Using CT effectively + flexibly: Conceptualize, motivate and intervene

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Workshop Overview

- **Hour 1.5: Core CBT elements + conceptualization**:
  - Maintaining reasonable structure + focus
  - Case conceptualization
- **Hour #1.5-3: Facilitating motivation + treatment integration + flexibility**
  - CBT + Motivational Interviewing
  - Exposure treatment: improving outcomes
  - Other issues? (time permitting)

CBT Core Elements

- Collaborative empiricism (Beck, 2011)
- Problem-focused
- Reasonably structured sessions
- Psycho-educational and...
- Focused on relapse prevention
- Action plans (homework) are <u>essential</u>

"Typical" CBT session structure

- Check in + mood check (+ objective data?)
- Collaboratively set <u>initial</u> session agenda
- Review action plan (homework)
- Re-prioritize <u>final</u> session agenda
- Discuss problems + **make interventions**
- Final session summary
- Review/develop next action plan (homework)
- Elicit CL feedback

Loss of session structure + focus

- Not adequately socializing CL to CBT
- Not discussing <u>specific</u> situations OR unfocused discussions:
  - Not focused on KEY thoughts, feelings, etc.
  - Unclear purpose of discussion OR no interventions made
  - TH's thoughts about interrupting
- Not eliciting or responding to CL feedback

Cbtscience/training/resources: Session assignment + feedback

- **Sample items: How well did**:
  - You feel heard + understood in today's session?
  - Today's session help address your problems?
  - How confusing was today's session?
  - How confident are you that you are progressing towards your therapy goals?

CBT Conceptualization

- **Can't treat what you can't conceptualize**
- Conceptualizations help us:
  - Organize CL info
  - Develop working hypotheses
  - Develop treatment plans + rationales for interventions
  - Build the working alliance

Why form working hypotheses? (Persons, 2015)

- One causal mechanism may underlie multiple problems
- ESTs may target a <u>single</u> disorder ONLY
  - There are no ESTs for many disorders
- Helps us address therapy-interfering thoughts + behaviors

Persons: Case Formulation

- Inclusive problem list
- Origins
- Precipitants (large events trigger current episode)
- **A**ntecedents (activating situations): triggers symptoms
- **B**ehaviors
- **C**onsequences (functional)
- **Causal mechanisms (mostly cognitive)**
- Organismic variables (unique vulnerabilities)

Case formulation example (adapted) (Ledley et al., 2010)

- Mike's parents held him to exacting standards and sent him to schools known for academic rigor (**ORIGINS**). As a result, Mike started seeing others as critical and feared being rejected for making mistakes (**CAUSAL MECHANISMS**). These thoughts occurred after deciding to enter the priesthood (**PRECIPITANT**). Afterwards he had ATs such as, "I make more mistakes than others" and "people will notice my anxiety...they'll think I'm incompetent" resulting in increased (social) anxiety (i.e., blushing, sweating, sleep disruption) (**SYMPTOMS/PROBLEMS**).

Case formulation (cont.)

- Having to give his first sermon triggered his anxiety again (**ACTIVATING SITUATION**). Mike coped by over-preparing sermons, only spoke to familiar people at social events and avoided discussing the priesthood with his family (**MECHANISMS**). This temporarily reduced his anxiety (**FUNCTIONAL CONSEQUENCES**) but he missed making valuable social contacts and did not self-disclose with his mentors which left him feeling more dejected and unsure of his future (**SYMPTOMS/PROBLEMS**).

## Inclusive problem lists

- **Problem areas:**
  - Health, psychiatric
  - Interpersonal/family
  - Job/school
  - Financial
  - Housing
  - Legal
  - Leisure functioning
- **Problems with lists:**
- Using vague terms/traits:
  - **Why is it a problem?**
- Ignoring non-psychological problems
- CL has "solved" it (?)
- **DO**: describe symptoms
- **DO**: look for themes or relationships among problems

What should be on Mike's problem list?

- #1:
- #2:
- #3:
- #4:
- #5:

David Tolin (Doing CBT, 2016) Automatic + Semi-Automatic cognition

- **Automatic thought**s > trigger mood congruent attention + recall
- **Intermediate beliefs** (Semi-Automatic)
  - Cognitive distortions, rules, interpretations
- **Core beliefs/schemas** (Semi-Automatic) > may trigger **compensatory strategies** (Young et al., 2006):
  - Maintenance/Surrender (do the usual...)
  - Avoidance/Escape (avoid your triggers)
  - Compensation/Counter-Attack (do the opposite)
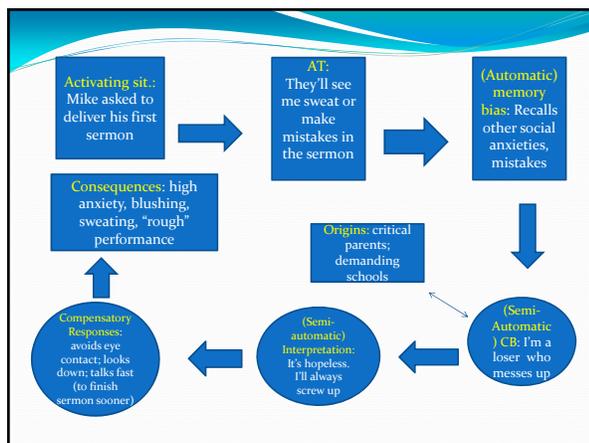
Why behavior is so important

- **World responds to what we say/do, not what we think**
- **Guideline #1**: Do better in order to feel better
- **Guideline #2:** Do the healthy opposite:
  - Teaches new coping skills
  - Disconfirms one's (maladaptive) beliefs
- **Guideline #3**: Avoid avoidance:
  - Short-term gain may enable long(er) term pain

ESTs: Lack of response

- **40% of CLs are in Pre-Contemplation stage** (Prochaska et al., 2014)
- **Driessen et al., 2013**: 16 sessions of CBT vs. psychodynamic therapy:
  - No differences on any outcome measures
  - Average 22% remission
- **Friborg & Johnsen (2017):** results of CBT for unipolar depression declined over time

cbtscience/training/resources: Lack of progress worksheet

- **Sample "lack of progress" factors:**
  - Relationship is weak, problematic
  - Little is known about treating CL's disorder
  - Goals are unrealistic (or we disagree on them)
  - Treatment dose is not meeting CL's needs OR
  - CL needs adjunct (or different) treatment
  - My own/CL's behaviors are interfering w/treatment
  - Substance use is interfering with treatment
  - CL has high social strain or lacks social supports

David Burns: Outcome + Process Resistance

- **Outcome:** CL resists due to "magical thinking," i.e., superstitious beliefs about treatment outcomes:
  - My anxiety protects me from something worse
  - My depression is the price I must pay for my sins
- **Process:** CL resists interventions due to magical thinking:
  - Exposure treatment resistance: My anxiety protects me from X

Beck: Therapy interfering beliefs

- **If I try + solve problems** >>>
  - I'll fail OR have to become more responsible
  - It means my TH is controlling me + I'm weak
- **If I get better, my life will get worse. WHY?**
  - CL fears not meeting others' (new) expectations
  - Loss of social support or enabling relationships
  - Facing life challenges directly: may lose your disability, lose your therapist, etc.

Other treatment challenges (Ledley, et al., 2010)

- CL thinks s/he must discuss the past in order to get better
- CL thinks her/his problems are biologically determined
- CL thinks that CBT may not work for her/him
- Are CL's meds interfering with treatment?
  - CL's attributions for change when taking meds?

Integrating CBT + MI for anxiety (Randall & McNeil, 2016

- **CBT elements consistent with MI:**
  - Problem-oriented > clear change targets
  - Highly collaborative relationship
  - Case formulation used to guide active treatment planning
  - Focus on skills + behavior change

Enhancing Motivation: Key MI processes

- **Engaging: Solid relational foundation**
  - Accurate empathy
  - **OARS** to understand ambivalence
  - Avoid the "righting" reflex (expert trap)
- **Focusing: Guide CL to a key change target:**
  - Identify behavior about which CL feels ambivalent
  - What's important to you? What could get in the way?

Enhancing Motivation: Key MI processes

- **Evoking: Draw out CL's reasons for change:**
  - Listen for "change talk" (vs. sustain talk)
  - Selectively reinforce + summarize change talk
  - Elicit-Provide-Elicit
- **Planning: Bridge to change:**
  - Selectively reinforce commitment language
  - Determine readiness for change + assist with specific change plans

Randall & McNeil (2016): Combining MI + CBT

- **Six case studies/uncontrolled trials + 11 RCTs**:
- *Treatment initiation and engagement can be improved* by adding MI as an adjunct to CBT... (p. 308)"
- MI may improve:
  - Readiness to change
  - Treatment acceptance + commitment

Preparatory change talk: DARN

- **D**esire to change
- **A**bility to change (CL has self-efficacy)
- **R**easons to change (the "pros" of changing)
- **N**eed to give up the status quo (<u>not</u> changing)

Change Talk: CAT

- **Commitment**: stated intention to change:
  - I'm going to do X.....I plan to...
- **Activation:** leaning into change (I'll try to...)
- **Taking steps: describe specific actions**:
  - I'll walk every night after dinner...
  - I'll try to (**activation**) eat 5 servings of fruit daily (**taking steps**)
  - I'll limit myself to one drink (**taking steps**)

Elicit-Provide-Elicit

- **Elicit**: ask permission to make a suggestion
- **Provide:** suggest in **non-personal** ways:
  - **NOT** "You should do X"
  - **BUT**: "This has helped some CLs..."
- **Elicit**: explore CL's reaction w/open ?s

Maximizing exposure treatment (Craske et al., 2014)

- **Fears may return after exposure treatment due to:**
  - Lack of repeated exposures <u>after</u> treatment ends OR
  - Phobic stimulus is encountered in a <u>different</u> context (EX: social phobia returns after a new social rejection)

Maximizing inhibitory learning (Craske et al., 2014)

Strategy	Catch phrase
Expectancy violation	**Test it out**
Deepened extinction	**Combine it** (2 cues)
Reinforced extinction	**Face your fea**r: present US in some trials
Variability	**Vary it**: vary stimuli + contexts
Remove safety behaviors	**Throw it out**: remove safety signals, acts

Strategies for maximizing inhibitory learning

Strategy	Catch Phrase
Attentional focus	**Stay with it**: focus on CS during exposure
Affect labeling	**Talk it out**: ask CL to describe emotions during exposure
Mental reinstatement or retrieval cues	**Bring it back**: use cue during extinction OR reinstate other successful exposures

CBT + Acceptance and Commitment Therapy

- Both address emotional self-regulation:
  - CBT uses **antecedent-focused** strategies
  - ACT uses **response-focused** strategies
- **Cognitive restructuring**: does it imply that your thoughts are "wrong"?
- **Heimberg + Ritter (2008):** CBT also promotes "cognitive defusion:"
  - Thoughts are "hypotheses" to test, NOT facts

Trans-theoretical approach: Stages of change

- **Prochaska et al (2014): % CLs per stage** >
  - Pre-Contemplation: 40-45%
  - Contemplation: 35-40%
  - Prepared for Action: about 20%
- Can double % taking action if progress <u>one stage in a month</u>

The right things (processes) at the right time (stages)

- **Rosen (2000):** 47 study meta-analysis:
  - Effect sizes of .70-.80 for use of different processes at different stages
  - Change processes for experiential, cognitive, psychoanalytic > best for Pre-Contemplation + Contemplation stages
  - Change processes for behavioral approaches: best for Action + Maintenance stages

Assessing stage of change (Prochaska et al., 2013)

- *Do you think behavior X is a problem for you now?*
  - If yes > Contemplation, Preparation, Action
  - If no > Maintenance, Pre-Contemplation
- *When do you intend to change behavior X?*
  - If not soon > Contemplation
  - If within next month > Preparation
  - If now > Action

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