to understand the patient's needs. She assumes the patient's presenting concerns will be tied to being transgender. • A male provider skipping over the military sexual trauma questions during an assessment with a male veteran. He assumes only female veterans experience military sexual trauma.	• A White provider being friendlier with White patients than with patients of color. • Appearing concerned or sad when a middle-aged female patient says she is single and does not have any children, assuming that being single would contribute to a negative emotional state.

How? (Instructions/Handouts)

You can use many techniques and methods to explicitly integrate culture into psychotherapy in both extended and brief treatment contexts. The following sections provide guidance and techniques to assist you when attending to culture and integrating culture into your practice.

ORIENT THE PATIENT TO BRIEF, TECHNICAL TREATMENT.

Discuss the patient's perspective of therapy and any perceived barriers:

- What are your thoughts about coming to psychotherapy? What do you want to know about therapy? What do you think about providers? Have you been in therapy before?

- How does your family view psychotherapy? Your friends? Your partner? Do they know

that you are coming to therapy? If so, what do/would they say? How do they view people who attend therapy?

- What are ways therapy may be difficult for you? What were some barriers you faced when making the decision to seek help? How can we work together to prevent any future barriers?

- Our time together will be brief; how have you dealt with brief relationships with other people that you've been close with in the past?

Exploring patients' culture can be difficult to achieve in time-limited therapy. It is common for a brief CBT provider to feel tension between sticking to the brief CBT therapy protocol and providing patients with enough time to expand on their experiences and concerns. However, most protocols emphasize the importance of building rapport; and addressing culture can help you build this therapeutic alliance. The exact "balance" between listening/assessing and forming a strong therapeutic relationship with the time necessary to deliver technical/skill-focused interventions will depend on many factors, including the needs of the patient, the duration of treatment, and the provider's skillfulness in rapidly and effectively forming a strong relationship while maintaining a focus on active, skill-oriented techniques.

ASSESSMENT OF CULTURE WILL HELP GUIDE TREATMENT MODIFICATIONS.

Begin assessing culture by asking broad, open-ended questions. Importantly, these questions can also be used to gather information about your own culture and experiences:

- What aspects of your culture are important to you?

- What are some cultural experiences that have shaped your life?

- How has your background, the way you identify yourself, or cultural experiences impacted your symptoms or presenting concerns?

- How have your concerns/presenting issues affected aspects of your culture that are important to you? To your family?

Highlight 5.1

<u>Cultural Faux Pas</u>

Assuming pronouns/identifiers

» Always ask about how individuals identify or how they'd prefer to be addressed. An individual's race and gender may not match stereotypical classifications. Example: he/she/they; Black/African American/Afro Caribbean; Mexican American/Latino/Hispanic

Using *illegal immigrant or illegal alien*

» Use undocumented citizen or undocumented immigrant.

Confusing gender and sexual orientation

» Gender and sexual orientation are not correlated. Transgender individuals can identify as any sexual orientation, regardless of their gender or natal sex.

Acknowledging the "plight" of living with disability

» Referring to the strength or courage of someone living with a disability can come off as offensive and can minimize their identity.

Associating race or gender with culture

» Two individuals of the same race or gender will not always associate with the same culture. Varying backgrounds can cause unique cultural experiences.

**YOUR APPROACH DURING TREATMENT SHOULD SHIFT,
BASED ON YOUR PATIENT'S PRESENTATION.**

Providers use language during treatment based on their training, their theoretical orientation, and their own cultural experiences. However, often technical language, jargon, and various descriptors can make patients feel uncomfortable. Use your patients' language and cues to shift your approach and be more aligned with them. Some examples include referring to the treatment process as talk therapy or counseling instead of psychotherapy, describing the patient's issues or concerns (e.g., "I am no longer able to do what I used to do") compared to symptoms used for diagnoses, using the term *client* rather than *patient* (taking into consideration the clinical context of your work), or referencing stressors instead of situations or triggers.

CONSIDER V-CODES WHEN MAKING DIAGNOSES.

The *Diagnostic &I Statistical Manual, Fifth Edition* includes diagnoses appropriate for patients when traditional diagnoses of psychopathology do not fit. Awareness of cultural influences may lead to consideration of these diagnoses, and they often decrease stigma related to receiving a more clinical diagnosis. These diagnoses are called "other conditions that may be a focus of clinical attention" and are referred to as "V Codes" in the ICD-9-CM and "Z Codes" in the ICD-10-CM. Some of the diagnoses include:

Relational Problems

- Parent-Child Relational Problem
- Upbringing Away from Parents
- Relationship Distress with Spouse/ Intimate Partner
- Uncomplicated Bereavement

Social Problems

- Target of (Perceived) Adverse Discrimination or Persecution
- Acculturation Difficulty
- Social Exclusion or Rejection
- Problem Related to Living Alone

Medical or Health Care Access Problems

- Unavailability or Inaccessibility of Health Care Facilities
- Unavailability or Inaccessibility of Helping Agencies

Environmental or Psychosocial Problems

- Religious or Spiritual Problem
- Victim of Terrorism or Torture
- Exposure to Disaster or War

Educational/Occupational Problems

- Academic or Educational Problem
- Problem Related to Current Military Deployment Status
- Problem Related to Employment

Housing and Economic Problems

- Homelessness or Inadequate Housing
- Extreme Poverty or Low Income
- Problem Related to Living in a Residential Institution
- Lack of Adequate Food or Safe Drinking Water

Tips

1. Engage in life-long learning and professional growth. This brief chapter scratches only the surface of cultural awareness in psychotherapy. Ongoing training throughout your career will ensure that you are continuing to grow and develop your awareness of culture.

2. "Cultural competency" is an evolving process. Due to the variable nature of human behavior and the complexity of culture, individuals will never reach full cultural competency and awareness. Your goal should be to practice being culturally competent, not assume that you have cultural competency.

3. Be curious. While exploring your own and your patients' culture, be appropriately curious about culture. When struggling with what is appropriate or inappropriate, consider your patient's perspective. What questions would you be OK with answering or being asked?

SUPPLEMENTAL READINGS & REFERENCES

American Psychiatric Association. (2013). Cultural Formulation Interview (CFI). Washington, D. C.: American Psychiatric Association.

American Psychological Association. (1990, August). Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Population. Retrieved from American Psychological Association: https://www.apa.org/pi/oema/resources/policy/provider-guidelines

Folkman, S., Lazarus, R. S., Gruen, R. J., & DeLongis, A. (1986). Appraisal, coping, health status, and psychological symptoms. *Journal of Personality and Social Psychology, 50*(3), 571–579. https://doi.org/10.1037/0022-3514.50.3.571

Hoffman, J. L., & Hoffman, J. L. (2006). Sculpting race: An innovative approach to teaching racial identity development. Retrieved from Summary Stages of Racial Identity Development: https://www.racialequitytools.org/resourcefiles/Compilation_of_Racial_Identity_Models_7_15_11.pdf

Module 6: Using Technology for Distance-Based Therapy

OBJECTIVES

- To understand how technology is used in psychotherapy and its effectiveness
- To identify special treatment considerations and barriers regarding the provision of psychotherapy through technology-based approaches
- To identify strategies to enhance patient engagement and intervention effectiveness when using telemental health services

What Is Telemental Health, and Why Is It Important?

Conducting therapy with technology-based modalities has rapidly increased for mental health care. Specifically, using technology-based approaches as a means for providing psychological services has served to reduce mental health disparities and overcome distance-based barriers. Telemental health is the practice of using technology to provide mental health services and may include telephone, two-way video conferencing, mobile phone applications, web-based text messaging, email-based interventions, web-based chat messaging, or asynchronous telepsychiatry (formerly store-and-forward services). These remote telecommunication modalities present opportunities to enhance mental health care through services offered clinic to clinic (e.g., provider located in one clinic while the patient is physically present at a different clinic location) as well as from a provider directly into patients' homes or other secure locations.

Telemental health services may be used effectively across an array of settings including, but not limited to, hospitals, short- and long-term care facilities, school systems, institutional correctional facilities, rural health centers, and community mental health clinics. Telemental health modalities are associated with clinical effectiveness, treatment adherence, patient and provider satisfaction, psychotherapeutic alliance outcomes, and cost effectiveness commensurate with services provided face-to-face. Telemental health services are useful in providing evidence-based psychotherapies to individuals, groups, and families.

When? (Indications/Contraindications)

Technological advances and the subsequent integration into healthcare services have made remote delivery of mental health care accessible to underserved and disadvantaged populations. Telemental health services help minimize barriers that prevent patients' access to care when they need it (see Figure 6.1). When traditional face-to-face therapies are unavailable or inaccessible, alternative treatment modalities may be appropriate for individuals that frequently travel for work, those who serve during military deployments, and people who work irregular schedules.

Figure 6.1 Barriers to Mental Care Access

CONSIDERATIONS

Potential risks of using technological modalities when providing remote mental health treatment must be considered. Risks involve the need for crises management procedures as well as clinical issues, including the potential for negative impact on patient functioning. For example, patients with anxiety may have fears associated with avoidance that are potentially maintained by using telehealth services and thereby reducing exposure to feared stimuli (e.g., going out of the house). Additional precautions may be warranted to effectively observe and assess mobility (e.g., ask the patient to walk across the room in front of the camera) and hygiene (e.g., inquire about the last time a patient showered or brushed their teeth).

Patients may be offered various telemental health modalities, but it is the provider's responsibility to ensure alignment with the patient's presenting concerns as well as to be knowledgeable about data to support the intervention using the selected delivery method.

Some smartphone applications, for example, provide treatment programs that are not empirically supported. Despite concerns about the appropriateness of technology-based modalities, telemental health services have been used successfully across an array of populations.

- **Age Group:** Research has been conducted on telemental health with all age groups. Providers should determine whether patients can effectively use a desired telemental health modality through direct conversations with patients about acceptability and feasibility. Occasionally, patients from various age groups (e.g., older adults) may require some education on how to use different modalities. Typically, younger patients are more likely to desire technology-based treatment. However, patients of all age groups can be instructed on how to use technology for treatment.

- **High Risk Populations:** Clinical concerns arise when providing telemental health to patients who endorse current suicidal ideation or substance use. For patients with past suicidal ideation, consider the level of suicide risk, the length of time since the last reported episode of suicidal ideation, and the number of past episodes when deciding the appropriateness of telemental health. High risk patients in crisis often require focused and highly intensive treatment approaches that may make weekly therapy inappropriate. However, telehealth modalities may be an important element of a broader treatment approach that includes a mixture of face-to-face and virtual appointments. Ultimately, the decision to use telemental health with high-risk patients should be based upon clinical expertise; and a clear emergency plan should always be identified (i.e., emergency contact, involving family and friends).

- **Patients with Severe Mental Illness:** Telemental health can be conducted with patients who have been diagnosed with severe mental illnesses. However, patients who are not adherent to psychotropic medication or other treatment recommendations may not be appropriate for telemental health treatment. Distance may pose an ethical risk in ensuring the safety of your patient. As with high-risk suicide patients, the use of telemental health procedures for those with serious mental illness may be most effective as part of a interdisciplinary treatment plan.

- **Rural or Out-of-State Population:** Telemental health is an optimal option for rural populations that do not have access to treatment. However, different states have regulations on providing treatment across state lines, which should be considered.

- **Exposure-Based Treatment:** Telemental health services can increase effectiveness of treatment of anxiety- and trauma-related disorders. Patients can use technology in their environment, allowing you to guide them through relevant exposure exercises.

- **Treatment-Avoidant Populations:** Telemental health options engage patients that may not otherwise use therapy. However, these care options can reinforce avoidance and limit patient progress in treatment. Use your clinical judgment to determine if a patient high in avoidance or low in motivation is appropriate for telemental health throughout the course of treatment.

PRIVACY

Consider the environment of your patient to ensure appropriate levels of privacy during treatment. Telemental health services are an option for patients that have access to reliable, private technology software, especially if transportation is an issue. Stay-at-home parents or caretakers may have issues in connecting that are contingent upon their caregiver duties or responsibilities. Additionally, ensure that your facility or office has designated areas to conduct telephone or video sessions. It is important to ensure secure network connections and video conferencing software to meet privacy standards and HIPAA requirements.

How? (Instructions/Handouts)

Providing telemental health services using technology can be a complicated process, and you should consider it on a case-by-case basis. As with any new procedure, you are encouraged to explore and be knowledgeable in the modalities and delivery. You must be vigilant and prepared (proactive) when using telehealth procedures. Various factors can be considered when using telemental health:

ASSESSING PATIENT SAFETY

Although no condition-specific populations are currently considered inappropriate for telemental health services, individual patient safety should always be considered before providing services through any telemental health modality. Current best practices include:

1. Assessing patient's current and past suicidal ideation

2. Obtaining emergency contact information for the patient as well as others that may be at the same location of the patient during each session

3. Obtaining the patient's physical location and address for the duration of the session

4. Obtaining contact information for the patient's local emergency services and law enforcement agencies (see American Psychiatric Association, American Telemedicine Association, and American Psychological Association in Resources)

5. Routine safety planning, which includes continuous monitoring of environmental changes such as patient's appearance and sobriety level, as well as access to lethal means

6. Establishment of crisis protocols, with consideration as to how these protocols may require deviations considering domestic violence situations and/or with patients located at settings other than those originally anticipated (e.g., patients may change locations to the home of a relative, friend, or other setting)

DETERMINING APPROPRIATENESS OF THE PATIENT'S CASE

Prospective telehealth providers are strongly encouraged to engage in self-assessment related to the provision of psychotherapeutic services across an array of telehealth modalities. It is important to review issues spanning state and regulatory licensure, technology, ethics, professional relationships, and specific training requirements (STEPS) before providing telehealth services (See Table 6.1).

Table 6.1 Self-Study Considerations (STEPS) Prior to Engaging in Telehealth with Patients

---

State Licensure and Regulatory Issues

☐ State licensing restrictions where services will be provided

☐ State licensing requirements to provide telehealth services

☐ Specific state regulations for providing telehealth services

---

Technology Issues

☐ Basic properties and operations of various telecommunication systems (e.g., internet & DSL)

☐ Strengths and limitations of various equipment (e.g., plug-and-play devices, set-top devices, and roll-about videoconferencing systems)

☐ Minimally acceptable video (15-18 frames per second) and audio quality standards

☐ Ways to respond to equipment and telecommunication failures

☐ Patient understanding of the uses, installation requirements, benefits, and drawbacks of telecommunication technologies involved

---

Ethical Issues

☐ Ways to communicate professional credentials and training to prospective telehealth patients

☐ Methods of obtaining informed consent in telehealth

☐ Confidentiality issues that must be addressed when providing telehealth

☐ Strategies to ensure confidentiality and privacy when providing telehealth

---

Professional Relationship Issues

☐ Practice parameters for telehealth (e.g., length of sessions, protocols for managing poor technical reception, waiting time before considering a patient a "no-show," record keeping, etc.)

☐ Discussion of reimbursement issues with telehealth patients and/or third-party insurers

☐ Record-keeping requirements for providing telehealth services

☐ Reporting obligations (e.g., duty to warn) in providing telehealth services

☐ How to manage situations that involve potential for self-harm and/or injury to others

☐ The types of information that should be included in a telehealth practice disclaimer

☐ Emergency coverage that will be provided for distant telehealth patients

☐ Information about the social or community network in which telehealth patient(s) reside

---

Specific Training

☐ Patient's knowledge and skill in using telecommunications equipment

☐ Professional telehealth training workshops, symposia, or caucuses

☐ The latest legislative, research, and clinical developments as informed by literature

☐ Telehealth research and practice literature related to the patients served

☐ Conceptual, methodological, and ethical issues in conducting telehealth assessments

DETERMINING PATIENT COMFORT

The decision to integrate innovative telehealth modalities into your practice must be carefully considered and discussed with patients. You must consider patient comfort and familiarity with technology as a patient's willingness to engage. Your patient's opinion of telehealth modalities impacts outcomes of implementation and efficacy of service delivery. Additionally, it is important to consider only technologies that are accessible, practical, and feasible for the patient because a patient's familiarity with technology may impact their view of a clinical professional (e.g., some patients may prefer in-person or technology-assisted clinical interactions). The primary and secondary language of the provider and patient may impact service delivery such that a telephone-based or in-person interpreter may be necessary. Finally, providing care through any technology-based delivery system will not be effective if you do not ensure availability of time and resources before offering contact, communication and care. You must be able to provide and maintain quality, consistent care for services to be effective.

TIPS FOR CONDUCTING A TELEMENTAL HEALTH SESSION

- Conduct a practice telesession before your first session with the patient. This will decrease the likelihood of equipment failure and allow you and the patient to become comfortable with the modality before the treatment session. Some facilities offer services that will conduct practice calls with patients before sessions with providers.

- Look directly into the camera if you are conducting a video session, instead of at the patient's image onscreen, to ensure good eye contact.

- Pay attention to your surrounding background area, and remove anything that may be distracting on camera.

- Wear plain clothing without busy patterns (e.g., plaid, geometric shapes) or bright colors.

- Obtain patient's emergency contact information at the beginning of every telemental health session and keep this information readily available through the session duration.

- Verify patient's physical address/location at the beginning of each appointment and note any changes that occur during the session. You should also take note of local emergency service information in the locality of the patient. **PLEASE NOTE:** If you call 911, you will be connected to emergency services where you are located. This can cause an unnecessary and potentially dangerous delay.

OVERCOMING BARRIERS

Providers who are unfamiliar with technology are often reluctant to provide psychotherapeutic interventions through technology-based modalities, due to fear of hampering the therapeutic alliance (e.g., communicating warmth, understanding, sensitivity, and empathy). Although specific challenges to providing telemental health services do exist (see Table 6.2), both providers and mental health patients have observed the therapeutic alliance over distance-based technologies to be comparable with that of face-to-face clinical interactions.

Table 6.2 Specific Telemental Health Challenges and Suggested Resolutions

<u>Lack of Control over Environment</u>   ☐ Set boundaries (e.g., patient will reserve a space where he/she will be uninterrupted for duration of the session) and require privacy at initial contact.
<u>Privacy/Confidentiality</u>   ☐ Complete written informed consent for treatment, review service that will be provided and limits of confidentiality when using electronic communications (e.g., wireless telephones, cellular devices); verify that the person engaging in the clinical interaction is the patient.   ☐ Make explicit to patients that all services are considered as taking place at the provider's place of work, regardless of the location of the remote site.
<u>Crisis Situations</u>   ☐ Exclude patients who are actively suicidal at intake; have knowledge of local resources available to patients within their community.
<u>Clinician Adjustment to Technology-based Psychotherapy</u>   ☐ Prepare to adjust some intervention delivery as needed, according to the capabilities and limitations of telehealth equipment.

SUPPLEMENTAL READINGS

American Psychological Association. (2013, July 31). *Guidelines for the practice of telepsychology.* http://www.apa.org/practice/guidelines/telepsychology

American Psychiatric Association. (2020). Telepsychiatry Toolkit. Retrieved July 02, 2020, from https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit

National Consortium of Telehealth Resource Centers. (2020). National Consortium of Telehealth Resource Centers. Retrieved July 02, 2020, from https://www.telehealthresourcecenter.org/

Shore, J. H., Yellowlees, P., Caudill, R., Johnston, B., Turvey, C., Mishkind, M., … & Hilty, D. (2018). Best practices in videoconferencing-based telemental health April 2018. *Telemedicine and e-Health, 24*(11), 827-832.

Turvey C., Coleman M., Dennison O. ATA practice guidelines for video-based online mental health services. (2013). *Telemed J E Health, 19*(9), 722-730. doi:10.1089/tmj.2013.9989

ESSENTIAL BRIEF CBT SKILLS

Module 7: Orienting the Patient to Brief CBT

OBJECTIVES
- To learn how to convey information about the structure and content of CBT
  - » To introduce the cognitive behavioral model
  - » To introduce the collaborative nature of the therapeutic relationship

<u>What is Orienting a Patient to Therapy, and Why Is This Process Important?</u>

Orienting the patient to therapy involves:
- A discussion of the theory underlying brief CBT
- A description of how the presenting problems can be conceptualized and treated with this approach
- Education about the structure, format, and expectations of therapy

Orientation for brief CBT involves a discussion of the focused and time-limited nature of the therapy, plus the provider's rationale for selecting brief CBT to treat a particular problem. As noted in Module 1, this rationale includes the strong research basis of brief CBT and the fact that it is an empirically supported treatment.

Many patients have little, if any, exposure to psychotherapy other than examples in the popular media. Although media may be a good avenue for disseminating innovative treatment strategies and therapies, there is an abundance of misinformation that patients may be exposed to. Conveying the legitimate science of CBT in ways that your patients can understand may help build motivation for change during the therapeutic process as well as debunk previously misinformed perspectives. Providing patients with an understanding of the therapeutic process allows them to be more active and aware of their role in the progression of therapy. Knowledge of the process of brief CBT enhances the collaborative nature of therapy.

<u>When? (Indications/Contraindications)</u>

Discussing the rationale for CBT and describing the process of therapy should occur in the first session. However, it is useful to revisit the model throughout treatment to expand upon the rationale for CBT skills. The explanation of the model can be tailored to the patient's presenting problem, and examples to explain each component can be drawn from those generated in discussing problems specific to your patients (e.g., "I can't seem to get out of bed, and then I feel worthless"). For patients who think in concrete terms, it might be necessary to provide many examples and initially focus on behaviors rather than cognitions.
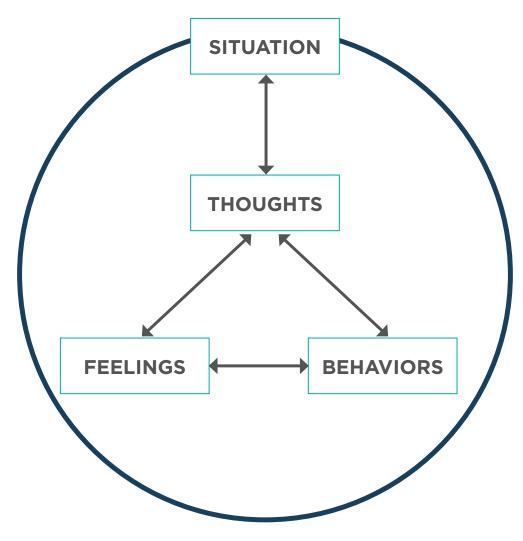
How? (Instructions/Handouts)

INTRODUCING THE COGNITIVE BEHAVIORAL MODEL

The cognitive behavioral model is a theoretical paradigm for explaining associations among thoughts, feelings, and behaviors. Most individuals believe that situations give rise to their emotions, as it may be easier to understand how intense emotional experiences occur in specific situations. However, the cognitive behavioral model suggests that thoughts we have about situations influence our behaviors and impact our emotions (Figure 7.1). This perspective does not negate the impact of external/internal stimuli (i.e., situations) on emotions, rather it facilitates a shift in perspective to facilitate the therapeutic process. For instance, individuals who are depressed or anxious tend to display patterns of unhelpful or "inaccurate" thinking. In the cognitive elements of CBT, the provider trains patients in specific skills that help them learn to improve their mood and change behavior by modifying the way they think about situations.

Figure 7.1 Cognitive Behavioral Model

INITIAL SESSION

To prepare for the initial session, thoroughly review all intake information and use modules in this manual. You need the intake information to initially conceptualize and formulate a therapeutic plan. Using the patient's presenting problems, symptoms, current level of functioning, culture, and history helps in developing the therapeutic plan. From the intake information, it is imperative that you assess the patient's suicidality. This can be done by asking about the patient's suicidal ideation, intent, or plan and determining his or her level of hopelessness, as well as the reasons for hopelessness. If the patient's suicidality seems high, then crisis intervention is above all other therapeutic considerations. In the case of an acutely suicidal patient, seek supervision or consultation and follow approved clinic procedures for managing a suicidal patient (e.g., contact on-call psychiatrist for evaluation).

Patient Expectations for Treatment

You should inquire about what the patient knows about how therapy is conducted. Orienting your patient to therapy includes describing the cognitive-behavioral model and answering any questions he/she might have about the progression of therapy. Using the patient's examples to help explain the cognitive-behavioral model will assist him/her in being able to see how the model can work and how it has worked for other patients with similar problems. Patients may confuse psychotherapy (i.e., typically uses Socratic dialogue, motivational enhancement strategies, and collaborative planning to foster patients' motivation for change to positively impact psychopathology) with counseling (i.e., advice is given and the focus may not be reducing the contribution of cognitive-behavioral components on patients' problems). Further, patients often think therapy is a place where they will come and be lectured and told what to do, or a place to vent without a focus on behavior change. It is essential in brief CBT that the patient understands that therapy is a partnership between the provider and the patient, in which they work together so that the patient can better understand feelings and solve problems.

Negotiating the amount of time the patient will need to be in therapy is also important. For brief CBT, patients typically attend weekly individual sessions for four to eight weeks. However, the amount of time in therapy and the number of days a week can be reassessed periodically and adjusted to meet the needs of the patient (see Module 8 – Goal Setting).

Discussing Symptoms and Diagnostic Issues with the Patient

Most patients want to know how they have been diagnosed. Explain the disorder in terms of cognitive and behavioral symptoms to clarify how CBT will directly address their problems. Giving patients descriptions of common symptoms of their disorder can also be helpful.

In-Session Example 7.1

Example: There are cognitive and behavioral aspects of feeling depressed. Cognitive characteristics of depression include having negative thoughts about yourself, such as "I am no good," or "Things are not going to get better." Behavioral characteristics are ways your body tells you you're depressed, such as changes in your appetite or sleep patterns.

<u>Feedback</u>
The collaborative piece of CBT involves asking a patient for feedback on the session (e.g., "What did you think about our session today? Did we leave out anything you think is important to discuss?") and on how the patient feels about the cognitive-behavioral model (e.g., "Do you feel you have at least a basic understanding of the model, or should we be sure to review it in detail again next week?") at the end of the first and subsequent sessions.

Encouraging patients to offer feedback strengthens the rapport and trust within the therapeutic relationship and indicates to patients that they are active members of the therapeutic process. It shows that the provider cares about what patients think and feel and values their input. This is also a time to resolve misunderstandings about the cognitive model or things that occurred in the session (e.g., "Was there anything that bothered you about the session, or anything that you'd like to change?"). Getting feedback from the patient shows how important it is to work as a team and helps you work on sharpening your abilities in therapy. It also allows you to attend to and repair any real or perceived therapeutic fissures or needed treatment modifications in a timely way.

Highlight 7.1

Important Introductory Elements

- Introduce Processes of Psychotherapy.
  - » Transparent
  - » Collaborative
  - » Time-limited
- Introduce Cognitive-Behavioral Model.
  - » Research basis
  - » Association between behaviors, thoughts, feelings, and situations
  - » Use of examples from patient's past week to clarify associations
- Educate the patient about his/her disorder.
  - » Description of patient's problems in cognitive and behavioral terms.
- Instill hope and empowerment.
  - » Request for feedback
  - » Creation of a warm, collaborative therapeutic environment

HOMEWORK ASSIGNMENT EXAMPLES

1. Keep a running list of questions you may have about the therapeutic process, and bring it with you to the next session.

2. Use the cognitive-behavioral model diagram for at least three situations you experience this week.

3. Create a short list of the things you liked about the previous session and a short list of the things you wish we could have changed about the previous session and/or concerns you might have.

SUPPLEMENTAL READINGS

Greenberger, D., & Padesky, C. A. (2016). *Mind over mood: Change how you feel by changing the way you think* (2nd ed.). Guilford Press.

Beck, J.S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford Press; Chapter 5.

Module 8: Goal Setting

OBJECTIVES
- To understand the concept of goal setting in brief CBT
- To acquire skills to set feasible and appropriate goals in brief CBT

What is Goal Setting, and Why Is It Important To Set Goals in Therapy?

Goal setting is the process of collaboratively identifying specific therapeutic outcomes for treatment. Goals must be observable, measurable and achievable and relate to cognitive or behavioral changes relevant to the patient's presenting problem. Goals are tied to specific skills to be addressed in treatment. Goals increase the continuity of sessions; allow directed, focused treatment; and enable the patient and provider to assess the progress of therapy and identify change in an objective manner.

When? (Indications/Contraindications)

In addition to identifying the problem and building rapport, goal setting is one of the first therapeutic activities to be completed in brief CBT. Although goals can be changed/modified at any point during therapy, to maximize applicability and benefit to the patient, a preliminary set of goals should be established and agreed upon by the end of the first or second session.

How? (Instructions/Handouts)

Goal setting begins with the identification of broad goals. These are global and refer to areas of functioning (e.g., family, work, social relationships, financial concerns, health). Broad goals are closely tied to your case conceptualization and the patient's presenting problem.

Once broad goals are identified collaboratively, you and the patient should prioritize goals. This process involves determining the most central issues that cause concern and arranging them from most important to least important. Starting with the problem that has the best chance of being solved and is central to the patient's presenting concerns can help increase the patient's commitment to therapy. If one skill is prerequisite to a subsequent goal, you can prioritize that goal in treatment (e.g., relaxation before exposure, awareness of thoughts before thought challenging).

Use a graded approach to goals, in which you take small steps in service of the larger goal each week through session content or homework assignments. Identifying and sequencing action steps involve breaking each goal into smaller steps to help the patient know what to do at every stage of accomplishing the goal without feeling overwhelmed by a huge task. It is important to note that all patient concerns may not be attended to in a brief treatment format.

Once goals have been identified and prioritized, they are operationalized, which involves defining the goal and all the steps that it will take to achieve it in concrete, observable/measurable cognitive or behavioral terms.

Another important process of brief CBT is ongoing measurement-based care (MBC) used to assess the progression of the patient's symptoms throughout therapy. Use disorder-specific, validated self-report tools allowing patients to identify the degree specific symptoms contribute to their distress. This process informs baseline distress and end-of-treatment progress and identifies areas still requiring attention during therapy. You can administer self-report tools to patients during the first and last sessions and as frequently as each therapy session. Some gold-standard instruments are as follows:

- Depression: Patient Health Questionnaire (PHQ-9, 9 items; PHQ-2, 2 items; Kroenke, Spitzer, & Williams, 2003)
- Anxiety: Generalized Anxiety Disorder-7 (GAD-7, 7 items; GAD-2, 2 items; Spitzer, Kroenke, Williams, & Lowe, 2006)
- Suicide: Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2010)
- PTSD: PTSD Checklist for DSM-5 (PCL-5; Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013)
- Alcohol Use: Alcohol Use Disorders Identification Test - Consumption (AUDIT-C; Bush, Kivlahan, McDonnell, Fihn, & Bradley, 1998)
- Drug Use: Drug Abuse Screening Test (DAST-10; Skinner, 1982)

In-Session Example 8.1

Example

Goal: Learn two cognitive and two behavioral strategies for coping with stress.

- ✓ Operational Cognitive Goal
  - Learn and use thought testing and problem solving to manage anxious thoughts/situations.

- ✓ Operational Behavioral Goal
  - Plan and complete one pleasant or social activity per week.

ASSESSING FACILITATORS, BARRIERS, IMPORTANCE, AND CONFIDENCE

Once a goal or multiple goals have been established, it is critical to assess the patient's situation and attitudes about the goals. For example, ask whether there are aspects of the patient's life that may facilitate or inhibit the goal. A strong family and social-support system may help a patient to reach a goal, but a functional limitation may create an obstacle. Explore facilitators and barriers and discuss strategies to maximize the chance of goal attainment.

Assessments of importance and confidence are also important. Ask the patients to rate the importance of the goal on a scale of 0 to 100 (where 0 is not important and 100 is very important). Discuss ratings lower than 60 or so, and refine goals to increase meaning. Similarly, ask patients to rate their confidence in obtaining the goal. Here, confidence ratings could be a little lower but would, hopefully, increase as treatment progresses.

TROUBLESHOOTING GOAL SETTING

Some clues that goals may need modification are worsening symptoms, no change in symptoms, patient failure to complete homework (see Module 10: Homework), and patient/collateral report that the patient is not benefitting from treatment. In these cases, it is important to revisit initial goals with the patient and elicit feedback about the progress of therapy (e.g., "What do you find helpful?"). Often, too-ambitious goals need to be modified. In these cases, it is important to frame the revision in terms of taking small steps towards lasting change, normalize the difficulty of making changes when depressed or anxious, and join the patient (e.g., "I think I may have gotten a little ahead of myself; let's modify these a little, so that they can be the most help for you"; "I may have missed the mark on this one; what do you think about adding/changing/removing a goal?"). Goal revision should not imply to patients that they have failed in therapy. It is an opportunity to model functional change in response to changing situations.

If a patient is worsening, discuss any changes in context (e.g., relationship, work, sleep, medication compliance, physical health) the patient is experiencing. Create a new goal pertinent to what the patient believes is worsening and what might help. At this point, you should also consult a supervisor/colleague or other professional (e.g., patient's treating physician).

If patients are not improving, elicit their feedback about changes they are experiencing and their perceptions about why these changes have occurred. If a patient seems to have trouble understanding the assignments, focus on more concrete and behavioral skills.

Highlight 8.1

Tips for Goal Setting

- Provide Rationale for Setting Goals.
  - » This helps painets understand the direction of treatment and how they will be involved in the process.
    - ▪ Example: "If you can identify what you want to change about your situation, we can then take steps to correct the problem."

- Elicit Desired Outcomes.
  - » This involves assisting the patient in defining goals and specifying reasons for coming to treatment.
    - Example: "List a few things you would like to get out of therapy."

- Be Specific About What the Goal Is.
  - » Determine each goal, what the goal is attempting to target, and what the patient's role is in reference to the goal.
  - » Guide patients toward goals that require change from then (vs. others).
    - Example: "You said that you want your wife to listen to you. Since we can't really make someone do what we want, what could you do to help you feel heard or cope with a situation when you don't feel heard?"

- State Goals in a Positive Light.
  - » This clarifies what patients want to do instead of highlighting what they don't want to do.
    - Example: "List some things that you want, instead of things that you don't want. For example, instead of 'I don't want to be depressed anymore,' you could list, 'I want to enjoy my favorite hobbies again.'"

- Weigh Advantages and Disadvantages of a Goal.
  - » This aids in understanding the costs and benefits of the patient's achieving the goal.
  - » It may be used to motivate an ambivalent patient or identify salient goals for a passive patient or a patient seeking to please the provider.
    - Example: "What would be the benefits if you accomplished this goal? What might be some of the costs to you?"

- Define Behaviors Related to Goal.
  - » This instructs the patient what actions to perform in relation to the goals that have been set.
    - Example: "What would it look like if you were less depressed? If I saw you and you were feeling happy, what would I see? What do other people do when they are happy? What things do you think have changed in your life since you have been depressed? What did you used to do that you enjoyed that you don't do anymore?"

- Define a Level of Change.
  - » This determines how much a patient should do a particular behavior.
  - » To increase the patient's chance of success, set achievable goals. In other words, it is usually not reasonable to try to do something every day; and setting a goal like this will result in failure if the patient misses just one day. Alternatively, discuss the goal with the patient; and start small. If patients succeed, they are more likely to remain actively engaged.
    - ▪ Example: How often do you think it is reasonable to do something pleasant? Once a week?

- Regularly Evaluate Symptoms.
  - » Track how effective the goals are in decreasing mental health symptoms and increasing functioning and quality of life.
  - » For example, assess the following areas during the intake process, during the actual intervention strategy, and a month to a year after termination of therapy:
    - ▪ Patient's level of satisfaction with your assistance and the results of therapy
    - ▪ Amount of growth the patient experienced from the beginning of therapy to the end
    - ▪ Benefits obtained by the change made by the patient and which treatment was effective in helping to accomplish the goal

EXAMPLE HOMEWORK ASSIGNMENTS

1. Make a short list of broad goals. What areas of your life do you wish to improve (e.g., work, family, social, recreational, financial, health, etc.)? Think about which goal would be most important.
2. List three issues, in order of importance, that you want to discuss in the next session.
3. Weigh the pros and cons of each goal that we have agreed upon in treatment.

SUPPLEMENTAL READINGS

Beck, J.S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford Press; Chapters 3, 4.

Cormier, L. S., Nurius, P., & Osborn, C. J. (2017). *Interviewing and change strategies for helpers.* Boston, MA: Cengage Learning; Chapters 3, 4, 5, and 7.

Module 9: Agenda Setting

OBJECTIVES

- To understand the rationale for setting an agenda
- To understand process of collaboratively setting an agenda
- To identify and address problems with setting an agenda

What Is Agenda Setting, and Why Is It Important?

Agenda setting is a collaborative process through which you and the patient decide how session time will be spent. You and the patient offer items you would like to discuss and then decide the order of items and the amount of time you will spend on each. Each item should serve a treatment goal (see Module 8: Goal Setting and Module 4: Cognitive Behavioral Case Conceptualization and Treatment Planning). Agenda setting ensures that session time is well spent and that both provider and patient have input into session content.

When? (Indications/Contraindications)

An agenda should be set within the first 10 minutes of every session. Without setting an agenda, it is very easy for vocal patients to "run away" with the session by recounting the events of the past week or describing the history of a problem. It is also easy for more passive patients to never indicate which items are most important to them. Collaboratively setting an agenda ensures that both your and the patient's needs are met. Setting a time limit for each item increases the chance all items can be covered.

Encourage patients to think between sessions about what they would like to discuss in session. If patients do not offer an agenda item, you can introduce an item and check with patients to see if they feel it would be valuable to discuss.

How? (Instructions/Handouts)

It is your responsibility to model how to set agendas for the patient. In the first few sessions, you will be setting the agenda because often the patient is unsure of what is being asked or what to discuss in therapy. You can help patients become more comfortable with setting their own agenda by asking questions like, "What is the main reason you came to therapy?" or "What is causing you the most trouble right now?" or "What are your most pressing issues today?" or "What are your thoughts about the focus of today's session?" It is also important to assist the patient in prioritizing issues on the agenda to give an acceptable amount of attention to each. After listing and prioritizing items, allot an approximate time to each item for discussion. In accordance with the collaborative process of psychotherapy, sometimes lower-priority patient or provider agenda items may need to be addressed at a later session (i.e., if it is not feasible to allocate adequate time for addressing said items during the current session).

Pay close attention to time management of issues on the agenda, and steer the patient away from superficial issues. As time passes, the responsibility of setting an agenda for the session should shift to patients. This will eventually help them to set agendas, prioritize problems, and suggest interventions for issues encountered after completing therapy. This level of increasing patient responsibility also translates into their overall functioning by increasing autonomy of functioning as they work toward ending treatment.

Highlight 9.1

Typical Session Outline

1. <u>Briefly review patient's mood and/or physical functioning (Five minutes).</u>
   Elicit responses concerning the patient's mood, and consider any and all discrepancies (e.g., change in strength or nature of usual mood, change from last week or beginning of treatment). Ask the patient to complete a self-report tool to measure symptom intensity and frequency. Medically ill patients may benefit from regular assessments and updates on their physical health symptoms and functioning. Also ask the patient to offer explanations for mood improvement or decline. This brief update allows you to gauge how the patient is progressing and identify positive and negative change. If medication management or physician collaboration is part of the patient's treatment, this is also a good time to check on any side-effects the patient might be having from medication and make adjustments as needed.

2. <u>Bridge discussion from previous session with the current session (Five minutes).</u>
   In bridging sessions, you are checking the patient's understanding of what was discussed in the previous session. Reinforcing what the patient learned in past sessions is essential to the improvement that the patient makes outside the therapeutic relationship. Having the patient complete a Bridging Worksheet can assist in this stage of the agenda. Some issues discussed during this phase could become items on the agenda for the current session.

3. <u>Set the agenda for the current session and prioritize the items (Five minutes).</u>
   First ask patients what they would like to discuss, and then offer an item. If patients bring several agenda items, they might need to indicate which is the most important to discuss first. When patients offer a situation as an item (e.g., fight with boyfriend followed by food binge), you can use the situation as part of their agenda item, that is, as part of the skill being taught. For example, you can use the above scenario to teach/review a thought record.

4. <u>Review any homework given in the previous session (Five to ten minutes).</u>
   Patients who do between-session homework improve more than those who do not. To reinforce and troubleshoot between-session learning, it is important to review homework. In-session review serves two purposes: it reinforces the importance of homework and allows you to assess skill acquisition. If you identify errors in homework, you can use additional session time to review the skill. Reviewing

homework can take a small amount of time; or it can take the entire session, depending on what patients have learned from doing it and what difficulties they have encountered in completing it.

5. <u>Discuss agenda items and set up homework (20-25 minutes).</u>
Discuss agenda items, starting with the first and most important. If you are running short on time, inform the patient that you will discuss the other items at your next appointment. Set up homework that is directly connected to what has been discussed in the session.

6. <u>Summarize the current session and exchange feedback (Five minutes).</u>
Two types of summarizing are recommended. The first is a brief summary that should be done after the conclusion of each section of the agenda to reinforce what has been discussed. The second type is used to clarify and remind patients of the thoughts they have presented and how those thoughts changed as a result of the exercise. It is important to use patients' specific words in summarizing their thoughts. At the end of the session, summarize the main points of the entire session. As the sessions progress, ask patients to do the summaries. Finally, exchange feedback about the session, skill, or progress of therapy. This is a time for you to encourage and motivate patients to continue working towards change.

TROUBLESHOOTING AGENDA SETTING

In discussing agenda items, there are many pitfalls for a new CBT provider. It is your responsibility to keep the discussion on track and focused. To prevent unfocused discussion, gently guide patients back to the topic when they drift; emphasize key emotions, beliefs , and automatic thoughts; and often summarize and rephrase what patients say. You can also discuss at the start of therapy that one of your roles is to keep sessions on track; so, you may, at times, need to shift the focus of conversation. Getting patients' agreement on this point at the beginning helps them feel more comfortable if you need to redirect or interrupt later in therapy. Pacing is also a concern for providers, but prioritizing and collaboratively agreeing on agenda items and times can help you and the patient stay within the allotted time. When guiding the conversation with your patient, you can use a mix of close-ended or open-ended questions in response to time constraints.

Patients and providers sometimes have difficulty setting the agenda together. Sometimes patients do not want to contribute to the agenda because of feeling hopeless or negative toward therapy. Occasionally, the patient may also be unfocused when setting the agenda (e.g., recount events of past week). It is often necessary to educate the patient about therapy by clarifying what kinds of issues constitute agenda issues and how session time may be optimally spent.

CBT suggests that change involves skill acquisition and not simply identifying distorted thinking. Therefore, recognizing an unhelpful thought can be enlightening, but you should also use session time to teach skills to address the problem (e.g., thought records, behavioral activation) and not simply discuss the issue with the patient or offer advice. The process of skill acquisition is what sets CBT apart from "talk therapies" (supportive therapy).

EXAMPLE HOMEWORK ASSIGNMENTS

1. Create an agenda for next session, using the given outline.
2. Think about adjustments you would like to make to our current agenda and reasons why.
3. Crate a list of concerns/discomfort in the agenda-setting process.

SUPPLEMENTAL READINGS

Beck, J.S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford Press; Chapter 5

[This worksheet is to be completed by the patient prior to beginning the session (e.g., in the waiting room) to prepare for therapy and assist in collaboratively selecting agenda items.]

BRIDGING SESSIONS

1. What main points did we reach in our last session? What did you learn from last session? Did anything come to mind in the past week about our last session that you'd like me to know or that you'd like to discuss?

2. Were you uncomfortable about anything we talked about in our last session? Is there anything you wish we had discussed that we didn't?

3. How is your mood? (How is your physical health?) Compared with last week, is it better or worse?

4. What treatment goals would you like to work on today? What problems would you like to put on the agenda?

5. What homework did you attempt or complete for last session? What did you learn from doing it?

Module 10: Homework

OBJECTIVES

- To understand how homework is introduced and used in brief CBT
- To understand techniques for increasing homework utility and compliance

What Is Homework, and Why Is It a Central Part of CBT?

Homework is an essential and effective component of brief CBT. Because of the condensed number of sessions in brief CBT, assignments such as readings, behavior monitoring, and practicing new skills should be given to the patient to practice and use outside sessions. Homework assignments facilitate patient skill acquisition, treatment compliance, and symptom reduction by integrating the concepts learned in sessions into daily life. Homework is a key mechanism for facilitating between-session work and progress.

When? (Indications/Contraindications)

Give homework assignments throughout treatment. The nature and frequency of assignments are left to your discretion. Consider patient characteristics when assigning homework, specifically, reading ability, cognitive functioning, cultural identity, level of distress, work/life balance, and motivation. During the beginning stage of therapy, suggest homework; but, as therapy progresses, encourage patients to generate their own between-session activities. This helps them to continue to use skills outside therapy and after the end of treatment. Some patients may be hesitant to participate in homework assignments, so it is your responsibility to be open to patient feedback about assignments, give reasons for each task, and personalize homework assignments for each patient. Also, patients may have a negative reaction to the word *homework,* which might prompt you to use practice or at-home exercises.

How? (Instructions/Handouts)

SEVEN TIPS FOR SETTING HOMEWORK ASSIGNMENTS

1. One Size Does Not Fit All.

Always tailor assignments to patients. Their reading level; desire to change; cognitive functioning; and, even, stage of life determine how much and what type of homework assignment fits them best. For example, a single, working mother who is also a full-time student may not have time to read a complete book as a bibliotherapy assignment. Assigning her a small part of the book or an article may be more reasonable. Breaking assignments down into smaller parts is also useful. Always consider the patient's diagnosis and presenting problem when assigning homework and ask yourself:

In-Session Example 10.1

> "Can the patient handle this homework, and will it be beneficial to his/her growth?"
> "Could there be a negative result from this assignment; and, if so, is the patient prepared to handle it outside session?"

2. Explain in Detail.

Knowing the reason for an assignment and how it relates to overall treatment goals help patients understand why they are doing the assignment and also may encourage him/her to complete it. Most patients are interested in how certain activities may improve their situation or relieve their symptoms. Explain assignments in the context of treatment goals and the cognitive model to enhance patient buy-in to the tasks.

3. Set Homework as a Team.

Involving patients in designing and scheduling homework increases the chances they will complete it. It is also important to get the patient's agreement to complete the homework. Suggest homework assignments, and then ask the patient if you can help make adjustments to it. Ask, for example, the following:

In-Session Example 10.2

> "Do you think this is reasonable?"
> "What would you change about the assignment?"
> "Let's do an example together first. Then we can make changes if we need to."

4. Create a Win-Win Situation.

Do not scold a patient for not completing homework assignments, but also do not dismiss their value. If a patient does not finish homework, which is common, you may learn about the patient's level of motivation, ability to follow-through, or level of distress (e.g., too depressed to complete it). Failure to complete homework is an opportunity for you to evaluate the patient's reason for noncompliance. The patient may have been anxious about completing an assignment incorrectly or may question the utility of the assignment. These thoughts are helpful to discuss in session.

5. Start Homework In-Session.

In the first few sessions after assigning homework, do a few examples with the patient in session, when possible. This gives the patient a clearer picture of what is expected and allows questions that he/she might have about the homework. It also gives the patient an idea how long the homework will take. In subsequent sessions, the patient may start the assignment with your assistance to troubleshoot questions about it.

<u>6. Ask About and Review Homework.</u>
To emphasize the importance of homework, always ask about and review homework the session after you assign it. If the patient did not complete homework, use session time, if possible, to complete the assignment, which may also help identify the aspects of the skill that need to be reviewed. If you do not review homework in session, patients may stop completing it.

<u>7. Anticipate and Prepare for Problems.</u>
With the first few homework assignments, help problem solve the assignment by eliciting feedback about it and planning when and how it will be completed. Assignments can be scheduled for a particular day and time to overcome barriers, and foreseeable problems for completing the assignment at that time can be discussed. For example, if the patient's behavioral activation is to walk for 15 minutes on Wednesday at 4pm, discuss what to do if it rains or other factors prevent completion. Agree upon and schedule a second option (e.g., using treadmill for 15 minutes).

USING SELF-HELP RESOURCES AS HOMEWORK

Assigning the patient reading materials relevant to brief CBT presenting problems is a useful tool for brief CBT because it allows patients to read about their disorder or CBT between sessions. This emphasizes the self-management focus of CBT and can accelerate therapeutic progress and maintenance of changes. Reading materials may be websites, book chapters, or sections of CBT patient manuals. Some common examples of CBT bibliotherapy are *Mind Over Mood* (Greenberger & Padesky, 2016) and *Feeling Good Handbook* (Burns, 1999).

HOMEWORK TROUBLESHOOTING

<u>Practical Problems</u>
Occasionally, providers may encounter a patient who waits until the day before a session to do the homework. This is problematic because certain assignments, such as monitoring automatic thoughts, are most effective and most accurate when completed in the moment. There are many reasons patients may put off doing homework; and your role is to explore these reasons in a proactive, nonjudgmental, nonpunitive way.

Sometimes patients may simply forget to do homework. They may have a busy schedule or have trouble remembering to complete homework. Using a calendar and scheduling time to do homework are useful in this situation and provide the opportunity for time-management skill building. You can also work with the patient to download self-management apps on his/her smartphone or tablets.

A few assignments described in this text might be difficult for some patients. If a patient is having trouble completing an assignment because of the level of difficulty, it is your job to explain how to complete it and gauge the patient's understanding. Some assignments may need to be broken down into smaller steps until the patient can fully grasp how it is to be completed.

<u>Psychological Problems</u>

Patients who don't complete homework might have unhelpful thoughts about themselves, the homework assignment, or therapy that need to be addressed. In these cases encouragement, thought testing, and listing the advantages and disadvantages of doing homework may be useful. Though outside the scope of this manual, techniques, such as motivational interviewing (Rollnick, et al., 1999), may also be used to address the ambivalence a patient may feel about homework. Patient perceptions of importance and confidence are very important for noncompliance issues.

Many patients have negative reactions to the word *homework.* They may feel overwhelmed by the perceived time or energy it will take to complete or concerned that therapy is like schoolwork. In giving homework, address any concerns the patient may have about time constraints; and explain how long each assignment should take, while working with the patient to generate reasonable tasks. If the patient dislikes the term *homework,* work with them collaboratively to select another label, such as *practice, between-session progress, task, or experiment*.

Homework may be problematic for patients who are perfectionists or those who desire to please the provider because they may spend too much time on an assignment or be overly concerned about getting the "right answer." Clarify that the exercise is not about getting the "right answer," and that they should concentrate on recording real feelings and thoughts and not concern themselves with spelling, grammar, or appearance of the assignment.

<u>Provider Homework Bias</u>

Although completion of homework is primarily the patient's responsibility, sometimes your thoughts about an assignment or approach to homework play a role in noncompliance. Check your own thoughts about assigning homework, and determine whether there is anything you can adjust in your approach that could better encourage the patient. Ask yourself, "Is the assignment too difficult?," "Did I explain the assignment thoroughly?," or "Have I led the patient to believe that homework is unimportant to therapy?"

SAMPLE HOMEWORK ASSIGNMENTS

Examples of homework that could be assigned for each cognitive and behavioral skill are included in each module. Examples of tailoring a homework assignment to a specific case are included in Appendix B.

SUPPLEMENTAL READINGS

Beck, J.S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford Press; Chapter 5.

Burns, D.D. (1999). *Feeling good handbook.* New York: Plume Books (Penguin USA).

Greenberg, D. & Padesky, C.A. (2016). *Mind over mood: Change the way you feel by changing the way you think.* New York: Guilford Press; Chapters 3, 6, 7, and 8.

Rollnick, S., Butler, C., & Mason, P. (1999). Chapters 3, 4, and 5. In *Health behavior change: A guide for practitioners.* New York: Churchill Livingstone.

Module 11: Identifying Unhelpful Thinking

OBJECTIVES:

- To understand the role of unhelpful thinking patterns in brief CBT.
- To learn methods for educating the patient about unhelpful thinking.

What Is Unhelpful Thinking, and Why Is It Important in Brief CBT?

The cognitive-behavioral model suggests that three layers of unhelpful thinking exist in individuals struggling with psychosocial difficulties: automatic thoughts, intermediate beliefs, and core beliefs (depicted below in Figure 11.1).

Figure 11.1 Layers of Unhelpful Thinking

Automatic Thought

Intermediate Belief

Core Belief

Automatic thoughts are immediate internal reactions that occur in response to situations and/or events. We are often unaware of automatic thoughts because of their almost instantaneous nature. Sometimes automatic thoughts are helpful, as they help us navigate our environments. However, automatic thoughts become unhelpful when they are attached to symptoms of psychopathology (e.g., social isolation, depression, anxiety, etc.) and negatively impact people's quality of life. One way that we gain insight about these automatic thoughts is by understanding our emotional reactions to them.

Unhelpful thinking styles are distorted reflections of situations that are often accepted as true. In essence, these unhelpful thought styles are real-time manifestations of negative beliefs (i.e., about oneself, the world, and the future) that are triggered by situations or exaggerated by psychiatric symptoms (e.g., anxiety or depression).
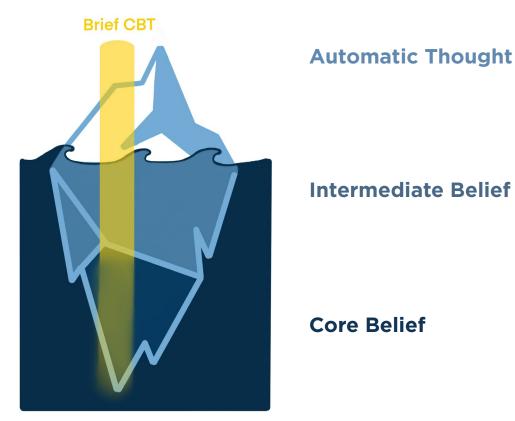
Intermediate beliefs are attitudes or rules that a person follows in life that typically apply across situations (not situation specific as with automatic thoughts). Intermediate beliefs can often be stated as conditional rules: "If x, then y." For example, *"If I am thin, then I will be loved by others."* Individuals create these assumptions by categorizing the information they receive from the world around them. These rules guide thoughts and subsequently influence behaviors.

Core beliefs drive rules and automatic thoughts. For example, the belief, "I am unlovable," may be driving the conditional rule, If I am thin, then I will be loved by others, which may drive obsessive thinking about one's appearance, excessive exercise, or disordered eating habits. Core beliefs are often formed in childhood and solidified over time as a result of one's perceptions of experiences. Because individuals with psychological disorders tend to store information consistent with negative beliefs but ignore evidence that contradicts them, core beliefs tend to be rigid and pervasive. Although automatic thoughts are often tied to a specific situational trigger, intermediate and core beliefs are more global and cut across domains. Individuals tend to have core beliefs that involve either interpersonal ("I'm unlovable") or achievement issues ("I'm incompetent").

When? (Indications/Contraindications)

Identifying unhelpful automatic thoughts is the first step in the cognitive component of therapy. The focus of intervention in brief CBT is the unhelpful automatic thought. Patients must master identifying and challenging thoughts to be able to grasp the concept and techniques of challenging beliefs. Because of the interrelated nature of thoughts and beliefs, an intervention targeting automatic thoughts may also change underlying beliefs (depicted below). Therefore, brief CBT can result in belief modification, even if the target of treatment was automatic thoughts.

Figure 11.2 Brief CBT and Unhelpful Thinking

Because patients progress through treatment at different rates, you may be able to identify and challenge some beliefs late in brief therapy (sessions 5-8) for some patients. For other patients, work will be limited to automatic thoughts.

Highlight 11.1

> Because skill building to alleviate symptoms and prevent relapse is a central focus of CBT, mastery of skills is paramount. Focus on building a skill set with patients that they can generalize to different situations, thoughts, or beliefs. It is less important to identify and modify deep-seated childhood beliefs. For most patients in brief CBT, this will not be necessary for symptom reduction. However, some patients may benefit from this work.

Although you may not discuss beliefs directly with patients, as part of the case conceptualization, they should constantly be forming hypotheses about what beliefs may be driving the thoughts (see Module 4: Case Conceptualization and Treatment Planning).

In identifying thoughts and beliefs, ask yourself several questions.

- Is the thought/belief secondary to another thought/belief?
- How much does the patient believe it?
- Does it affect the patient's life negatively?

- Is the patient prepared to work on it now, or should they tackle the belief later?

After an automatic thought or belief is identified, it is challenged using the skills in Module 11

<u>How? (Instructions/Handouts)</u>

EXPLAINING AUTOMATIC THOUGHTS TO YOUR PATIENT

It is important for patients to understand he rationale for identifying automatic thoughts before gaining skills to address their own thoughts. Using the situation-->thought--> feeling triangle introduced in Module 7 (Orienting the Patient to Brief CBT) can be helpful in explaining automatic thoughts. Completing the triangle with the patients' recent or current automatic thoughts can facilitate their understanding.

In-Session Example 11.1

> **Provider:** **"So, Pamela, how have you been feeling this week?"**
>
> Patient: "Just really sad...as usual. It seems like I'm always feeling that way."
>
> **Provider:** **"Did anything in particular trigger this sad feeling this weekend?"**
>
> Patient: "Yes, I had to go to my cousin's wedding; and it was really difficult because I started thinking about how I will never get married."
>
> **Provider:** **"Pamela, that's what we call an automatic thought. It's something that just pops into our heads over and over again without our really thinking about it or examining the truth of the thought. It affects the way we feel and act in a negative way. Maybe we should look at some of your automatic thoughts a little closer."**

Using the patient's example, describe the association between thoughts and feelings to build awareness of the connection. This is a good time for the patient to write down the thought and begin using the cognitive-behavioral model (Figure 11.3).

In-Session Example 11.2

> **Provider:** **"So, let's write down this automatic thought that you are having. *I will never get married.* Your going to your cousin's wedding was the situation that triggered the thought, 'I will never get married.'"**
>
> Patient: "Yes, that's true."
>
> **Provider:** **"When you were at the wedding and that thought came to you, how did you feel?"**
>
> Patient: "I felt really sad and hopeless."
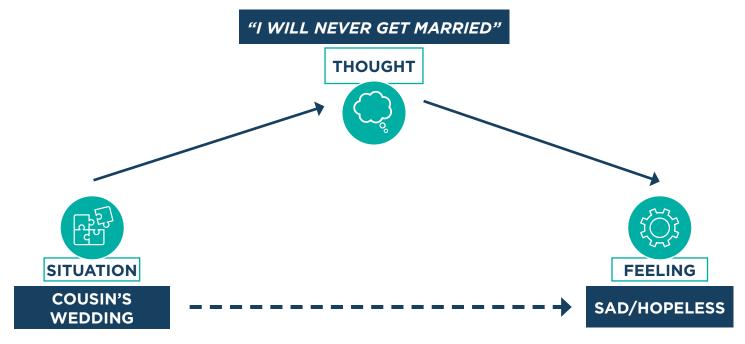
Provider: "So, can you see how our thoughts can affect our mood and change the   way we are feeling?"

Pamela: "Yeah, I guess if I hadn't had that thought, I wouldn't have felt so bad."

Figure 11.3 Example Patient Cognitive Model

"I WILL NEVER GET MARRIED"

THOUGHT

SITUATION

COUSIN'S WEDDING

FEELING

SAD/HOPELESS

ELICITING AUTOMATIC THOUGHTS

It is important for providers to teach patients how to identify automatic thoughts during and outside of session.

AUTOMATIC THOUGHTS IN SESSION

Be aware of patients' **hot thoughts** during sessions. Hot thoughts are automatic thoughts that occur in combination with a change in emotion or mood. Hot thoughts are particularly poignant or strong thoughts that are often associated with unhelpful core beliefs and should be targeted in therapy. Hot thoughts and the accompanying situation and emotion are tracked on the first three columns of the thought record (see p. 81).

To identify which automatic thoughts are "hot," listen for verbal cues, such as the language used in the thought (see Cognitive Distortion worksheet, p. 83), and watches nonverbal cues, such as increased volume of speech or fidgeting. Changes in facial expression, shifts in position, or hand movements can be helpful in determining whether a patient is experiencing an automatic hot thought. Listening to tone, pitch, volume, and the pace of a patient's speech is also beneficial. When you notice these actions, this is an opportune time to bring it to the patient's attention and assist them in identifying an automatic

thought associated with the shift in emotions. In these instances, you are simply an observer of the behavior and make a note of your observation to the patient ("You are speaking more loudly; what is going through your mind right now?"). The patient then provides an explanation of the behavior.

In-Session Example 11.3

Patient   "My boss reprimanded me again yesterday" (sighs heavily.)

Provider: "Tell me more."

Patient: "Well, we were at a meeting; and I had just made my presentation, and he said he had expected a better product for the client." (voice gets softer, beings wringing hands).

Provider: "Your voice changed a little when you said that; tell me what is going through your mind right now?"

Example continued:

Patient: "I just feel like a failure at everything. My work has always been the one thing I was good at, and now I am failing at that, too."

Provider: "Let's take a look at that line of thinking and the feelings it creates. It seems that when that thought entered your mind, your mood changed very quickly. Did you notice that?"

Patient: "Yeah, I guess it did upset me pretty fast."

You usually will also need to use specific questions to elicit an automatic hot thought. These questions are found in Module 12.

AUTOMATIC THOUGHTS BETWEEN SESSIONS

In brief CBT, a principal characteristic is the work the patient does outside of session. Because identifying automatic thoughts is a novel concept to many, practicing outside of session will facilitate movement and change in therapy. In fact, Burns and Nolen-Hoeksema (1992) found that patients who completed homework had significantly better treatment outcomes than those who did not. Practicing key skills between sessions allows session time to be used for new skill acquisition and troubleshooting. Initially, when a specific situation is brought up in session, always ask, "What was going through your mind at that moment?" This helps the patient build awareness of an automatic thought, both within and outside of session.

Because automatic thoughts may occur outside awareness, asking for a more detailed description of the situation is also helpful in pinpointing unhelpful thinking. For example, you could "take the patient back" to when it happened, using imagery (e.g., Where were you when this happened? What time of day was it?). If the patient reverts to past tense, remind them to tell the story in present tense to help bring back the thoughts and feelings that occurred in this situation.

With continued questioning, it is possible that there may be more than one automatic thought associated with a problematic situation. Elicit and record all automatic thoughts given for a particular situation.

In-Session Example 11.4

Provider: **"Craig, what else were you thinking during this phone call with your wife?"**

Craig: "I was thinking that she knows how bad I feel for not coming to the party and she wants me to feel even worse."

Provider: **"So you weren't thinking only that they were using you. You were also thinking that they knew you felt bad, and they wanted you to feel worse?"**

Craig: "Yes."

Provider: **"So, that is really three different thoughts that you were having that were creating feelings of anger?"**

Craig: "I guess so."

Remember that a patient's automatic thoughts should be the actual words or images that go through their mind. Patients (or providers) may often interpret or rephrase thoughts; however, the goal is to get unprocessed thoughts verbatim.

DECIDING WHICH AUTOMATIC THOUGHTS TO FOCUS ON

Once patients become aware of how many automatic thoughts they have, they may feel overwhelmed by their sheer number. Uncovering one thought may lead to another and so on. Therefore, it is important to focus on the most important automatic thoughts and the hot thoughts that are likely to bring about the greatest change. There are several things patients can do once they have identified an automatic thought. They can decide to focus on that thought, choose another thought associated with the situation, or move on to another topic if they feel that there is a more powerful thought that they would like to tackle.

You can help the patient choose automatic thoughts to focus on by frequently checking:

- Goals for this session

- Patient's agenda items and addressing those problems

- The importance of the thought chosen in reaching therapeutic goals

Another technique is to identify a few automatic thoughts and then rate them on a scale of 0-100, based on how intense the associated feeling is (rate the feeling from 0-100), and how much patient believes the thought (rate believability from 0-100). This helps to quantify which automatic thoughts are most important. The thoughts with the strongest ratings should be considered first.

Unhelpful automatic thoughts often fall into certain categories. These are common "cognitive distortions" or thinking errors. Identifying patterns of cognitive distortions in the patient's thought records or speech is instrumental for choosing a hot thought, conceptualizing the case, and planning treatment. A patient often has one or two common patterns of unhelpful thinking. Identifying these patterns helps him/her identify them when they come up and provides you an opportunity to intervene on a thought triggered in multiple situations. Therefore, changing a particular thought that is part of an unhelpful thinking pattern (e.g., tendency to ignore the positive) may have multiple benefits for the patient. For a list of common thinking errors, see the Unhelpful Thinking Styles at the end of this module.

INTERMEDIATE BELIEFS

To identify an intermediate belief, you must first know how to recognize patients' automatic thoughts. You can do this by identifying an automatic thought and then attempting to identify an attitude or assumption patients feel about themselves, the future, others, or the world. These assumptions can be identified by listening for themes in the patient's thoughts and behavior. You can use several techniques to identify an intermediate belief:

- Look for an intermediate belief that comes in the form of a patient's automatic thought.

- Provide the first part of an assumption ("If x…"), and enlist the help of the patient to complete it.

- Elicit a rule or an attitude from the patient and change it into an assumption.

- Look for themes in the patient's automatic thoughts. Either come up with a hypothesis or ask the patient to identify a theme.

- Ask patients directly about their beliefs.

- Have patients complete a questionnaire or inventory that will help identify their beliefs.

CORE BELIEFS

Throughout therapy, hypothesize core beliefs that may be underlying unhelpful behaviors and thoughts. These hypotheses aid development of the case conceptualization and treatment plan (see Module 4). A belief that is likely to be core will appear in several different areas of the patient's life (i.e., relationships, work, parenting). If time permits in Brief CBT, after you have collected enough evidence to support the alleged core belief, present and discuss it with the patient.
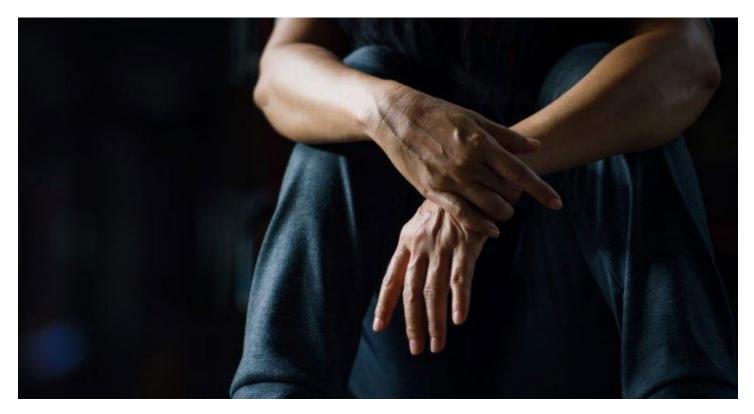
In-Session Example 11.5

> "I've heard you say several times that you either didn't do a good job, or that someone else put in more time and energy. It seems to me that you feel inadequate a lot of the time. Is that right?"

At this point, you can elicit earlier life experiences consistent with the belief. This helps identify the possible origin of the belief and helps you explain it to the patient.

In educating the patient about core beliefs, make several things clear:

- Core beliefs are only ideas. Feeling them strongly does not make them true.
- These beliefs started developing during childhood and are formed over time. Patients believe them today because they have stored evidence to support them and rejected evidence to contradict them.
- These beliefs can be tested and changed through use of the techniques that will be taught in therapy.

EXAMPLE HOMEWORK ASSIGNMENTS

1. Keep a notepad with you and attempt to list automatic thoughts you have during the day.

2. Use the triangle diagram to dissect three to five situations when you experienced a strong emotion.

3. Create a list of assumptions and evidence for and against those assumptions.

4. Complete the first three sections of the Thought Record for one to two situations.

SUPPLEMENTAL READINGS

Beck, J.S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford Press; Chapters 9-14

Safran, J. D., & Greenberg, L. S. (1982). Eliciting "hot cognitions" in cognitive behaviour therapy: Rationale and procedural guidelines. *Canadian Psychology/Psychologie canadienne, 23*(2), 83–87. https://doi.org/10.1037/h0081247

Greenberg, D. & Padesky, C.A. (2016). *Mind over mood: Change the way you feel by changing the way you think.* New York: Guilford Press; Chapters 5, 6, 7, 8, and 9.

THOUGHT RECORD

(1) Situation	(2) Automatic Thought(s)	(3) Emotion(s) & Mood	(4) Evidence That Supports Thought	(5) Evidence That Doesn't Support Thought	(6) Alternative Thought	(7) Rate Mood Now
Out of breath when I played in the park with my granddaughter	I'm too old to play with her. I can't do what I used to do. I can't be her caregiver. I have nothing to offer my family any more. I am a burden to my family. I am no good to my family.	Defeated Sad Sad Disappointed Hopeless Hopeless Worthless Hopeless (80) Hopeless (90				
What actually happened? Where? What? How? When?	*What thought(s) went through your mind? How much did you believe it? (1-100)*	*What emotion(s) did you feel at the time? Rate how intense they were (1-100).*	*What has happened to make you believe the thought is true?*	*What has happened to prove the thought is not true?*	*What is another way to think of this situation?*	*0-100*

HELPFUL QUESTIONS

SITUATIONAL QUESTIONS	FEELING QUESTIONS	THOUGHT QUESTIONS
• What happened? What were you doing? • Who was there? • Who were you speaking to? • When did this happen? • What time of day was it? • Where did this incident occur?	• How were you feeling before this happened? • How did you feel while it was happening? • What mood were you in after this happened? • Can you rate your mood on a scale of 1-100?	• What was going through your mind before you started to feel that way? • What made you feel that way? • Do you have any other thoughts? • Which thought bothered you the most? • What images did you have with these thoughts? • What are you afraid might happen? • What if this is true? What does this say about you? • What could happen if this were true? • What other ways could we think of this?

UNHELPFUL THINKING STYLES

1. **All-or-nothing thinking:** Viewing situations on one extreme or another instead of on a continuum.

    Ex. "If my child does bad things, it's because I am a bad parent."

2. **Catastrophizing**: Predicting only negative outcomes for the future.

    Ex. "If I fail my final, my life will be over."

3. **Disqualifying or discounting the positive**: Telling yourself that the good things that happen to you don't count.

    Ex. "My daughter told her friend that I was the best dad in the world, but I'm sure she was just being nice."

4. **Emotional reasoning**: Letting one's feelings about something overrule facts to the contrary.

    Ex. "Even though Steve is here at work late every day, I know I work harder than anyone else at my job."

5. **Labeling**: Giving someone or something a label without finding out more about it/them.

    Ex. "My daughter would never do anything I disapproved of."

6. **Magnification/minimization:** Emphasizing the negative or playing down the positive of a situation.

    Ex. "My professor said he made some corrections on my paper, so I know I'll probably fail the class."

7. **Mental filter/tunnel vision**: Placing all one's attention on, or seeing only, the negatives of a situation.

    Ex. "My husband says he wishes I was better at housekeeping, so I must be a lousy wife."

8. **Mind reading**: Believing you know what others are thinking.

    Ex. "My house was dirty when my friends came over, so I know they think I'm a slob."

9. **Overgeneralization**: Making an overall negative conclusion beyond the current situation.

    Ex. "My husband didn't kiss me when he came home this evening. Maybe he doesn't love me anymore."

10. **Personalization**: Thinking the negative behavior of others has something to do with you.

    Ex. "My daughter has been pretty quiet today. I wonder what I did to upset her."

11. **"Should" and "must" statements:** Having a concrete idea of how people should behave.

    Ex "I should get all A's to be a good student."

Module 12: Challenging Unhelpful Thinking

OBJECTIVES

• To learn techniques for addressing unhelpful thoughts

• To understand and manage potential difficulties using thought records

What Are the Techniques for Challenging Unhelpful Thought Patterns, and Why Are These Techniques Important for Brief CBT?

Several techniques can be used to challenge unhelpful thinking. Most are used in conjunction with a thought record. Challenging thoughts and beliefs in a collaborative, Socratic way allows patients to use their own statements to counter unhelpful thinking. Generating counter-statements based on the data patients bring to session increases the believability of the thoughts/beliefs and, thus, the effectiveness of the counter thoughts/beliefs.

When? (Indications/Contraindications)

Typically, unhelpful automatic thoughts are the first targets in the cognitive component of CBT. Following the introduction of the cognitive model (see Module 7: Orienting Patient to Brief CBT), and skills for identifying automatic hot thoughts and their accompanying emotions (see Module 11: Identifying Unhelpful Thoughts), introduce techniques for challenging hot thoughts. These techniques should immediately follow the session on identifying hot thoughts, to build continuity and familiarity with the skill set and instill hope of change after identifying problematic thinking patterns. Although intermediate and core beliefs will be challenged in advanced stages of therapy, the techniques are similar for challenging thoughts. Many techniques below can be used interchangeably for challenging thoughts or beliefs. Brief CBT session time is best used for modifying thoughts or beliefs that are tightly held and strongly believed.

How? (Instructions/Handouts)

Socratic questioning is a provider stance for questioning unhelpful thinking. This process involves asking a series of open-ended, brief questions that guide patients to discover their idiosyncratic thoughts, feelings, or behaviors associated with a particular situation. Socratic questioning is nonjudgmental but is based on the provider's insight that the original premise of a thought or belief may be untrue; therefore, the questions are designed to expose the unhelpful thought or belief so that it may be challenged.

The Thought Record is the staple of cognitive work in brief CBT. The first three columns (see Thought Record handout at the end of Module 11) are used for identifying troubling situations and the accompanying emotions and unhelpful thoughts. These three columns are used in conjunction with Module 10 in that when the situation-->thought--> feeling triangle is unfolded, it forms the first three columns of a Thought Record.

A seven-column Thought Record is used to challenge unhelpful thoughts and beliefs. Instructions for completing columns 4-7 are described in detail below.

Once a hot thought and its accompanying emotion have been identified and rated, the hot thought is questioned to generate evidence for and against it. Building evidence may be introduced in the following way:

In-Session Example 12.1

Example: We have identified a thought that is very powerful for you. You rated this thought as 90 out of 100 for sadness. Before spending a lot of time and energy on this thought, I want to know whether or not it is true. Often when people are depressed or anxious, they take thoughts like this at face value, without first asking whether they are true. Accepting thoughts like this as true would certainly lead to the symptoms you've been struggling with. If I thought, "I am worthless and can't do anything right," I wouldn't want to get out of bed in the morning either, and I would probably feel pretty hopeless and sad. When we test a thought like this, we are going to generate evidence for and against the thought. It is as though the thought were on trial, and you were a lawyer for the case. Remember, you have to be able to prove the evidence you are generating. So, now let's see how your thought stands up....

DEVELOPING BALANCED THINKING

These instructions might be useful to help patients develop balanced thinking:

1. Help the patient question automatic thoughts by asking:
    - What evidence is there that this thought is true?
    - What evidence is there that this thought is not true?
    - What would I tell someone I loved who was in this situation and had these thoughts?
    - If my automatic thought is true, what is the worst that could happen?
    - If my automatic thought is true, what is the best thing that could happen?

2. Once you and the patient have generated evidence, combine it to form a more balanced thought. This thought will likely be much longer and more nuanced than the original hot thought.

In-Session Example 12.2

Example: Taking all this information (from columns 4-5) into consideration, what is a more balanced thought that more accurately reflects the facts?

You might want to ask the following questions:

- Taking the information into account, is there an alternative way of thinking about the situation?

- Can someone I trust understand this situation in a different way?

3. Rate the believability of the alternative thought between 0-100%. If the thought is not more than 50% believable, more work is needed to identify an alternative thought. Go back to the evidence and keep working. After the patient has generated an alternative thought, they should rate how much they believe the thought from 0-100% (0% = no belief at all, 100% = greatest belief). If the alternative thought is not rated at more than 50%, this may indicate that the patient has actually provided a more deeply rooted belief (as opposed to an automatic thought) as the initial automatic thought. It is important to recognize the difference between beliefs and automatic thoughts because patients have to be motivated to change their thinking during the cognitive restructuring process. This motivation to change is less likely to happen if patients don't believe in the change that they are trying to make.

4. Once a believable alternative thought is generated, re-rate the mood associated with the hot thought (0-100%) after reading the new thought. Reducing a thought/belief to a rating of 0% is not a realistic goal. Instead, a reduction of 30-50% often provides relief. Often patients will generate new emotions from the alternative thought. However, it is most important first to re-rate the old mood before generating new emotions.

The same strategy of generating an alternative thought for an unhelpful thought is used when challenging a core belief. Once the belief is identified, the evidence is weighed, and a new more balanced belief is generated.

Highlight 12.1

Summary: Completing Thought Records

✓ Identify situation and corresponding thoughts and feelings.

✓ Identify unhelpful thinking styles in thoughts (e.g., all or none thinking).

✓ Use Socratic questioning to identify hot thought.

✓ Elicit and rate emotions associated with hot thought.

✓ Rate believability of hot thought.

✓ Generate evidence for and against hot thought.

✓ Generate alternative thought from evidence.

✓ Rate believability of alternative thought.

✓ Re-rate emotion of hot thought that is elicited by alternative thought.

TROUBLESHOOTING THOUGHT/BELIEF MODIFICATION

Some patients can see the benefits of doing a Thought Record immediately, but others might need to be motivated to be engaged. It is helpful to use positive reinforcement to praise the effort of completing a thought record, point out the sections completed correctly, and review skills for the sections completed incompletely or inaccurately. If a thought record is assigned for homework, it must always be reviewed during the subsequent session. Taking session time to review the thought record emphasizes its importance to the patient.

Introducing the Thought Record as an "experiment" helps alleviate any performance anxiety the patient may have about completing it and may generate interest ("Give the thought record a try this week, and we'll see how it works for you. Let me know next session how the experience to complete it was. That will help us decide whether or not this is a useful tool for you.")

Occasionally, a patient will show disinterest in doing the Thought Record or get tired of it after a while. For instances like this, there are other ways you can suggest that the patient can continue to attempt the Thought Record:

- If a patient complains of never having time to do a Thought Record when certain situations occur, suggest that they carry a blank Thought Record in a wallet or purse.

- Patients can use their cell phone to record Thought Records or voice/audio record their thoughts.

- If a patient has done the Thought Record for a while and is becoming disinterested, suggest doing a "mental" Thought Record, since they are familiar with the process.

- Suggest reading old Thought Record that have similar situations and automatic thoughts of their own.

- The patient can verbally dictate a Thought Record to someone and have that person write it down.

- Instruct the patient to incorporate completion of the Thought Record into their daily routine, either at the same time of day or in an easily accessible location.

There will not always be an immediate change to a patient's mood after a Thought Record is completed. It might be necessary to assess why there is no change. It could be attributed to the patient's deeply rooted belief in the automatic thought, to an unchanged underlying core belief, or to additional automatic thoughts that have not been evaluated. It is necessary to ask: Why was there no mood change after completion of the Thought Record? These other questions will also be helpful:

- Have I described the situation in enough detail?

- Did I identify and rate the right moods?

- Is the thought I am testing an automatic thought?

- Do I believe an unhelpful core belief is driving this thought?

- Did I list multiple thoughts? Do I need more information for each individual thought?

- Is there a stronger automatic thought that I have not put in my Thought Record?
- Do I believe the alternative thought? What other alternative thoughts are available?

If thought/belief testing is ineffective in reducing negative mood, you can also explore the advantages and disadvantages of maintaining a thought/belief. As we know, there are many disadvantages to negative beliefs we have, but there are also advantages. The patient's perceptions of the advantages may be obstructing the change process. Understanding the function of the thought/belief for the patient may be useful in clarifying why certain thoughts/beliefs are resistant to modification. The provider should evaluate both the advantages and disadvantages of a patient's assumptions and beliefs but, in doing so, work to diminish the advantages and highlight the disadvantages.

Often, when working to modify thoughts and beliefs, the patient may find evidence that supports the negative belief instead of evidence that contradicts it. If there is a good amount of evidence to support that negative core belief, then problem solving, rather than thought testing, is an appropriate strategy (see Module 15).

Highlight 12.2

Seven Tips for Effective Thought Records

1. You must have mastered the use of Thought Records before introducing it to patients.

2. Reinforce and make sure that the patient believes in the cognitive model being used.

3. Teach the Thought Record in two sections: (1) The first three columns; Situation, Automatic thought(s), and Emotion(s), and (2) the last four columns; Evidence for and against thought, Alternative response, and New rating of emotion.

4. Use the patient's exact words when recording thoughts and feelings. Working with thoughts verbatim preserves the emotions or personal meaning for each thought.

5. The patient should be able to adequately complete the first three columns of the Thought Record before learning about the last four columns.

6. Completing a Thought Record is a skill and, like other brief CBT skills, requires practice. Success depends on the patient's understanding of the steps. Encourage the patient to take time with the skill and work through any frustration.

7. If the patient is not collaborative in completing the Thought Record in session or does not complete Thought Record homework, it is possible that they might have automatic thoughts about this type of exercise. Ask the patient to create a Thought Record of the Thought Record experience

EXAMPLE HOMEWORK ASSIGNMENTS

1. List the advantages and disadvantages of keeping a Thought Record.

2. Use an old Thought Record and analyze it using the Automatic Thought Questions we have discussed.

3. Complete the first three columns of a Thought Record for homework, and complete columns 4-7 with you in session.

SUPPLEMENTAL READINGS

Beck, J.S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford Press; Chapters 9-14

Greenberger, D., & Padesky, C. A. (2016). *Mind over mood: Change how you feel by changing the way you think* (2nd ed.). Guilford Press.

THOUGHT RECORD

(1) Situation	(2) Automatic Thought(s)	(3) Emotion(s) & Mood	(4) Evidence That Supports Thought	(5) Evidence That Doesn't Support Thought	(6) Alternative Thought	(7) Rate Mood Now
Out of breath when I played in the park with my granddaughter	I'm too old to play with her. I can't do what I used to do. I can't be her caregiver. I have nothing to offer my family any more. I am a burden to my family. I am no good to my family.	Defeated Sad Sad Disappointed Hopeless Hopeless Worthless Hopeless (80) Hopeless (90	My family has to look in on me more often than they used to.	I can still babysit my grandkids. I contribute to my new family in new ways, such as offering advice and support. I still live independently. I am able to do many things physically, though I do have more limitations than I used to.	Because of my COPD and because I am getting older, I have more physical limitations than I used to, and I do need my family's help form time to time, but I am able to offer them many valuable things and contribute to my grandkids' lives. (80)	Hopeless (10) Worthless (5)
What actually happened? Where? What? How? When?	*What thought(s) went through your mind? How much did you believe it? (1-100)*	*What emotion(s) did you feel at the time? Rate how intense they were (1-100).*	*What has happened to make you believe the thought is true?*	*What has happened to prove the thought is not true?*	*What is another way to think of this situation?*	*0-100*

90

Module 13: Behavioral Activation

OBJECTIVES
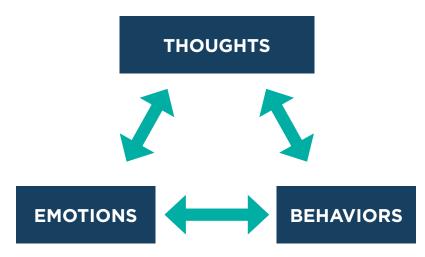
- To understand the important clinical components and applications of behavioral activation strategies in brief CBT.

- To learn skills and techniques to effectively use behavioral strategies for positive patient change (especially related to increasing pleasant events)

<u>What Is the Behavioral Connection, and Why Is It Important?</u>
Behaviors represent the "B" in CBT interventions, and it is important that patients become aware of the connection between thoughts, emotions, and behaviors (see Figure 13.1 below). Patients may not be as aware of the impact that thoughts and emotions may have on their behaviors. For instance, helpful thoughts (e.g., "Today is going to be a great day") may be related to more positive emotions (e.g., happiness, excitement, etc.) and subsequent behavioral engagement (e.g., socializing with others, completing meaningful activities, etc.). On the other hand, unhelpful thinking (e.g., "My life will never get better") may be linked to negative emotions (e.g., sadness, anxiety, frustration) and avoidant behavioral coping (e.g., social isolation, not going to work or attending school, not attending important family events). Thoughts, emotions, and behaviors may influence each other at any given moment throughout the day, and this relationship is bidirectional.

Figure 13.1 Thoughts, Emotions, and Behaviors

THOUGHTS

EMOTIONS

BEHAVIORS

Helping patients understand the connection between what they do (behavior), what they think, and how they feel can help them gain insight, increase motivation for change in therapy, and improve therapy outcomes. Just as it is important to understand how past experiences have impacted patients' problems, it is equally as important to focus on things patients can do now to change their emotional experiences as they move forward in life. However, it may be more difficult to influence behavioral change if patients are not aware of the connections between these three components of the cognitive-behavioral treatment model.

What Is Behavioral Activation, and Why Is It Important?

Behavioral activation includes a set of procedures and techniques aimed at increasing patient activity and access to reinforcing situations that improve mood and functioning. From this behavioral standpoint, depression, for example, contains a host of characteristics that function to maintain depressive affect (e.g., passivity, fatigue, feelings of hopelessness) and decrease the chance of adaptive coping by increasing avoidance. The key here is that difficulty with mood often serves to increase avoidance of adaptive coping, including pleasant events, which help to alleviate and avoid depression. Re-introducing pleasant events (one form of behavioral activation) can serve to improve mood in many different ways - 1) reversing avoidance, 2) increasing physical activity, 3) increasing self-confidence and 4) increasing feelings of usefulness and purpose.

An important point for providers: Behavioral activation (alternatively referred to as increasing pleasant activities) consists of a host of possible behaviors including, but not limited to:

1. Reintroducing prior pleasant activities

2. Introducing new pleasant activities

3. Active coping or mastery activities (e.g., taking some form of behavioral action) to alleviate or reduce a life stressor; examples of active/behavioral coping that are not pleasant-event driven include
   - ☐ Filing or getting taxes done
   - ☐ Cleaning out a messy closet
   - ☐ Calling an estranged family member

The goal of active coping is to decrease stress through accomplishment or overcoming avoidance.

When? (Indications/Contraindications)

Because of its relatively simple and straightforward approach, behavioral activation is a good technique for initial stages of treatment and can be highly effective for patients with limited insight into their difficulties. Activation is also easily measured (e.g., number, frequency, or duration of activities) and, therefore, can be used to document and convey progress to patients (e.g., to increase treatment investment and improve patient self-confidence and influence over symptoms).

Behavioral interventions are particularly powerful for depressed mood. Activation for depression generally serves to get the patient moving. Integrating pleasant activities can be effective in improving depressed mood. However, getting the patient to complete activities is key. Almost all behaviors that include physical activity, planning, or accomplishing tasks are appropriate here.

How? (Instructions/Handouts)

STEP #1: PROVIDE PATIENT WITH RATIONALE FOR BEHAVIORAL ACTIVATION.

It is important to educate the patient as to what behavioral activation is and how it can be useful for improving depression and anxiety. Let patients know that feeling a little down or having a bad day and not feeling well physically can make it more likely that they will stop doing many activities that used to be pleasurable. When this happens, patients can get into the habit of avoiding pleasant activities that might actually help them feel better. It is also important for patients to understand the connection between what they do and how they feel, both mentally and physically. You are encouraged to explain to patients that increasing activity and/or taking action, even when we do not feel like it, help us to feel better physically, as well as decrease depression.

Provider:	**I would like to talk a little about what your day looked like yesterday. Walk me through your day (e.g., what did you do in the morning, afternoon, evening)**
Patient:	Well, in the morning I woke up at 10 am and ate breakfast. I watched TV until noon. Then I ate lunch. Around 2:30 I took a shower. At 3:00 I went for a walk with my dog.
Provider:	**Okay, thanks. How did you feel in the morning?**
Patient:	Tired. I just couldn't get motivated and did not want to do anything. I guess I was feeling sorry for myself – depressed, I guess.
Provider:	**You say you were feeling depressed. If you had to rate that feeling on a scale of 0 to 100 (100 is worst depression) what would you say your depression was?**
Patient:	65.
Provider:	**What about in the afternoon after your shower and walk? How would you rate your depression?**
Patient:	20.
Provider:	**To what do you attribute this change in your depression?**
Patient:	I guess I just got off my couch and started moving, which helped me feel better.
Provider:	**That would be my guess as well. (Subsequently, explain the connections between mood and behavior and encourage use of behavioral activation).**
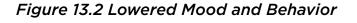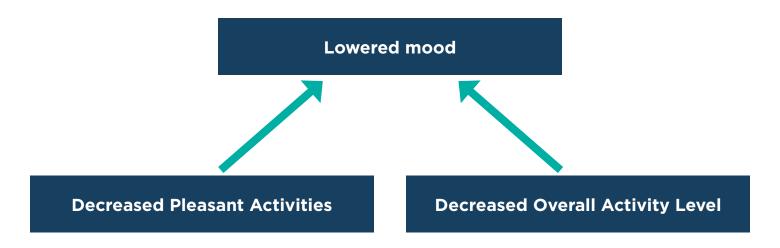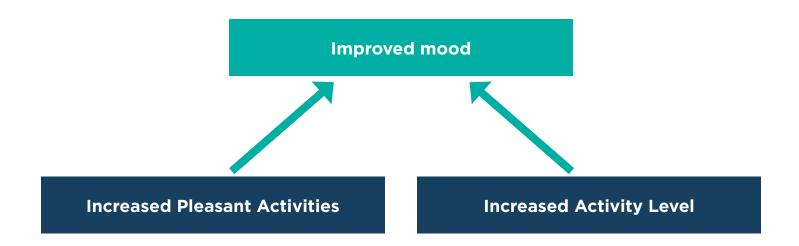
The figure below visually describes the connection between mood and behavior and can be an effective aid in communicating with patients. To maximize the utility of Figures 13.2 and 13.3, you are encouraged to use the patient's own examples. For example, you and the patient can work together to complete a daily activity log (see handout). From this activity log, you might highlight activities that appeared to raise or lower the patient's mood.

Figure 13.2 Lowered Mood and Behavior

Lowered mood

Decreased Pleasant Activities

Decreased Overall Activity Level

For depressed persons, increasing their activities daily improves mood and decreases symptoms of depression.

Figure 13.3 Improved Mood and Behavior

Improved mood

Increased Pleasant Activities

Increased Activity Level

STEP #2: IDENTIFY BEHAVIORS – DISCUSS ACTIVITIES.

Identification of potential activities begins by exploring with the patient activities that would be most meaningful. This may begin by having a general discussion about values that are important to the patient as well as goals that they may want to accomplish. Values clarification (i.e., identifying the most important things to patients) can help patients feel heard and convey the collaborative process of the therapeutic relationship. Explicitly identifying values may enhance a patient's motivation to change and guide the identification of behaviors that the patient would be willing to engage in related to his/her values. Additionally, a patient's values can help identify therapeutic goals to incorporate into the treatment plan.

Exploring targets for behavioral activation may begin with asking patients about 1) the types of things they would like to do but have not been able to do, or 2) activities they already do but would like to do more often. It may be important to anchor these behaviors within the context of values or goals that are important to them. You might want to ask if there is something that they need to do that they have been unable to do or have been avoiding. Although you want patients to do activities that are purely pleasurable to elicit positive mood, some patients may want to accomplish something rather than focus on doing something pleasant.

Possible questions might include:

- "Can you think of any activities or hobbies that you used to enjoy doing but have now stopped doing?"
- "Can you think of any activities or hobbies that you would like to do but have never done?
- "Are there things in your life that you would like to change? If so, what would you like to do about these issues that you have previously not done?"

For patients who have difficulty identifying activities, you can introduce a behavioral activity checklist (see Appendix).

Before completing the next steps (e.g., setting a plan), it is important to discuss the potential importance of the behavior with the patient. If he/she reports low importance, encourage the patient to find another, more meaningful activity.

STEP #3: SET AN ACTION PLAN.

Once the patient has identified a meaningful activity to engage in, help shape this work into a meaningful therapeutic goal. Action plans are one mechanism for creating meaningful behavioral goals for therapy. Action plans in their most basic form stipulate the specific goal to be accomplished, defined in terms of observable and measurable characteristics and a timeframe for monitoring progress.

In-Session Example 13.1

Example:

Goal: To read at least three times per week (a minimum of 30 minutes per reading session)

Timeframe: Patient will complete three reading sessions over the next week.

An expanded action plan might also include:

a. Additional details of the plan – e.g., how the goal will be obtained

b. Possible barriers to reaching the goal and ways to address barriers if they arise

c. Possible facilitators of obtaining the goal, e.g., important people or situations that might aid the patient

d. Patient's confidence in reaching the goal in the timeline established; if confidence is low, you might wish to alter the plan to increase chances of success.

e. Skills that the patient might want to enlist to help reach the goal (e.g., relaxation skills, problem-solving skills, etc.)

STEP #4: MONITOR PROGRESS IN MOOD, MASTERY, AND CONFIDENCE.

It is important to monitor the patient's mood and feelings of mastery and confidence. Outcomes such as improvement in mood, mastery, or confidence can be best identified through homework assignments that ask the patient to document the frequency and use of the behavioral activity and any corresponding emotions or feelings of mastery or confidence.

On the basis of this monitoring of outcomes, evaluate the action plan and the patient's ability to work towards achieving goals. If problems arise, make changes accordingly (e.g., breaking down goals into smaller steps, determining patient perceptions of importance and changing goals accordingly). Monitoring shows the patient that you continue to believe in the importance of the technique/exercise and also serves to further motivate many patients by increasing the effectiveness of the intervention.

TIPS FOR MANAGING BARRIERS TO DOING ACTIVITIES

1. Help the patient break down more difficult activities into smaller steps. Look for alternative behaviors to accomplish a goal prohibited by a chronic illness, environmental stressors, or depressed mood. For example, a structural/mechanical engineer who was forced to retire because of a physical limitation may feel that life is no longer productive. Although the patient is physically unable to fulfill prior job duties, you can work with them to identify meaningful activities related to the prior occupation. In this case, the patient might benefit from volunteering at a university; providing consultation (e.g., over email or telephone calls); or volunteering for a local school, youth or church organization (e.g., talking about engineering).

2. It is also helpful and supportive to look for ways to help with behavioral activation. Family or other social networks that the patient has not yet fully engaged might exist, which might assist the patient in moving forward on goals. The patient can also download smartphone applications that help with planning activities and that send reminders.

3. Pleasant activities are the best first step. Pleasant activities are doubly beneficial to the patient, as they increase activity and feelings of pleasure. Activities designed to overcome avoidance or increase a sense of accomplishment should be entertained as the first goals only if highly important to the patient or apparently salient to the attainment of future goals.

Highlight 13.1

Summary of Steps

Step 1.   Introduce behavioral activation and its potential influence to the patient.

Step 2.   Use patient examples to show relationship between mood and behavior.

Step 3.   Identify pleasant activities/active-coping behaviors.

Step 4.   Set an action plan.

Step 5.   Monitor progress.

4. It is important to monitor anxiety and avoid behavioral activation procedures that further aid in the patient's avoidance of fearful situations (e.g., presenting problem is avoiding interpersonal difficulties with spouse, and patient chooses to shop or be on the internet for pleasure but specifically when spouse is in the house to avoid confrontation/talking about issues). The goal is to introduce behaviors that will facilitate improvements in the patient's life, while not reinforcing avoidance of uncomfortable situations and emotions. For example, patients with anxiety symptoms often avoid situations out of fear of negative consequence occurring in response to engaging in a particular activity. Although behavioral activation can aid these patients, you must also understand that the activity itself is not reinforcing (pleasant) but rather feared. It is only the resulting completion of the task that may generate positive affect (e.g., I faced my fear, and nothing terrible happened). This response differs from depression in that depressed patients will often look at behavioral activation as a positive outcome in and of itself (e.g., "exercising is enjoyable," or "I love talking with my granddaughter"). Please reference Module 14 for more information about anxiety, avoidance, and exposure treatments.
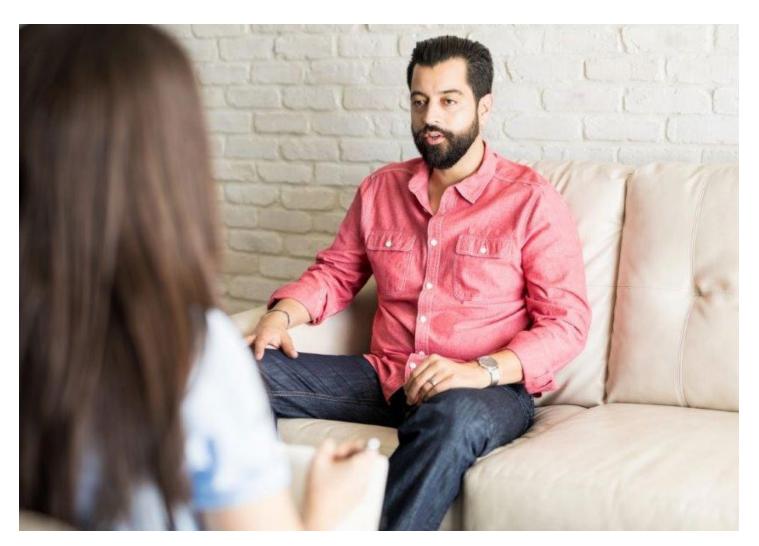
EXAMPLES OF HOMEWORK ASSIGNMENTS

1. What activities did you previously enjoy that you would like to start participating in again?

2. List activities that you need to do to better your current situation (enroll in school, get your inspection sticker, etc.).

3. Create a schedule of the new activities you will perform. Which ones did you accomplish? Were there any barriers? Why? How did you handle them?

SUPPLEMENTAL READINGS:

Hopko, D. R., Lejuez, C. W., Ruggiero, K. J., & Eifert, G. H. (2003). Contemporary behavioral activation treatments for depression: Procedures, principles, and progress. *Clinical Psychology Review, 23*(5), 699-717.

Lejuez, C. W., Hopko, D. R., Acierno, R., Daughters, S. B., & Pagoto, S. L. (2011). Ten year revision of the brief behavioral activation treatment for depression: revised treatment manual. *Behavior Modification, 35*(2), 111-161.

ACTIVITY MONITORING AND MOOD RATING CHART

For each block of time, list the activity you did and use the rating scale below to rate your mood at that time from 0 to 10.

Emotion Rating Scale:

0	5	10
Negative Emotion	**Neutral Emotion**	**Positive Emotion**
Nervous • Sad • Frustrated Angry • Afraid	Neither Positive nor Negative	Happy • Satisfied • Elated Content

	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	Activity	R	Activity	R	Activity	R	Activity	R	Activity	R	Activity	R	Activity	R
7-8 AM														
8-9														
9-10														
10-11														
11-12														
12-1 PM														
1-2														
2-3														
3-4														
4-5														
5-6														
6-7														
7-8														
8-9														
9-10														
10-11														
11-12														
12-1 AM														

Module 14: Exposure Therapy in Brief CBT

OBJECTIVES
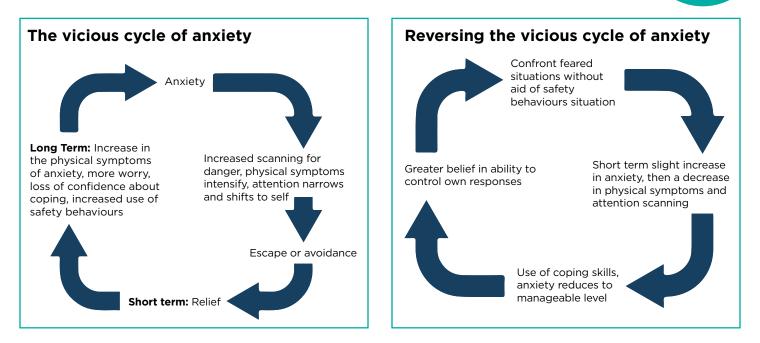
- To introduce exposure-based therapy and provide basic instructions for use within brief CBT
- To discuss advantages and limitations for using exposure-based interventions in brief CBT

<u>What Is Exposure Therapy?</u>

Exposure therapy is an approach commonly used to treat anxiety conditions (namely, panic, agoraphobia, social phobia, and specific phobias – such as animals, heights, flying, choking, and blood-injury-injection). Exposure therapy is defined by its systematic approach to confronting feared stimuli in the presence of a safe environment. Feared stimuli can be external (e.g., objects, activities, situations) or internal (e.g., feared thoughts, physical sensations). The aim of exposure therapy is to reduce the patient's anxiety response to feared stimuli and increase the patient's ability to experience and tolerate anxiety. The process includes creating a thoughtfully constructed hierarchy of feared stimuli organized by the patient's reported degree of fear. The patient and provider systematically work their way up the hierarchy by exposing the patient to the feared stimuli with a variety of exposure exercises, allowing the patient to habituate to their anxiety over time.

Exposure therapy is rooted in classical conditioning theory, which posits that fear, an emotion, becomes linked with previously neutral or unfeared stimuli through cognitive and emotional processes that result in associated symptoms of anxiety. Subsequently, anxiety becomes a conditioned behavioral response to these stimuli through the activation of fear and engagement in avoidance/escape behaviors. It is important to note that these previously neutral stimuli may be animate (e.g., spiders, clowns, people), inanimate (e.g., toilets, knives, numbers, places), situational (e.g., driving, darkness, feeling uncertain), cognitive (e.g., "impure" thoughts, memories of traumatic events, premonitions), or physiological (e.g., racing heart, feeling out of breath, flushed skin) and would not otherwise elicit a strong or intense fear response. Exposure therapy seeks to "undo" this prior associative learning by reducing the conditioned anxiety/fear response through repeated confrontation with the feared stimuli. Most importantly, the individual undergoing exposure therapy must learn to tolerate the fear while building self-efficacy within the context of processing emotional reactions (see Figure 14.1).

Figure 14.1. Breaking the cycle of anxiety

The vicious cycle of anxiety

Anxiety

Increased scanning for danger, physical symptoms intensify, attention narrows and shifts to self

Escape or avoidance

Short term: Relief

Long Term: Increase in the physical symptoms of anxiety, more worry, loss of confidence about coping, increased use of safety behaviours

Reversing the vicious cycle of anxiety

Confront feared situations without aid of safety behaviours situation

Short term slight increase in anxiety, then a decrease in physical symptoms and attention scanning

Use of coping skills, anxiety reduces to manageable level

Greater belief in ability to control own responses

ELEMENTS OF EXPOSURE

Exposure therapy, typically delivered in 8 to 12 sessions in specialty mental health settings, is efficacious for anxiety disorders as well as other conditions such as obsessive-compulsive disorder (OCD) and posttraumatic stress disorder (PTSD; Hofmann & Smits, 2008; Rauch, et al. 2012). Although exposure therapy requires adequate time for extinction, recent advances in treatment have shown that briefer formats of exposure therapy (e.g., four to six sessions) are effective for patients with anxiety and PTSD (Cigrang, et al. 2017).

Exposure therapy is generally conducted using one or a combination of different types of exposure exercises:

- Imaginal exposure, or exposure to one's own thoughts and mental images, may be used to help patients experience their most feared thoughts more fully. Sometimes, imaginal exposure may be used as a first step toward a strongly feared in vivo exercise. An example of an imaginal exposure is to have patients write a short story in which the things they fear the most eventually come true.

- Interoceptive exposure, or exposure to physiologic sensations associated with anxiety and panic symptoms, should be used to systematically "expose" patients to the most common somatic symptoms associated with their fear responses. This should be done in a controlled way to ensure the health and safety of the patient. Interoceptive exercises may include simulation exercises and naturalistic activities to help patients increase their tolerance of physiologic bodily sensations without using safety behaviors.

- In vivo exposure, or real-life exposure to feared objects or situations, may be used to help patients overcome anxiety and panic insomuch as they negatively impact their quality of life. In-vivo exposure is associated with reduced symptoms of anxiety and panic, PTSD, and OCD over the long term.

Table 14.1 lists common terms and elements often associated with exposure therapy.

Table 14.1. Common Terms in Exposure Therapy

Emotional Processing	The use of reflection to assist in the development of new, more realistic beliefs about feared objects, activities, or situations. Believed to be one of the critical active ingredients of exposure therapy.
Extinction	Weakening or removing previously learned associations between feared objects, activities or situations, and bad outcomes.
Fear vs. Anxiety	Fear -- the emotional and cognitive response to an object or situation of concern. Anxiety -- the constellation of symptoms that manifest when a feared response occurs.
Flooding	Starting exposure with the most difficult tasks of the fear hierarchy.
Graded exposure	The use of a fear hierarchy to systematically and gradually expose an individual to increasingly distressing objects, situations, or activities.
Habituation	Decreasing the intensity of anxiety reactions to feared objects or situations over time through repeated exposure.
Panic	Sudden uncontrollable fear or anxiety that often involves psychological and biological (bodily sensations) reactions. Within exposure therapy, fear associated with bodily sensations decreased by building tolerance to the sensation during exposure exercises.
Safety Behaviors	Behaviors used by patients to tolerate or reduce fear and, thus, avoid exposure to the feared object or situation. During exposure work, important to monitor and avoid safety behaviors during exposure exercises. Ultimate goal of exposure therapy: to translate skills into real-world situations; important to help patients minimize use of safety behaviors in their daily lives.
Stress	Stress -- the way in which the body responds to any demand or challenge. Experienced daily by everyone. Importantly, not all stress bad but long-term stress harmful to health.
SUDs	Subjective units of distress. Commonly used to "quantify" levels of perceived stress. Typically used on a 0-100 scale.
Systematic desensitization	Combining exposure with relaxation exercises to make them more manageable. However, pairing with relaxation may interfere with the exposure experience. Must be monitored accordingly. Relaxation techniques possibly best used after the exposure exercise is completed.
Worry	A state of anxiety and uncertainty over actual or potential problems. Usually related to something impending or anticipated.

SUMMARY OF CRITICAL ELEMENTS IN EXPOSURE THERAPY

- Identification and articulation of the specific feared objects, activities, and situations, as well as the associated anxiety symptoms (for monitoring and fear hierarchy construction).

- Development of comprehensive fear hierarchy.

- Selecting feasible and clear exposure exercises. Ideally, should occur through in-vivo exercises and include attention to interoceptive experiences.

- The goal of exposure to increase tolerance of panic/anxiety during exposure exercises.

- Emotional processing of the exposure exercise to develop more accurate thoughts about the relationship between the feared object/activity and negative outcomes.

When? (Indications/Contraindications)

Ultimately, you should use your clinical judgment and the most current empirical literature to determine the most appropriate course of treatment when considering exposure therapy as an option. The information contained in this module provides an overview and basic strategies for using an exposure-based approach in a brief setting. However, these basic strategies may not be appropriate for specialty mental health settings dealing with more complicated presentations. Because brief approaches to psychotherapy are not appropriate for all clinical presentations, we encourage providers to use specific (and often more intensive) treatment protocols when facing more severe or complicated clinical presentations of anxiety. For patients with less severe symptoms or when full protocols are simply not feasible – providers may consider the techniques in this chapter – while recognizing the potential limitations.

Exposure interventions require appropriate provider technical expertise and adequate time for learning, reflection, and extinction of fear responses. Clinical situations in which these ingredients are not present should be approached carefully or with additional supports/alternatives. For example, most brief exposure-based protocols require four to six sessions, at minimum.

GENERAL CONSIDERATIONS FOR BRIEF COGNITIVE BEHAVIORAL THERAPY:

1. Exposure therapy is an emotionally intense experience for patients and may lead to avoidance of therapy to avoid exposure exercises. Exposure should be graded and based on the patient's presenting fear and fear hierarchy (explained later in this chapter).

2. Technical expertise on the part of the provider is required. Homework and in-session exposures must be done accurately, effectively, and efficiently (e.g., detailed hierarchies and appropriately targeted interventions) to avoid unnecessary negative patient experiences.

3. If you are unfamiliar with exposure principles, consult with other providers and/or receive supervision for initial or complex cases.

4. Consider medication referral (e.g., antidepressants or benzodiazepine) with an awareness that medications may serve to increase feelings of safety (e.g., safety behaviors) and could compromise exposure-therapy impact if used to reduce anxiety during exposure sessions.

How? (Instructions/Handouts)

EXPOSURE PROCESSES

The process of conducting exposure-based brief CBT follows a general framework (Barlow and Craske, 2007):

1. **Psychoeducation:** a) provision of information and education about fear and physiological sensations and b) instruction in how to self-record and track fear responses, using a "scientific approach"

2. **Teaching Coping Skills:** a) cognitive restructuring or threat forecasting to challenge myths or unhelpful thinking styles associated with fear and b) breathing skills training

3. **Exposure Exercises:** a) repeated and graded exposure to situations in which fear or physiological sensations are anticipated

4. **Planning for the Future:** a) discussions about symptom return and relapse prevention.

INITIAL STEPS: BUILDING THE FOUNDATION

Assessment and Psychoeducation
Initial steps should focus on gathering information about patients' symptoms, feelings, thoughts, and behaviors regarding the feared stimulus. Specifically, you need to clearly understand factors associated with the onset and maintenance of symptoms (i.e., precipitating circumstances, symptom duration), as well as alleviating or exacerbating factors. Figure 14.2 is an example of how to assess for this information.
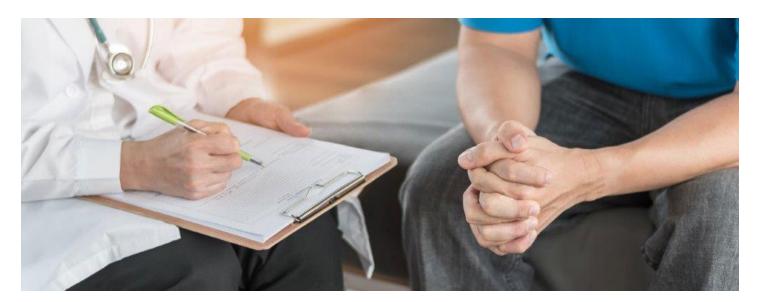
Figure 14.2. Example Anxiety Assessment Handout

Physical Signs: How does your body react to worry/stress?	
[ ] Muscle tension [ ] Rapid pulse [ ] Shortness of breath [ ] Butterflies in stomach	[ ] Shaking/trembling [ ] Sweating [ ] Other: _____
Thoughts: What is running through your mind (including areas of concern)?	
[ ] Health (own and others') [ ] Finances [ ] Issues related to aging [ ] Family/friends	[ ] Daily events [ ] Work/volunteer [ ] Other: _____
Behaviors: What actions do you take to reduce worry/stress (e.g., such as avoiding feared situations or doing something over and over)?	
Avoidance [ ] Not making decisions [ ] Avoidance of activities [ ] Procrastination	[ ] Ignoring [ ] Other: _____
Doing too much [ ] Checking [ ] Smoking [ ] Snacking	[ ] Cleaning [ ] Asking for reassurance [ ] Other: _____

Psychoeducation is critical to provide an accurate foundation about fear and to help avoid misunderstandings. You should provide the patient with a comprehensive understanding of the fear response, including symptoms related to fear responses, mechanisms that maintain symptoms, and common myths associated with exposure treatment (see Table 14.2). Symptom monitoring, a foundation for symptom management in CBT, should be introduced through structured worksheets and exercises.

Table 14.2. Common Myths Related to Fear and Exposure

Myth	Fact
Anxiety is not very common. People with anxiety are weak.	Nearly one in five people experiences some type of anxiety disorder in any given year. Anxiety and stress happen to us all.
Anxiety will get better over time if you just leave things alone.	Anxiety and fear lead to avoidance, which maintains the response over time. Exposure and facing fears and anxiety are effective at reducing anxiety and fear.
Therapy for anxiety will take years.	Most anxiety conditions can be treated effectively in 10-12 weekly sessions. Anxiety reductions can often be seen within the first weeks of therapy, and some providers offer abbreviated treatment that involve four to six sessions.
A panic attack can make you lose control or pass out.	Fainting usually occurs from a sudden decrease in blood pressure and is not associated with panic attacks.
Someone with anxiety should avoid situations that cause stress.	Avoiding stress often leads to immediate reductions in anxiety but creates a host of additional problems, including avoidance and continued fear responses. Often, what feels natural (e.g., avoiding stress) actually turns out to maintain or make anxiety worse.

Introduction to Exposure Treatment

Actively inform your patients about the nature of exposure treatment (e.g., in-vivo, imaginal, or interoceptive exposures) and a rationale behind the approach. It is important to communicate that exposure exercises will be done gradually, in a predictable manner, safely, and under your control as the provider. Exposure therapy yields positive outcomes when done correctly and when the patient understands the rationale. Often, patients may feel that exposure therapy is daunting or overwhelming. Regularly check-in with patients before and during the process to ensure that patients display high levels of self-efficacy to complete the exposure process. You should refer to other modules in this guide outlining other skills to address concerns that may impede success with exposure therapy (i.e., cognitive restructuring, relaxation).

Receiving benefits from exposure therapy requires continued practice in-session and between sessions. The more the patient can complete exposure exercises, the more their fear will begin to decrease. Habituating to fear is a learned process that has to be reinforced over time. You and your patient will practice exposure in session, but the patient will have to practice exposure exercises three to four times each week, depending on the activity.
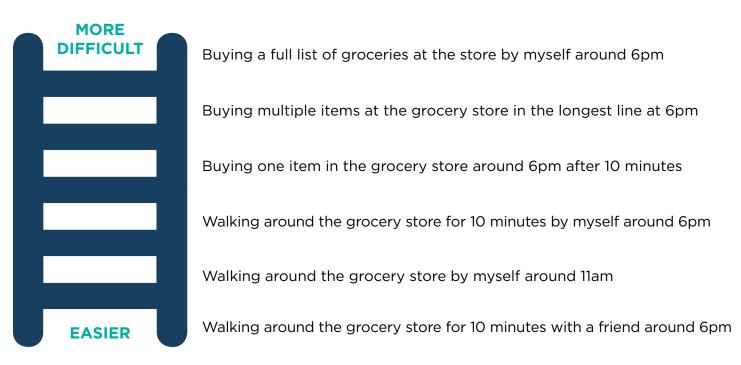
Collaboratively Building a Fear Hierarchy

Collaboratively building a hierarchy of feared situations and formulating a treatment plan are critical steps for exposure. Leverage your patient's daily symptom recordings (e.g., panic attack records, daily mood ratings, avoidance of stimuli reports) to facilitate a comprehensive fear hierarchy. The patient can use levels of anxiety, distress, or panic to identify a list of feared situations, animals, objects, or sensations. The patient should account or track distress over a period of time or use historical evidence to begin forming the hierarchy.

You and your patient will work together to decide target stimuli for the exposure exercises in treatment, based on the patient's presenting concerns, reported symptoms and case conceptualization. Once stimuli are chosen, work with the patient to create specific and detailed targets to base exposure exercises on, ranked by SUD (subjective units of distress) levels. These targets should be detailed enough for you to create an exposure exercise tailored to the patient's fear. You should work to understand why the patient fears certain stimuli. For example, a patient may fear and avoid going to grocery stores. The fear could be because the patient has social anxiety and fears embarrassment. Or, the patient could fear having a panic attack in the middle of the store in front of others and not being able to escape. As part of the construction of the fear hierarchy, you must also attend to patient safety behaviors that contribute to the maintenance of anxiety and may undermine future exposure exercises.

Figure 14.3. Example Hierarchy

Targeted avoidance behavior: <u>Avoiding grocery stores with too many people</u>

MORE DIFFICULT

Buying a full list of groceries at the store by myself around 6pm

Buying multiple items at the grocery store in the longest line at 6pm

Buying one item in the grocery store around 6pm after 10 minutes

Walking around the grocery store for 10 minutes by myself around 6pm

Walking around the grocery store by myself around 11am

EASIER

Walking around the grocery store for 10 minutes with a friend around 6pm

INTERMEDIATE STEPS: EFFICIENT USE OF EXPOSURE
An exposure activity is essentially broken into a series of seven steps. Exposure starts with a low-level feared exercise according to the fear hierarchy to prevent inducing a response too high for the patient to cope with and to increase the likelihood of the patient's habituating to the response. Providers should ensure that safety behaviors are accounted for and monitored during the exposure exercise. Before and after the exposure, collect fear/anxiety symptom ratings as well as the patient's cognitive and emotional response to the exercise to correct unhelpful thinking or behaviors, and commend the patient for completing the activity. Following successful completion of the exercise, work collaboratively with your patient to move up the fear hierarchy until symptom remission is attained. Repeated practice is critical for symptom remission.

Treatment Duration and Frequency
Exposure sessions may vary in terms of duration and temporal spacing as well as the level of involvement of the provider and/or significant others. Duration of treatment may be short or longer term. Shorter durations may include single sessions or abbreviated/ weekend treatments, but such work often uses longer sessions and may be facilitated through delivery in group settings where interpersonal learning is possible between patients. Temporal spacing of sessions may include the traditional one session per week over a period of four to six weeks (or more) but may also be spaced such that exposure is heavily weighted at the beginning—with high levels of provider involvement—and then tapered into less frequent sessions (greater spacing between sessions) and/or less involvement of the provider.

An exposure exercise is typically completed in session, and then the patient is instructed to complete more exercises at home. The exercise consists of a series of trials. Each trial consists of the same level of exposure to the fear stimuli, over a period of time, within the same time frame. For example, the patient may complete 10 trials of sitting in a dark room for 20-second intervals within 15 minutes total. Or, the patient may read an imaginal exposure script you both created three times during 15 minutes.

Ultimately, by you in collaboration with patients in terms of their needs and preferences of the patient.

Attention to Safety Behaviors
Critical processes for exposure therapy require interoceptive and in vivo exposure as well as careful attention to the restriction of safety behaviors that undermine the exposure activity. Exposure requires that a patient tolerate and accept anxiety and fear rather than avoid it through compensatory strategies. For example, the goal of an exposure exercise is to learn to tolerate the distress associated with the feared stimulus. Other CBT skills such as cognitive restructuring and relaxation skills should not be used during an exposure exercise, as they can serve as "distractions" and may reduce the experience of the exposure itself, serving only to prolong or solidify the fear. Additionally, the use of anti-anxiety medications (e.g., benzodiazepines) has been found to complicate and even negatively impact treatment outcomes both immediately and over time.

More examples of safety behaviors:

- A patient who goes to the grocery store only with a friend so the friend can stand in the long lines.

- A patient who sits closest to the exit during meetings in case of a panic attack and they need to get out quickly.

- A patient who carries paper towels in case they start sweating in front of others.

<u>Steps of Exposure Exercise:</u>

1. Choose exposure activity (e.g., interoceptive exposure, in-vivo exposure, imaginal exposure)
   a. Imaginal exposure
      i. Goal: Indirectly increase tolerance of a feared object or situation to allow a corrective learning experience through vivid imagination.
      ii. You choose this exercise when real-life exposure to that feared stimuli is not feasible or would be too intense for the patient to do at that time.
      iii. Imaginal exposure consists of you and your patient writing a detailed scenario of the feared stimuli, in first person. The scenario should include vivid details that tap into the patient's specific fears and include the worst possible outcome of the feared situation. The patient reads the script completely as one trial of the exposure.
      iv. Examples: Imagining standing on top of a skyscraper, imagining talking to a friend, imagining a traumatic experience from the past, imagining taking a plane ride, or imagining not locking the house door
   b. Interoceptive exposure
      i. Goal: Increase tolerance of a feared bodily sensation or physical response to allow a corrective learning experience.
      ii. You would choose interoceptive exposures when the feared stimulus is experiencing a bodily sensation. The patient will build tolerance to a specific sensation with repeated exposure over time.

In Session Example 14.1

Feared Sensation	Exposure Activity
Racing heart	Jumping jacks, running in place, push-ups
Dizziness	Shaking head, chair spinning, twirling in place
Shortness of breath	Straw breathing, voluntary hyperventilation, stair climbing
Derealization/ dissociation	Staring at self in a mirror, voluntary hyperventilation, staring at a fixed point on the wall

    c. In vivo exposure
-      i. Goal: Directly increase tolerance of a feared object or situation to allow a corrective learning experience in real life.
-     ii. Choose this type of exposure when the patient is ready to build tolerance in situations that are accessible in real life. These exposures can be conducted during the session but often will be planned for the patient to complete in between sessions.
-    iii. Examples: Staying on an elevator, remaining in dark environments, being surrounded in crowds, purposely standing in long lines, holding a snake, touching a spider, giving a speech in front of an audience, or talking to a stranger

2. Monitor safety behaviors.
   a. It is important to help patients understand safety behaviors (i.e., overt behavioral or covert internal thoughts and beliefs) and signals (i.e., internal or external cues of safety) as an unhelpful part of their fear response that maintains their symptoms.

2. Assess for anticipatory anxiety subjective units of distress (SUDs).
   a. It is important to help patients understand their levels of anxiety and distress as they complete exposure exercises in-session as well as homework assignments. SUDS range from 0 to 100 and function as an emotional thermometer, where 0 is perfectly relaxed, and 100 is the worst anxiety and distress ever experienced.
   b. It is useful to rate SUDs before beginning an exposure exercise.

4. Conduct exposure with specified duration or trial number.
   a. It is important to agree upon the number of exposure trials as well as the duration of such beforehand.
   b. It may be best to think of duration in terms of the cumulative length of time of an exposure exercise as well as the amount of time it may take for SUDs to decrease to a sufficient level.

5. Assess for SUDs/intensity of sensations.
   a. The general goal is for the SUDs to reduce across the repeated trials.
   b. The amount of reduction will depend on the patient's first exposure exercise.

6. Process patient's feelings, thoughts, and associated SUDs over time

7. Complete exposure process repeatedly, until SUDs reduce to the agreed level.

You may find it difficult to develop an effective hierarchy and might struggle to identify an exposure exercise that leads to an appropriate level of intensity. As with other treatment types, trial and error (with reflection) and clinical consultation are critical to modifying and refining exposure-based treatments.

Exposure may require modifications depending on the feared stimulus. For example, it is common for patients with blood-injury-injection phobias to experience a fainting response (a physiological reaction that is associated with increased heart rate and blood pressure) during exposure exercises. Prior to exposure exercises, counter measures or techniques such as applied tension strategies (tensing the large muscle groups) may be required to reduce heart rate and blood pressure spikes and, therefore, avoid a fainting response.

TERMINATING STEPS: ADVANCED PRACTICE CONSIDERATIONS

Dealing with Setbacks

Setbacks are also learning experiences if handled accordingly. You should prepare your patients for setbacks, as they are a normal and an expected part of growth and development. Building a foundation that includes setbacks helps to ensure open communication between the provider and patient about both positive and negative therapy experiences. If patients accept that setbacks will occur, you will be in a strong position to use any setbacks as growth and development for building skills and maintaining future changes.

Involving Others

Significant others can have a positive or negative impact on the maintenance of fear and anxiety. Although others may provide invaluable support for a specific treatment plan, they may also serve to unknowingly maintain anxiety by providing safety and support during critical exposure work. Providers who directly involve significant others in anxiety management treatments must ensure that communication is effective. Others involved in the care plan must have appropriate psychoeducation about anxiety and fear and ways anxiety is maintained.

REFERENCES AND SUPPLEMENTAL READINGS

Barlow, D. H. & Craske, M. C. (2007). *Mastery of Your Anxiety and Panic, Therapist Guide.* (4th edition). New York: Oxford University Press.

Cigrang, J. A., Rauch, S. A., Mintz, J., Brundige, A. R., Mitchell, J A , et al. (2017). Moving effective treatment for posttraumatic stress disorder to primary care: A randomized controlled trial with active duty military. *Family Systems & Health, 35* (4), 450-462.

Hofmann, S.G. & Smits J. A. (2008). Cognitive-behavioral therapy for adult anxiety disorders: a meta-analysis of randomized placebo-controlled trials. *Journal of Clinical Psychiatry, 69,* 621-632.

Rauch, S. A., Eftekhari, A., & Ruzek, J. I. (2012). Review of exposure therapy: A gold standard for PTSD treatment. *Journal of Rehabilitation Research Development, 49*(5), 679-88.

Module 15: Problem Solving

OBJECTIVES

- To introduce problem solving and its potential use in psychotherapy
- To learn how to apply problem-solving skills during brief CBT

<u>**What is problem solving, and why is it important in therapy?**</u>

Problem-solving techniques generally involve a process by which individuals attempt to identify effective means of coping with problems of everyday living. This often involves a set of steps for analyzing a problem, identifying options for coping, evaluating the options, deciding upon a plan, and developing strategies for implementing the plan.

Problem-solving strategies can be used with a wide range of problems, including depression, anxiety, anger and aggression, stress management, coping with medical illness, addiction, and relationship/family difficulties. Problem-solving techniques teach skills that aid the patient in feeling increased control over life issues that previously felt overwhelming or unmanageable. In this manner, problem solving can help with practical problem resolution as well as emotion-focused coping (e.g., increasing control, decreasing stress, and increasing hopefulness).

<u>**When? (Indications/Contraindications)**</u>

Thoughts and beliefs are challenged when a thought or belief is not true or a situation is unchangeable. Alternatively, problem solving may be used when the root of an issue is a changeable situation; and the thoughts associated with the noxious situation might be accurate. Problem solving can be especially effective when a specific problem is able to be addressed and operationalized. A specific operationalized problem is one that is easily explained, identified, and/or measured. Problem solving works best when a practical solution is available. For example, a patient complaining of social isolation likely has potential solutions to this difficulty (e.g., calling a friend, joining a group, engaging in a socially driven hobby).

Examples of problems appropriate for problem solving include:

1. How to communicate with a partner about a difficult issue

2. How best to cope with the functional limitations of a medical condition

3. How to reduce financial distress

Note that you, as the provider, are not responsible for finding answers to these questions but rather should aid patients in finding their own answers. In this manner you are a facilitator who possesses problem-solving skills.

PROBLEM SOLVING MAY BE DIFFICULT FOR THE FOLLOWING INDIVIDUALS:

1. Patients with serious mental illness (psychotic disorders, bipolar disorder)

2. Patients with severe depression, who might require more focused cognitive work or medications

3. Patients who have difficulty thinking about long-term effects (e.g., persons with cognitive impairment)

4. Patients with problems that are largely emotional; for example, a person who feels incompetent at work and often feels that others are overly critical may be reacting to emotions (e.g., depression). This problem may be better served using another skill (e.g., Unhelpful Thoughts modules).

How? (Instructions/Handouts)

PROBLEM-SOLVING THERAPY (PST)

In problem-solving therapy, it is important that you first educate the patient about the problem-solving strategies that will be used during sessions. To enable patients to use the strategies after therapy ends, teach them to carefully examine a problem, create a list of solutions, and make decisions about which strategies are appropriate for a variety of problems.

General guidelines for using problem-solving strategies are as follows:
*   Training should be tailored and specific to each patient.
*   Obtain a thorough assessment of the problem before proceeding with problem-solving therapy.
*   Encourage the patient to try as many solutions as possible.
*   Decide whether the patient requires more problem-solving work or more emotional work to experience growth through the therapeutic process.

STRATEGIES FOR EFFECTIVE PROBLEM SOLVING

The SOLVED technique helps guide you through the steps to most effectively identify and solve problems in your life.

S (Selecting a Problem) … the patient would like to solve.
Ask the patient to think about situations when they feel distress or difficulty problem solving. If planning does not seem to be possible, suggest a different therapeutic technique (e.g., changing unhelpful thoughts). The decision to remain with problem solving or move to a different skill is largely dependent on you to direct.

O (Opening Your Mind to All Solutions)

Here, it is important to be as broad as possible. You are encouraged to work with patients to "brainstorm" all possible solutions. Writing may be particularly helpful for some patients. Even ideas that seem ridiculous at first may generate realistic solutions.

In-Session Example 15.1

For example, Allison's family would often drop by several times a week without calling beforehand and expect her to care for their children. She enjoyed this but felt tired many times and was beginning to get concerned about her ability to continue child sitting at such a frequent pace. Her first idea was to tell them she could no longer baby-sit. Although she did not like this idea, it led her to consider related ideas, such as telling them they had to call beforehand to make sure she felt up to the task.

Highlight 15.1

Tips for generating possible solutions:

- Ask the patient to think about advice they would give someone else with this problem.
- Ask the patient to examine the ways they have handled similar situations.
- Instruct the patient to **consult with a close friend or relative** for additional solutions.

L (Listing the Potential Pros and Cons of Each Potential Solution)

Often, writing options, along with listing pros and cons, can be helpful in considering potential options. Writing allows additional thought, as well as a visual image of options. Recommend that patients consider solutions in a logical manner, thus reducing the time spent ruminating. It may also help to identify additional thoughts that might benefit from changes using the techniques, such as changing thoughts. In some cases, identification of pros/cons may require obtaining information from other people, such as lawyers or financial advisors.

V (Verifying the Best Solution)

Examine the pros and cons of the solutions listed. Patients may wish to "rank order" the solutions based on which solutions are most practical and/or desirable.

E (Enacting the Plan)

Identify the steps needed to carry out the solution selected. Patients may need to break actions down into steps small enough to facilitate achievement of goals. Once you and the patient finish formulating a specific plan, encourage the patient to carry it out.

<u>**D (Deciding if the Plan Worked)**</u>
Follow-up with the patient to see how well the chosen solution worked. If the solution was effective, give positive reinforcement. If the solution was not effective, return to the first step in the SOLVED technique to specify a new problem or move to "O" or "L" to identify other goals or potential solutions for the same problem. The decision to move back and to which step is largely up to you, who might now have additional information about pros and cons and possible solutions.

PROBLEM-SOLVING EXAMPLES

To facilitate patient learning, you might wish to provide examples of the SOLVED program at work. The following section provides several examples of the SOLVED technique.

Table 15.1 Examples of Specifying the Problem in SOLVED: Common Problems in Chronic Illness

Physical/Symptom Problems	Emotional/Social/Relationship Problems
Overcoming or Working With Physical Limitations	Managing Mood
Medication Adherence Issues	Difficulty Asking for Help
Transportation and Mobility Issues	Difficulty Communicating
Minimizing Influence of Symptoms	Marital Stress
Minimizing Influence of Medication Side-Effects	Family Stress

**To effectively use the SOLVED technique, problems may need to be more specific than those listed above.

Table 15.2 Opening Your Mind Through Brainstorming to Solve Problems through SOLVED

SELECT A SPECIFIC PROBLEM: <u>Minimizing Effect of Symptom</u>
OPEN your MIND to ALL possible SOLUTIONS
1. Talk to your doctor.
2. Change or modify medications.
3. Engage in healthy life choices, including proper diet and exercise.
4. Educate yourself by talking to others and by reading about your illness
5. Explore alternative treatments.

SELECT A SPECIFIC PROBLEM: Forgetting to Take Medications
OPEN your MIND to ALL possible SOLUTIONS
1. Turn several alarm clocks on to remind you.
2. Put your medication in a place you will notice it at the time you are supposed to take it.
3. Have a friend or family member remind you.
4. Buy a medication dispenser to help you remember whether you have taken the medication.
5. Take it at the same time every day.

Other examples of problem-solving worksheets are listed at the end of this module. These worksheets expand the common pros and cons lists to help a patient consider multiple perspectives and outcomes before making a decision.

HOMEWORK EXAMPLES:

1. Create a list of possible solutions to your identified problem (brainstorm).
2. Implement your identified solution, assess it effectiveness, and modify as necessary.

SUPPLEMENTAL READINGS

Cormier, L. S., Nurius, P., & Osborn, C. J. (2017). *Interviewing and Change Strategies for Helpers.* Boston, MA: Cengage Learning; Chapter 12.

There are no sources in the current document.

SOLVED: PROBLEM-SOLVING EXERCISE

Specific problem: _____

_____

_____

Open Your Mind To Possible Solutions	**L** ist PROS AND CONS
1.	
2.	
3.	
4.	

Verify the best solution by circling your choice.

Enact the Solution.

Steps and Time Frame of Solution:

1. _____ Time: _____

2. _____ Time: _____

3._____ Time: _____

Decide if Your Solution Worked: [_____] YES   [_____]NO

PROS AND CONS

Behavior: _____

Positive Effects of Doing the Behavior	Positive Effects of Not Doing the Behavior

Negative Effects of Doing the Behavior	Negative Effects of Not Doing the Behavior

Short-Term Positive Consequences	Long-Term Positive Consequences

Short-Term Negative Consequences	Long-Term Negative Consequences

Module 16: Relaxation

OBJECTIVES

- To understand the concept and importance of relaxation in brief CBT
- To acquire specific relaxation skills (e.g., muscle relaxation, deep breathing, imagery)

<u>What Are Relaxation Techniques, and Why Are They Important?</u>

Relaxation techniques consist of a collection of psychotherapeutic techniques designed to reduce tension, stress, worry, and/or anxiety. Relaxation techniques vary in their focus (e.g., physical sensations or changes in cognition/thoughts) and can be selected based on presenting difficulties, as well as patient preferences. Some patients respond to physical procedures (e.g., muscle relaxation and/or deep breathing), while others respond favorably to guided imagery.

Relaxation techniques are important for brief therapy for several reasons. First, they focus on skills that alleviate stress, anxiety, worry, and tension that are often debilitating and interfere with patient functioning. Second, stress, anxiety, worry, and tension are often very uncomfortable for patients; and providing help to alleviate distress can go a long way towards increasing positive treatment expectations and rapport. Relaxation techniques are easily conveyed as a method of increasing control and often do not include a direct discussion of mental health difficulties, which can be important for some patients who are concerned about mental health stigma. Finally, relaxation techniques are generally easy to teach and learn. For these reasons, it is often advantageous to teach these techniques early in treatment to give patients an easy-to- learn, yet highly effective, skill set.

<u>When? (Indications/Contraindications)</u>

As indicated, relaxation techniques are quite effective early in treatment to reduce tension and increase early treatment successes. They generate increased self-efficacy, perceived control over stress, and improved coping.

Examples of applications might include daily relaxation exercises to reduce an overall sense of tension or stress not affiliated with any specific situation (e.g., general worry or apprehension) or the use of relaxation techniques to manage work-related stress in preparation for an upcoming social or family event.

Relaxation procedures can also be appropriate for persons with depressive symptoms to increase their perceptions of control. However, it might not be appropriate for depressive symptoms occurring outside comorbid anxiety/worry. For example, teaching a severely depressed person, who is experiencing fatigue and lack of motivation, to relax would not be useful unless the patient has a specific need for relaxation. Additionally, relaxation techniques might not be appropriate for patients with anxiety and panic symptoms as they may use them as avoidance behaviors. Use of relaxation when faced with feared stimuli can reinforce anxiety and further exacerbate fear.

Relaxation techniques are appropriate for persons with chronic pain, migraines, and insomnia, as well as in smoking cessation treatment and weight management programs. These techniques can aid in symptom reduction and underlying issues that make it difficult for patients to cope with physical ailments. However, it is important to consider how various relaxation techniques are impacted by any physical limitations.

How? (Instructions/Handouts)

Regardless of the actual relaxation technique, it is imperative that the physical environment be attended to so as to maximize results. Before beginning relaxation techniques, it is suggested that you create a safe, quiet, and comfortable environment. You are encouraged to work with patients to create such an environment. Patients may be comfortable with certain recommendations (e.g., unfolding arms) but may be uncertain or uncomfortable with others (e.g., closing their eyes). The following list of options can be used to create an effective atmosphere for relaxation-based interventions.

Setting up the room:
- Comfortable chair (a high-backed chair to support the patient's neck, if possible)
- Safe and relaxing room (e.g., temperature, noise, and lighting)

Highlight 16.1

Other tips to increase stress-management effectiveness include:
- Having the patient loosen tight clothing (collars, belts, shoes, etc.) or remove glasses
- Having the patient sit in a comfortable fashion (e.g., uncrossing arms and legs, placing feet flat on the floor)
- Dimming the lights or removing bright sunshine from the room
- Having patients close their eyes
- Asking patients whether they need a bathroom break before starting
- Asking patients to clear their mind and focus on your voice and instructions

The following sections of this module addresses three specific techniques: progressive muscle relaxation, deep breathing, and imagery. You largely determine selection of a specific technique, but you should select it with the patient's expressed interests and learning preferences/abilities in mind. For example, patients who are largely somatically focused may prefer muscle relaxation or deep breathing. Other patients, especially those who appreciate the association between thoughts and mood, might be best served using guided imagery procedures. However, the ultimate decision of which procedure to use may relate to exposure to all three techniques and a trial-and-error approach.

PROGRESSIVE MUSCLE RELAXATION (PMR)

PMR consists of learning how to tense and then relax various groups of muscles all through the body in a sequential fashion, while paying close attention to the feelings associated with both tension and relaxation. Although muscle relaxation has been around for many years, it has become more popular recently for dealing with different anxiety and panic disorders. With this procedure, the patient learns how to relax and how to recognize and pinpoint tension and relaxation in the body to identify tension and reduce its influence before each reaches high levels/impairment.

In teaching patients muscle relaxation, you should first explain the reason for using muscle relaxation and how it will benefit the patient (rationale). You should also give a full explanation and demonstration of how it is done.

Step #1: PMR Increases Control.
Introduce PMR principles and procedures. PMR begins by letting patients know that they can create sensations of relaxation and that this process of "inducing" relaxation begins by being able to identify and discriminate between sensations of tension and relaxation.

Step #2: Note the Incongruence of Tension and Relaxation.
Inform the patient that sensations of tension and relaxation cannot occur at the same time. No muscles in the body can be tensed and relaxed at the same time. This principle is critical, and you should ensure that patients fully understand how this applies to their current difficulties.

Step #3: Identify States of Tension.
Explain to the patient that tension often builds gradually without conscious awareness. Learning to detect the initial signs of an increase is an important step towards avoiding a full-blown occurrence of tension. Inform patients that, no matter the level of intensity, they can stop and reverse the tension using knowledge of PMR – in essence, it is never too late to reduce tension. Over time patients become increasingly skilled at identifying stress earlier and earlier (e.g., their awareness increases).

Step #4: Tense Muscle Groups.

Highlight 16.2

A brief word of caution: If at any point during the technique a patient experiences pain, alter or completely discontinue the technique. If the patient experiences chronic pain in any part of the body, it is best to avoid the tensing component when the patient gets to those muscle groups.

PMR asks the patient to tense and release different muscle groups in sequence, moving from the arms to the face, neck, chest and shoulders, torso, and legs. For each specific muscle group, it's important to try to tense only that muscle group during the tensing part of the exercise. Throughout the procedure, it is important to concentrate on the sensations produced by the different exercises. Asking the patient to describe bodily sensations is

very important for the learning process. Statements or phrases from you might include: "What are you noticing about your body right now?" These questions help the patient to focus on the way the body "feels" when tense and relaxed.

TENSING INSTRUCTIONS

Model each tension procedure. Ask the patient to practice, and provide feedback. Check to be sure that the patient can identify tension in each group before moving on to the next.

a. Dominant arm. Make a fist and tense biceps; pull wrist upward, while pushing elbow down against the arm of chair or bed.

b. Nondominant arm. Same as above.

c. Forehead, lower cheeks and jaw. Lift eyebrows as high as possible, bite teeth together, and pull corners of mouth tightly.

d. Neck and throat. Pull chin down toward chest; at the same time, try to prevent it from actually touching the chest. Counterpose muscles in front part of neck against those in the back part of neck.

e. Shoulders, chest, and upper back/abdomen. Take a deep breath and hold it. At the same time, pull the shoulder blades back and together, trying to make them touch. Try to keep your arms as relaxed as possible while tensing this muscle group. At the same time make the stomach hard by pressing it out, as if someone were going to hit you in the stomach.

f. Dominant leg. Lift foot off the floor and push down on the chair with thigh.

g. Nondominant leg. Same as above.

Step #5: Debrief After the Exercise.
After relaxation training, question the patient about his or her reaction to the muscle-relaxation exercise. It is also important to make any adjustments needed to the training. Monitor any pain the patient experienced to adapt and improve the technique for the individual patient's needs.

Step #6: Continue to Practice Outside Session.
It will be important for the patients to practice PMR at least once a day over the first week or two to build skills and confidence. As they become increasingly skilled at PMR, they might find it possible to relax without having to actively tense the muscles. The patients should use regularly scheduled homework to practice in a nondistracting environment. When they have learned to relax in a calm environment, it should be easier to relax in more distracting situations, whenever they notice tension developing.

DEEP-BREATHING TECHNIQUE

Another physiological-based relaxation technique is deep breathing. Deep breathing focuses on reducing rapid and shallow (ineffective) breathing that often occurs during periods of stress, worry, or anxiety. Rapid and shallow breaths can lead the patient to have decreased oxygen in the system, which can cause hyperventilation, dizziness, lightheadedness, or decreased ability to concentrate. Alternatively, taking a deep, full breath can produce a feeling of calmness or slowing by increasing oxygen-rich blood flow. It can also strengthen muscles in the chest and stomach, which can make it easier to breathe on a daily basis.

STEPS TO DEEP BREATHING:

Step #1: Introduce the patient to Deep Breathing. Indicate why Deep Breathing was chosen, and provide an overview of the procedures and potential benefits.

Step #2: Ask the patient to put one hand on the abdomen, with the little finger about one inch above the navel, and to place one hand on the chest.

Step #3: Ask the patient to pay attention to their breathing (pause for several seconds to allow the patient the opportunity to assess breathing) and then to tell you which hand is doing more of the moving. Ideally, the hand on the abdomen should be moving; while the hand over the chest remains still. This ensures that the breaths are deep.

Step #4: Work with the patient to take deeper breaths by getting the hand over the stomach to move while having little movement of the hand over the chest. Inform the patient, "Your hand on your diaphragm should move out as you inhale and in as you exhale."

Highlight 16.3

NOTE: Patients with a lung or heart condition might have difficulty with deep breathing. If patients report difficulty, slow the process down and help them to maximize the exercise comfortably.

Step #5: To pace the patient, you might suggest saying the words *in* and *out* slowly, while taking breaths. Inhalations and exhalations should build to approximately three seconds in duration.

Step #6: Ask patients if they notice any changes in breathing and feelings of relaxation. Ask for general feedback about the technique.

Step #7: Repeat the breathing exercise three or more times until the patient reports skill understanding and benefit.

Step #8: Ask the patient to identify situations when deep breathing might be appropriate.

Step #9: Continue practice outside of session. Work with the patient to set a homework assignment that encourages application of Deep Breathing to situations when the patient feels stress.

Highlight 16.4

Other tips for Deep Breathing:

1. Inhale through nose and out of mouth.
2. Ask patient to purse lips (as if blowing on hot soup) while exhaling.
3. Do not pause between inhales and exhales.
4. Ask patient to close eyes during the exercise.
5. Patient may want to use mantra such as "relax" during each exhale.
6. Pair up deep breathing with imagery once the patient has begun to master breathing skills.
7. Point out that deep breathing is a portable skill that can be used in a variety of situations and relatively without notice of others (PMR is less portable).

IMAGERY

Imagery is a cognitive relaxation technique that can be used to ease stress and promote an overall sense of well-being. Imagery focuses on increasing cognitive, emotional, and physical control by changing the focus of an individual's thoughts. We all have daydreamed about pleasant things that have distracted us and made us feel better. Imagery uses much the same process but encourages positive adaptive "dreaming" that distracts and relaxes the individual. Imagery is highly effective for depression and anxiety, as well as specific situations that require clarity, focus, distraction, or feelings of mastery. The following are examples:

Table 16.1 Imagery Examples

TOPIC	FOCUSED TOPIC	IMAGE	OUTCOME
Depression	Negative Self-worth	Images of success or past situations of success, images of a pleasant past experience	Increased self-confidence, reduced negative thoughts' distraction from negative mood
Anxiety/ Worry	Public Speaking	Image of speech that goes well, image of something funny	Reduced negative focus, distraction, increased positive expectations
Medical Anxiety	Fear of Procedure (e.g., needles)	Relaxation, peacefulness, pain-free environment	Less tension, reduced anxiety, toleration of procedure with less distress
Sports Performance	Focused efforts during golf game	Envisioning the desired shot, positive words of advice	Increased focus, increased self-confidence, positive thinking

How Guided Imagery Works

Research has shown that the mind can affect how the body functions. It seems the body may not know the difference between an actual event and a thought. Guided imagery uses the power of the brain—images and the perception that you are either somewhere else or in a different state of mind—to increase pleasant experiences and performance to promote wellness and health. On the flip side, imagery helps to reduce stress tension and anxiety by changing thoughts and emotions or through distraction.

Imagery is commonly referred to as guided imagery. Guided imagery refers to a process whereby you facilitate or guide the initial images the patient uses. The following section describes how you can guide the patient into the effective use of imagery for relaxation or performance improvement.

Step #1: Introduce Imagery.
Introduce imagery to the patient, pointing out the power of the brain or thoughts and how images, when accessed correctly, can change physical and emotional states.

Step #2: Identify the Desired Outcomes, Such as Decreased Anxiety, Increased Focus, Distraction.

Step #3: Develop an Image or Scene.

Work with the patient on the third step to identify a situation, either in the past or a desirable place to be, that both you and the patient feel might benefit or produce the desired outcome. Sample imagery scripts are provided below and can be used if the patient has difficulty creating a personal situation. Selection of a powerful image is critical to the success of this technique. Selection of an image that the patient is able to fully embrace increases the odds of treatment success. Selection of a "weak" image (e.g., not viewed as important by the patient or unable to be fully visualized) will likely lead to treatment failure.

Step #4: Increase Vividness of the Image.

To ensure that patients find a "strong" image, ask them to explore as many senses as possible to increase vividness of the image. For example, when imagining a glass of lemonade, imagine holding a glass that feels icy and cold; visualize the color of the lemonade; think of the fresh citrus smell; and, finally, think of how the lemonade tastes. This is an example of imagery that uses multiple senses and increases vividness of the image.

Increasing vividness is largely a matter of increasing the details the patient experiences. The more details described by the patient, the more powerful the technique.

Step #5: Ask Patients if They Notice Any Changes After the Imagery Exercise. Ask for general feedback about the technique.

Step #6: Repeat the Imagery Exercise Until the Patient Reports Skill Understanding and Benefit.

Step #7: Ask the Patient to Identify Situations When Imagery Might Be Appropriate. Expand upon the patient's responses by adding other situations (e.g., how the technique can be used).

Step #8: Continue Practice Outside Session. Work with the patient to set a homework assignment that encourages application of imagery to situations when the patient feels stress or feels that imagery might be beneficial.

Highlight 16.5

Other tips for imagery:

1. Pair up imagery with deep-breathing exercises.

2. Ask patient to close eyes during the exercise to increase vividness.

3. Interject during the imagery experience aspects that you feel might benefit the patient. For example, a patient might use a beach image; and you might ask how the sun feels on the skin, whether there are sounds, or what else is visible.

4. Help the patient focus on aspects of the image that will guide them towards the goal. Help the patient to avoid too many unnecessary details that might distract from the goal.

5. Point out that imagery is a portable skill that the patient can use in a variety of situations and completely without notice of others (PMR is less portable).

6. Avoid imagery with psychotic patients, who might confuse reality with images.

Imagery: Example Scripts/Guides for Providers

In-Session Example 16.1

Script #1: Generic Example

Once your whole body feels relaxed, travel to your favorite place to read, it can be any time or any place. This place is calm and safe... there are no worries here... Look around this place. What do you see? Do you hear the sounds around you? What are some of the sounds you hear in this place you are imagining? How does this special place smell? Walk around a little, and take in all the wonderful sights... Feel the air around you and relax.... The air is fresh, and it's easy to breathe here. Pay attention to how your body feels..... Say to yourself, "I am totally relaxed... without worries... all the tension has drained away from my body." Take a moment to fully experience your favorite place.... Notice the sounds, the sights, smells, and how it feels to be in this very special place. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here... this place is special and makes me feel at peace."

When you are done with your visit to this special place, open your eyes and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion. Take as long as you want to enjoy and relax. Feel at ease knowing your special place is always available to you; and find that you feel relaxed, even after you leave.

In-Session Example 16.2

Script #2 – The Beach:

Imagine yourself walking down a sandy beach. The sand is white and warm between your toes. You are looking out over the calm, blue water. The waves are gently lapping at the shore. You feel the pleasant warmth of the sun on your skin... it's a perfectly comfortable temperature outside. Breathe in deeply. There is a gentle breeze, and the sun is shining. Big, cotton-like clouds drift by as you hear sea gulls in the distance. You taste traces of salt on your lips. You are completely relaxed... there are no worries on this beach. There is nothing to distract you from feeling tranquil. Worries drift away. Notice the sounds, sights, smells, and how it feels to be in this very special place.

Feel the sand under your feet... you decide to stretch out on the warm, fine, white sand... breathe deeply... feel the warm air. Your body is completely relaxed, and you have an overall feeling of warmth and comfort. You look up at the clouds passing by slowly across the beautiful blue sky. You are feeling rejuvenated and completely at peace. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here... this place is special and makes me feel peaceful and content."

When you are done with your visit, open your eyes and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion; take as long as you want to enjoy and relax. You feel at ease knowing your special place is always available to you, and you find that you feel relaxed even after you leave.

In-Session Example 16.3

Script #3 – The Meadows:

Imagine yourself walking through a lovely meadow. The breeze feels pleasant against your skin. You are looking out over the calm, beautiful green grass. The blades of grass are gently swaying in the breeze. You feel the pleasant warmth of the sun on your skin... it's a perfectly comfortable temperature outside. Breathe in deeply. There is a gentle breeze, and the sun is shining. Big, cotton-like clouds drift by as you hear birds in the distance. You hear the wind blow gently through the trees. You taste the sweet summer air on your lips. You are completely relaxed... there are no worries in this meadow. There is nothing to distract you from feeling tranquil. Worries drift away. Notice the sounds, the sights, the smells, and how it feels to be in this very special place.

Feel the cool grass under your feet... you decide to stretch out on the soft, cushiony grass... breathe deeply... feel the warm air. Your body is completely relaxed, and you have an overall feeling of warmth and comfort. You look up as the clouds pass by slowly across the beautiful blue sky. You are feeling rejuvenated and completely at peace. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here... this place is special and makes me feel peaceful and content."

When you are done with your visit, open your eyes and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion; take as long as you want to enjoy and relax. You feel at ease knowing your special place is always available to you, and you find that you feel relaxed even after you leave.

Highlight 16.6

Other Guided Imagery Scene Suggestions:

- A garden where you watch big, beautiful clouds in a blue sky, while you inhale the scent of flowers and feel a gentle breeze on your skin as the sunshine warms you.

- A mountain scene where you feel calm and relaxed as you look out over the valley. Just you and the vegetation and you dip your feet into a cool mountain stream; and let your foot rest on a big, slippery stone as the sunshine warms you and the wind blows through the trees.

- Advanced scenarios developed with assistance of patient (family, past experiences, etc.).

HOMEWORK ASSIGNMENT EXAMPLES

1. Practice PMR before you go to bed each night this week.

2. Attempt your deep-breathing exercise during a stressful time this week.

3. Create your own personal guided imagery script, and attempt to use it this week. Bring it to the next session.

SUPPLEMENTAL READINGS

Cormier, S., Nurius, P. S., & Osborn, C. J. (2016). *Interviewing and change ctrategies for helpers, 8th Edition.* Boston, MA: Cengage Learning; Chapter 13.

Module 17: Adaptation of bCBT for Special Clinical Populations

OBJECTIVES

- To recognize cultural and diagnostic components associated with clinical populations
- To understand clinical considerations of specific clinical populations
- To learn how to adapt brief CBT for specific clinical populations

Introduction

Special clinical populations present unique life experiences, therefore requiring a therapeutic approach that understands this uniqueness and appreciates the context of the individual when engaging in clinical interventions. We describe four general clinical populations that may require more critical analysis of how best to apply brief CBT techniques.

Military Populations

Military personnel face unique and often intense physical and psychological challenges when serving their country. A 2014 research article (*JAMA Psychiatry,* 2014) found that one in four active duty military personnel had signs indicating the presence of a mental health condition. Common mental health disorders in military populations include depression, anxiety, substance abuse and posttraumatic stress disorder. Individuals may also face physical health changes due to injury. Common somatic and emotional health symptoms may include chronic pain, insomnia, and anger management difficulties. Notably, somatic symptoms may be related to emotional health difficulties; and substance abuse issues may "mask" other mental health difficulties – especially those related to trauma. Finally, military personnel are at increased risk of suicide regardless of service era – but personnel from the recent Iraq and Afghanistan conflicts have been found to have high rates (20% or greater) of traumatic brain injury (TBI), which further elevates mental health difficulties and suicide risk.

While on active duty, military personnel often face challenges that range from mild but chronic stressors (e.g. requiring to be "on guard" while in combat environments regardless of actually being in conflict) to acute and severe stressors (e.g. physical injury or death or injury to a colleague or civilians). Although combat stressors are commonly associated with increased stress and mental health demands, other aspects of military life create challenges that may include post deployment reintegration into civilian life, social isolation, or possibly even severe non combat trauma such as military sexual assault. Regardless of the specific stressors or "triggering events," it is important to recognize that not all military personnel require mental health services. However, many military personnel will face mental health challenges that do not reflect weakness on the part of the service member. These challenges must also be understood within the context of the service

member's home and/or social environment to fully appreciate the impact and potential sources of support to address any mental health conditions.

THERAPEUTIC CONSIDERATIONS AND ADAPTATIONS

Providers are encouraged to explore the meaning of military service and the possible relationship between military service, military-related stressors, and resiliency factors. Military culture may play a significant role in the way in which service members approach mental health treatment. For example, military culture places a premium on strength and resilience, which may be at odds with help-seeking behaviors. In some instances, emphasis on strength and resiliency may lead to social isolation and/or limited sharing of emotional or psychological struggles. Additionally, service members may face ramifications for seeking help that impact their careers such as pilots no longer being allowed to fly or security forces no longer being allowed to carry weapons. Stigma around seeking help can carry over for Veterans if they continue to work in national security positions as civilians or contractors. For all service members and Veterans, providers must attend to suicidal ideation and/or plans and should be prepared to actively manage these concerns using a comprehensive suicide assessment and safety plan (where needed). Importantly, this population tends to have greater access to firearms and lethal means than civilians. Providers should know their state laws for how to ensure lethal means safety for at risk groups.

POTENTIAL BRIEF CBT ADAPTATIONS

Providers may wish to consider the following adaptations to their traditional CBT approaches when working with military personnel and Veterans:

1. Integration of prior military experiences. For military personnel who strongly relate to their current and prior military service, providers are encouraged to explore the patient's military experiences for examples of challenges, coping, and successes. These examples may provide valuable information for treatment planning while also helping in understanding the patient's military context and developing rapport.

2. Peer support and social connection. Given the elevated potential for suicide, social isolation can be a critical contributing factor to the maintenance of emotional health difficulties. Many military personnel place a high value on service, family, and country. Although they do not want to be a burden on others, they are often willing to consider the value of others in their lives and the need to connect (re-connect) through the encouragement of a planned therapeutic plan.

3. Romantic relationship status. Among military members, relationship problems are among the most common antecedents for suicide. Routinely monitoring relationship status is important and can signal any acute mental health status changes that may arise.

4. Attending to physical health and functional changes. Many military personnel will face physical and/or functional health changes that require lifestyle modifications. Many of these challenges push patients away from activities that previously brought them pleasure. Providers are encouraged to consider these prior activities (and the losses) the military member is now facing, and then identify new activities,

especially social activities, where possible, that remain available to the patient. For example, a patient who had been runner who is now no longer physically able to run may identify meaning in being outdoors, being with others during early morning runs, or feeling a sense of accomplishment. Although running is no longer possible, activities that are outdoors, involve others, and provide as sense of accomplishment are often possible.

RESOURCES

www.mentalhealth.va.gov

Veterans Crisis Line 800 273 8255 Option #1

Older Adult Populations

Older adults, particularly those ages 65 and up, represent a unique population that often face life circumstances and challenges related to work and retirement and changes in family dynamics or living arrangements, as well as increased attention to physical health conditions including changes in cognition and memory. These changes may include physical or functional changes but many individuals will face these challenges especially with advanced age. Older adults are at increased risk for social isolation and suicide, and these issues are further complicated when combined with a physical illness or changes in cognitive functioning (e.g. dementia).

POTENTIAL ADAPTATIONS TO CBT FOR OLDER ADULT POPULATIONS

1. Speed and pace of therapy. Older adults, especially those new to psychotherapy, are likely to benefit from a pace of therapy that meets their emotional and cognitive needs. As a population, older adults vary greatly in their functional and cognitive abilities, and you must be prepared to adapt your approaches accordingly. Some older adults will require no modifications while others will need a pace and speed of therapy that are slower and use simplified language and intervention approaches. For example, some older adults may better identify and grasp the concepts of behavioral activation (e.g. pleasant events) versus more psychologically complex concepts, such as exposure or cognitive/thinking patterns that maintain behaviors.

2. Inclusion of caregivers and significant others. Although not appropriate for all older adults, the inclusion of caregivers may offer unique opportunities for providers to engage family or friends for at-risk older adults – especially those facing cognitive impairment, increased suicide risk, or social isolation. Caregivers may serve as passive supporters or as active members that facilitate treatment planning and/or between-session skill assignments.

3. Auditory or visual impairments. Providers are encouraged to assess for any auditory or visual needs when working with older adults. Specific needs may require alteration in telephone or other virtual platform delivery and may be important for written between-session assignments.

4. <u>Cognitive impairments.</u> Patients with cognitive impairments may benefit from simplified treatment plans and the incorporation of caregivers and/or significant others to facilitate treatment plans. See below for a specific section on cognitive impairment.

Medically Ill Populations

Patients that present with chronic medical diagnoses or with terminal sickness include a wide array of medical conditions such as cardiovascular disease, diabetes, cancers, HIV/AIDS, and autoimmune disorders (i.e., rheumatoid arthritis, lupus, and multiple sclerosis). These vulnerable health populations often have comorbid mental health diagnoses or related symptomology. Individuals with chronic or long-term health conditions are two to three times more likely to present with mental health disorders, including anxiety and depression (Hudson & Moss-Morris, 2019). Due to the likelihood of acute changes in health care and status, use of brief CBT techniques is optimal to deal with specific and short-term distress concerns.

POTENTIAL BRIEF CBT ADAPTATIONS

Providers may consider the following when working with medically ill patients:

1. <u>Prevalence of health-related distress.</u> Experiencing acute distress in response to receiving medical diagnoses or sudden changes to health status are expected within this population. Providers should keep in mind that health-related distress may be the focus of much of the therapy. Patients' anxiety or depression may be symptoms of coping with their changing health status. Providers may consider introducing behavioral activation activities that require low levels of physical involvement and cognitive restructuring around any thoughts related to negative views of the self or world in this new stage of life.

2. <u>Need for flexible treatment delivery.</u> The setting of the therapy will be dependent on patients' current health status. Providers may have to shift from their traditional office setting to treat patients that are in the hospital or cannot leave their home. Providers are encouraged to pay special attention to the patient's medical appointment schedule and allow for flexibility in the timing and amount of allowed session cancellations. Additionally, use of telehealth services becomes more important with this population and can increase the level of access to mental health treatment.

3. <u>Between-session workload.</u> Homework and in-between session practice are important to treatment success with CBT. However, providers should consider each patient's health status and use judgment in the amount and appropriateness of in-between session expectations. Talk with your patients about how feasible and/or likely it is they will be able to complete activities for that week.

4. <u>Caregiver presence.</u> Patients with severe health complications or dealing with functional impairments may require assistance from caregivers. Be mindful that caregivers may become integral in facilitating therapy for patients. Also, be aware that caregiver concerns and interpersonal issues between the patient and caregivers may be a central focus in therapy.

Populations with Cognitive Impairment

More than 16 million people in the United States are living with cognitive impairment such as mild cognitive impairment disorder, traumatic brain injury, Alzheimer's disease and other dementias, and developmental disorders (e.g., autism spectrum disorder) (Centers for Disease Control and Prevention, 2019). Cognitive impairment can affect individuals of all age groups and impact an individual's memory, concentration, and decision-making. These difficulties can cause issues with processing information, ability to communicate effectively, and everyday functioning. Patients will have related mental health concerns stemming from their clinical diagnoses or related to distress of coping with functional changes.

POTENTIAL BRIEF CBT ADAPTATIONS

Providers may consider the following when working with medically ill patients:

1. Timing and pace of therapy. Patients in this population may struggle with maintaining attention, processing information, or communicating their treatment needs. Consider a slower pace when communicating information and routinely checking in with patients to ensure they are keeping up with you during the session. Also, allow more time during the assessment phase to gain understanding of the patients' needs and to develop a treatment plan tailored to their clinical presentation.

2. Patient support. Providers should consider integrating caregivers, family members, or other support for these patients. These individuals will be liaisons between sessions, communicate information that the patient might have missed during the session, and help maintain treatment progress throughout the course of treatment.

3. Technique appropriateness. Consider the appropriateness of cognitive restructuring techniques for this population. These techniques are based on abstract themes and can be difficult for patients to understand, especially if cognitive impairment exists. Use aspects of patients' interests when describing examples of CBT and cognitive restructuring to aid in their understanding. If patients lack the capability to grasp this technique, focus your energy on behavioral activation or problem-solving techniques that are safe for patients to integrate into their schedule.

Module 18: Ending Treatment and Maintaining Changes

OBJECTIVES

• To understand the process for preparing the patient for ending treatment
• To learn techniques for preventing relapse

What Is Ending Treatment, and Why Is It Important To Plan for It?

End-of-treatment planning is the collaborative process of preparing the patients and assessing their readiness for ending treatment and moving beyond reliance on the provider to apply skills. Planning allows the patient to prepare for the end of treatment, to review skills learned in treatment, and to vocalize and problem-solve concerns about functioning outside treatment. All these factors reduce anxiety and allay fears a patient might have about ending a therapeutic relationship.

When? (Indications/Contraindications)

End-of-treatment planning begins at the first session when you give the patient some indication of the frequency and duration of treatment. End-of-treatment planning is an ongoing process, culminating in the final sessions with a review of treatment and introduction of relapse-prevention skills.

Patients with personality disorders or disorders of attachment may be particularly sensitive to feeling abandoned or upset as a result of ending the therapeutic relationship. For these patients, it is important to discuss treatment termination in an empowering and thoughtful way—recognizing and normalizing their fears, assuring them safeguards are in place (e.g., emergency resources, booster sessions), and encouraging them via reminders that the purpose of CBT is self-management of symptoms.

Measurement-based care used throughout treatment will inform an appropriate time for end-of-treatment. You can decide if additional sessions, a complete end-of-treatment, or booster sessions are needed depending on the type or intensity of symptoms the patient is still reporting. However, measurement-based care should be used in addition to ongoing conversations with the patient, your clinical judgment, and clinical requirements and procedures of the clinical facility.

How? (Instructions/Handouts)

REVIEWING WHAT WAS LEARNED

The last session of brief CBT should be spent reviewing and recording the different cognitive and behavioral skills the patient has learned. Use Socratic questioning to elicit this list ("What have you learned as a result of our time together? Is there anything that was particularly meaningful to you about your time in therapy?"), as patients may generate skills or benefits of therapy not known to you. Patients should have a list of

these skills they can take with them. They should also be encouraged to keep the other handouts (e.g., Thought Records) completed during treatment as a reminder of their skills.

RELAPSE PREVENTION

Many patients are concerned that they will not be able to manage future psychological problems or psychosocial stressors without the aid of therapy. In planning for the end of treatment, you and patients anticipate potential stressors and symptoms and plan: 1) What tools the patients have learned in therapy that they could use for particular stressors/symptoms, and 2) when patients might need to contact a mental health professional for additional assistance (e.g., suicidal ideation). Preparing for inevitable difficulties is empowering and encouraging for patients. A functional assessment may be used to identify future problematic situations (see Module 4).

In-Session Example 18.1

Relapse-Prevention Questions

1. When I feel <u>(symptom)</u>, I will <u>(tool learned in therapy)</u>.

2. If <u>(stressor)</u>, I will <u>(tool learned in therapy)</u>.

Example:
When I feel <u>sad for two days</u>, I will <u>go for a walk and call a friend to have lunch</u>.

When I feel <u>depressed for a month</u>, I will <u>schedule an appointment with my primary care physician/mental health provider</u>.

If <u>my boyfriend breaks up with me</u>, I will <u>do a Thought Record to evaluate any unhelpful thoughts.</u>

TROUBLESHOOTING END OF TREATMENT

Give Yourself Adequate Time to End Treatment.
Plan on an entire session devoted to ending treatment, wrapping up, and maintaining changes. It is highly recommended that you not introduce new concepts during the final session, as new issues may arise; and ending treatment during the session may become impossible.

GIVE THE PATIENT CREDIT

Patients often attribute positive change to external entities and negative change to themselves. Therefore, at the end of treatment, discuss the patient's progress (using objective data, such as symptom-rating scales, when available), praise the patient, and emphasize the patient's role in positive changes.

RESPOND TO CONCERNS

Checking in with the patient regularly about questions or concerns about ending treatment helps maintain the therapeutic relationship and offset negative emotions about treatment that could result in negative outcomes, such as feeling abandoned. If patients seem particularly concerned about ending treatment, they could use a Thought Record to identify and challenge unhelpful thoughts associated with leaving therapy.

PLAN SELF-MANAGEMENT TIME

Patients may be interested in planning self-management time when preparing for the end of treatment. Self-management times are a few minutes each week that patients set aside, once therapy is complete, to check mood and use of skills and problem solve situations or feelings that may be negatively affecting their mood. These times last approximately 10-15 minutes and follow a structure similar to therapy. Self-management time is beneficial because it is free, can be conducted at and when and where it is convenient for the patient, and helps prevent relapse. A self-management worksheet (found at the end of this module) may be used during these times.

BOOSTER SESSIONS

Booster sessions can be scheduled approximately one month following the end of treatment and then as needed thereafter. During a booster session, you:

- Check in with the patient about self-management of symptoms and stressors.
- Refresh skills learned in therapy.
- Discuss questions or concerns the patient might have about the transition.
- Review treatment goals and maintenance of treatment gains.

SUPPLEMENTAL READINGS

Allsop, S. & Saunders, B. (1991). Reinforcing robust resolutions: Motivation in relapse prevention with severely dependent problem drinkers. In Miller, W.R. & Rollnick, S. (Eds.). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford Press, pp. 236-247.

Beck, J.S. (2011). *Cognitive therapy: basics and beyond* (2nd ed.). New York: Guilford Press; Chapter 18.

SELF-MANAGEMENT TIME GUIDE

1. **Mood Check**
    a. List five emotions you are feeling right now, and rate their intensity from 0- 100%.

    b. List three emotions you have felt this past week, and rate their intensity from 0-100%.

2. **Review the Previous Week**
    a. Did I use any tools I learned in therapy this week?
        i. If I did not, what problem did I have this week that could have been helped through the use of these skills?

    b. What good things happened this week?
        i. How did I make those good things happen?

3. **Current and Future Problematic Situations**
    a. What are my current problems?
        i. How can I think about these problems in a different way?
        ii. What can I do to change the feelings associated with these problems?

    b. What problems can occur before my next self-management time?
        i. What skills can I use to deal with these problems?

REFERENCES

REFERENCES

Supplemental Readings and References

Allsop, S. & Saunders, B. (1991). Reinforcing robust resolutions: Motivation in relapse prevention with severely dependent problem drinkers. In Miller, W.R. & Rollnick, S. (Eds.). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford Press, pp. 236-247.

American Psychiatric Association. (2020). Telepsychiatry Toolkit. Retrieved July 02, 2020, from https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit

American Psychological Association. (2013, July 31). Guidelines for the practice of telepsychology. http://www.apa.org/practice/guidelines/telepsychology

American Psychological Association. (1990, August). Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Population. Retrieved from American Psychological Association: https://www.apa.org/pi/oema/resources/policy/provider-guidelines

Beck, J.S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford Press.

Bernard, J. M. & Goodyear, R.K. (2004). *Fundamentals of clinical supervision* (3rd ed.). New York: Pearson.

Burns, D.D. (1999). *Feeling good handbook.* New York: Plume Books (Penguin USA).

Cormier, L. S., Nurius, P., & Osborn, C. J. (2017). *Interviewing and change strategies for helpers.* Boston, MA: Cengage Learning.

Folkman, S., Lazarus, R. S., Gruen, R. J., & DeLongis, A. (1986). Appraisal, coping, health status, and psychological symptoms. *Journal of Personality and Social Psychology, 50*(3), 571–579. https://doi.org/10.1037/0022-3514.50.3.571

Greenberger, D., & Padesky, C. A. (2016). *Mind over mood: Change how you feel by changing the way you think* (2nd ed.). Guilford Press.

Hoffman, J. L., & Hoffman, J. L. (2006). Sculpting race: An innovative approach to teaching racial identity development. Retrieved from Summary Stages of Racial Identity Development: https://www.racialequitytools.org/resourcefiles/Compilation_of_Racial_Identity_Models_7_15_11.pdf

Hopko, D. R., Lejuez, C. W., Ruggiero, K. J., & Eifert, G. H. (2003). Contemporary behavioral activation treatments for depression: Procedures, principles, and progress. *Clinical Psychology Review, 23*(5), 699-717.

Lejuez, C. W., Hopko, D. R., Acierno, R., Daughters, S. B., & Pagoto, S. L. (2011). Ten year revision of the brief behavioral activation treatment for depression: Revised treatment manual. *Behavior Modification, 35*(2), 111-161.

Liese, B.S. & Beck, J.S. (1997). *Cognitive therapy supervision*. In Watkins, C.E. (Ed). *In Handbook of psychotherapy supervision*. New York: Wiley; pp114-133.

National Consortium of Telehealth Resource Centers. (2020). National Consortium of Telehealth Resource Centers. Retrieved July 02, 2020, from https://www.telehealthresourcecenter.org/

Nezu, A. M., Nezu, C. M., & D'Zurilla, T. (2012). *Problem-solving therapy: A treatment manual.* Springer Publishing Company.

Persons, J.B. & Tompkins, M.A. Cognitive-behavioral case formulation. In Ells T. (Ed.). *Handbook of psychotherapy and case formulation*. New York: Guilford Press, pp. 314-339.

Rollnick, S., Butler, C., & Mason, P. (1999). Chapters 3, 4, and 5. In *Health Behavior Change: A Guide for Practitioners.* New York: Churchill Livingstone.
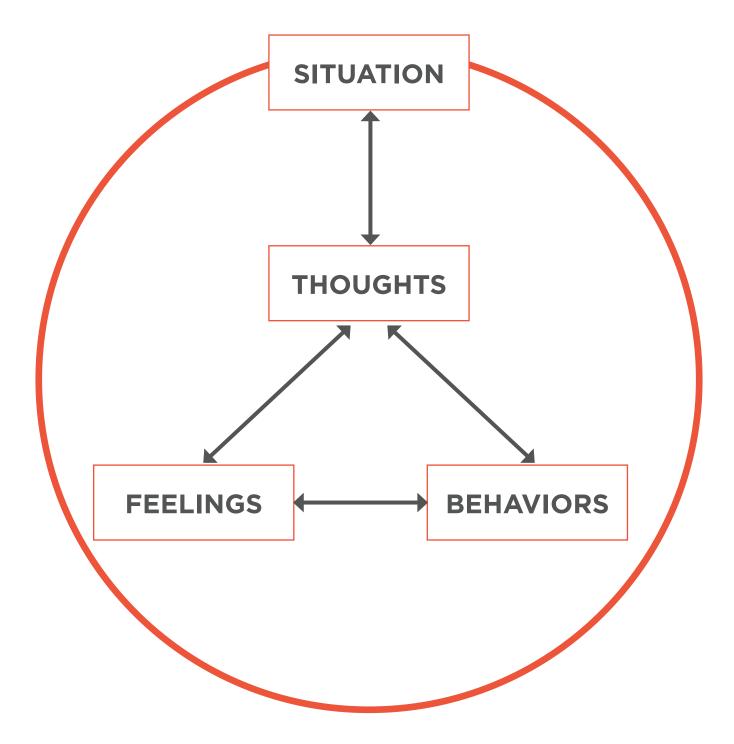
Safran, J. D., & Greenberg, L. S. (1982). Eliciting "hot cognitions" in cognitive behaviour therapy: Rationale and procedural guidelines. *Canadian Psychology/Psychologie Canadienne, 23*(2), 83–87. https://doi.org/10.1037/h0081247

Shore, J. H., Yellowlees, P., Caudill, R., Johnston, B., Turvey, C., Mishkind, M., ... & Hilty, D. (2018). Best practices in videoconferencing-based telemental health April 2018. *Telemedicine and e-Health, 24*(11), 827-832.

Turvey C, Coleman M, Dennison O, et al. ATA practice guidelines for video-based online mental health services. *Journal of Telemedicinie and e-Health.* 2013;19(9):722-730. doi:10.1089/tmj.2013.9989

APPENDIX A

Cognitive Behavioral Model

Bridging Sessions

1. What main points did we reach in our last session? What did you learn from last session? Did anything come to mind in the past week about our last session that you'd like me to know or that you'd like to discuss?

2. Were you uncomfortable about anything we talked about in our last session? Is there anything you wish we had discussed that we didn't?

3. How is your mood? Compared with last week, is it better or worse?

4. What treatment goals would you like to work on today? What problems would you like to put on the agenda?

5. What homework did you attempt or complete for last session? What did you learn from doing it?

Unhelpful Thinking Styles

1. **All-or-Nothing Thinking:** Viewing situations on one extreme or another instead of on a continuum.

    Ex. "If my child does bad things, it's because I am a bad parent."

2. **Catastrophizing:** Predicting only negative outcomes for the future.

    Ex. "If I fail my final, my life will be over."

3. **Disqualifying or Discounting the Positive:** Telling yourself that the good things that happen to you don't count.

    Ex. "My daughter told her friend that I was the best Dad in the world, but I'm sure she was just being nice."

4. **Emotional Reasoning:** Feeling about something overrules facts to the contrary.

    Ex. "Even though Steve is here at work late everyday, I know I work harder than anyone else at my job."

5. **Labeling:** Giving someone or something a label without finding out more about it/them.

    Ex. "My daughter would never do anything I disapproved of."

6. **Magnification/Minimization:** Emphasizing the negative or downplaying the positive of a situation.

    Ex. "My professor said he made some corrections on my paper, so I know I'll probably fail the class."

7. **Mental Filter/Tunnel Vision:** Placing all your attention on the negatives of a situation or seeing only the negatives of a situation.

    Ex. "My husband says he wished I was better at housekeeping, so I must be a lousy wife."

8. **Mind Reading:** Believing you know what others are thinking.

    Ex. "My house was dirty when my friends came over, so I know they think I'm a slob."

9. **Overgeneralization:** Making an overall negative conclusion beyond the current situation.

    Ex. "My husband didn't kiss me when he came home this evening. Maybe he doesn't love me anymore."

10. **Personalization:** Thinking the negative behavior of others has something to do with you.

    Ex. "My daughter has been pretty quiet today. I wonder what I did to upset her."

11. **"Should" and "Must" Statements:** Having a concrete idea of how people should behave.

    Ex. "I should get all A's to be a good student."

Thought Record

(1) Situation	(2) Automatic Thought(s)	(3) Emotion(s) & Mood	(4) Evidence That Supports Thought	(5) Evidence That Doesn't Support Thought	(6) Alternative Thought	(7) Rate Mood Now
What actually happened? Where? What? How? When?	*What thought(s) went through your mind? How much did you believe it? (1-100)*	*What emotion(s) did you feel at the time? Rate how intense they were (1-100).*	*What has happened to make you believe the thought is true?*	*What has happened to prove the thought is not true?*	*What is another way to think of this situation?*	*Rate from 0-100 (worst to best)*

Helpful Questions

SITUATIONAL QUESTIONS	FEELING QUESTIONS	THOUGHT QUESTIONS
• What happened? What were you doing? • Who was there? • Who were you speaking to? • When did this happen? • What time of day was it? • Where did this incident occur?	• How were you feeling before this happened? • How did you feel while it was happening? • What mood were you in after this happened? • Can you rate your mood on a scale of 1-100?	• What was going through your mind before you started to feel that way? • What made you feel that way? • Do you have any other thoughts? • Which thought bothered you the most? • What images did you have with these thoughts? • What are you afraid might happen? • What if this is true? What does this say about you? • What could happen if this were true? • What other ways could we think of this?

Thought Record
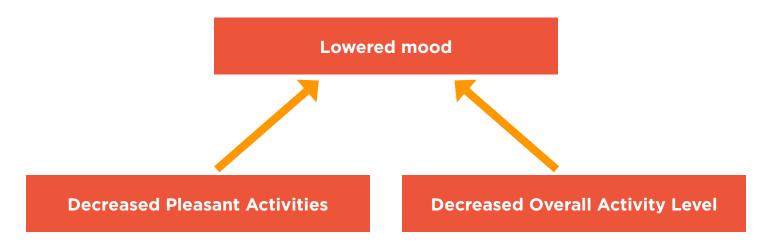
(1) Situation	(2) Automatic Thought(s)	(3) Emotion(s) & Mood	(4) Evidence That Supports Thought	(5) Evidence That Doesn't Support Thought	(6) Alternative Thought	(7) Rate Mood Now
What actually happened? Where? What? How? When?	*What thought(s) went through your mind? How much did you believe it? (1-100)*	*What emotion(s) did you feel at the time? Rate how intense they were (1-100).*	*What has happened to make you believe the thought is true?*	*What has happened to prove the thought is not true?*	*What is another way to think of this situation?*	*Rate from 0-100 (worst to best)*

Functional Assessment ABC's
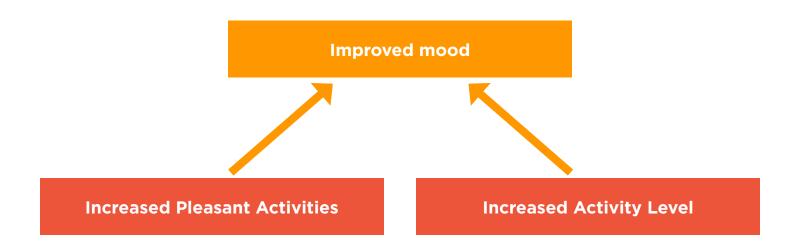
Antecedents (What happened before?)	Behaviors (What did you do?)	Short-Term Consequences (What was the result 1 second, 1 hour following behavior?)	Long-Term Consequences (What were the lasting results?)

Mood and Behavior

Lowered mood

Decreased Pleasant Activities	Decreased Overall Activity Level

If depressed persons increase their activities on a daily basis, it improves mood and decreases symptoms of depression.

Improved mood

Increased Pleasant Activities	Increased Activity Level

Activities Checklist

EXCURSIONS/COMMUNITY	✓	SOCIAL ACTIVITIES AND INTERACTIONS WITH OTHERS	✓
• Going to the park or beach		• Going together with friends	
• Going out to dinner		• Visiting a neighbor	
• Going to the library or a book store		• Having family visit or visiting family	
• Going to the movies		• Eating out with friends or associates	
• Going shopping		• Going to a local community center	
• Going fishing		• Playing bingo, cards, dominos with others	
HEALTH AND WELLNESS	✓	**PHYSICAL ACTIVITY**	✓
• Putting on makeup or perfume		• Walking for exercise or pleasure	
• Eating healthier		• Light housekeeping, such as sweeping	
• Relaxing, meditating or doing yoga		• Swimming or doing water exercise	
• Improving one's health		• Gardening or planting	
SPIRITUAL, RELIGIOUS, AND KIND ACTS	✓	**RECREATIONAL AND OTHER LEISURE ACTIVITIES**	✓
• Going to a place of worship		• Knitting, sewing or needlework	
• Attending a wedding, baptism, bar mitzvah, religious ceremony or function		• Writing in a journal or diary or keeping a scrapbook or photo album	
• Reading the Bible		• Playing with or having a pet	
• Attending a Bible study group		• Drawing, painting or crafts	
• Doing favors for others or volunteering		• Singing or listening to music	
• Volunteering for a special cause		• Reading the newspaper or magazines	
		• Watching TV or listening to the radio	
		• Doing word puzzles or playing cards	

Mood Monitoring and Activity Chart

For each block of time, list the activity you did and rate (from 0-100) the level of Anxiety (A) and Depression (D) you experienced at that time.

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6-7 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
7-8 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
8-9 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
9-10 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
10-11 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
11-12 Noon	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
12-1 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
1-2 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
2-3 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
3-4 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
4-5 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
5-6 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
6-7 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
7-8 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
8-9 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:

SOLVED: Problem-Solving Exercise

Specific problem: _____

_____

_____

Open Your Mind	**L** ist		
To Possible Solutions	PROS	AND	CONS

1.

2.

3.

4.

Verify the best solution by circling your choice.

Enact the Solution.

Steps and Time Frame of Solution:

1. _____ Time: _____

2. _____ Time: _____

3._____ Time: _____

Decide if Your Solution Worked: **[_____] YES   [_____]NO**

Pros and Cons

Behavior: _____

Positive Effects of Doing the Behavior	Positive Effects of Not Doing the Behavior
Negative Effects of Doing the Behavior	Negative Effects of Not Doing the Behavior
Short-Term Positive Consequences	Long-Term Positive Consequences
Short-Term Negative Consequences	Long-Term Negative Consequences

Tensing Instructions

Model each tension procedure:

Dominant arm:

Make a fist and tense biceps; pull wrist upward while pushing elbow down against the arm of chair or bed.

Nondominant arm:

Same as above.

Forehead, lower cheeks and jaw:

Lift eyebrows as high as possible, bite teeth together and pull corners of mouth tightly.

Neck and throat:

Pull chin down toward chest; at the same time, try to prevent it from actually touching the chest. Counterpose muscles in front part of neck against those in the back part of neck.

Shoulders, chest, and upper back/abdomen:

Take a deep breath and hold it. At the same time, pull the shoulder blades back and together, trying to make them touch. Try to keep your arms as relaxed as possible while tensing this muscle group. At the same time make stomach hard by pressing it out, as if someone were going to hit you in the stomach.

Dominant leg:

Lift foot off the floor, and push down on the chair with thigh.

Nondominant leg:

Same as above.

Deep-Breathing Technique

Step #1: Put one hand on your abdomen, with the little finger about one inch above the navel, and place one hand on your chest.

Step #2: Pay attention to your breathing (pause for several seconds to assess your breathing). Ideally, the hand on the abdomen should be moving, while the hand over the chest remains still. This ensures that the breaths are deep.

Step #3: Take deeper breaths by getting the hand over the stomach to move, while having little movement of the hand over the chest.

NOTE: If you have a lung or heart condition and you are having difficulty with this exercise, slow the process down to your comfort level.

Step #4: Continue your slow, even, deep breaths. To pace yourself, you can say the words in and out slowly while taking breaths. Inhalations and exhalations should build to approximately three seconds in duration.

Step #5: Repeat the breathing exercise three or more times.

Other tips for deep breathing:

1. Inhale through your nose and out your mouth.
2. Purse your lips (as if blowing out hot soup) while exhaling.
3. Do not pause between inhales and exhales.
4. Close your eyes during the exercise.
5. Use a mantra such as "relax" during each exhale
6. Pair up deep breathing with imagery once you have mastered the breathing skills.
7. REMEMBER: Deep breathing is a portable skill that can be used in a variety of situations and relatively without notice of others.

Imagery: In-Session Example Scripts

Script #1: Generic Example

Once your whole body feels relaxed, travel to your favorite place... it can be any time or any place. This place is calm and safe... there are no worries here... Look around this place. What do you see? Do you hear the sounds around you? What are some of the sounds you hear in this place you are imagining? How does this special place smell? Walk around a little, and take in all the wonderful sights... Feel the air around you and relax.... The air is fresh, and it's easy to breathe here. Pay attention to how your body feels..... Say to yourself, "I am totally relaxed... without worries... all the tension has drained away from my body." Take a moment to fully experience your favorite place.... Notice the sounds, the sights, smells, and how it feels to be in this very special place. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here... this place is special and makes me feel at peace."

When you are done with your visit to this special place, open your eyes, and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion. Take as long as you want to enjoy and relax. Feel at ease knowing your special place is always available to you, and find that you feel relaxed, even after you leave.

Script #2 – The Beach:

Imagine yourself walking down a sandy beach. The sand is white and warm between your toes. You are looking out over the calm, blue water. The waves are gently lapping at the shore. You feel the pleasant warmth of the sun on your skin... it's a perfectly comfortable temperature outside. Breathe in deeply. There is a gentle breeze, and the sun is shining. Big, cotton-like clouds drift by as you hear sea gulls in the distance. You taste traces of salt on your lips. You are completely relaxed... there are no worries on this beach. There is nothing to distract you from feeling tranquil. Worries drift away. Notice the sounds, sights, smells, and how it feels to be in this very special place.

Feel the sand under your feet... you decide to stretch out on the warm, fine, white sand... breathe deeply... feel the warm air. Your body is completely relaxed, and you have an overall feeling of warmth and comfort. You look up at the clouds pass by slowly across the beautiful blue sky. You are feeling rejuvenated and completely at peace. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here... this place is special and makes me feel peaceful and content."

When you are done with your visit, open your eyes and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion; take as long as you want to enjoy and relax. You feel at ease knowing your special place is always available to you, and you find that you feel relaxed even after you leave.

Imagery: In-Session Example Scripts

Script #3 – The Meadows:

Imagine yourself walking through a lovely meadow. The breeze feels pleasant against your skin. You are looking out over the calm, beautiful green grass. The blades of grass are gently swaying in the breeze. You feel the pleasant warmth of the sun on your skin... it's a perfectly comfortable temperature outside. Breathe in deeply. There is a gentle breeze, and the sun is shining. Big, cotton-like clouds drift by as you hear birds in the distance. You hear the wind blow gently through the trees. You taste the sweet summer air on your lips. You are completely relaxed... there are no worries in this meadow. There is nothing to distract you from feeling tranquil. Worries drift away. Notice the sounds, the sights, the smells, and how it feels to be in this very special place.

Feel the cool grass under your feet... you decide to stretch out on the soft, cushiony grass... breathe deeply... feel the warm air. Your body is completely relaxed, and you have an overall feeling of warmth and comfort. You look up as the clouds pass by slowly across the beautiful blue sky. You are feeling rejuvenated and completely at peace. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here... this place is special and makes me feel peaceful and content."

When you are done with your visit, open your eyes and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion; take as long as you want to enjoy and relax. You feel at ease knowing your special place is always available to you, and you find that you feel relaxed even after you leave.

Other Guided Imagery Scene Suggestions:

- A garden where you watch big, beautiful clouds in a blue sky, while you inhale the scent of flowers and feel a gentle breeze on your skin as the sunshine warms you.

- A mountain scene where you feel calm and relaxed as you look out over the valley. Just you and the vegetation and you dip your feet into a cool mountain stream; and let your foot rest on a big, slippery stone as the sunshine warms you and the wind blows through the trees.

- Advanced scenarios developed with assistance of patient (family, past experiences, etc.).

Rating Moods

Describe a recent event. Rate the intensity of your mood at the time the event occurred on a scale of 0-100 (There is a list of different moods at the bottom if you need help).

1. Event: _____

_____

Mood: 0____10____20___30___40___50___60___70___80___90___100___

2. Event: _____

_____

Mood: 0____10____20___30___40___50___60___70___80___90___100___

3. Event: _____

_____

Mood: 0____10____20___30___40___50___60___70___80___90___100___

4. Event: _____

_____

Mood: 0____10____20___30___40___50___60___70___80___90___100___

Angry	Anxious	Ashamed	Confident	Depressed
Disgusted	Embarrassed	Enraged	Hopeless	Nervous
Excited	Hurt	Panicky	Furious	Humiliated
Sad	Frightened	Frustrated	Guilty	Happy
Hopeful	Insecure	Irritated	Jealous	Livid
Mad	Scared	Tense	Warm	

Self-Management Time Guide

1. **Mood Check**
   a. List five emotions you are feeling right now, and rate their intensity from 0- 100%.

   b. List three emotions you have felt this past week, and rate their intensity from 0-100%.

2. **Review the Previous Week**
   a. Did I use any tools I learned in therapy this week?
      i. If I did not, what problem did I have this week that could have been helped through the use of these skills?

   b. What good things happened this week?
      i. How did I make those good things happen?

3. **Current and Future Problematic Situations**
   a. What are my current problems?
      i. How can I think about these problems in a different way?
      ii. What can I do to change the feelings associated with these problems?

   b. What problems can occur before my next self-management time?
      i. What skills can I use to deal with these problems?

APPENDIX B

Sample Brief CBT Outline #1

Patient Description

Maria is a 60-year-old airline pilot who is about to retire from 15 years of flying. Maria was diagnosed with Type II diabetes five years ago and has had difficulties maintaining her health since that time. She has suffered bouts of severe fatigue and dizziness. Maria says that flying is her "first love," but that it has become increasingly dangerous for her to fly. She states that she "feels like a failure" because she worked so hard to become a pilot and now "it is over." Maria says that she is usually a very active person but has lost interest in her hobbies and doesn't have the energy to do them, anyway. She says that her depression has been worsened by her deteriorating health.

Case Conceptualization: Maria is experiencing depression in response to a diagnosis of diabetes. She is unsure how to change her thoughts and behaviors to adjust to her new medical condition. Therapy will aid her adjustment by targeting unhelpful thoughts about being a "failure" and exploring and increasing the things that she enjoys and feels a sense of achievement from, both for work and recreation.

Goals
Behavioral Activation
Identifying Unhelpful Thoughts/Beliefs Challenging Unhelpful Thoughts/Beliefs

Session 1

Establish relationship.
Identify Maria's presenting problem. Introduce Cognitive Behavioral Therapy. Introduce the Cognitive-Behavioral Model. Describe Problem in Context of Model.
Set Goals.
Receive Feedback from Maria.

Session 2

Check Mood.
Introduce Behavioral Activation, and Explore Potential Activities to Improve Mood. Set Homework: Mood and Activity Tracking.
Receive Feedback From Maria.

Session 3

Check Mood.
Review Mood and Activity Tracking.
Use Tracking Sheet to Plan Where and What Behavioral Activation Will Be Employed. Troubleshoot Completing Activity.
Assign Homework: 1 Behavioral-Activation Exercise.
Receive Feedback From Maria.

Sample Brief CBT Outline #1

Session 4

Check Mood.
Review Behavioral Activation,
Introduce Three-Column Thought Record and Idea of "Hot Thought." Practice Three Column With Event From Past Week.
Homework: 1 behavioral activation
                   1 three-column Thought Record
Receive Feedback From Maria.

Session 5

Check Mood.
Discuss Progress of Therapy and Termination.
Review Homework.
Introduce Unhelpful Thinking Styles.
Complete Three-Column in Session, and Have Maria Identify Hot Thought. Introduce Concept of Challenging Hot Thought.
Homework: 1 behavioral activation
                   1 three-column Thought Record
Receive Feedback From Maria.

Session 6

Check Mood.
Review Homework.
Introduce Challenging Thoughts and Seven-Column Thought Record. Complete Seven-Column in Session.
Introduce Concept of Challenging Hot Thought.
Homework: 1 behavioral activation
                   1 three-column Thought Record
Receive Feedback From Maria.

Session 7

Check Mood.
Review Homework.
Complete Seven-Column in Session (With Maria Writing and Talking Through as She Completes It)
Homework: 1 behavioral activation
                   1 seven-column Thought Record
Receive Feedback From Maria.

Session 8

Check Mood.
Review Homework.
Review Progress of Treatment.
Complete Relapse Prevention.
Introduce and Schedule Self-Management Sessions.
Homework: Self-Management Session

Sample Brief CBT Outline #2

Patient Description

James is a 24-year-old college student on a full academic scholarship. He called the provider to discuss his feelings of anxiety and whether there is anything that can help him "calm his nerves." James said that he is used to getting anxious in certain situations, but that it is starting to affect all areas of his life. He says that he doesn't have a girlfriend because he gets "too freaked out" to ask anyone on a date. He also says that his anxiety is starting to affect his grades because he gets so nervous during exams that he breaks into a cold sweat and cannot concentrate. He wants to be able to control his anxiety but feels there is no hope.

Case Conceptualization: James is experiencing cognitive and physiological anxiety in response to evaluative situations. Therapy will focus on stress-management skills for his physiological symptoms and identifying unhelpful thoughts or worries about his performance in academic and social situations. Specifically, therapy will identify catastrophic thoughts he has about failure.

Goals
Relaxation
Identifying Unhelpful Thoughts / Beliefs Challenging Unhelpful Thoughts / Beliefs

Session 1

Establish relationship.
Identify James' presenting problem.
Introduce cognitive behavioral therapy.
Introduce the cognitive-behavioral model.
Describe problem in context of mode.
Set goals.
Receive feedback from James.

Session 2

Check mood.
Introduce and practice progressive muscle relaxation.
Set homework: Plan two times during week to practice progressive muscle relaxation.
Receive feedback from James.

Session 3

Check mood.
Review progressive muscle relaxation. Introduce and practice imagery.
Homework: 1 progressive muscle relaxation
                          1 imagery exercise
Receive feedback from James.

Sample Brief CBT Outline #2

Session 4

Check mood.
Review imagery.
Introduce three-column thought record and idea of "hot thought." Practice three-column with event from past week.
Homework: 1 relaxation technique
                     1 three-column thought record
Receive feedback from James.

Session 5

Check mood.
Discuss progress of therapy and termination.
Review homework.
Introduce cognitive distortions.
Complete three-column in session, and have James identify hot thought. Introduce concept of challenging hot thought.
Homework: 2 relaxation techniques
                     1 three-column thought record
Receive feedback from James.

Session 6

Check mood.
Review homework.
Introduce challenging thoughts and seven-column thought record. Complete seven-column in session.
Introduce concept of challenging hot thought.
Homework: 2 relaxation techniques
                     1 three-column thought record
Receive feedback from James.

Session 7

Check mood.
Review homework.
Complete seven-column in session.
Homework: 2 relaxation techniques
                     1 seven-column thought record
Receive feedback from James.

Session 8

Check mood.
Review homework.
Review progress of treatment.
Complete relapse prevention.
Introduce and schedule self-management sessions.
Homework: self-management session