



Provider Manual 2.2



How to Use This Manual

This manual is intended to help you successfully implement bCBT by providing an overall structure for the intervention. Content is divided into six sessions, each focused on a particular set of skills and objectives:

1. Getting Started (Session 1)	
2. Engaging in Activities to Improve Mood	
3. Managing Unhelpful Thoughts	CORE
4. Using Relaxation Skills to Manage Stress & Tension	
5. Improving Health and Wellness	
6. The Final Session	

- Please initiate treatment with the “Getting Started” session.
- “Engaging in Activities to Improve Mood,” and “Managing Unhelpful Thoughts” are core bCBT components and should be a central focus of treatment if possible.
- *Most patients will likely not complete each content area.* You are encouraged to determine with your patient which content will be the most beneficial to cover in the time allotted.
- You may spend more than one appointment on a given session.
- Portions of this manual are color keyed in order to aid presentation of the material:

Refers to Workbook Page

Will help ensure that you and the patient view the same material.

Provider Tips

Clinical considerations and suggested strategies to overcome barriers during the session.

Using the Patient Workbook

- Each section of the provider manual:
 1. Follows the order of the corresponding section in the patient workbook
 2. Begins with a summary of the objectives to be covered, referred to as the session “roadmap.”
- You are not expected to walk patients through every line on every page of the patient workbook. Instead, please use the patient workbook flexibly as:
 1. A tool to facilitate discussion with patients.
 2. A source of examples for how the skills introduced can be used in daily life.
 3. A tool for planning and monitoring between-session work.

Using the Abbreviated Manual

- The abbreviated manual contains only the information necessary for quick reference and organization, including the session roadmap and thumbnails of the patient workbook pages.
- You are encouraged to use the abbreviated provider manual after you are familiar with delivery of each content area.

Additional Resources

- You may access electronic versions of the provider manual and patient workbook on the MyBriefCBT website here: (insert link)
- For additional information on brief CBT, please see "[*A Therapist's Guide to Brief Cognitive Behavioral Therapy*](#) (Cully & Teten, 2008).



Session 0

Provider Manual

Session 0

- The goal of Session 0 is to gain a foundational understanding of the Veteran's most pressing issues and initiate a transition into brief Cognitive Behavioral Therapy (bCBT).
- Session 0 is conducted within the framework of the "5-A's," a common assessment structure in VA Primary Care (for more information, see the Clinical Resources webpage hosted by the VA VISN 2 Center for Integrated Healthcare ([CIH](#); https://www.mirecc.va.gov/cih-visn2/clinical_resources.asp).
- In this session, we present an overview for each of the 5 A phases, followed by a step-by-step description of content to be covered. Example provider dialogue is also included to guide this process.
- Session 0 was developed to be used within a 20-30 minute brief assessment for VA primary care settings. The approximate time for the Assess Phase is 10-15 minutes with final 10-15 minutes focused on the other Phases (i.e., Advise, Agree, Assist, and Arrange).

1. Assess

Summary: During this phase, after discussing limits of confidentiality, you will conduct a functional assessment (for more information, see the Clinical Resources webpage hosted by the VA VISN 2 CIH), risk assessment (mandatory), clinical reminders (i.e., mandatory screenings), a depression-specific assessment using the PHQ-9, and other optional screenings and symptom measurements that may apply to the Veteran's most pressing concerns / focus of treatment (e.g. anxiety symptoms, PTSD symptoms, functional impairment).

In addition to your clinical and functional assessment, you will want to identify risk factors, problematic (maladaptive coping) and helpful (adaptive coping) behaviors, social supports and/or opportunities for community engagement/behavioral activation, as well as Veteran attitudes and preferences that may inform treatment planning. This information will allow you to begin to formulate a basic conceptualization of the Veteran's problems, coping styles (successful and unsuccessful) and treatment options. These initial case formulations should pay close attention to the cognitive and behavioral elements that contribute to or mitigate the Veterans presenting symptoms. This information will be important for future treatment decisions such as brief CBT module use.

Ultimately, information collected during the assess phase should be used to guide clinical decision-making about whether bCBT for depression is a preferred initial treatment option to address the Veteran's most pressing concerns.

Content to Be Covered

- A. Discuss confidentiality (some patient information may trigger a required release of information –e.g., suicidal or homicidal thoughts, child or elder abuse).
- B. Conduct a functional assessment per standard clinic procedures, including the following elements:
 - Assess the Veteran's most pressing concerns.
 - Assess depressive symptoms using the PHQ-9.
 - Conduct a risk assessment.
 - Administer any additional screeners and/or symptom measurements as determined by you or your clinic that may apply to the Veteran's most pressing concerns / focus of treatment (e.g. Anxiety, PTSD, Functional / Social).
- C. Determine if bCBT for Depression may be an appropriate treatment recommendation given the Veteran's functional assessment and attitudes/treatment preferences
 - Gain a sense of the Veteran's needs and motivation to participate in bCBT
 - Identify potential problems that could be addressed in a 3 to 6-week individualized treatment sessions. Develop an initial, brief synopsis of symptoms that are most distressing or impairing to the Veteran (e.g., low mood, anxiety, grief, lonely, unemployed, recent discharge from service).

2. Advise

Summary: Discuss additional treatment options with the Veteran to ensure the Veteran is able to make a fully informed and committed decision for their depression care.

Additional treatment options may include: other psychotherapy approaches within primary care, referral for a depression medication evaluation, referral to a general or specialty mental health clinic outside of primary care, and watchful waiting within primary care.

When discussing brief CBT as an option, the clinician should provide a rationale about why bCBT is well-suited to address the Veteran's presenting concerns, integrating information from the functional assessment and the PHQ9. This conversation will segue into the Agree phase. Providing tailored information about bCBT should help the Veteran make an informed choice about his/her care. This is also a great time to elicit the Veteran's motivation for treatment and provide an installation of hope.

Content to Be Covered

- A. Calculate total score of the PHQ-9.
- B. Review PHQ-9 results with Veteran. Follow-up with Veteran regarding any suicidal/homicidal ideation, conduct a risk assessment and safety planning (as needed), and/or provide elevated care or referrals as needed (discontinue assessment for brief CBT).
- C. Engage in a collaborative discussion with the Veteran about available treatment options (e.g., bCBT, other psychotherapies, pharmacotherapy, watchful waiting/case management).
 - Provide a tailored treatment rationale for brief CBT and elicit Veteran's motivation.
- D. Briefly introduce bCBT, including how it is structured and its concepts in lay language, and introduce the four modules that go along with bCBT. Describe how brief CBT is well-suited to address the problems the Veteran reported during the Assess phase. Highlight the following:
 - This is a skills-based program to help the Veteran improve mood and well-being
 - Each session lasts approximately 30-45 minutes
 - The variety of skill modules available allow the Veteran to choose what will work most effectively for his/her needs
 - Treatment involves an individualized plan of action and treatment success requires the Veteran's active engagement in treatment and between session exercise
 - We generally recommend Veterans engage in 6 sessions, however, the clinician and Veteran will decide together how many sessions are best for him/her
 - If needed, sessions can be conducted by telephone

3. Agree

Summary: During this phase, the goal is for the Veteran and Clinician to agree on the treatment plan. Discussion should also aim at gaining agreement on what the specific intervention targets will be and what treatment will do to address those targets.

Content to Be Covered

- A. Collaboratively, agree to pursue brief CBT. If Veteran is interested in pharmacotherapy, arrange for Veteran to be evaluated by a prescribing provider.
- B. Discuss/explore the Veteran's motivation and/or challenges for treatment.

4. Assist

Summary: This is the action phase of the appointment; time is spent providing education and can include identifying/addressing facilitators and barriers to treatment. Providing the Veteran with the brief CBT patient workbook and introducing core concepts during Session 0 is recommended as a means of engaging the Veteran in treatment and reducing the amount of content that is covered with the Veteran during Session 1.

Content to Be Covered

- A. Review what the Veteran can expect, and what is expected of the Veteran to maximally benefit from treatment. Look to identify potential barriers to the Veteran's participation and plan for how to address those barriers (e.g. option for conducting sessions by telephone). Veteran's responsibilities/expectations include:
 - Being an active participant during and outside of treatment sessions.
 - Keeping scheduled appointments to help maintain momentum (discuss scheduling and/or cancelation procedures).
 - After learning skills during each session, we will create an action plan for you to put them into practice.
 - Putting these skills to use in your daily life is key to improving your mood and well-being.
- B. Introduce and provide a copy of the brief CBT patient workbook to the Veteran.

5. Arrange

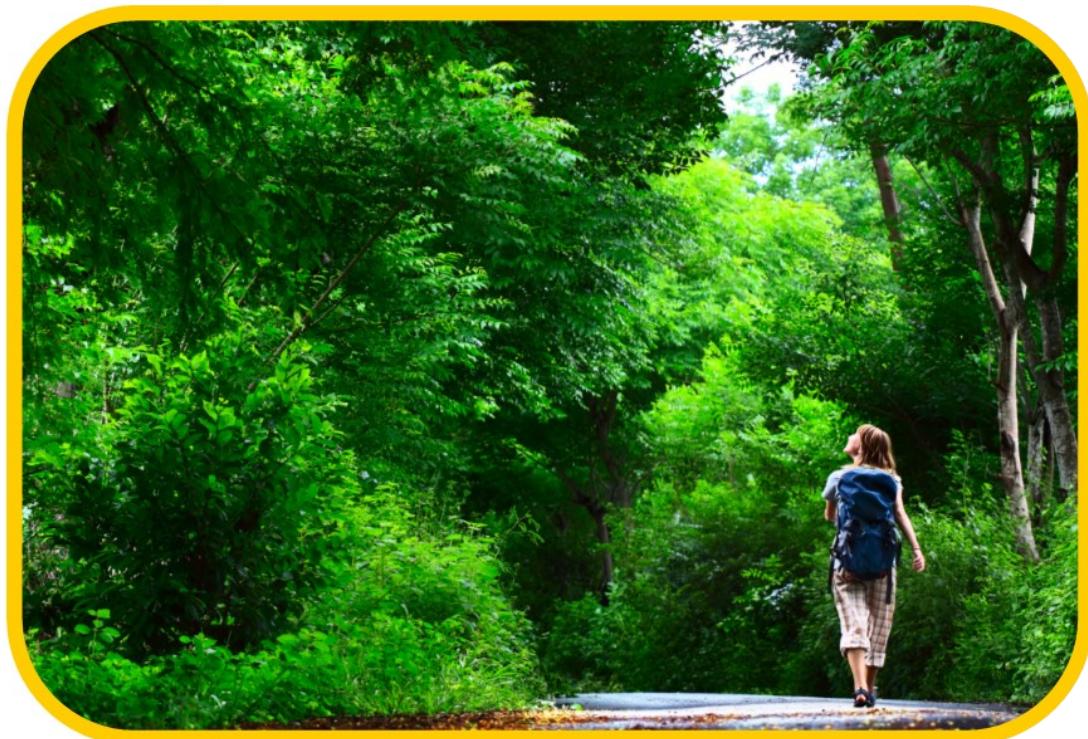
Summary: This phase includes making plans for follow-up (scheduled appts., referrals, other elements of the treatment plan such as at-home assignments, and why they are important). Additionally, the Clinician should summarize what was covered during Session 0 as it will provide a foundation to build on in Session 1.

Content to Be Covered

- A. Briefly summarize what was discussed during Session 0 and review plan for the Veteran to receive around 6 sessions of bCBT, meeting once weekly.
- B. Identify a return to clinic date and time for Session 1.

Getting Started:

Session 1



Provider Manual

Session checklist:

Session Roadmap and Check-in

1. Provide information about the program—how we intend to help.
2. Establish a session roadmap (agenda) with the patient.
3. Complete a mood “check-in,” using the PHQ-9.

Identifying Areas to Improve mood and well-being

4. Discuss the patient’s goals related to mood and well-being.
5. Discuss interaction of thoughts and behaviors in relationship to mood, and provide rationale for self-management.
6. Introduce Dave and how he identified goals to improve his mood and well-being.
7. Introduce goal-setting, using the SMART framework.
8. Develop an action plan for next session.
9. Briefly introduce skill modules, and select a module for next session. Areas include: Engaging in Activities to Improve Mood; Managing Unhelpful Thoughts; Using Relaxation Skills to Manage Stress and Tension; and Improving Health and Wellness.

Provider Manual Key:

Refers to workbook page

Provider Tips

1. Provide information about the program—how we intend to help.

- A. Discuss confidentiality (some patient information may trigger a required release of information – e.g., suicidal or homicidal thoughts, child or elder abuse).
- B. Introduce the purpose and rationale for the intervention.
 - Instill hope.
 - Empower individuals and learn skills to self-manage.
- C. Discuss the patient workbook.
 - Give patient the workbook. Explain purpose and expected use (e.g., resource for between sessions, workbook exercises, telephone sessions).
- D. Summarize overview highlights (convey to patient in summary fashion):
 - This is a skills-based program to help you improve your mood and well-being.
 - The variety of skill modules allows you to choose what will work most effectively for your individual needs.
 - It involves an individualized plan of action.
 - We recommend completing at least six sessions, but you and I will work together to decide how many sessions will be best for you.
 - Each session will last approximately 30-45 minutes.
 - Telephone meetings are an option. You can decide whether you prefer to have any or all remaining sessions by telephone.
- E. Discuss patient responsibilities/expectations.
 - Being an active participant during and outside sessions is important.
 - Keeping your scheduled appointments will help you maintain momentum (discuss scheduling and/or cancelation procedures).
 - After learning the skills during the session, we will create an action plan for you to put them into practice.
 - Putting these skills to use in your daily life is key to improving your mood and well-being.

2. Establish the roadmap (set the agenda).

Refer to workbook, page A3, "What to Expect in this Session."

Review the session roadmap with the patient (in the patient workbook).

What to Expect in this Session

Session Roadmap

- 1. We will discuss a treatment overview and how we intend to help.
- 2. We will set an agenda for the session.
- 3. How are you doing? We will complete a quick mood “check-in.”

Getting Started

- 4. We will identify areas of your life that you want to improve.
- 5. We will talk about how your mood relates to what you think and do, and explore ways to help.
- 6. We will introduce Dave, who will be used as an example throughout our workbooks.
- 7. We will introduce the concept of SMART goals.
- 8. We will develop an action plan to help you meet your goals.
- 9. We will review the skill menu and select a skill for next session.



A3

3. Complete a Mood Check-in (Administer the PHQ-9).

Refer to workbook, page A4, "Rate Your Mood."

A. Administer the PHQ-9 and review the responses.

- Record the responses in the CPRS note template

B. Provide feedback to the patient about his/her depression status.

- PHQ-9 Scoring:

0-4 = minimal depression

5-9 = mild depression

10-14 = moderate depression

15-19 = moderately severe depression

20+ = severe depression

Rate your Mood				
Over the last 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several Days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

Clinician Tips: Depression Assessment & Patient Feedback

- 1) Communicate depression results to your patients and encourage them to actively monitor their depression symptoms. Patient awareness is an important first step towards change.
- 2) Use thoughtful and effective language for communicating depression symptom feedback. Patients will benefit from accurate but encouraging feedback using language they can understand. For example, when communicating PHQ-9 results that fall in the moderately severe or severe range – you may wish to use the term *high* rather than *severe*.
- 3) Consider discussing treatment progress related to any changes in depression total score or specific depression items. Reinforcing positive change is important – change may occur in total score or specific depression symptoms, depending on the focus in the prior session(s).
- 4) Addressing negative change is often patient-specific. However, it should also be addressed with encouragement and continued practice, and by exploring treatment options both within and beyond bCBT.

4. Discuss the patient's goals related to mood and well-being.

Refer to workbook, page A5, "Improving your Well-being."

Identify areas for improvement.

- For patients who have difficulty answering these questions, you may have to help construct goals through informed questions.
- Identify one or two broad goals for the intervention.

The following worksheet lists different aspects of your life that we might be able to target as part of our work together. Place a check mark next to the items that you think would make a difference in your quality of life.

Emotional Health

- Improving self-image and self-esteem
- Increasing feelings of hopefulness about the future
- Increasing feelings of being useful and engaged in life
- Decreasing stress or tension
- Decreasing feelings of depression

Family, Social, and Spiritual Life

- Increasing involvement with family and friends
- Increasing social activities
- Becoming more active in hobbies
- Increasing spiritual or religious activities
- Improving your social support system

Physical Health

- Learning healthy habits to improve sleep
- Learning strategies to help manage pain
- Increasing healthy eating habits
- Increasing physical activity

Supportive Others (people & animals)

A5

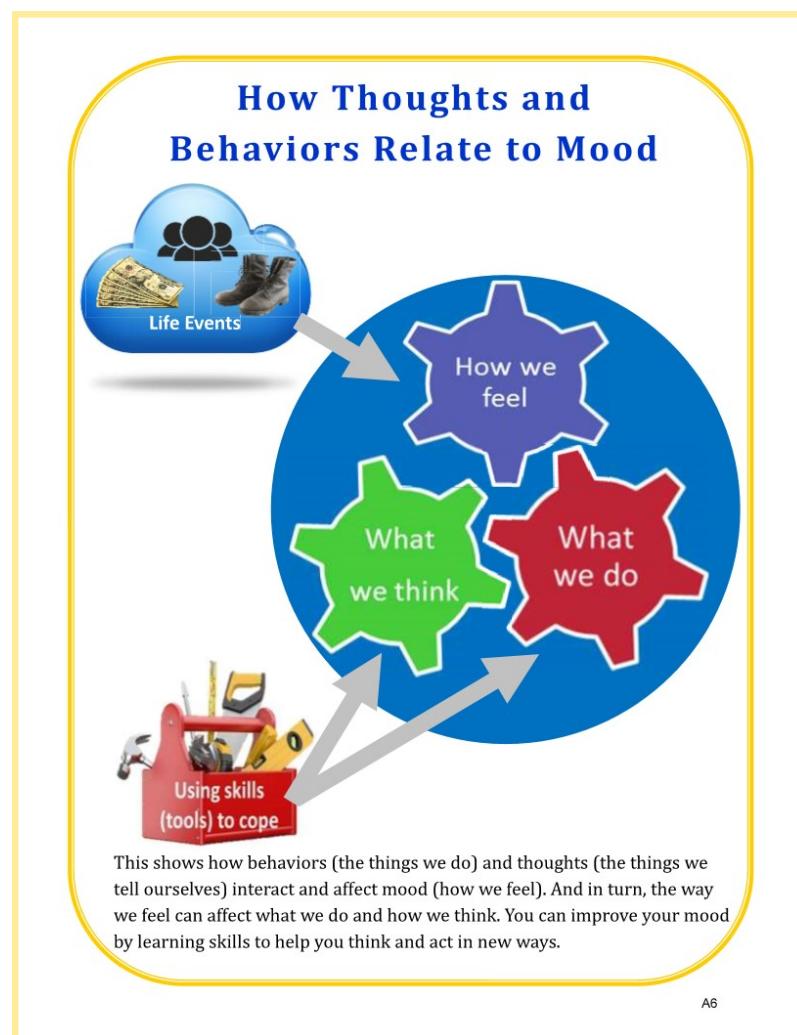
Clinician Tips: The Role of others in the intervention

- 1) Patients may isolate if they think no one understands what they are experiencing or that they should be able to deal with challenges on their own. Social isolation can present a major barrier to implementing effective goals/action plans that will help patients activate behaviorally.
- 2) We recommend clinicians support and encourage goals that a) reduce social isolation (i.e., make new connections or strengthen existing connections) and b) leverage the support that valued others can provide. *Note: Avoid setting goals that depend on the behavior of other people for success.

5. Discuss interaction of thoughts and behaviors in relation to mood, and provide rationale for self-management.

Refer to workbook, page A6, "How Thoughts and Behaviors Relate to Mood."

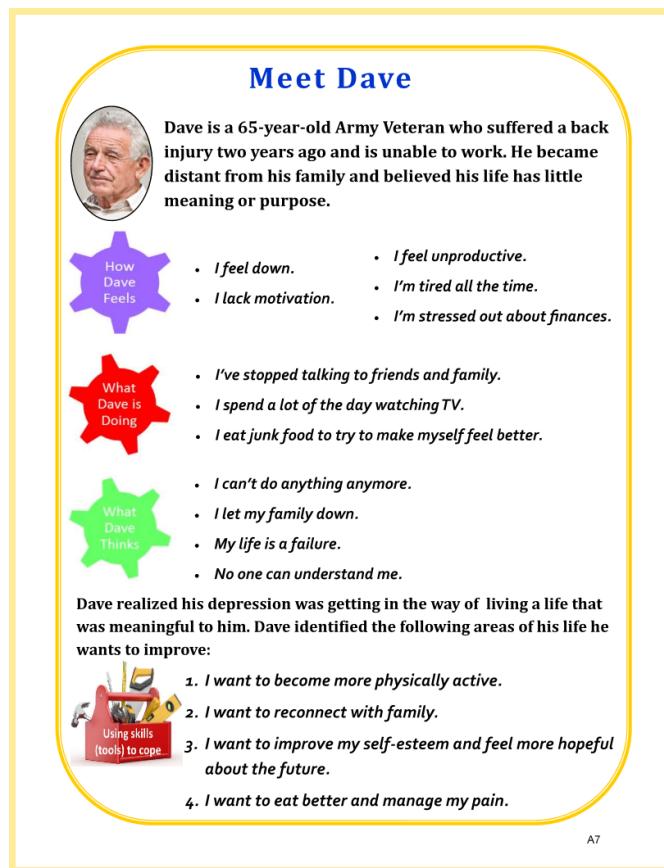
- A. Use the diagram to demonstrate how behaviors (the things we do) and thoughts (the things we tell ourselves) interact and affect emotions (how we feel). The way we feel in turn affects what we do and how we think.
- B. Provide examples of how the elements of the triad interact and impact one another (consider examples of both positive and negative cycles).
- C. Ask patient how they related to those examples and if there are time when their thoughts/feelings/behaviors interfere with living their life.
- D. Clarify the toolbox graphic—the skills learned in the intervention can be thought of as tools to self-manage thoughts and behavior, and thus feelings or mood.



6. Introduce Dave and how he identified goals to improve his mood/well-being.

Refer to workbook, page A7, “Meet Dave.”

Use the example of Dave to help explain the emotional, behavioral, and cognitive elements of his depression.



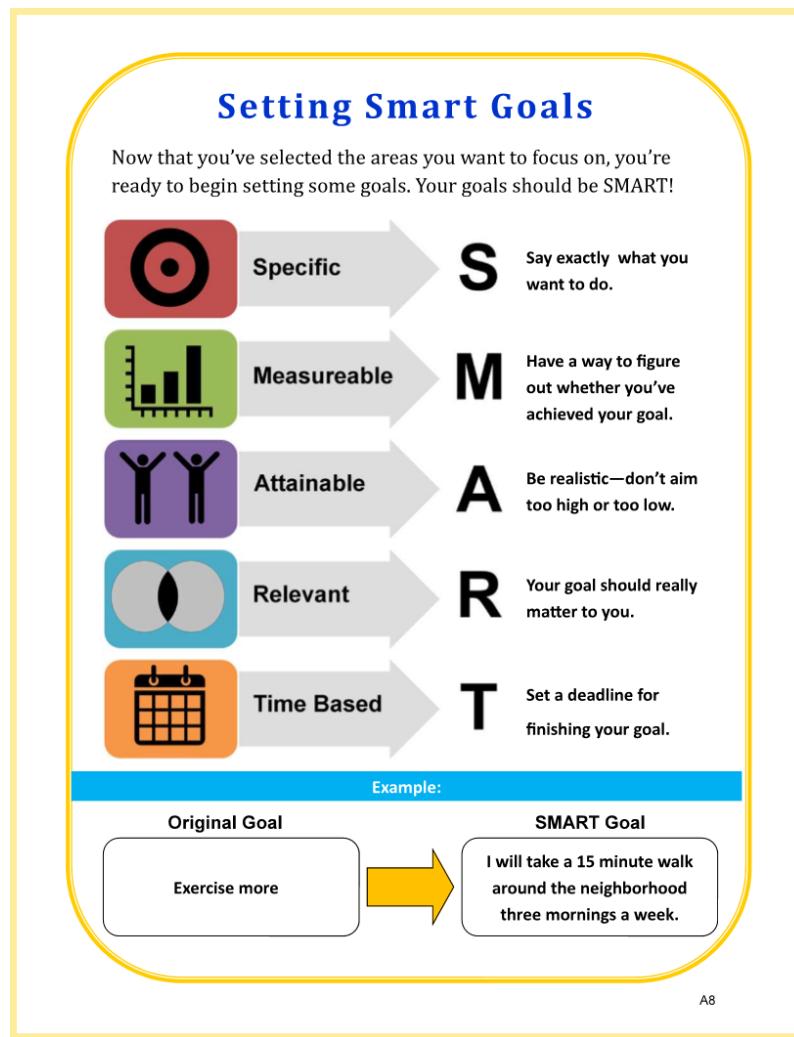
Clinician Tips: Using the case example of Dave

- 1) The case example of Dave will be included in each skill module, so this worksheet serves as the introduction to Dave and the initial application of the CBT framework. The “Meet Dave” worksheet provides a concrete illustration of the concepts introduced on page A6 — how thoughts and behaviors relate to mood.
- 2) If the patient is already knowledgeable and/or quickly understands these principles, you are encouraged to summarize the example rather than walking through the specifics.
- 3) The bottom section of the “Meet Dave” worksheet includes broad areas of Dave’s life he wants to improve. You can return to this example when introducing the SMART goals framework for goal-setting in section 7 of this module to illustrate how to translate broad goals into actionable SMART goals.

7. Introduce goal-setting using SMART framework.

Refer to workbook, page A8, "Setting SMART Goals."

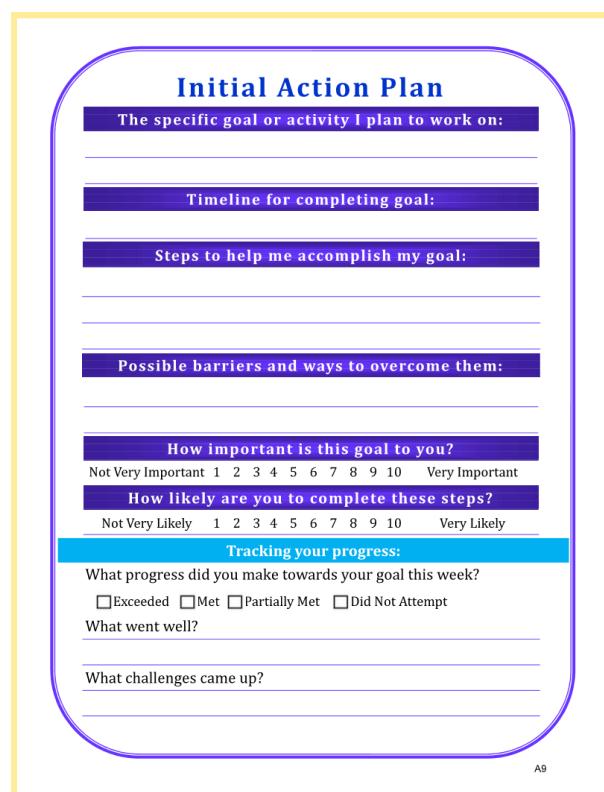
- A. Explain what SMART goals are and how defining goals in these terms increases likelihood of success.
- B. Use Dave's example (A7) to illustrate how to turn more broadly defined areas for improvement into SMART goals.
 - "Become more physically active" = take a 15 minute walk around the neighborhood three times this week
- C. Choose one of the patient's goals to begin working on. Use SMART goal criteria to specify the goal and to lead into action planning.



8. Develop an action plan for next session.

Refer to workbook page A9, “Initial Action Plan.”

- A. Define the term 'action plan' and explain how action plans relate to the patient's goals.
- B. Explain the basics of a successful action plan.
 - Guide the patient in selecting a simple behavior-specific goal
 - Help brainstorm possible ideas if the patient seems stuck.
 - Consider one or two examples of action plans that other bCBT patients have selected in the past (e.g., a first action plan for the goal of increasing social interaction might be to call a particular friend or family member).
- C. Complete the “Initial Action Plan” worksheet using the patient’s goal. Ensure the goal follows the SMART guidelines.
- D. Refer back to the initial action plan next session to review his/her progress. Use the lower half of the worksheet to facilitate a discussion about factors that facilitated or interfered with progress.



The image shows a worksheet titled "Initial Action Plan" designed for patients to fill out their goals and action plans. The form is divided into several sections:

- Initial Action Plan**
- The specific goal or activity I plan to work on:** (Handwritten area)
- Timeline for completing goal:** (Handwritten area)
- Steps to help me accomplish my goal:** (Handwritten area)
- Possible barriers and ways to overcome them:** (Handwritten area)
- How important is this goal to you?** (Scale from 1 to 10)
Not Very Important 1 2 3 4 5 6 7 8 9 10 Very Important
- How likely are you to complete these steps?** (Scale from 1 to 10)
Not Very Likely 1 2 3 4 5 6 7 8 9 10 Very Likely
- Tracking your progress:**
What progress did you make towards your goal this week?
 Exceeded Met Partially Met Did Not Attempt
What went well?

What challenges came up?

A9

9. Introduce skill modules and select module for next session.

Refer to workbook, page A10, "Skill Menu."

- A. Review the different modules with the patient.
- B. Select a module for the next session. Negotiate which module to start with, being sure to take into account the patient's preferences.
- C. Instill hope and encourage patient participation.
 - Ask the patient for feedback on his/her experience during the session and how he/she perceives the program.
 - Address any reservations or concerns the patient might have about you or the intervention.

Skill Menu

Work with your provider to select two to three skills that best meet your needs. Here is a list of the skill areas we offer:

Engaging in Activities to Improve Mood
This module focuses on increasing the number of enjoyable or meaningful activities you engage in, as well as reconnecting with the important people in your life. These exercises will help you to feel better about yourself by becoming more active in the things you like to do.



Managing Unhelpful Thoughts
This module was designed to change the way you think about stressful situations. These exercises help you to challenge negative or pessimistic thinking and learn to use more practical and balanced thinking strategies.



Using Relaxation Skills to Manage Stress and Tension
This module teaches you to use skills such as deep breathing and imagery to relax yourself physically and mentally. These skills are particularly helpful for individuals who experience stress or tension.



Improving Health and Wellness
This module introduces skills to help improve areas such as physical activity, eating habits, sleep, and pain. Special attention will be given to when you should contact a medical provider.



- D. Wrap up and schedule the next session

Engaging in Activities to Improve Mood



Provider Manual

Session checklist:

Session Roadmap and Check-in

1. Establish a session roadmap (agenda) with the patient
2. Complete a mood “check-in” using the PHQ-9
3. Review the previous session’s assignment and any other ongoing skills being used by the patient

Developing New Skills – Engaging in Activities

4. Briefly review the connection between activity and mood.
5. Explore how Dave used the Engaging in Activities session to become more active.
6. Identify how patient’s current activities relate to their mood.
7. Help the patient identify the activities they would like to engage in more regularly.
8. Develop an action plan for next session.

Provider Manual Key:

Refers to workbook page

Provider Tips

Session Roadmap & Check-in

1. Establish the roadmap (set the agenda).

Refer to workbook, page B3, "What to Expect in this Session."

Review the session roadmap with the patient (in the patient workbook).

What to Expect in this Session

Session Roadmap

1. We will set an agenda for the session.
2. How are you doing? We will complete a quick mood "check-in."
3. We will review the previous session's assignment and any other skills you are using.

Developing New Skills – Engaging in Activities

4. We will discuss how what we do impacts our mood.
5. We will look at how Dave uses the Engaging in Activities session to become more active.
6. We will see how your current activities relate to your mood.
7. We will identify activities you want to engage in more regularly.
8. We will develop an action plan to help you meet your goals.



B3

2. Complete a Mood Check-in (Administer the PHQ-9).

Refer to workbook, page B4, "Rate Your Mood."

- A. Administer the PHQ-9 and review the responses.
 - Record the responses in the CPRS note template

- B. Provide feedback to the patient about his/her depression status.

- PHQ-9 Scoring:

0-4 = minimal depression

5-9 = mild depression

10-14 = moderate depression

15-19 = moderately severe depression

20+ = severe depression

- C. For patients entering their third treatment session or later—explore and discuss patient treatment response, where appropriate.

- Measurement-based treatment response definition: PHQ-9 Total score below 10 **OR** 50% reduction in symptoms.

Rate your Mood				
Over the last 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several Days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

B4

Clinician Tips: Depression Assessment & Patient Feedback

- 1) Communicate depression results to your patients and encourage them to actively monitor their depression symptoms. Patient awareness is an important first step towards change.
- 2) Use thoughtful and effective language for communicating depression symptom feedback. Patients will benefit from accurate but encouraging feedback using language they can understand. For example, when communicating PHQ-9 results that fall in the moderately severe or severe range – you may wish to use the term *high* rather than *severe*.
- 3) Consider discussing treatment progress related to any changes in depression total score or specific depression items. Reinforcing positive change is important – change may occur in total score or specific depression symptoms, depending on the focus in the prior session(s).
- 4) Addressing negative change is often patient-specific. However, it should also be addressed with encouragement and continued practice, and by exploring treatment options both within and beyond bCBT.

3. Review previous session's home practice goal and action plan.

Refer to their prior week's action plan sheet

A. ACTION PLAN—NEXT STEPS

- Discuss the prior week's action plan with the patient. For example – ask about progress towards the goal (exceeded, met, partially met, did not attempt). Explore what went well and any challenges.
- Re-evaluate goal moving forward (continue, modify, discontinue)

B. ACTION PLAN—OTHER SKILLS

- Revisit any other skills (e.g. prior action plans) being used by the patient. Briefly review these skills and how they are being used. Problem-solve where appropriate and support continued skill use.

Prior week's action plan (front)

The front page of the Action Plan worksheet. It features a large central area for writing. At the top, there are four horizontal blue boxes with white text: "Action Plan", "The specific goal or activity I plan to work on:", "Timeline for completing goal:", and "Steps to help me accomplish my goal:". Below these are three more blue boxes: "Possible barriers and ways to overcome them:", "How important is this goal to you?", and "How likely are you to complete these steps?". The "How important" scale ranges from "Not Very Important" (1) to "Very Important" (10). The "How likely" scale ranges from "Not Very Likely" (1) to "Very Likely" (10). At the bottom, there is a section for "Tracking your progress:" with a scale from "Exceeded" to "Did Not Attempt", and space for notes on "What went well?" and "What challenges came up?". The page number "9" is at the bottom right.

Prior week's action plan (back)

The back page of the Action Plan worksheet. It has a large central area for writing. At the top, there are two horizontal blue boxes: "Action Plan" and "Next Steps". The "Next Steps" section contains three options: "Continue" (keep doing what you are doing), "Modify" (change your plan to better meet your needs), and "Use a different skill" (use a different skill that better meets your needs). Below this is a section titled "Next Steps—Notes" with a blank lined area. In the center, there is a blue box titled "Other Skills" with a list of questions: "Questions to think about: • What other skills are you using? • Are these skills working for you? • Do you see any changes needed for these skills?". At the bottom, there is a section titled "Next Steps—Plans to use these skills" with a blank lined area. The page number "10" is at the bottom right.

Clinician Tips: Homework / Action Plan Progress

- 1) The main reason for reviewing action plan progress is to encourage and help the patient problem solve to use skills more effectively. Get creative and follow the interests of the patient in making skills work and modifying skills for future use.
- 2) For patients who are able to easily acquire a specific skill (e.g. accomplish a goal) – consider exploring additional uses or broader applications of the skill. For example, using a relaxation strategy for pain management or sleep – or using a cognitive strategy for a new area in the patient's life.
- 3) For patients who are struggling to complete an action plan – consider reviewing the initial goal and the patient's interest in the goal. Modifications might involve breaking the action plan down into more manageable steps or changing to a new skill.

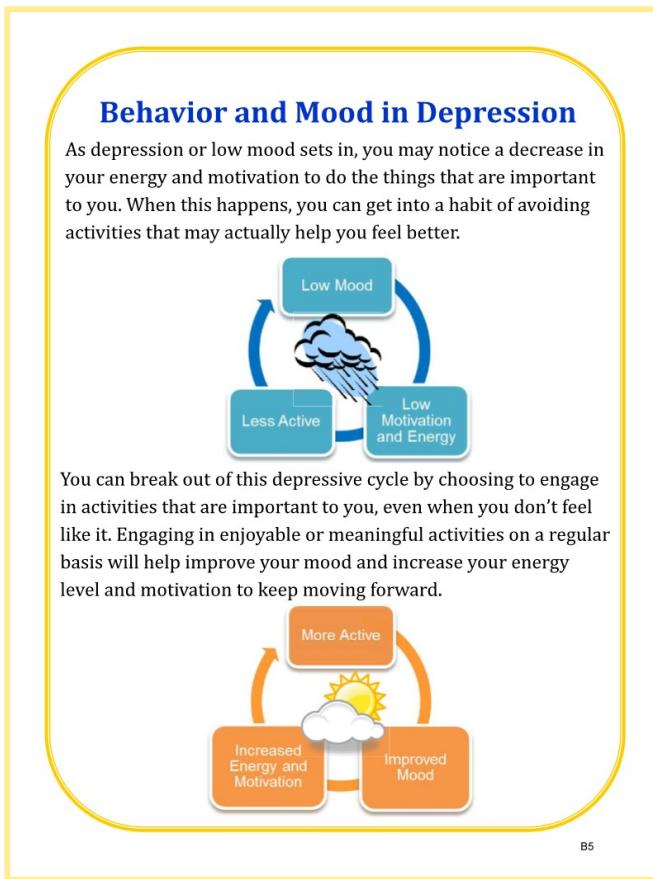
Developing New Skills

4. Review the connection between activity and mood.

Refer to workbook, page B5, “Behavior and Mood in Depression.”

Explain the rationale for becoming more active to improve mood.

- Provide psychoeducation on positive and negative cycles of mood and behavior.
- Discuss how mood can be improved by reincorporating rewarding activities that patient has disengaged from.
- Emphasize how taking action, despite feeling sad, tired, or unmotivated can improve mood and energy levels.



5. Explore how Dave used the session to become more active.

Refer to workbook, page B6, "Dave's Activities."

Use the example of Dave to help explain how increasing activities can improve mood.

Dave's Activities



How Dave Feels

- I feel down.
- I'm ashamed that I'm unproductive.
- I feel alone.
- I feel stressed out about finances.
- I lack motivation.



What Dave is Doing

- I spend a lot of the day in bed or watching TV.
- I avoid social activities and talking with friends and family.
- I stopped going to church.
- I stopped taking care of things around my home.

Dave's Desired Activities:



- Reconnect with friends and family
- Go to church regularly
- Get my house in order

Dave's SMART Goals:

This week, Dave set two goals to increase the frequency of activities he is already doing:

1. Play with dog for 10 minutes five days a week.
2. Take shower by 10 AM three days this week.

The following week, Dave added these new goals:

1. Do a load of dishes on Tuesday.
2. Call my daughter on Thursday.
3. Go to church on Sunday with neighbor.

B6

Clinician Tips: Using the case example of Dave

- 1) Use the case example to educate the patient on how activities (behaviors) relate to mood. The clinician is encouraged to summarize the case example rather than walking through the specifics if the patient is already knowledgeable and/or quickly understands this connection.
- 2) The case of Dave includes a description of SMART goals. The patient is not expected to develop SMART goals at this time but rather later in the session. Dave's SMART goals are provided for example purposes only so the patient can see how to transform desired activities into an action plan.

6. Identify how patient's current activities relate to their mood.

Refer to workbook, page B7, "Record of Daily Activities and Mood."

Assist the patient in completing the worksheet.

- Focus on a recent day— identify fluctuations in mood and how these fluctuations might be connected with the patient's behavior.
- Pay particular attention to activities that lead to increased positive mood.

Record of Daily Activities and Mood

Complete the following form for a recent "typical day" (possibly yesterday) to see the connection between your current activity level and your mood. This will help you understand what activities may fit into your day and help your mood.

What were you doing?	How did you feel?	Why did you feel that way?
Morning Activities		
	<input checked="" type="checkbox"/> ☺ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻	
	<input checked="" type="checkbox"/> ☺ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻	
Afternoon Activities		
	<input checked="" type="checkbox"/> ☺ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻	
	<input checked="" type="checkbox"/> ☺ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻	
Evening Activities		
	<input checked="" type="checkbox"/> ☺ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻	
	<input checked="" type="checkbox"/> ☺ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻ <input type="checkbox"/> ☻	

B7

7. Identify activities the patient would like to engage in more regularly.

Refer to workbook, page B8, "Enjoyable and Meaningful Activities."

A. Distinguish between enjoyable and meaningful activities.

- Some patients may want to accomplish something rather than focus on doing something pleasant. Be sure to reinforce the patient for choosing something personally meaningful or pleasant.

Enjoyable and Meaningful Activities

Each person has his or her own ideas about activities that are important.

Doing what you like: Enjoyable activities

Some activities are fun, help you feel happier, and are more fulfilling.
Examples: Spending time with friends, going to a movie, or fishing.



Getting things done: Meaningful activities

Other activities may not be fun while you are doing them; but once you finish, you feel good about what you have just completed.
Examples: cleaning, exercising, or catching up on paperwork



Taking Action and Next Steps

Do current activities more often.
OR
Restart activities you did in the past.
OR
Try a new activity that interests you.

B8

Refer to workbook page B9, "Identifying Activities "

B. Discuss the 1) activities the patient would like to do but has not been able to do, and 2) activities he/she already does but would like to do more often, within the context of values or goals that are important to them.

- In the first table, help the patient to identify and write down some enjoyable or meaningful activities he/she currently does.
- In the second table, help the patient to identify activities he/she is currently not doing that he/she would like to do.

Identifying Activities

What enjoyable or meaningful activities are you doing currently?

Current Activities
1)
2)
3)



What other enjoyable or meaningful activities would you like to do that you are not doing now? Could you include a friend or family member?

Desired Activities
1)
2)
3)



B9

Clinician Tips: Identifying Activities

- 1) If necessary, use the Activity Cheat Sheet page B10 of the workbook to generate ideas. Suggest some activities on this list based on what you already know about the patient, and ask the patient which ones look appealing to him/her.
- 2) You may want to ask if there is something that he/she needs to do, has been unable to do, or is avoiding.
- 3) Don't worry at this point about whether the patient thinks he or she can do the activity. For now, just try to create a master list of activities that might provide increased reinforcement and enjoyment.

8. Develop an action plan for next session.

Refer to workbook, page B11, "Action Plan"

- A. Help the patient select one or more activities to engage in to improve their mood.
Formulate an realistic action plan for completing the activity.
- Remind the patient to define their goal in terms of SMART guidelines.
 - Encourage the patient to monitor their progress implementing the action plan (see "tracking progress" section at the bottom of the page).

Action Plan									
The specific goal or activity I plan to work on:									
Timeline for completing goal:									
Steps to help me accomplish my goal:									
Possible barriers and ways to overcome them:									
How important is this goal to you?									
Not Very Important 1 2 3 4 5 6 7 8 9 10 Very Important									
How likely are you to complete these steps?									
Not Very Likely 1 2 3 4 5 6 7 8 9 10 Very Likely									
Tracking your progress:									
What progress did you make towards your goal this week? <input type="checkbox"/> Exceeded <input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Did Not Attempt									
What went well?									
What challenges came up?									

B11

Refer to workbook, page B13, "Engaging in Activities Tip Sheet"

- B. Refer to the optional tip sheet for additional guidance and encouragement with this skill.
- Follow your action plan, not your mood.
 - Monitor your progress and problem-solve barriers.
 - Include others.
 - Be patient and acknowledge success.

Engaging in Activities Tip Sheet									
Follow your action plan, not your mood.									
Engaging in activities, even when you don't feel like it, will help improve your mood. You may be surprised to find yourself enjoying the activity once you get going. Use your action plan to help you stay on track in meeting your goals.									
Monitor your progress and problem-solve barriers.									
 Keeping track of your progress will help you know what's working and what you might need to change. Take note of any obstacles you run into in completing your action plan, and talk with others or problem-solve about how to overcome them. Stay positive and get creative.									
Include others.									
 Consider how you can include a friend or family member in your activities. They may be able to do the activity with you, or they may help hold you accountable and increase your motivation to follow through on your action plan.									
Be patient and acknowledge success.									
 Adding activities back into your life gets easier as it becomes part of your regular routine. Each step you take toward meeting your goals is important, so be sure to acknowledge your accomplishments! Early success can build your confidence and increase your motivation to keep moving forward.									

B13

Clinician Tip: Ensuring positive reinforcement for the first action plan.

Success with the first action plan will encourage the Veteran to continue engaging in enjoyable and meaningful activities. Work with the Veteran to identify one or two activities he/she is likely to complete and that are likely to result in an increase in mood. Activities that can be repeated throughout the week are ideal because they offer more opportunities for positive reinforcement.

Clinician Tips: Increasing the likelihood of success

- 1) Break activities down into smaller steps: Goals may need to be broken down into discrete steps to make an activity more manageable.
 - Example: Veteran sets a goal of planting a small vegetable garden.
 - Solution: Assist the Veteran by breaking down the overall goal into specific steps, such as selecting which vegetables to grow, planning the garden layout, purchasing plants and other materials, preparing the soil, etc.
- 2) Work around physical limitations: Physical disabilities may limit a Veteran's ability to participate in an activity in the way he/she did in the past. However, there are likely modifications that can be made to enable the Veteran to engage in the activity. Often functional limitations can be overcome with a focus on meaning and importance of elements related to a physical activity.
 - Example: Veteran previously found pleasure running but is now limited by a physical condition.
 - Potential solutions:
 - Modify the goal to make it more realistic. Perhaps the Veteran is able to walk shorter distances or for shorter periods of time or by taking breaks as needed.
 - The clinician may wish to explore the meaningful associated with running in the past. The Veteran may relate to physical rewards (e.g., felt good to be in shape, endorphins, etc.) but may also have enjoyed the camaraderie of running with others, waking up early to see the sunrise, or the dedication and training schedule required to run consistently. If physical limitations do not allow for the physical rewards of running, then the clinician may wish to explore activities associated with the other meaningful elements (e.g., activating to wake up early and enjoy the sunrise with a cup of coffee, finding a social activity to meet camaraderie needs, or helping the patient to find a challenging activity that requires dedication and planning).
- 3) Maximize the Veteran's control over activities: It is important to ensure that success of the action plan is dependent on the Veteran's actions, not the actions of someone else.
 - Example: Veteran sets a goal of going to a movie with a friend on Friday but has not already confirmed that the friend is available that day. Thus the successful completion of this goal is uncertain and largely dependent on the friend.
 - Potential solutions:
 - Encourage the Veteran to join an activity that is already scheduled.
 - Plan for a back-up option should the friend not be able to attend.
 - Modify the goal so the outcome is within the Veteran's control.

Clinician Tips: When to use the optional mood monitoring worksheets

1) Hourly Monitoring Activity/Mood (page B17)

- This detailed worksheet may be useful for Veterans who have difficulty making the connection between mood and activities using the in-session monitoring activity/mood worksheet.
- Some individuals may have difficulty remembering the activities they do each day and/or may not be aware of how much time they spend doing things like lying in bed, watching TV, or surfing the internet.
- This worksheet may also be useful in identifying specific times during the day when the Veteran experiences low mood. Knowing this information can help in developing targeted action plans to disrupt these periods of low mood.

**Monitoring Activity/Mood:
Hourly Monitoring Form**

Instructions: Choose 1 day and keep track of your activity and mood:

1. Write down what you were doing each hour
2. Rate how you were feeling each hour

time	What was I doing?	What was I feeling?
8:00am		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
9:00am		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10:00am		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
11:00am		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
12:00pm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
1:00pm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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3:00pm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4:00pm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
5:00pm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
6:00pm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
7:00pm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
8:00pm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
9:00pm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10:00pm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

B17

2) Daily Monitoring Activity/Mood (page B15)

- This worksheet is meant to supplement the “Tracking your progress” section of the Action Plan and can help reinforce the connection between activity and mood.
- It is best suited to track activities that will be repeated throughout the week (e.g., read for 20 minutes every day, take a shower by 10am three days this week, etc.).

**Monitoring Activity/Mood:
Daily Monitoring Form**

List two activities you would like to accomplish this week:

1. _____ 2. _____

1) For each day, check the yes or no box in the Activity 1 and 2 columns to show whether you completed each activity.
2) Rate your mood at the end of the day.

	Activity 1	Activity 2	How was I feeling that day?			
Monday	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuesday	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wednesday	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thursday	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friday	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Saturday	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunday	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B15

Managing Unhelpful Thoughts



Provider Manual

Session checklist:

Session Roadmap and Check-in

1. Establish a session roadmap (agenda) with the patient
2. Complete a mood “check-in” using the PHQ-9
3. Review the previous session’s home practice goal and action plan.

Developing New Skills – Managing Unhelpful Thoughts

4. Briefly review the differences between feelings and thoughts.
5. Distinguish between unhelpful and helpful thinking patterns.
6. Explore how Dave used the Managing Unhelpful Thoughts session to address his unhelpful thought patterns.
7. Identify unhelpful thoughts that are causing distress for the patient.
8. Introduce skills to manage unhelpful thoughts: Coping statements
9. Introduce skills to manage unhelpful thoughts: Evaluating unhelpful thoughts {optional/advanced skill}
10. Develop an action plan for next session.

Provider Manual Key:

Refers to workbook
page

Provider Tips

Session Roadmap & Check-in

1. Establish the roadmap (set the agenda).

Refer to workbook, page C3, "What to Expect in this Session."

Review the session roadmap with the patient (in the patient workbook).

What to Expect in this Session

Session Roadmap

1. We will set an agenda for the session.
2. How are you doing? We will complete a quick mood “check-in.”
3. We will review the previous session’s assignment and any other skills you are using.

Developing New Skills – Managing Unhelpful Thoughts

4. We will review the differences between thoughts and feelings.
5. We will identify common types of unhelpful thoughts.
6. We will look at how Dave used the Managing Unhelpful Thoughts session to address his unhelpful thought patterns.
7. We will identify unhelpful thoughts that are causing you distress.
8. We will introduce coping statements to manage unhelpful thoughts.
9. We will discuss how to evaluate unhelpful thoughts (optional skill).
10. We will develop an action plan to help you meet your goals.



C3

2. Complete a Mood Check-in (Administer the PHQ-9).

Refer to workbook, page C4, “Rate Your Mood.”

- A. Administer the PHQ-9 and review the responses.
- Record the responses in the CPRS note template

- B. Provide feedback to the patient about his/her depression status.

- PHQ-9 Scoring:

0-4 = minimal depression

5-9 = mild depression

10-14 = moderate depression

15-19 = moderately severe depression

20+ = severe depression

- C. For patients entering their third treatment session or later—explore and discuss patient treatment response, where appropriate.

- Measurement-based treatment response definition: PHQ-9 Total score below 10 **OR** 50% reduction in symptoms.

Rate your Mood				
Over the last 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several Days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

C4

Clinician Tips: Depression Assessment & Patient Feedback

- 1) Communicate depression results to your patients and encourage them to actively monitor their depression symptoms. Patient awareness is an important first step towards change.
- 2) Use thoughtful and effective language for communicating depression symptom feedback. Patients will benefit from accurate but encouraging feedback using language they can understand. For example, when communicating PHQ-9 results that fall in the moderately severe or severe range – you may wish to use the term *high* rather than *severe*.
- 3) Consider discussing treatment progress related to any changes in depression total score or specific depression items. Reinforcing positive change is important – change may occur in total score or specific depression symptoms, depending on the focus in the prior session(s).
- 4) Addressing negative change is often patient-specific. However, it should also be addressed with encouragement and continued practice, and by exploring treatment options both within and beyond bCBT.

3. Review previous session's home practice goal and action plan.

Refer to their prior week's action plan sheet

A. ACTION PLAN—NEXT STEPS

- Discuss the prior week's action plan with the patient. For example – ask about progress towards the goal (exceeded, met, partially met, did not attempt). Explore what went well and any challenges.
- Re-evaluate goal moving forward (continue, modify, discontinue)

B. ACTION PLAN—OTHER SKILLS

- Revisit any other skills (e.g. prior action plans) being used by the patient. Briefly review these skills and how they are being used. Problem-solve where appropriate and support continued skill use.

Prior week's action plan (front)

The front page of the Action Plan worksheet. It features a large central area for writing. At the top, there are four horizontal blue bars with white text: "Action Plan", "The specific goal or activity I plan to work on:", "Timeline for completing goal:", and "Steps to help me accomplish my goal:". Below these are sections for "Possible barriers and ways to overcome them:", "How important is this goal to you?", and "How likely are you to complete these steps?". There are scales from 1 to 10 for both importance and likelihood. At the bottom, there are sections for "Tracking your progress:" (with a scale from 1 to 10), "What went well?", and "What challenges came up?". The page is numbered 9 at the bottom right.

Prior week's action plan (back)

The back page of the Action Plan worksheet. It features a large central area for writing. At the top, there are two horizontal blue bars: "Action Plan" and "Next Steps". Below these are three options for next steps: "Continue with your plan as is—keep doing what you are doing.", "Modify your plan to better meet your needs.", and "Use a different skill that better meets your needs.". There is a section for "Next Steps—Notes" with a line for writing. In the middle, there is a section titled "Other Skills" with a list of questions: "Questions to think about: • What other skills are you using? • Are these skills working for you? • Do you see any changes needed for these skills?". At the bottom, there is a section for "Next Steps—Plans to use these skills" with a line for writing. The page is numbered 10 at the bottom right.

Clinician Tips: Homework / Action Plan Progress

- 1) The main reason for reviewing action plan progress is to encourage and help the patient problem solve to use skills more effectively. Get creative and follow the interests of the patient in making skills work and modifying skills for future use.
- 2) For patients who are able to easily acquire a specific skill (e.g. accomplish a goal) – consider exploring additional uses or broader applications of the skill. For example, using a relaxation strategy for pain management or sleep – or using a cognitive strategy for a new area in the patient's life.
- 3) For patients who are struggling to complete an action plan – consider reviewing the initial goal and the patient's interest in the goal. Modifications might involve breaking the action plan down into more manageable steps or changing to a new skill.

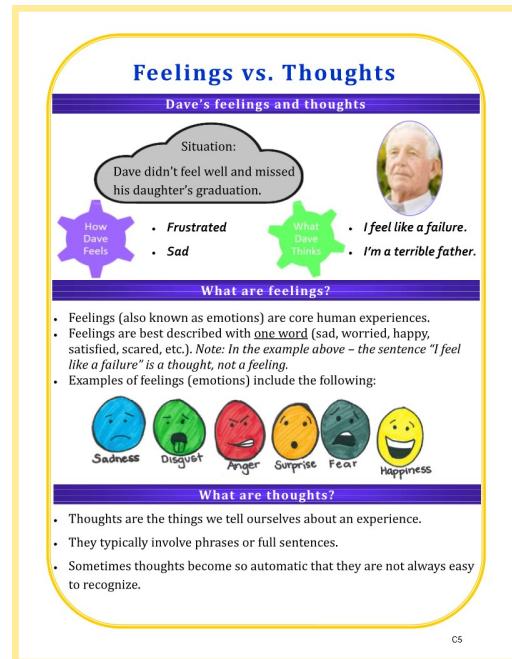
Developing New Skills

4. Review the differences between feelings and thoughts.

Refer to workbook, page C5, “Feelings vs. Thoughts.”

- A. Use the Feelings vs. Thoughts worksheet to examine how thoughts are related to mood or feelings.
 - Discuss the difference between thoughts and feelings.
 - These are distinct concepts, but many people use the words thoughts and feelings interchangeably as a way to indicate what they are experiencing.

- B. Emphasize that while feelings cannot be changed directly, it is possible to impact feelings indirectly by challenging negative thought patterns.
 - The key here is to understand that the way one interprets a situation directly relates to mood and overall quality of life. Taking control of thought patterns can improve how one feels.
 - Understanding thought patterns can help one identify ways of thinking that are and are not helpful.



Clinician Tips: Introduction to Managing Unhelpful Thoughts

- 1) Clinicians should remember that this section of the session is dedicated to establishing that thoughts and feelings are different – a critical step for future sections of this work. This section DOES NOT ask the clinician to help the patient identify unhelpful thinking – those steps will occur later in the session.

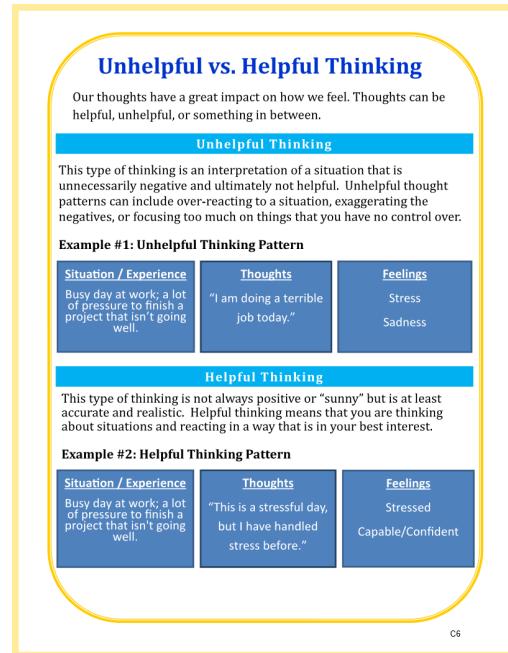
- 2) Feelings are core emotional experiences and are generally not the target of intervention techniques for CBT. Thoughts ARE challengeable – sometimes thoughts are accurate while other times thoughts can be overly negative, unhelpful, or even emotionally driven (rather than factually driven).

5. Distinguish between unhelpful and helpful thinking patterns.

Refer to workbook, page C6, "Unhelpful vs. Helpful Thinking."

A. Review the Unhelpful vs. Helpful Thinking worksheet with the patient.

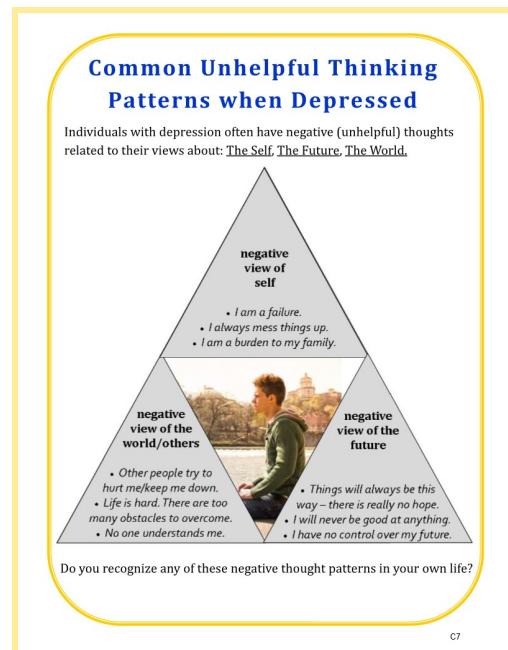
- Explain how reactions to a situation can be unhelpful or helpful and can influence feelings either negatively or positively.



Refer to workbook, page C7, "Common Unhelpful Thinking Patterns."

B. Review the Common Unhelpful Thinking Patterns worksheet with the patient, and identify the three types of negative thoughts that are commonly associated with depression.

- Ask the patient to identify examples of these negative thinking patterns in his/her own life.



Clinician Tips: Identifying common types of unhelpful thoughts

1) Your goal in this section is two-fold:

- a) to help the patient understand how unhelpful thinking patterns connect to situations and feelings through a series of examples, and
- b) to explore the concept of adaptive thinking and how changes to thought patterns can translate into improved outcomes (e.g., reduced stress, tension, depression, etc.).

Highlight the difference between the objective reality of the situation (e.g., busy day), and the subjective interpretation of the situation (e.g., thoughts like “I’ll never get everything done”/“this is more than I can handle”).

- 2) It is important to communicate that the goal of this work is not to create a “sunny” or overly positive way of thinking – rather it is to create a realistic and helpful way of thinking and to reduce the negative impact of unhelpful thoughts. In reviewing the example of helpful thinking on page C6, note that the feeling of stress remains, but new, adaptive feelings of confidence and determination emerge.
- 3) Remember that NOT all negative thoughts are unhelpful or maladaptive. A patient facing a chronic illness may have thoughts like “I do not want to be a burden on my family” or “I am likely to die in the next few years.” Neither of these thoughts is maladaptive without additional evidence. If the thoughts were “I am a burden on my family” or “I am a failure”– these thoughts hint towards a more distorted or overly negative interpretation that may in fact be maladaptive thought patterns.
- 4) Beck’s cognitive triad for depression is provided in this section to assist future work identifying unhelpful thinking patterns. Identification of unhelpful / maladaptive thoughts can be challenging and often takes multiple sessions to accomplish. Given the brief nature of this program, the clinician will be challenged to rapidly help the patient identify unhelpful thinking. The Beck model is provided here to structure and ground the patient’s thinking around possible subject areas where unhelpful thoughts may occur. Please avoid using this section in an overly “didactic” or “teaching” style; rather, you are encouraged to introduce these concepts in a way that facilitates the identification of unhelpful thought patterns. This may vary from patient to patient, depending on their level of psychological insight.

6. Explore how Dave used the session to address unhelpful thought patterns.

Refer to workbook, page C8, "Dave's Thought Worksheet."

Use the example of Dave to help explain how helpful thinking can be used to improve mood.

Dave's Thought Worksheet

First let's take a look at how Dave's unhelpful thoughts impacted his mood and behaviors. Then, notice how Dave used helpful thinking strategies to improve his mood.



Original thoughts	
Situation 	<i>Sitting at home watching TV during the middle of the day</i>
Thoughts 	<ul style="list-style-type: none"><i>I am truly useless now. (negative view of self)</i><i>This is pathetic - I am wasting my life away. (negative view of future)</i><i>There is no one helping me and it seems that no one cares. (negative view about others)</i>
Feelings 	<ul style="list-style-type: none"><i>Depressed</i><i>Mad / angry</i><i>Lethargic / without energy</i>
Behaviors 	<ul style="list-style-type: none"><i>Stay on the couch – no motivation to get going</i><i>Isolate from others</i>
New thoughts	
New / Alternative Thought 	<ul style="list-style-type: none"><i>Nothing is going to change until I make a change.</i><i>I will not stand by and waste my life. I insist on taking action.</i><i>My family is supportive, maybe they just don't know how to help.</i>
New Feelings 	<ul style="list-style-type: none"><i>Determined</i><i>Hopeful</i><i>Motivated</i>

C8

Clinician Tips: Using the case example of Dave

- 1) Use the Dave example to highlight the connection between what happens and how the patient reacts in terms of thoughts, feelings, and behaviors. Of most importance is to show that although Dave may not have control over his situation (e.g., pain and disability), he does have control over his thoughts and behaviors.
- 2) Alternative thoughts can be difficult to generate – it is not expected that the patient develop skills in creating more adaptive thoughts at this stage. Rather, the Dave example is simply showing where Dave “ends up” with his work. Try to refrain from spending too much time on the final column for this example.
- 3) It may be helpful to elicit questions or comments from the patient after you review the Dave example. Checking in with the patient may help you (the clinician) to more fully understand what the patient understands from this work and what they expect to get moving forward.

7. Identify unhelpful thoughts that are causing distress for the patient.

Refer to workbook, page C9, "Identifying Unhelpful Thoughts."

Review example table (situation/thoughts/feelings/behaviors/alternative thoughts)

- Ask patient to complete at least one example on their own. Where possible, have the patient complete two situations.
- The patient should only complete the first four rows of the table at this time. The focus here is simply on identifying unhelpful thoughts.
- Tell the patient to stop at the stop signs, and that you will return to the bottom two rows later in the session.

	Situation #1: Original thoughts	Situation #2:
Situation <i>What actually happened? Where? When? How?</i>		
Thoughts <i>What was going through your mind? What views did you have about yourself, your future, or others?</i>		
Feelings <i>What emotions did you feel at the time?</i>		
Behaviors <i>What did you do in response? Also include any withdrawal of activities - like staying at home or staying in bed.</i>		
New thoughts		STOP
New/Alternative thoughts <i>What is another, more helpful way to think about this situation?</i>		STOP
New Feelings <i>What emotions did you feel after identifying alternative thoughts</i>		

Clinician Tips: Identifying unhelpful thoughts.

- Identifying unhelpful thinking patterns can be challenging since not all negative thoughts are maladaptive. Maladaptive thoughts are interpretations of situations or experiences that are exaggerated or inaccurate.
- Clinicians may need to revisit this section, given the psychological insight required to distinguish between thoughts / feelings and the complexity of identifying unhelpful thinking patterns. It may be helpful to explore different situations where the patient is experiencing difficulties. Linking the thought patterns between disparate situations will give the clinician a broader perspective on the patient's unhelpful thinking patterns.

Strategies to help patients identify unhelpful thoughts when:

- The patient has a hard time verbalizing thoughts: You might try starting with the emotion, and then work back to the thought: "What might have been going through your mind to make you feel that way?" Or start with the situation, and ask: "What went through your mind right after that happened?"
- The patient provides more surface-level, superficial thoughts: Try asking "If that were true, what would that mean to you?" "What would be the worst part about that for you?"
- The patient phrases automatic thoughts as questions (e.g., "Will I be able to cope?"): They are more challengeable if you transform them into the statement underneath (e.g., "I won't be able to cope").
- The patient gives you part of the automatic thought (e.g., "I thought, 'oh, no!'"): Ask: "And then what might happen?" or "What are you worried might happen?"
- You're not able to identify a challengeable automatic thought right away: Try asking some probing questions to understand the meaning of what the patient is saying to you. It's OK to not know exactly what the challengeable thought is right away.

8. Introduce skills to manage unhelpful thoughts: coping statements.

Refer to workbook, page C10, "Using Coping Statements to Manage Thoughts."

A. Introduce Coping Self-Statements (including rationale).

- Provide example coping self-statements.

Using Coping Statements to Manage Unhelpful Thoughts

What are Coping Statements?

A coping statement is a statement you make to yourself to help decrease feelings of stress and depression. It is a way to provide "instructions" to yourself to reduce how much negative thoughts get in the way.

Coping statements can serve as "alternative thoughts" when unhelpful thinking patterns are getting you down. Remember, coping statements are not "pie-in-the-sky" statements but, rather, should be statements that you actually believe to be true.

Example Coping Statements:

"I can do what I need to do."
"Even if I make mistakes, it will be okay."
"If I take it one step at a time, I can meet this challenge."
"I can take control of my stress by getting up and doing things."
"I choose to think positively and to remember the things I can still do."
"I am not going to let my pain limit my life."
"I have people in my life who care about me."
"I can ask for help when I need it."



C10

Refer to workbook, page C11, "My Coping Statements."

B. Work with the patient to identify coping statements he/she can use in a variety of stressful situations.

- Review tips for using coping statements.

My Coping Statements

Coping Statements I Can Use:

Stressful Situation	Coping Statement(s)
1.	
2.	
3.	

Tips for Using Coping Statements:



- Don't be afraid to talk to yourself! Say coping statements aloud to yourself instead of just reading them.
- It can sometimes be helpful to audio record the statements and listen to them when necessary.
- Place your coping statements where you will see them regularly (a note on your refrigerator, on your phone, etc.).

C11

Clinician Tip: Coping statements

Coping statements are introduced here as a quick way to begin to insert helpful thinking patterns. On the plus side they are easy to develop but on the downside they are often quite general and may not have the potency needed to address more entrenched unhelpful thinking patterns. For these more difficult patterns, clinicians are encouraged to use the advanced skill in this module.

9. Introduce skills to manage unhelpful thoughts: Evaluating unhelpful thoughts

Refer to workbook, page C15, "Evaluating Unhelpful Thoughts."

- A. Introduce the rationale for evaluating unhelpful thoughts. Describe how to examine the evidence for and against thoughts and how to use this information to identify new thoughts.

Evaluating Unhelpful Thoughts

You previously learned how to identify unhelpful thoughts and use coping statements to decrease stress and depression. However, it can also be useful to challenge these unhelpful thoughts in a more direct way.

How to Evaluate your Thoughts:

1. EXAMINE THE EVIDENCE

Think like a scientist—look for evidence for and against a specific thought to evaluate how realistic it is. Approach your thoughts as if they are scientific hypotheses (or guesses), rather than facts. Often, we focus on one explanation or interpretation of a situation, rather than looking at the whole picture and considering other possible interpretations. In depression, people tend to focus only on the negative aspects of a situation rather than examining all the evidence and taking a balanced perspective.

Inspect the evidence *for* the thought.

- What has happened to suggest the thought is true?

Inspect the evidence *against* the thought.

- What has happened to suggest the thought is not true?

TIP: Ask yourself these questions:

- Is this thought based on feelings or facts?
- Am I 100% certain this thought is true? If not, why not?
- Is there another possible explanation or interpretation of the situation?

2. IDENTIFY ALTERNATIVE THOUGHTS.

The next step is to come up with an alternative, more balanced way of thinking about the situation. Remember, we tend to assume that the first thought that comes into our head is the “truth,” so it’s important to open your mind to ALL other possibilities. One way to generate alternative thoughts is to ask yourself, *What would I tell someone I loved if he/she were in this situation and had these thoughts?*“

C15

Refer to workbook, page C16, "Evaluating Dave's Unhelpful Thoughts."

- B. Use the example of Dave to help explain how examining the evidence for and against a thought can provide a more realistic view of a situation and help identify new, more helpful thoughts.

Evaluating Dave's Unhelpful Thoughts

Let's take a look at how Dave used a scientific approach to evaluate his unhelpful thoughts in a more direct way.

Original Thoughts

Situation What actually happened? Where? When? How?	My friend cancelled on me at the last minute.
Thoughts What thoughts went through your mind? What views did you have about yourself, your future, or others?	<ul style="list-style-type: none">• She must be sick of me.• I'm a failure at relationships — no one wants to spend time with me.
Feelings What emotions did you feel at the time?	<ul style="list-style-type: none">• Sad• Lonely• Worthless
Behaviors What did you do in response? Also include any withdrawal of activities — like staying at home or staying in bed.	<ul style="list-style-type: none">• Stayed at home by myself all day• Watched boring daytime TV

Evidence

Evidence to support the thought What has happened to make you believe this thought is true?	<ul style="list-style-type: none">• She cancelled our plans.
Evidence that does not support the thought What has happened to prove the thought is NOT true?	<ul style="list-style-type: none">• She said she had to care for her sick granddaughter.• We have spent a lot of good time together recently.

New Thoughts

New/alternative thought What is another, more helpful, way to think about this situation?	<ul style="list-style-type: none">• This time didn't work out to get together, but we can make plans in the near future.
New feelings What emotions did you feel after identifying the new/balanced thought?	<ul style="list-style-type: none">• Helpful• Comforted

C16

Refer to workbook, page C17, "Evaluating My Unhelpful Thoughts."

- C. Work with the patient to identify 1 or 2 unhelpful thoughts, then evaluate the evidence for and against each thought and generate a new, more helpful thought.

Evaluating My Unhelpful Thoughts		
	Situation #1: Original Thoughts	Situation #2:
Situation <i>What actually happened? Where? When? How?</i>		
Thoughts <i>What did your thoughts go through your mind? What views did you have about yourself, your future, or others?</i>		
Feelings <i>What emotions did you feel at the time?</i>		
Behaviors <i>What did you do in response? Also include any withdrawal of activities – like staying at home or staying in bed.</i>		
Evidence		
Evidence to support the thought <i>What has happened to make you believe this thought is true?</i>		
Evidence that does not support the thought <i>What has happened to prove the thought is NOT true?</i>		
New Thoughts		
New/alternative thought <i>What is another, more helpful, way to think about this situation?</i>		
New feelings <i>What emotions did you feel after identifying the new/balanced thought?</i>		

C17

Clinician Tips: Evaluating unhelpful thoughts

- 1) Emphasize to the patient that thoughts should be treated as merely thoughts, not facts. Examining the evidence for and against a thought allows the patient to take a step back from a thought and evaluate its validity from an objective standpoint. Because depressed patients tend to view situations in an overly negative fashion, evaluating the evidence for a thought will likely provide corrective information to suggest a more balanced interpretation.
- 2) Remind the patient that the goal of generating alternative thoughts is not to “turn a negative into a positive”, but rather to identify a thought that accurately reflects the evidence of the situation and is more helpful in moving the patient toward his/her goals.
- 3) This can be a difficult skill for patients to grasp, so be sure to walk through multiple examples until the patient shows good understanding of the process. Remind the patient that the skill will become easier with practice, and that over time the patient will learn to evaluate his/her thoughts more quickly and easily as the process becomes second nature.

Strategies to overcome common obstacles in evaluating unhelpful thoughts:

- The patient generates a thought that may or may not be true, with no way to know: (e.g., “I probably won’t get this job I applied for”). Don’t try to convince the patient that the thought is necessarily *inaccurate* (e.g., they will definitely get the job), but that the thought is *unhelpful* because the outcome is uncertain and buying into the thought could lead to problematic behaviors (e.g., less confidence and motivation in the job interview).
- The patient generates a thought that is actually true: (e.g., “I should not have said that rude thing to my wife when I was angry.”). A true thought is not challengeable. You can often generate a challengeable thought by asking “What does it mean about you that you said that rude thing?” to elicit the patient’s beliefs that they must be an awful person to have said such a thing (a more challengeable thought).

10. Develop an action plan for next session.

Refer to workbook, page C19, "Action Plan."

Help the patient select one or more activities to engage in to improve their mood. Formulate an realistic action plan for completing the activity.

- Remind the patient to define their goal in terms of SMART guidelines.
- Encourage the patient to monitor their progress implementing the action plan (see “tracking progress” section at the bottom of the page).

The Action Plan worksheet consists of several sections:

- Action Plan**: The specific goal or activity I plan to work on:
- Timeline for completing goal:** (A blank line for writing a timeline.)
- Steps to help me accomplish my goal:** (A blank area for listing steps.)
- Possible barriers and ways to overcome them:** (A blank area for listing barriers and solutions.)
- How important is this goal to you?** (A scale from Not Very Important to Very Important with numbers 1 through 10 in between.)
- How likely are you to complete these steps?** (A scale from Not Very Likely to Very Likely with numbers 1 through 10 in between.)
- Tracking your progress:** (A section for tracking weekly progress with options: Exceeded, Met, Partially Met, Did Not Attempt.)
- What went well?** (A blank line for noting successes.)
- What challenges came up?** (A blank line for noting challenges.)

Clinician Tips:

- 1) **Ensuring positive reinforcement for the first action plan:** Success with the first action plan will encourage the Veteran to continue using relaxation skills. Make sure that they initially develop a plan that is focused on practicing these skills *outside* of stressful situations. Later action plans can focus on application after they have acquired experience with the techniques.
- 2) **Action plans for coping statements:** An action plan for this skill may target unhelpful thinking patterns and substitutes with coping statements for those unhelpful thoughts in the patient’s daily life.
- 3) **Clinician Tip: Action plans for evaluating unhelpful thoughts:** Action plans for this skill typically involve asking the patient to complete a specific number of *Evaluating My Unhelpful Thoughts* worksheets over a specific period of time.

Using Relaxation Skills to Manage Stress & Tension



Provider Manual

Session checklist:

Session Roadmap and Check-in

1. Establish a session roadmap (agenda) with the patient.
2. Complete a mood “check-in,” using the PHQ-9.
3. Review the previous session’s home practice goal and action plan.

Developing New Skills – Reducing Stress and Tension

4. Introduce using relaxation and how it applies to the patient.
5. Explore how Dave uses relaxation skills to address his needs.
6. Review information and skills related to the selected skill and practice the skill in session.
7. Develop an action plan for next session.

Provider Manual Key:

Refers to workbook
page

Provider Tips

Session Roadmap & Check-in

1. Establish the roadmap (set the agenda).

Refer to workbook, page D3, "What to Expect in this Session."

Review the session roadmap with the patient (in the patient workbook).

What to Expect in this Session

Session Roadmap

1. We will set an agenda for the session.
2. How are you doing? We will complete a quick mood “check-in.”
3. We will review the previous session’s assignment and any other ongoing homework or skills you are using.

Developing New Skills – Using Relaxation Skills

4. We will discuss stress and tension and introduce two relaxation skills that can be applied in your life.
5. We will review how Dave used the relaxation skills session to address his stress and tension.
6. We will review information about the relaxation skill you choose and then practice the skill in session.
7. We will develop an action plan to help you meet your goals.



D3

2. Complete a Mood Check-in (Administer the PHQ-9).

Refer to workbook, page D4, “Rate Your Mood.”

- A. Administer the PHQ-9 and review the responses.
- Record the responses in the CPRS note template

- B. Provide feedback to the patient about his/her depression status.

- PHQ-9 Scoring:

0-4 = minimal depression

5-9 = mild depression

10-14 = moderate depression

15-19 = moderately severe depression

20+ = severe depression

- C. For patients entering their third treatment session or later—explore and discuss patient treatment response, where appropriate.

- Measurement-based treatment response definition: PHQ-9 Total score below 10 **OR** 50% reduction in symptoms.

Rate your Mood				
Over the last 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several Days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

D4

Clinician Tips: Depression Assessment & Patient Feedback

- 1) Communicate depression results to your patients and encourage them to actively monitor their depression symptoms. Patient awareness is an important first step towards change.
- 2) Use thoughtful and effective language for communicating depression symptom feedback. Patients will benefit from accurate but encouraging feedback using language they can understand. For example, when communicating PHQ-9 results that fall in the moderately severe or severe range – you may wish to use the term *high* rather than *severe*.
- 3) Consider discussing treatment progress related to any changes in depression total score or specific depression items. Reinforcing positive change is important – change may occur in total score or specific depression symptoms, depending on the focus in the prior session(s).
- 4) Addressing negative change is often patient-specific. However, it should also be addressed with encouragement and continued practice, and by exploring treatment options both within and beyond bCBT.

3. Review previous session's home practice goal and action plan.

Refer to their prior week's action plan sheet

A. ACTION PLAN—NEXT STEPS

- Discuss the prior week's action plan with the patient. For example – ask about progress towards the goal (exceeded, met, partially met, did not attempt). Explore what went well and any challenges.
- Re-evaluate goal moving forward (continue, modify, discontinue)

B. ACTION PLAN—OTHER SKILLS

- Revisit any other skills (e.g. prior action plans) being used by the patient. Briefly review these skills and how they are being used. Problem-solve where appropriate and support continued skill use.

Prior week's action plan (front)

The front page of the Action Plan worksheet. It features a large central area for writing. At the top, there are four horizontal blue boxes with white text: "Action Plan", "The specific goal or activity I plan to work on:", "Timeline for completing goal:", and "Steps to help me accomplish my goal:". Below these are three more blue boxes: "Possible barriers and ways to overcome them:", "How important is this goal to you?", and "How likely are you to complete these steps?". The "How important" scale ranges from "Not Very Important" (1) to "Very Important" (10). The "How likely" scale ranges from "Not Very Likely" (1) to "Very Likely" (10). At the bottom, there are sections for "Tracking your progress:" (with a scale from "Exceeded" to "Did Not Attempt") and "What challenges came up?".

Prior week's action plan (back)

The back page of the Action Plan worksheet. It has a large central area for writing. At the top, there are two horizontal blue boxes: "Action Plan" and "Next Steps". The "Next Steps" section contains three options: "Continue with your plan as is—keep doing what you are doing.", "Modify your plan to better meet your needs.", and "Use a different skill that better meets your needs.". Below this is a section titled "Next Steps—Notes" with a blank line for writing. Further down is a section titled "Other Skills" with a list of questions: "Questions to think about: • What other skills are you using? • Are these skills working for you? • Do you see any changes needed for these skills?". At the bottom is a section titled "Next Steps—Plans to use these skills" with a blank line for writing.

Clinician Tips: Homework / Action Plan Progress

- 1) The main reason for reviewing action plan progress is to encourage and help the patient problem solve to use skills more effectively. Get creative and follow the interests of the patient in making skills work and modifying skills for future use.
- 2) For patients who are able to easily acquire a specific skill (e.g. accomplish a goal) – consider exploring additional uses or broader applications of the skill. For example, using a relaxation strategy for pain management or sleep – or using a cognitive strategy for a new area in the patient's life.
- 3) For patients who are struggling to complete an action plan – consider reviewing the initial goal and the patient's interest in the goal. Modifications might involve breaking the action plan down into more manageable steps or changing to a new skill.

Developing New Skills

4. Introduce using relaxation and how it applies to the patient.

Refer to workbook, page D5, "Stress & Tension in Your Life."

A. Use the worksheet to discuss sources of stress in the patient's life and how stress impacts their functioning.

- You might use an analogy to discuss the impact of stress, such as the body being like "an engine that is idling on high" - relaxation skills can be used to slow that engine down.

Stress & Tension in Your Life

We all experience stress and tension at times. This is an important and natural response to the demands in our lives. If we didn't feel stress or tension, then we would not feel motivated to deal with these demands.

Most of us like some challenges! However, **too much stress can cause problems and impact our health and well-being**. You may experience stress and tension in a number of ways. Check any of these signs that look familiar to you.

Common sensations of stress and tension	
<input type="checkbox"/> Muscle tension	<input type="checkbox"/> Heart pounding
<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Irritability
<input type="checkbox"/> Feelings of worry or fear	<input type="checkbox"/> Sweaty palms
<input type="checkbox"/> Thinking the worst might happen	<input type="checkbox"/> Fatigue

What are sources of stress and tension in your life?

How has this impacted your life?

D5

Refer to workbook, page D6, "Taking Control with Relaxation Skills."

B. Introduce the relaxation skills of imagery and deep breathing.

- Suggest that the signs of stress and tension described by the patient can be reduced with relaxation exercises.
- Point out that the exercises target physical signs of tension as well as cognitive components, such as racing thoughts and feelings of fear / anxiety.
- Choose one of the two relaxation methods and briefly describe each method to the patient.

Taking Control with Relaxation Skills

The purpose of relaxation exercises is for you to gain skills to guide your mind and body away from stress and tension and into a more relaxed state.

Relaxation and tension are incompatible states that cannot occur together.

If you are relaxed, then you are not tense. If you are tense, then you are not relaxed.

Here are two simple, effective skills to help you gain control over your stress and tension.

	
Deep Breathing	• Learn how to breathe optimally for oxygen "transfer" to reduce bodily tension and lower your heartbeat.
	Imagery
	• Learn to use vivid, soothing mental imagery to focus your attention away from unhelpful thoughts and feelings.

Which skill would be the most helpful to you?

D6

Clinician Tips: Identifying a Focus of Treatment

If you feel it is clinically advantageous, you can recommend starting with imagery OR deep breathing, based on your knowledge of the patient and his/her concerns. It is not mandatory that you cover both techniques—choose what best applies for the patient.

5. Explore how Dave used the relaxation skills to address his needs.

Refer to pages D7 & D8, "How Dave Uses Deep Breathing/Imagery."

- A. Use the first example (page D7) to demonstrate how Dave applies deep breathing to a stressful situation in his life.
 - Highlight that Dave was able to calm himself enough to complete a task he would have otherwise avoided.
- B. Use the second example (page D8) to demonstrate how Dave uses imagery to cope with his back pain.

How Dave Uses Deep Breathing

Dave starts feeling anxious while waiting in line at the bank. He needs to talk to the teller about his overdrawn account balance and see if he can reverse some incorrect charges.

How Dave Feels

- Worried.
- Feels tightness in his stomach.
- Feels stressed out about finances.

What Dave is Doing

- Snaps at the teller when he gets to the counter, because he feels so stressed out.
- Sometimes he leaves the line altogether to avoid talking to the teller.

What Dave Thinks

- "I am going up to the teller, and she'll tell me there is no money in my account."
- "The teller is going to think I am a low-life."
- "I have no control over my finances."

Dave uses his deep breathing skills from the session:

1. Dave realizes his breathing is "portable;" therefore, he can practice it in line or anywhere else he starts feeling stressed.
2. By focusing on his breath, Dave stops thinking about his anxious thoughts, and his stomach tightness loosens. He is able to remain waiting in line.
3. By the time Dave gets to the teller, he feels more in control and is able to explain his situation calmly to the bank teller.

D7

How Dave Uses Imagery

Dave wakes up, and the first thing he notices that morning is his chronic pain.

How Dave Feels

- Low mood.
- Frustrated.
- Preoccupied with his pain.

What Dave is Doing

- Avoids physical activity when he is in pain.
- Stays in bed and watches TV to try and distract himself.

What Dave Thinks

- "I am in too much pain to do anything productive."
- "I have no control over my pain—it is taking over my life."

Dave decides to use his imagery skills from the session:

1. The imagery exercise helps him relax and distracts him from his pain.
Dave has noticed that when his stress decreases, his muscles relax, and his pain often decreases
2. This exercise helps him shift his way of thinking.
He realizes he could make some positive changes to manage some of his pain.
3. Dave finds that, with regular practice, this technique improves his overall sense of well-being.

D8

Clinician Tips: Using the case example of Dave

You do not have to review both Dave examples. These are available for you to use if you feel the patient would benefit from concrete examples of how relaxation skills can be applied to cope with different problems.

Turn to the page 7 of this manual for deep breathing.

Turn to page 9 of this manual for imagery.

6. (Deep breathing) Use deep breathing to reduce stress and tension.

Refer to workbook, page D9, "Using Deep Breathing to Reduce Stress & Tension."

A. Introduce deep breathing, and review information about the skill.

- Discuss how deep breathing works to relieve stress and tension.

Using Deep Breathing to Reduce Stress & Tension

Why is deep breathing used?

There needs to be a balance between oxygen and carbon dioxide in the blood for the body to run efficiently. This balance is maintained through how fast and how deeply we breathe.



Rapid and shallow breathing disrupts the oxygen-carbon dioxide balance and can cause many of the physical sensations that accompany stress and tension.

One thing that can help is deep breathing.

- Changing the rate and way you breathe can make your entire body feel more relaxed and function more effectively.
- Taking a deep, full breath can produce a feeling of calmness and relaxation by increasing your oxygen-rich blood flow.
- Deep breathing can help you start to form good habits for reacting to stressful situations.

D9

Refer to workbook, page D10, "How to Practice Deep Breathing."

B. Instruct the patient in how to perform deep breathing.

- Prior to practicing in session, have patient attend to how he/she is breathing naturally. Ask the patient to rate their tension on a 1-10 scale.
- Adjust the pace to a rate that is comfortable for the patient.
- Repeat until patient appears to be comfortable with the technique.
- Guide the patient through three to five minutes of deep breathing.
- After practicing, process the experience with the patient:
 - Ask for any general feedback about how this skill seemed to work and to think of a stressful situation when this skill might be useful.

How to Practice Deep Breathing

Take notice of your breathing. Is your chest or stomach moving? You most likely breathe more from the **chest** than the stomach. We want to teach you to breathe more with your **stomach** and diaphragm rather than your chest.

How to Deep Breathe:

- Place one hand on your abdomen, with your little finger about one inch above your navel, and place the other hand on your chest. If you are lying down, you can place a book on your stomach instead of your hands.
- Inhale "into your stomach,"** through your nose, pausing naturally before exhaling. You should see the hand or book on your stomach move more than your chest.
- Exhale** gradually through your lips, by tightening your stomach muscles and pausing naturally before inhaling again.
- Take slow, even, deep breaths. Breathe in and out at a comfortable rate. Do not pause at the top of each breath.

Other Resources

You can view an animated video demonstrating how to perform deep breathing at this web address:
<https://youtu.be/YdsipKCAcAc>

D10

Refer to workbook, pages D10 & D11, "How to Practice Deep Breathing" and "Instructions for Practice ."

C. Review instructions for practicing at home.

- Stress the importance of mastering the technique before attempting to use it in stressful situations.
- Refer patient to the optional video demonstration link at the bottom of page D10.
- Encourage patient to keep track of situations where relaxation skills can be applied. This can guide relaxation goal setting.
- Continue to the goal setting and action planning worksheet if you will not be covering imagery in session.

How to Practice Deep Breathing

Take notice of your breathing. Is your chest or stomach moving? You most likely breathe more from the **chest** than the stomach. We want to teach you to breathe more with your **stomach** and diaphragm rather than your chest.

How to Deep Breathe:

1. Place one hand on your abdomen, with your little finger about one inch above your navel, and place the other hand on your chest. If you are lying down, you can place a book on your stomach instead of your hands.
2. **Inhale "into your stomach,"** through your nose, pausing naturally before exhaling. You should see the hand or book on your stomach move more than your chest.
3. **Exhale** gradually through your lips, by tightening your stomach muscles and pausing naturally before inhaling again.
4. Take slow, even, deep breaths. Breathe in and out at a comfortable rate. Do not pause at the top of each breath.

Other Resources

You can view an animated video demonstrating how to perform deep breathing at this web address:
<https://youtu.be/YdsipKCAcAc>

D10

Instructions for Practice Exercises

Changing your experience of stress is like learning a new skill - *it gets easier with practice!*

- Practice regularly. Try three five-minute sessions a day.
- Once you are comfortable with deep breathing, try the following:
 1. Inhale at a normal speed.
 2. Exhale for four seconds.
 3. Pause for four seconds, then repeat.
- Focus on the count during your exhalations, and pause before inhaling again. This will activate your body's relaxation response!
- Start by practicing only in non-stressful situations. Once you feel comfortable with it, you can use deep breathing in stressful situations.
- Increase awareness of stress! Identify stressful situations and write down feelings, physical signs, thoughts, and behaviors associated with those situations. This will help you be aware of when you can use deep breathing skills to help relax.
- Deep breathing can be done anytime, such as while sitting in traffic or waiting in line at the grocery store.





D11

Clinician Tips:

- 1) **Posture:** The easiest way to learn and practice deep breathing is in a lying position. However, this is not always practical, and some body positions make it difficult to practice deep breathing. You might recommend the opposite of "standing at attention" - lowering the shoulders and letting them slouch forward slightly, leaning back into the chair, and relaxing the chest and abdomen muscles.
- 2) **Pulmonary Disease:** Relaxation training, including diaphragmatic breathing, is standard in many pulmonary rehabilitation programs, as it can increase oxygen saturation, decrease respiratory rate, and decrease dyspnea. However, some patients with obstructive airway diseases may experience dyspnea or discomfort when air is trapped or not properly expelled from the lungs. Consider the patient's preferences when engaging in deep-breathing exercises. Some patients with pulmonary disease may prefer to focus on guided imagery as an alternative form of relaxation.

6. (Imagery) Use imagery to reduce stress and tension.

Refer to workbook, page D12, "Using Imagery to Reduce Stress & Tension."

A. Introduce imagery and review information about the skill.

- Discuss how imagery works to relieve stress and tension.

Using Imagery to Reduce Stress & Tension

What is imagery?
Imagery is a simple process that uses your imagination to communicate with your body. To your body, images and experiences created in your mind can be as real as actual events. Your body will react as though the experience is happening. It seems the body may not know the difference between an actual event and a thought!

Why is imagery used?
You can take advantage of this by using your imagination to visualize pleasant experiences. Using imagery this way can ease stress and promote an overall sense of well-being.
Think about times when you have daydreamed. We have all daydreamed about pleasant things that made us feel better.
Of course, the opposite is also true! The difference is that daydreaming usually happens "on accident." Imagery is used on purpose with a specific goal in mind; to feel better!
Imagery, therefore, can be a powerful tool when used correctly.



D12

Refer to workbook, page D13, "How to Practice Using Imagery."

B. Instruct the patient in how to practice imagery exercises.

- Have patient find a comfortable position.
- Have patient rate his/her level of tension on a 1-10 scale before practicing deep breathing.
- Find a specific scene; it can be either one the patient selects or one of the specific example scripts (pgs. 68-70.).
- Guide the patient through a guided imagery exercise.
- After practicing, process the experience with the patient:
 - Ask the patient to indicate whether he/she notices feeling any more relaxed.
 - Ask for any general feedback about how this skill seemed to work.

How To Practice Using Imagery

1. Find a quiet space where you can either sit or lie down.
2. Start with a quick check-in on what you are thinking and how you feel in your body.
3. Practice deep breathing for a few minutes if you wish (see deep breathing instructions).
4. Imagine going to a place where you feel safe, peaceful, and calm. This place can be a real place or somewhere you invent yourself.
5. Take some time to develop the image of this place in your mind so you can fully experience all of the sights, sounds, smells, tastes, and textures.
6. Practice relaxing as you use all of your senses, and imagine being in this special place.

Example:

Imagine a glass of lemonade. The glass feels icy and cold; visualize the color of the lemonade, think of the fresh citrus smell, think of how it tastes.
You probably are salivating thinking of this juice, aren't you?
Try to create a pleasant, positive image that fits your preferences and has meaning to you.



D13

Refer to workbook, page D17, "Instructions for Practice Exercises."

C. Review instructions for practicing at home.

- Discuss different imagery scene possibilities for home practice.
- Stress the importance of mastering the technique before applying it in stressful situations.
- Encourage patient to keep track of situations where relaxation skills can be applied. This can guide relaxation goal setting.

Instructions for Practice Exercises

- Changing your experience of stress is like learning a new skill - it gets easier with practice! 
- Practice makes perfect! Make sure you find several times a day to apply this technique. Practice for 10-15 minutes at a time in non-stressful situations. Once you feel comfortable with it, then you can use imagery in stressful situations.
- When ready to practice, choose a comfortable position, close your eyes, and give yourself permission to relax.
- Some people find using imagery before going to bed and first thing in the morning to be helpful.
- Remember, when using imagery, to use a scene that incorporates all of your senses and make it as elaborate and realistic as you can.
- You will find that, after practice, imagery will become a powerful tool to help you feel better. 

D17

7. Develop an action plan for next session.

Refer to workbook, page D19, "Action Plan."

Using the relaxation skill(s) that the patient has selected, develop an action plan that is a realistic first step toward improving their management of stress and tension .

- Remind the patient to define their goal in terms of SMART guidelines.
- Encourage the patient to monitor their progress implementing the action plan (see “tracking progress” section at the bottom of the page).

The form is titled "Action Plan" and contains the following sections:

- The specific goal or activity I plan to work on:** (Handwriting area)
- Timeline for completing goal:** (Handwriting area)
- Steps to help me accomplish my goal:** (Handwriting area)
- Possible barriers and ways to overcome them:** (Handwriting area)
- How important is this goal to you?** (Scale from Not Very Important to Very Important)
Not Very Important 1 2 3 4 5 6 7 8 9 10 Very Important
- How likely are you to complete these steps?** (Scale from Not Very Likely to Very Likely)
Not Very Likely 1 2 3 4 5 6 7 8 9 10 Very Likely
- Tracking your progress:**
 - What progress did you make towards your goal this week?
 Exceeded Met Partially Met Did Not Attempt
 - What went well?
(Handwriting area)
 - What challenges came up?
(Handwriting area)

D19

Clinician Tip: Ensuring positive reinforcement for the first action plan.

Success with the first action plan will encourage the Veteran to engage in treatment and skill usage. Work with the Veteran to identify one or two situations where relaxation skills are likely to be helpful. Encourage the patient to practice the relaxation techniques and develop familiarity with them before applying them .

Improving Health & Wellness



Provider Manual

Rationale for Incorporating Health & Wellness in CBT

Background

- Patients seen in nontraditional mental health settings (e.g., primary care and community-based outpatient clinics) often have concerns (e.g., stigma) or negative expectations about mental health treatment expectations that make engaging in care difficult.
- Patients seen in these “medical care” settings often prefer their mental health care to include elements that link directly to their physical health.
- Clinicians have the option to align with the patient’s overall health and wellness by initially focusing on physical health and then transitioning into more traditional mental health intervention efforts.

Module Rationale

- The purpose of the Improving Health and Wellness skill module is to engage patients who wish to begin treatment by talking about physical health concerns.
- The skills included in the module are closely aligned to common health concerns including weight and eating behaviors, physical activities and exercise, improving sleep, and managing pain. The content is consistent with a general cognitive behavioral approach of focusing on skills and goal setting related to behavioral activation, relaxation, and reducing maladaptive thinking.

When to use / not use this module

Clinicians are most likely to use this module during the initial stages of treatment to engage patients in the broader bCBT approach. Although the content focuses on health and well-being, the processes and strategies broadly apply to patient behavioral and cognitive skill development, which should help patients feel more comfortable with the “core” CBT for depression skills (cognitive, behavioral, and relaxation).

This module was NOT developed to be the sole focus of treatment. Although improving physical health and well-being may indirectly improve depression, this is not considered a “core” element of CBT for depression. These skills were intended to help patients transition into the more traditional “core” elements of CBT for depression; namely behavioral activation, reducing maladaptive thinking patterns, and increasing relaxation.

In conclusion, clinicians are encouraged to use the Health and Wellness module for one or possibly two sessions, but then transition to other modules that address depression more directly.

Session checklist:

Session Roadmap and Check-in

1. Establish a session roadmap (agenda) with the patient
2. Complete a mood “check-in” using the PHQ-9
3. Review the previous session’s assignment and any other ongoing skills being used by the patient

Developing New Skills – Improving Health and Wellness

4. Briefly review the different health and wellness areas included in this session. Areas include: Healthy Eating, Physical Activities/ Exercise, Improving Sleep, and Overcoming Pain.
5. Explore how Dave used the Improving Health and Wellness session to address his pain and healthy eating goals.
6. Identify the area(s) of health and wellness that the patient wants to improve.
7. Use the tip sheets to identify patient-centered health and wellness skills.
8. Develop an action plan for next session.

Provider Manual Key:

Refers to workbook page

Provider Tips

Session Roadmap & Check-in

1. Establish the roadmap (set the agenda).

Refer to workbook, page E3, “What to Expect in this Session.”

Review the session roadmap with the patient (in the patient workbook).

What to Expect in this Session

Session Roadmap

1. We will set an agenda for the session.
2. How are you doing? We will complete a quick mood “check-in.”
3. We will review the previous session’s assignment and any other ongoing homework or skills you are using.

Developing New Skills – Improving Health and Wellness

4. We will briefly review the skills included in this session. Areas Include: Healthy Eating, Physical Activities/Exercise, Improving Sleep, and Overcoming Pain.
5. We will take a look at how Dave used the Improving Health and Wellness session to address his pain and eating goals.
6. We will identify the areas of health and wellness that you want to improve.
7. We will work together to identify specific skills you can put into your toolbox to improve your health and wellness.
8. We will develop an action plan to help you meet your goals.



E3

2. Complete a Mood Check-in (Administer the PHQ-9).

Refer to workbook, page E4, “Rate Your Mood.”

- A. Administer the PHQ-9 and review the responses.
- Record the responses in the CPRS note template

- B. Provide feedback to the patient about his/her depression status.

- PHQ-9 Scoring:

0-4 = minimal depression

5-9 = mild depression

10-14 = moderate depression

15-19 = moderately severe depression

20+ = severe depression

- C. For patients entering their third treatment session or later—explore and discuss patient treatment response, where appropriate.

- Measurement-based treatment response definition: PHQ-9 Total score below 10 **OR** 50% reduction in symptoms.

Rate your Mood				
Over the last 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several Days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

E4

Clinician Tips: Depression Assessment & Patient Feedback

- 1) Communicate depression results to your patients and encourage them to actively monitor their depression symptoms. Patient awareness is an important first step towards change.
- 2) Use thoughtful and effective language for communicating depression symptom feedback. Patients will benefit from accurate but encouraging feedback using language they can understand. For example, when communicating PHQ-9 results that fall in the moderately severe or severe range – you may wish to use the term *high* rather than *severe*.
- 3) Consider discussing treatment progress related to any changes in depression total score or specific depression items. Reinforcing positive change is important – change may occur in total score or specific depression symptoms, depending on the focus in the prior session(s).
- 4) Addressing negative change is often patient-specific. However, it should also be addressed with encouragement and continued practice, and by exploring treatment options both within and beyond bCBT.

3. Review previous session's home practice goal and action plan.

Refer to their prior week's action plan sheet

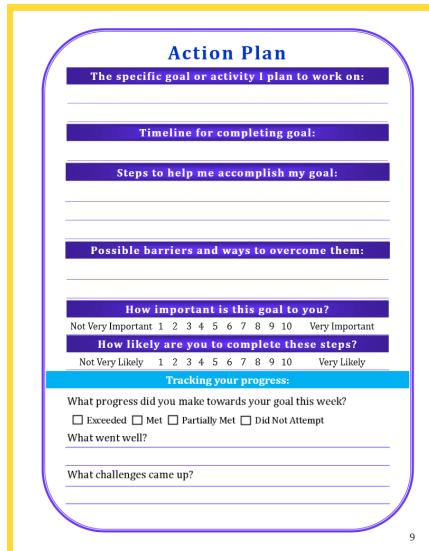
A. ACTION PLAN—NEXT STEPS

- Discuss the prior week's action plan with the patient. For example – ask about progress towards the goal (exceeded, met, partially met, did not attempt). Explore what went well and any challenges.
- Re-evaluate goal moving forward (continue, modify, discontinue)

B. ACTION PLAN—OTHER SKILLS

- Revisit any other skills (e.g. prior action plans) being used by the patient. Briefly review these skills and how they are being used. Problem-solve where appropriate and support continued skill use.

Prior week's action plan (front)



The specific goal or activity I plan to work on:

Timeline for completing goal:

Steps to help me accomplish my goal:

Possible barriers and ways to overcome them:

How important is this goal to you?

Not Very Important	1	2	3	4	5	6	7	8	9	10	Very Important
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How likely are you to complete these steps?

Not Very Likely	1	2	3	4	5	6	7	8	9	10	Very Likely
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Tracking your progress:

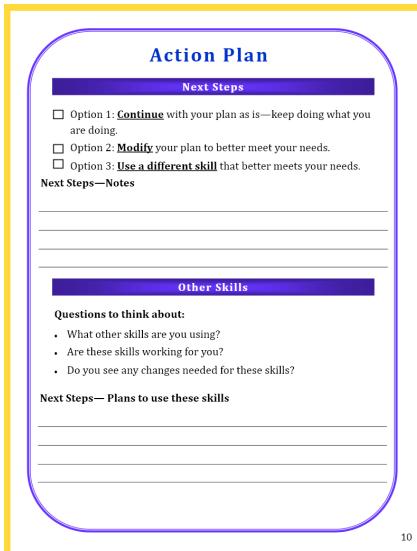
What progress did you make towards your goal this week?

Exceeded Met Partially Met Did Not Attempt

What went well?

What challenges came up?

Prior week's action plan (back)



Action Plan

Next Steps

Option 1: Continue with your plan as is—keep doing what you are doing.
 Option 2: Modify your plan to better meet your needs.
 Option 3: Use a different skill that better meets your needs.

Next Steps—Notes

Other Skills

Questions to think about:

- What other skills are you using?
- Are these skills working for you?
- Do you see any changes needed for these skills?

Next Steps—Plans to use these skills

Clinician Tips: Homework / Action Plan Progress

- 1) The main reason for reviewing action plan progress is to encourage and help the patient problem solve to use skills more effectively. Get creative and follow the interests of the patient in making skills work and modifying skills for future use.
- 2) For patients who are able to easily acquire a specific skill (e.g. accomplish a goal) – consider exploring additional uses or broader applications of the skill. For example, using a relaxation strategy for pain management or sleep – or using a cognitive strategy for a new area in the patient's life.
- 3) For patients who are struggling to complete an action plan – consider reviewing the initial goal and the patient's interest in the goal. Modifications might involve breaking the action plan down into more manageable steps or changing to a new skill.

Developing New Skills

4. Provide a brief rationale and review of skills included in this session.

Refer to workbook, page E5, "Physical Health."

A. Provide a rationale to encourage the patient and structure in-session work.

- Emphasize that multiple interrelated factors contribute to physical health, and that some of these can be influenced by behavioral/lifestyle changes.

B. Review the health and wellness areas.

- Ask patient to start thinking about which primary area they would like to start with.

Physical Health

Healthy Eating

Improve your health through diet/eating changes.

- Lose weight.
- Eat healthier foods like fruits and vegetables.
- Improve your eating habits by creating an eating plan and avoiding unhealthy fast food options.



Physical Activity/ Exercise

Increase your activity level to improve your health.

- Find activities that you enjoy.
- Start an exercise plan that works for you.
- Increasing activity can be difficult—this skill topic will help you find solutions to barriers and support you in your exercise plan.



Improving Sleep

Get a better night's sleep and feel more rested.

- Introduce sleep habits to improve sleep quality.
- Start a sleep schedule and routine.
- Reduce stress to help you more quickly fall and stay asleep.



Overcoming Pain

Take action to reduce the impact of pain on your life.

- Explore skills to help you shift your focus away from your pain.
- Learn relaxation strategies to reduce muscle tension, which often makes pain worse.
- Start a pain management plan that fits your needs.



E5

Clinician Tips: Reviewing the Physical Health Areas of Focus

- 1) The key here is to orient the patient to the general domains covered in the session.
- 2) The patient does NOT need to select his/her most salient issue at this time (this occurs in section 6).

5. Explore how Dave used the session to address his pain/healthy eating goals.

Refer to workbook, pages E6 & E7; “Dave & Pain/Healthy Eating.”

- A. Use the first example of Dave to help explain the emotional, behavioral, and cognitive elements of his PAIN.

Dave & Pain

Dave has been in constant pain because of his back injury and has not been able to work because of this disability.

How Dave Feels

- Frustrated
- Down
- Unmotivated
- Unproductive
- Tired
- Stressed out about finances

What Dave Is Doing

- I usually oversleep or just stay in bed after I wake up.
- I spend a lot of the day watching TV.
- I haven't cleaned up my house in ages; it really needs it.

What Dave Thinks

- My pain controls everything in my life.
- There is nothing more I can do to control my pain.
- Pain is the reason my life is the way it is.
- I can't go back and change anything.

Dave used the *Pain Tip Sheet* to create a three-pronged approach:

- Set a plan to become more physically active.
I'll walk at least three times a day for at least 20 min. each.
- Shift the way he thinks about his pain.
I can make positive changes to control some of my pain and get my life back on track.
- Use deep breathing.
It will be great if I can stop and relax when I notice that I am tensing up.

E6

- B. Use the second example of Dave to help explain the emotional, behavioral, and cognitive elements related to his healthy eating goals.

Dave & Healthy Eating

Dave has gained 25 pounds over the past year.

How Dave Feels

- Embarrassed
- Ashamed
- Overwhelmed and unsure about how to lose weight.

What Dave Is Doing

- I never have anything good at home, so I just eat fast food.
- I just don't do much physically; my back bothers me, and I get out of breath easily.
- I don't get out much, either to see friends or to just go shopping and things like that.
- I have let myself go and now I look terrible.
- I have no idea how to fix my eating behaviors—I just feel like giving up.

What Dave Thinks

Dave decided to use the *Healthy Eating Tip Sheet*:

- Improve nutrition
I'll go shopping this week and buy what I need to have two healthy meals at home this week.
- Plan for success
I'll start keeping track of what I eat; if I get on a regular routine, I probably won't snack as much.

Dave knows these are only the first steps, but he wants to start small so he can start seeing improvement without feeling overwhelmed. He can add to his plan over time.

E7

Clinician Tips: Using the case example of Dave

- Use the case examples to educate the patient on how thoughts, feelings, and behaviors relate to physical health and physical health skill use. If the patient is already knowledgeable and/or quickly understands these principles, you are encouraged to summarize the case examples rather than walking through the specifics.
- The case of Dave includes a description of skill use. Skills will not be covered at this time but later in the session. The skill listing is provided for example purposes only so the patient can see the relationship between the exercise and eventual skill selection and use.

6. Identify the area(s) of health and wellness that the patient wants to improve.

- Areas include: Healthy Eating, Physical Activities / Exercise, Improving Sleep, and Overcoming Pain.
- When necessary, clinicians may wish to direct the patient back to page E5 of the workbook to review the areas.

Clinician Tip: Identifying a Focus of Treatment

- 1) Attempt to find the most salient physical health concern, and focus on it first. If additional areas are of interest to the patient – let him/her know that you can revisit those after you work through his/her most pressing concern first.
- 2) When in doubt – attempt to have the patient focus on a physical health skill area that is likely to benefit the patient in the near future. Early success in treatment is important. For more information, please see the goal setting and action plan training section on the website.

7. Work to identify patient-centered health and wellness skills.

Refer to workbook, page E8, "Improving Your Physical Health."

A. Walk the patient through this worksheet to identify the emotional, behavioral, and cognitive elements related to the patient's primary physical health concern.

- Complete icons #1 through #4 on the worksheet in collaboration with the patient. This worksheet includes:
 - 1) The physical health concern bubble
 - 2) Mood, thoughts, and behavioral impact
 - 3) What the patient has tried in the past.
- Summarize icons #1 through 4 with statements that highlight the important emotional, behavioral, and cognitive influences on the patient's overall health and wellness.

The worksheet is titled "Improving Your Physical Health". It features four main sections, each with a corresponding icon and a list of items for the patient to check off:

- How You Feel** (purple cloud): Includes items like Healthy Eating, Improving Sleep, Exercise, and Deconditioning.
- What You Are Doing** (red starburst): Includes items like Walking, Stretching, Deep Breathing, and Relaxation Techniques.
- What You Think** (green gear): Includes items like Positive Thinking, Cognitive Behavioral Therapy, and Mindfulness.
- Using skills (tools) to cope** (toolbox): Includes items like Medications, Therapy, and Self-care.

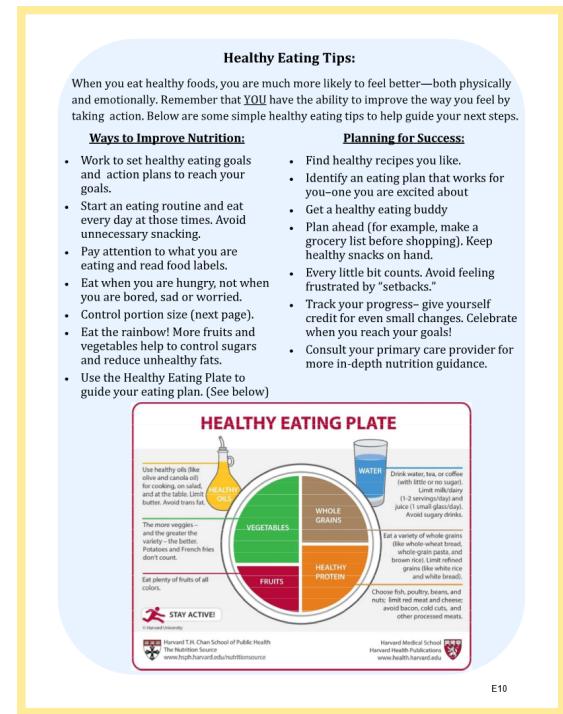
Clinician Tip: Completing the Health and Wellness Worksheet

- 1) Pay close attention to the cognitive, behavioral, and emotional elements in this worksheet to help the patient to later transition into the core brief CBT skills.
- 2) Some patients may find this exercise complicated and/or difficult. You are encouraged to help the patient by asking focused or directive questions. You should also be flexible in "letting go" of elements that may be of secondary importance or prove particularly difficult for the patient. For example, some patients may have difficulty identifying thoughts associated with their physical health concern(s) but easily identify behaviors and emotions. You may wish to spend less time with the cognitive elements and focus in on other elements that provide opportunities for intervention and are in line with the comfort of the patient.

Refer to Tip Sheets in workbook, pages E10-E14.

B. Review the selected tip sheet with the patient.

- Collaboratively explore skills / strategies that best fit the patient's needs and interests.
- Guide the patient towards tips that will address his/her most pressing cognitive, behavioral, and emotional concerns (as identified during the "Improving Your Physical Health" Worksheet).
- Select one or two strategies that can be developed into an action plan (next step). The patient is NOT expected to do all of these activities.



E10

C. List the tips he/she identified in the toolbox section of the patient's worksheets on page E8-E9.

Clinician Tip: Selecting Skills from the Tip Sheets

- 1) Skill selection MUST be collaborative to ensure patient buy-in and motivation. An activated and empowered patient is much more likely to benefit from the treatment. Selection of skills is a critical opportunity to empower.
- 2) Skills that have the potential to be rapidly and easily used are the best to begin with. Similarly, if a skill has multiple points of impact (behavioral, cognitive, or relaxation), the chances of success and use of the skill go up. For example, a skill like exercise (e.g., walking for 20 minutes three times per week) may improve physical functioning but may also reduce depression through behavioral activation, may improve thinking patterns (e.g., increased efficacy and sense of accomplishment), and may help the patient to relax or even sleep better.

8. Develop an action plan for next session.

Refer to workbook, page E15, “Action Plan.”

Help the patient formulate an action plan for one or more of the tips identified on workbook page E8. Develop a plan that is a realistic first step toward improving their health-related behavior in that area.

- Remind the patient to define their goal in terms of SMART guidelines.
- Encourage the patient to monitor their progress implementing the action plan (see “tracking progress” section at the bottom of the page).

Action Plan

The specific goal or activity I plan to work on:

Timeline for completing goal:

Steps to help me accomplish my goal:

Possible barriers and ways to overcome them:

How important is this goal to you?

Not Very Important 1 2 3 4 5 6 7 8 9 10 Very Important

How likely are you to complete these steps?

Not Very Likely 1 2 3 4 5 6 7 8 9 10 Very Likely

Tracking your progress:

What progress did you make towards your goal this week?

Exceeded Met Partially Met Did Not Attempt

What went well?

What challenges came up?

E15

Clinician Tip: Ensuring positive reinforcement for the first action plan.

Success with the first action plan will encourage the Veteran to maintain healthy behaviors. Work with the Veteran to identify one or two of the tips that he/she is likely to complete and that are likely to enhance self-efficacy.

Final Session



Provider Manual

Rationale for a Final Session

The purpose of the Final Session is to assist patients with:

- Recognizing change over the course of treatment, including attributions of this change
- Identifying ways to maintain this change
- Creating a plan for continued health and well-being

The final session includes a collaborative review of treatment progress, including changes in PHQ-9 scores, patient report, and goal attainment. The final session attempts to maximize treatment success by anticipating and addressing possible barriers to ongoing skill use, goal attainment, and symptom reduction.

- Special attention should be paid to reviewing the “core” elements of CBT for depression that were delivered during this program (i.e., behavioral activation, reducing maladaptive thinking patterns).
- Encourage patients to continue applying these foundational depression management skills to new problems or situations after the termination of treatment.

Before a Final Session

The Final Session is a way to collaboratively and thoughtfully engage patients in their treatment. This includes collaborating with patients to decide when to terminate the program, based on both patient and provider impressions of progress. This flexible process also allows for additional bCBT sessions (up to nine sessions as indicated) and/or additional services following the bCBT program.

- Discuss treatment ending prior to the last session. Ending treatment is a *process*, even in the context of brief treatment.
- Consider overall treatment progress in deciding when to end treatment. The Final Session allows for a “big picture” look at the participant’s progress and challenges during treatment and provides support for maintaining this progress.
- Treatment wrap-up is variable and up to the clinician and the patient. Although standard bCBT treatment is six sessions, providers may extend bCBT treatment up to nine sessions.
- Clinicians are encouraged to refer to the additional training on **Treatment Length Considerations** to inform the duration of treatment with participants in this program.

Session checklist:

Session Roadmap: Final Session

1. Establish a session roadmap (agenda) with the patient.
2. Complete a mood “check-in” using the PHQ-9.
3. Review the previous session’s assignment and any other ongoing skills being used by the patient.
4. Review patient’s progress over the course of treatment, including goal attainment and overall mood.
5. Introduce and discuss the tip sheet for maintaining progress, including review of anticipated barriers.
6. Discuss when to seek follow-up treatment, including crisis referral
7. Wrap-up and close.

Provider Manual Key:

Refers to workbook
page

Provider Tips

Session Roadmap & Check-in

1. Establish the roadmap (set the agenda).

Refer to workbook, page F3, "What to Expect in this Session."

Review the session roadmap with the patient (in the patient workbook).

What to Expect in this Session

Session Roadmap

1. We will set an agenda for the session.
2. How are you doing? We will complete a quick mood “check-in.”
3. We will review the previous session’s assignment and any other ongoing homework or skills you are using.
4. We will discuss your goals and overall progress during the program.
5. We will discuss how to maintain your progress.
6. We will discuss next steps and wrap up our work together.



F3

2. Complete a Mood Check-in (Administer the PHQ-9).

Refer to workbook, page F4, "Rate Your Mood."

- A. Administer the PHQ-9 and review the responses.
- Record the responses in the CPRS note template

- B. Provide feedback to the patient about his/her depression status.

- PHQ-9 Scoring:

0-4 = minimal depression

5-9 = mild depression

10-14 = moderate depression

15-19 = moderately severe depression

20+ = severe depression

- C. For patients entering their third treatment session or later—explore and discuss patient treatment response, where appropriate.

- Measurement-based treatment response definition: PHQ-9 Total score below 10 **OR** 50% reduction in symptoms.

Rate your Mood				
Over the last 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several Days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

F4

Clinician Tips: Depression Assessment & Patient Feedback

- 1) Communicate depression results to your patients and encourage them to actively monitor their depression symptoms. Patient awareness is an important first step towards change.
- 2) Use thoughtful and effective language for communicating depression symptom feedback. Patients will benefit from accurate but encouraging feedback using language they can understand. For example, when communicating PHQ-9 results that fall in the moderately severe or severe range – you may wish to use the term *high* rather than *severe*.
- 3) Consider discussing treatment progress related to any changes in depression total score or specific depression items. Reinforcing positive change is important – change may occur in total score or specific depression symptoms, depending on the focus in the prior session(s).
- 4) Addressing negative change is often patient-specific. However, it should also be addressed with encouragement and continued practice, and by exploring treatment options both within and beyond bCBT.

3. Review previous session's home practice goal and action plan.

Refer to their prior week's action plan sheet

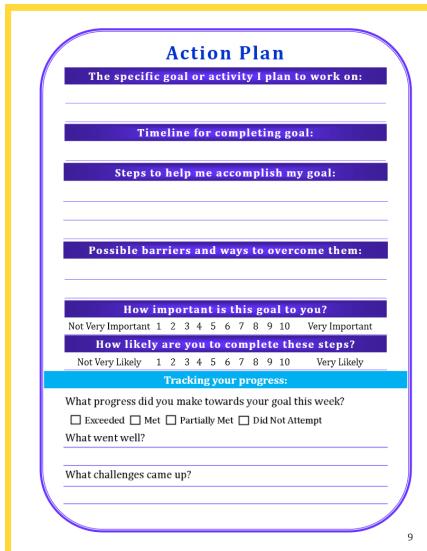
A. ACTION PLAN—NEXT STEPS

- Discuss the prior week's action plan with the patient. For example – ask about progress towards the goal (exceeded, met, partially met, did not attempt). Explore what went well and any challenges.
- Re-evaluate goal moving forward (continue, modify, discontinue)

B. ACTION PLAN—OTHER SKILLS

- Revisit any other skills (e.g. prior action plans) being used by the patient. Briefly review these skills and how they are being used. Problem-solve where appropriate and support continued skill use.

Prior week's action plan (front)



The specific goal or activity I plan to work on:

Timeline for completing goal:

Steps to help me accomplish my goal:

Possible barriers and ways to overcome them:

How important is this goal to you?

Not Very Important	1	2	3	4	5	6	7	8	9	10	Very Important
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How likely are you to complete these steps?

Not Very Likely	1	2	3	4	5	6	7	8	9	10	Very Likely
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Tracking your progress:

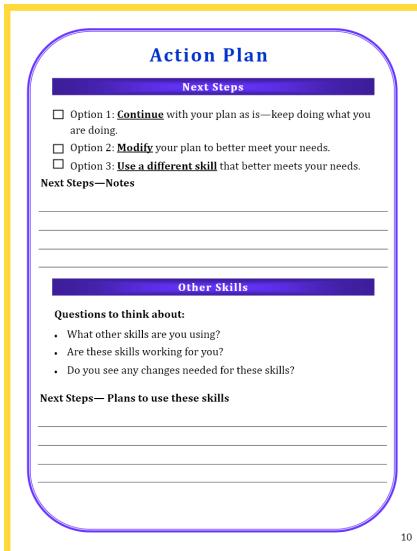
What progress did you make towards your goal this week?

Exceeded Met Partially Met Did Not Attempt

What went well?

What challenges came up?

Prior week's action plan (back)



Action Plan

Next Steps

Option 1: Continue with your plan as is—keep doing what you are doing.

Option 2: Modify your plan to better meet your needs.

Option 3: Use a different skill that better meets your needs.

Next Steps—Notes

Other Skills

Questions to think about:

- What other skills are you using?
- Are these skills working for you?
- Do you see any changes needed for these skills?

Next Steps—Plans to use these skills

Clinician Tips: Homework / Action Plan Progress

- 1) The main reason for reviewing action plan progress is to encourage and help the patient problem solve to use skills more effectively. Get creative and follow the interests of the patient in making skills work and modifying skills for future use.
- 2) For patients who are able to easily acquire a specific skill (e.g. accomplish a goal) – consider exploring additional uses or broader applications of the skill. For example, using a relaxation strategy for pain management or sleep – or using a cognitive strategy for a new area in the patient's life.
- 3) For patients who are struggling to complete an action plan – consider reviewing the initial goal and the patient's interest in the goal. Modifications might involve breaking the action plan down into more manageable steps or changing to a new skill.

4. Review patient's progress over treatment.

Refer to workbook, page F5, "Progress Review."

Use the "Progress Review" worksheet to review patient progress over the course of treatment. Focus discussion first on the patient's treatment progress, then on his/her attributions for the changes identified.

A. Summarize PHQ-9 scores over the course of treatment, as deemed clinically useful.

The PHQ-9 can be used as a tool to communicate changes in depression symptom severity/frequency and for discussing patient progress and further referral options (for non-responsive or worsening PHQ-9 scores).

- *Program treatment response is defined as:* PHQ-9 total score < 10 or a 50% reduction in PHQ-9 score.

B. Elicit patient's perception of success during treatment regarding goal attainment and use of bCBT skills. Assess what change the patient has noticed, including broader improvements such as quality of life or relationships.

- If a patient accurately identifies his/her progress during treatment, you are encouraged to reinforce this progress and elicit patient examples of progress/improvement. You may also offer a summary of the changes demonstrated in treatment. Ideally, the provider will link this to the previous discussion of PHQ-9 scores and mood over treatment. Then, you may continue to step C.

- If a patient has difficulty identifying his/her progress, you are encouraged to take a more directive stance in assisting the patient with identifying change during treatment.

The graphic shows a circular dial with four segments: 'Partially Unsuccessful' (orange, value 2), 'Successful' (yellow, value 3), 'Exceeded Successful' (green, value 4), and 'Completely Unsuccessful' (red, value 1). A needle points to the 'Successful' segment. Below the dial is a purple header 'Progress Review'. The first section asks 'Rate your overall success in reaching your goals:' with a scale from 1 to 4. The second section asks 'What areas of your life have changed?' with a list of checkboxes: Overall quality of life, Mood/depression/mental health, Physical health, Ability to cope with stressors, Relationships with others, and Other: _____ . The third section asks 'What contributed to this change?' with several blank lines for writing.

C. The next focus of inquiry is identifying attributions for this change over treatment. Assist patients in identifying *their* role in any progress—what actions and skills helped them with this success? Identifying change and attributing the mechanisms of change will likely require your assistance.

- Ask “*What contributed to this change [noted in previous discussion]?*”
- Does the patient attribute his/her progress to his/her own actions? If a patient accurately attributes treatment progress to his/her own actions, you are encouraged to reinforce this and again elicit patient examples of how he/she enacted change.
- If a patient has difficulty attributing treatment progress to his/her own actions, you are again encouraged to be directive and disclose observations of the patient over the course of treatment.

Clinician Tips: Reviewing Progress

- 1) Help patients give themselves credit—the key here is for patients to accurately identify progress and attribute such progress to their own actions. You are encouraged to take an active and directive approach when reviewing treatment progress, particularly with patients who struggle to see any progress or change.
- 2) If a patient rates his/her progress as partially successful, compare it to another, lower anchor: Why partially successful and not unsuccessful? This can open the door to discussing change and helping the patient recognize areas of improvement.
- 3) Focus on the patient’s improvement, however small, by sharing reflections of progress throughout treatment. For example, a patient might rate his/her progress as very low, in which case you may assist the patient in finding small but important areas in which he/she did make progress—even if that means attending session regularly!
- 4) It is also crucial that the patient attribute this progress to his/her actions and engagement in treatment. Many patients may need guidance and directions from you in making this connection—so don’t be afraid to be bold!

5. Review tips for maintaining improvement/discuss maintaining progress.

Refer to workbook, pages F6 & F7, “Maintaining Improvement” and “Next Steps.”

A. Transition to discussing “next steps” with the patient now that treatment is ending.

- Discuss ways to maintain treatment gains, using the “Maintaining Improvement” tip sheet as a guide to conversation. This includes both tips for maintaining improvement as well as tips for addressing set-backs.

Maintaining Improvement

Tips for Maintaining Improvement:

- Continue using your skills to maintain a high quality of life.
- Remain socially connected—be it in your faith community, social groups, the VA, or with friends and family.
- Tell someone close to you about your progress in this program and any ongoing goals. That way, you have accountability and support.
- Remember to set reasonable goals to avoid feeling let down or frustrated. Small steps are more likely to lead to accomplishment and positive feelings. Don’t forget your SMART goals!
- Track your progress. When you reach a goal, recognize your effort!

Bumps in the Road:

Despite our best intentions, things happen! We expect that people might hit bumps in the road. When you do, be kind to yourself and remember:

- Anticipating and addressing barriers to your goals will help you continue benefiting from this program long after your last session.
- Think about the bumps in the road you’ve encountered in the past—how did you get past them?
- What skills can you use to continue reaching your goals?
- Be flexible with new situations. When stressors occur, think about how you can use your toolbox in a different way.

F6

B. Collaborate with the patient to complete the “Next Steps” worksheet as part of this discussion of maintaining improvement.

- Discuss the patient’s ongoing goals—these can be specific (e.g., continue practicing relaxation techniques daily before bed) or broad (e.g., increase my social engagement).
- Assist patient in creating a general action plan for achieving future goals, with particular emphasis on skills taught in bCBT. Finally, guide the patient in identifying obstacles to his/her goals and problem-solve accordingly.
- Refer back to the “Maintaining Improvement” tip sheet as needed.

The worksheet is titled "Next Steps" in blue at the top. It has four main sections with purple headers and white lines for writing:

- What are your goals moving forward?
- What steps can you take to achieve your goals?
- Who can help you move forward?
- What might stand in the way?

At the bottom of each section is a row of five small icons representing different scenarios: a person stretching, two people talking, a group of people, a couple in a park, and a person dancing. The page number "F7" is in the bottom right corner.

Clinician Tip: Maintaining Improvement

- 1) Engage patient in ways he/she can continue to improve. Follow his/her lead! Social connections and continued use of bCBT skills (including self-monitoring) are likely to be important.
- 2) Anticipate “bumps in the road” once bCBT has ended. There are likely to be two types of stressors—those that are expected and those that are unexpected. Use the Tip Sheet to facilitate this discussion.
- 3) In addition, normalize setbacks for the patient, including the chance of depressive symptoms returning or worsening.
- 4) Patient may need assistance brainstorming possible barriers—have some common ones identified (e.g., time, money, worsening of depressive symptoms, motivation).
- 5) Encourage patient to think about the generalizability of bCBT skills and how these might be flexibly adapted to new stressors and situations.

6. Discuss when to seek follow-up treatment and provide crisis referral.

Refer to workbook, page F8, "Additional Help."

- A. Assist the patient in completing the top portion of the worksheet. Encourage the patient to write down signs and symptoms that his/her depressive symptoms are returning or worsening. This will serve as a resource to identify when to seek additional help after the discontinuation of bCBT treatment.
- B. Direct the patient that he/she can access behavioral health care at a later date by contacting his/her mental health care provider. If the patient does not have a mental health care provider, refer the patient to his/her VA primary care provider to access care. Finally, point out the Veterans' Crisis Line contact information.

The worksheet has a yellow border and a blue header bar. The title 'Additional Help' is centered above the first section. The first section is titled 'Signs you should seek additional help:' and contains four blank lines for writing. The second section is titled 'Options for seeking additional help:' and contains text about contacting VA primary care providers and mental health care providers. It also provides information on the Veterans' Crisis Line, listing a phone number, text message option, website, and availability. The page number 'F8' is at the bottom right.

Additional Help	
Signs you should seek additional help:	
Options for seeking additional help:	
Sometimes, despite attempts to use the skills you learned in this program, you may need additional help. If you notice symptoms of depression returning or worsening, remember that you can contact your VA primary care provider and/or your mental health care provider to get back into care.	
If things are getting to the point of a crisis and you need immediate help, contact the Veterans' Crisis Line:	
• Phone: 1-800-273-8255 (press 1)	
• Send text to 838255	
• Website: www.veteranscrisisline.net	
• Available 24 hours a day, 7 days a week, 365 days a year	

Clinician Tip: Ensuring plan for continuation of treatment as needed.

Assisting the Veteran to proactively identify signs that he/she may need additional services makes it more likely that he/she will engage in treatment when needed. Work with the Veteran to identify symptoms and signs that he/she was experiencing at the beginning of the bCBT program, and use this as a framework for early detection of the return or worsening of depressive symptoms in the future.

7. Close session.

Refer to workbook, page F9, "Finish Line."

Congratulate the patient on completing the bCBT program, and thank him/her for participating.



F9



Measurement-Based Care & Treatment Duration

Provider Manual

Measurement-Based Care

What is Measurement-Based Care?

Measurement based care (MBC) entails using data to monitor treatment outcomes (or response) over time and to use these data to inform care decisions.

Example: Psychiatrist administers PHQ-9 at each treatment visit (every 4-6 weeks) to monitor response to an antidepressant medication. Data from the PHQ-9 are used to inform dose titration, medication switch, or to change/add treatments.

Why Use Measurement-Based Care?

Measurement based care (MBC) is important for determining the effectiveness of a given treatment. In addition to providing information, MBC serves several key functions for improving the quality and impact of psychotherapy:

1. MBC is a core component of cognitive behavioral therapy (CBT).

MBC is a foundational element of CBT, which uses patient self-report inventories to assess change in outcomes related to depression, anxiety, anger, etc. CBT uses a structured approach with routine assessment of symptoms and progress toward goals to inform treatment. Thus, MBC is a natural fit with the current brief CBT protocol.

2. MBC improves intervention outcomes.

Research has shown that systematically monitoring depressive symptoms can improve treatment outcomes in specialty mental health (Knaup, et al., 2009; Lambert, et al. 2002) and primary care settings (Yeung, et al. 2012). These improvements are above and beyond standard interventions that do not use MBC. Therefore, MBC is an intervention in and of itself. MBC improves outcomes by informing treatment decisions.

3. MBC can help to identify non-responders.

MBC helps to assess whether or not a given treatment is working for the patient. This may inform a decision to continue treatment with careful monitoring, change the focus of treatment (e.g. change of skill module, goal, or action planning exercises), add a treatment (medications, medical treatment, spiritual referral), or in some cases, discontinue the primary treatment.

4. MBC can help detect residual symptoms.

MBC can help identify symptoms that remain even during effective treatment (e.g., depressed mood has remitted but sleep patterns remain disrupted). Identification of these residual symptoms can help clinicians and patients to more effectively identify skills to address these problem areas. It may also help patients to target and prepare for future difficulties.

5. MBC can help increase patient engagement in treatment.

The use of regular symptom monitoring including feedback and discussion with the patient is a meaningful way to include the patient in the treatment process. Engaged patients are much more likely to benefit from psychotherapy. This engagement also helps to crystallize common treatment goals between the patient and therapist. Transparency is key and MBC helps to improve treatment communication between the therapist and patient.

6. MBC can help patients recognize change.

Often patients discount their progress and their contributions to positive therapeutic change. By documenting change, clinicians are in a better position to show “tangible evidence” of improvement. Clinicians can take this a step further by exploring the reasons for change with the patient to highlight the patient’s contributions and efforts to realize this change. This process can be critical to building self-confidence and post treatment planning (e.g. the patient has the skills to maintain progress).

How do Clinicians Use Measurement Based Care in the Brief CBT Project?

The current Brief CBT project will use the PHQ-9 to regularly assess for depression.

- Clinicians are asked to use the PHQ-9 during each session as part of a brief mood check-in with the patient.
- PHQ-9 will be used to inform care decisions – especially related to treatment ending / treatment response.
- The brief CBT project team has created a CPRS note template with the PHQ-9 embedded to facilitate documentation of the PHQ-9.
- The PHQ-9 may be administered manually using the session note pages included in the abbreviated provider manual.

Why the PHQ-9?

- It is the depression measure of choice in the VHA.
- It is psychometrically strong.
- It provides clinically useful data on symptoms and diagnosis.
- It is practical for frontline practice.

Practical Tips for Using Measurement-Based Care:

- Build MBC (the PHQ-9) into your standard practice by creating routines.
- We recommend using the PHQ-9 at every visit and discussing the results with the patient as a foundational piece for each session.
- Use the CPRS template provided to increase ease of use, guide administration, and chart the patient's progress. The CPRS note will graphically display the patient's last three PHQ-9 total scores over time. However, you may want to track individual symptoms over time to show specific impact or change – especially if the patient's overall PHQ-9 score is relatively stable.
- The use of paper format administration is available using the abbreviated clinician manual (not required).
- Use the PHQ-9 to reinforce patient progress and to identify residual symptoms. Adjust treatment accordingly by selecting goals and focused skill modules to address specific issues or symptoms.

Treatment Duration

General guidelines for determining treatment length:

You can expect variation in each patient's clinical presentation (e.g. depression severity, mental / physical health complexity, social support, etc.) and preferences and/or availability for treatment. Given this, we cannot specify an exact length of treatment that will fit the needs of each patient. However, evidence suggests that brief psychotherapies such as CBT can be effective in as few as 2-3 sessions with many patients showing response by 4-6 sessions. That said, some patients may progress more slowly and may benefit from a few additional sessions beyond a normal course of treatment. The brief CBT for depression program uses a variable treatment intensity to allow providers and patients to determine treatment length.

During the development and testing of the brief CBT for depression intervention, response was defined as a PHQ-9 reduction of 50%. Example PHQ-9 targets include:

PHQ-9 At Treatment Initiation	PHQ-9 Response Target
26	13
24	12
22	11
20 (Severe)	10 (moderate)
18	9
16 (15 = Moderately Severe)	8
14	7
12	6
10 (Moderate)	5 (Mild)

Determination of treatment length should be based on clinical evidence, but more importantly within a collaborative relationship between the provider and patient. The following sections provide considerations for determining treatment length:

Patient is not appropriate for brief CBT.

Despite our best efforts to select appropriate treatments for individual patients, it may occur during treatment that brief CBT is not appropriate for the needs of a given patient. A provider may identify serious mental, physical, or social/contextual factors that require focused attention. For example, a provider may identify serious substance abuse issues that require immediate attention. In such cases it is imperative that providers discontinue brief CBT (where appropriate) and place effective referrals to address the most pressing needs of the Veteran.

Patient has partially responded to regular course (e.g. 4-6 sessions) of brief CBT.

Partial responders are patients who have not achieved their stated goals or have reduced depressive symptoms but remain at a moderate to high level of distress. In such cases, the provider should weigh the pros and cons related to the following options:

- 1) Continue brief CBT up to 9 sessions if the patient is making progress and is engaged in the process. This option also provides better continuity of care in that the patient will not be forced to develop a new relationship with a new therapist.
- 2) Referral to a new provider who can deliver more intensive depression services. This option is obviously contingent upon availability of such services and may or may not involve a delay or interruption in care. Ideally, a brief CBT therapist would remain in contact with the patient during the transition process to ensure continuity for the Veteran.
- 3) Prescribe an active period of watchful waiting where the brief CBT therapist may take a case management approach (e.g. following up by telephone on a monthly basis). Case management sessions may include depression symptom checkups but also to assess whether the patient is interested in discontinuing follow up or alternatively ready to engage in a more intensive course of treatment.

Partial response decision making is highly related to your local clinical setting, clinical procedures, and availability of services. Brief CBT is flexible and should always be delivered within the larger clinical context.

Patient has rapidly responded to brief CBT (e.g. within 1-2 sessions).

Some patients may demonstrate rapid improvements after beginning treatment. Ideally, brief CBT should include no fewer than three sessions even for rapid responders. Three sessions allow the provider to more fully assess the stability of depression symptoms. Even if stable, a second or third session allows the provider to work with the patient on matters related to maintaining change and how to prepare for symptom re-occurrence and steps to take if symptoms do in fact return.

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