Evidence-Based Psychotherapy
Shared Decision-Making
Toolkit for Mental Health Providers

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Preface

Far too many Veterans and other individuals with mental health needs in the United States and throughout the world fail to receive treatment. For those who do get care, the treatments they receive frequently do not resemble treatments highly recommended by clinical experts for their condition. This is especially the case for evidence-based psychotherapies (EBPs)—psychotherapies shown to be efficacious in randomized controlled trials—which are recommended at the highest level and as first-line treatments for a number of mental and behavioral health conditions. These circumstances have resulted in innumerable missed opportunities for significant clinical and functional improvement and have created a gap in evidence-based treatment that is larger than in virtually any other health care context.

At the same time, increasing data over the past decade have revealed that Veterans who receive EBPs often reap significant improvements in symptoms and quality of life. A number of these experiences include heartwarming stories in which treatment helped to greatly change key aspects and the trajectory of Veterans' lives, sometimes after many years of suffering. Yet, relatively few Veterans who may benefit from these treatments receive them.

Among the most significant and widely unrecognized barriers contributing to missed opportunities for EBPs are key patient factors, namely limited knowledge of EBPs, negative treatment perceptions, and stigma—factors that are often particularly relevant for Veterans. Many Veterans are not aware that EBPs exist. And the meaning and distinction of "evidence-based psychotherapy," as well as acronyms such as CBT, CPT, PE, and MET, are foreign to most Vets. For most Veterans, mental health treatment is a mysterious "black box," with their knowledge and perceptions of mental illness and treatment shaped largely by often inaccurate or incomplete media portrayals and anecdotal information or references from peers.

In addition to, and compounding, limited knowledge and related patient factors, there infrequently exist systematic processes in mental health care settings, unlike in other health care settings, to inform patients about treatment options and engage them in an individualized discussion of possibilities. Such processes are the essence of the growing and now common practice of treatment shared decision-making (SDM) in a number of areas of health care. Within mental health care, the systematic adoption of SDM has

been limited, leading to unrealized opportunities for (1) facilitating the very important and personal decision to address mental health problems; and (2) engaging patients in the selection of treatment and the ensuing treatment process. We believe, and recent research and experience support, that when patients have an opportunity to actively contribute to the decision about treatment, they are more likely to initiate treatment and engage in the treatment process.

This *Evidence-Based Psychotherapy Shared Decision-Making Toolkit for Mental Health Providers* was developed to facilitate the implementation of clinical processes and procedures for empowering and engaging patients in treatment decision-making as part of the delivery of mental health care. Based on key principles and best practices of SDM and patient engagement, the toolkit sets forth a structured yet flexible process for incorporating shared decision-making beginning prior to the initiation of treatment. A primary focus of the toolkit is identifying and describing key components and steps for implementing an *SDM Session* prior to the initiation of EBPs (or other mental health treatments) to promote informed choice and increase initial treatment engagement. The toolkit includes clinical dialogue, decision aids, and other patient and provider tools and applied content to help guide mental health providers in implementing the SDM principles and steps described in the toolkit. The toolkit also identifies practical and logistical requirements and guidelines to help clinicians, program managers, and administrators implement these processes locally.

Beyond advancing principles and processes of SDM for promoting informed choice and initial engagement in EBPs and other mental health treatments, this toolkit includes information and resources for increasing *ongoing* engagement among Veterans who choose to begin treatment. Specifically, the toolkit identifies and describes opportunities for increasing patient engagement during the treatment process by placing important focus on assessing and enhancing the therapeutic alliance and incorporating principles and practices of measurement-based care.

Check it out!
Treatment Works for Vets website

This toolkit is part of an initiative sponsored by the Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) for Veteran Suicide Prevention designed to promote Veterans' awareness of and engagement in EBPs and address key patient factors contributing to low EBP uptake and delivery. In addition to this toolkit, this initiative includes the development of an innovative public education website—Treatment Works for Vets—designed to promote awareness of EBPs and instill hope and motivation among Veterans and family members using interactive information and exercises and animated, character-based videos. In this way, Treatment Works for Vets serves as a direct-to-consumer education resource intended to promote interest, conversation, and initial help-seeking behaviors (e.g., asking primary care providers about EBPs, reaching out for mental health care). Once "in the door," Veterans may then proceed to participate in the SDM Session described in this toolkit. Thus, the pairing of these components—direct-to-consumer outreach and SDM—represents a two-pronged approach for engaging Veterans in care. In addition, mental health providers may incorporate or introduce Treatment Works for Vets during the SDM Session. Patient decision aids and other patient and provider resources that accompany this toolkit may also be accessed through the Provider portal of the website (www.mirecc.va.gov/visn19/treatmentworksforvets/providers).

Because providing the best care possible to those who provide for us is a collective responsibility and moral imperative, this toolkit is designed to serve as a public resource

for mental health providers and administrators in all practice settings who care for Veterans—whether public or private system, local clinic, or private practice. We hope this toolkit and the Treatment Works for Vets website are useful resources for enhancing treatment engagement and outcomes with Veterans. We would be delighted to hear about your experiences and feedback as you use these resources. Thank you for your commitment to improving the well-being of our nation's Veterans—and for reducing missed opportunities in the delivery of mental health care.

Introduction to the Toolkit

This toolkit was developed to address key patient factors that represent significant needs and opportunities for increasing uptake and engagement of EBPs among Veterans, building on recent dissemination and implementation efforts that have primarily addressed important implementation needs at provider, systems, and organizational levels.

The past several decades have witnessed substantial progress in the psychological treatment of mental and behavioral health conditions. The quest for new treatments and the application of scientific procedures to evaluate and validate psychological treatments have yielded a number of evidence-based psychotherapies (EBPs) for a wide range of conditions. Based on this research, many EBPs are recommended at the highest level in clinical practice guidelines and, in some contexts, as first-line treatments. For years, however, the promise of EBPs has failed to become reality as these treatments are infrequently available in real-world treatment settings.

Recognizing the need and opportunity to realize the potential of EBPs for Veterans, the U.S. Department of Veterans Affairs (VA) health care system has worked to disseminate and implement more than 15 EBPs throughout the VA health care system, guided by a multi-level model informed by implementation science (Karlin & Cross, 2014a). Now underway for more than 10 years and representing the largest dissemination and implementation of EBPs in the nation, this effort has resulted in the training of more than 11,000 VA mental health staff in one or more EBPs. Most significantly, program evaluation results from this initiative have shown that training and implementation of these therapies has yielded robust improvements in therapist and patient outcomes in routine treatment settings, including overall large increases in therapist competencies and positive beliefs toward EBPs, and clinically significant reductions in patient symptoms and improvements in quality of life (Eftekhari et al., 2013; Karlin et al., 2012; Karlin, Trockel, Taylor, Gimeno, & Manber, 2013; Stewart et al., 2014; Stewart et al., 2015; Walser, Karlin, Trockel, Mazina, & Taylor, 2013). Evaluation data have also revealed significant decreases in suicidal ideation among Veterans receiving several of these treatments (Brown et al., 2016; Trockel, Karlin, Taylor, Brown, & Manber, 2015; Walser et al., 2015).

Despite unprecedented efforts to make EBPs more widely available and the positive impact they have had on the lives of many Veterans—many of whom have been struggling with mental health problems for years—recent data indicate that a relatively small proportion of Veterans who can benefit from EBPs receive them (Kehle-Forbes, Meis, Spoont, & Polusny, 2016; Lu, Plagge, Marsiglio, & Dobscha, 2016; Watts et al., 2014). This

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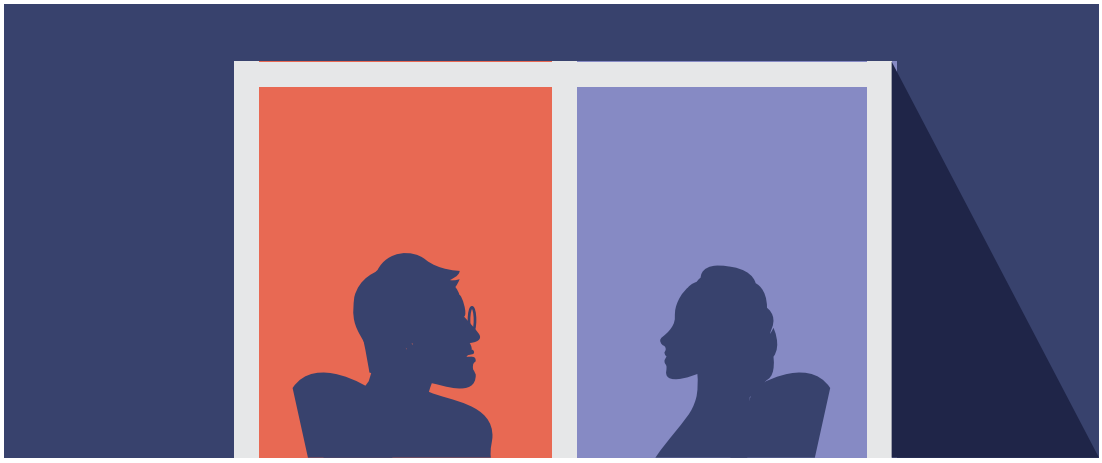
toolkit was developed to address key patient factors that represent significant needs and opportunities for increasing uptake and engagement of EBPs among Veterans, building on recent dissemination and implementation efforts that have primarily addressed important implementation needs at provider, systems, and organizational levels. **Notwithstanding the essential "supply side" developments in promoting the availability of EBPs, many Veterans initially present for care unfamiliar with mental health treatments, how they may be beneficial to their personal situations, and what they would like to see change in their lives. Veterans also often have differing perceptions of treatment, past treatment experiences, and reasons for seeking care.** These patient factors serve as significant gaps to seeking and engaging in EBPs. Addressing these factors and promoting provider-patient alignment and partnership is critical prior to treatment selection and initiation.

Fundamental to increasing engagement in EBPs is involving Veterans in a process of shared decision-making (SDM) beginning prior to the initiation of treatment. Increasingly part of high-quality, person-centered care in other health care contexts, SDM principles and processes provide significant opportunities for promoting initial and ongoing engagement in EBPs. Accordingly, the primary focus of this toolkit is on identifying key components and steps for implementing a pre-treatment SDM process to increase initial engagement in EBPs. Central to this process is the delivery of a highly collaborative SDM Session that is designed to promote informed choice, treatment motivation, and patient readiness for EBP. The SDM Session includes six key components:

1. **Connect:** Establish initial trust and interpersonal connection
2. **Motivate:** Assess and enhance motivation for treatment
3. **Educate:** Educate Veteran about EBPs and other treatment options
4. **Explore:** Explore values and preferences
5. **Set Goals:** Identify potential treatment goals
6. **Choose:** Select treatment or determine next steps

In addition to providing information and tools to promote initial treatment engagement, the toolkit includes treatment process and related resources in two key areas for increasing *ongoing* engagement for Veterans who choose to receive EBPs—the therapeutic alliance and measurement-based care. These two areas represent significant opportunities for keeping Veterans engaged in treatment, reducing dropout, and maximizing treatment outcomes.

This toolkit is made available as a public education resource to support mental health providers and administrators throughout the nation, including those who work in the VA health care system, as well as those who work in systems and settings outside of the Veterans Health Administration (VHA). Within the VA health care system, it is anticipated that this toolkit will be an essential resource for Local Evidence-Based Psychotherapy Coordinators—–champions for EBPs at each VA medical center whose role is to promote the local implementation of EBPs. Local EBP Coordinators are encouraged to use this toolkit and associated resources with clinical staff, clinic directors, and program leadership to implement the processes described in this toolkit.



Increasingly part of high-quality, person-centered care in other health care contexts, SDM principles and processes provide significant opportunities for promoting initial and ongoing engagement in EBPs.

Although the focus of this toolkit is on promoting engagement of Veterans in evidence-based psychotherapies, the principles and processes of shared decision-making, informed choice, and patient engagement described in the toolkit offer opportunities for enhancing the treatment experience and maximizing outcomes more broadly. Indeed, the concepts and strategies recommended in the toolkit represent core components and processes for maximizing engagement and outcomes that may also be incorporated into other types of mental health services.

Section 1 of the toolkit provides a foundational review of the principles, goals, and practices of SDM. Building on the tenets and practices of SDM, Section 2 introduces a clinical process, known as the *SDM Session*, for promoting patient informed choice and shared decision-making beginning prior to the initiation of treatment to increase initial engagement of Veterans in EBPs (or other mental health treatments). The toolkit next describes how to implement the six steps of the SDM Session and presents clinical dialogue and clinician and patient education materials and decision aids to facilitate the delivery of this pre-treatment session. After introducing and describing the clinical steps of the SDM Session, the toolkit provides practical and logistical guidelines and considerations designed for clinicians, program managers, and administrators to implement this pre-treatment SDM process locally. Moving beyond initial engagement, Section 3 presents clinical strategies and resources for increasing *ongoing* treatment engagement with Veterans who elect to begin treatment, including incorporating regular assessment and enhancement of the therapeutic alliance and ongoing assessment of outcomes to guide treatment decision-making (measurement-based care) into EBP treatment.

This toolkit may be accessed electronically through the Provider portal of Treatment Works for Vets (www.mirecc.va.gov/visn19/treatmentworksforvets/providers) an innovative public education website designed to promote awareness of and engagement in EBPs among Veterans and family members. Patient decision aids and other patient and provider resources that accompany this toolkit may also be accessed through the Provider portal.

SECTION 1

Introduction to Shared-Decision Making

1

INTRODUCTION TO SHARED-DECISION MAKING

The concept of shared decision-making (SDM) has existed for well over 30 years and was borne out of increasing societal emphasis on patient rights and patient advocacy in the 1980s (Hoving, Visser, Mullen, & van den Borne, 2010). Historically, the role of the patient in health care delivery was seen as passive, with the physician viewed as the clear authority who decided what was right for the patient and developed the treatment plan that the patient was expected to follow. Beliefs, values, and preferences of the patient were generally not directly factored into treatment decisions or the treatment process (Hoving et al., 2010). In the 1960s and 1970s, research on physician-patient communication led to increased attention to patient education. However, this typically consisted of passive and non-systematic methods of one-way information exchange (e.g., patient brochures), with patients generally not seen as active participants in the treatment process. In the 1980s and the decades to follow, empowering patients with information and the notion of patients taking a more active role and shared responsibility in the treatment process gained attention, contributing to a more sophisticated conceptualization of SDM. One important development in this regard was the identification and description of SDM by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in 1982. This Commission, appointed by then-President Carter, advanced the following definition of SDM:

> [SDM] will usually consist of discussions between professional and patient that bring knowledge, concerns, and perspectives of each to the process of seeking agreement on a course of treatment. Simply put, this means that the physician or other health professional invites the patient to participate in dialogue in which the professional seeks to help the patient understand the medical situation and available courses of action, and the patient conveys his or her concerns or wishes (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1982, p. 44).

The key concept underlying SDM is that both the provider and the patient contribute actively to decisions about the patient's health.

The key concept underlying SDM is that both the provider and the patient contribute actively to decisions about the patient's health. **Specifically, the provider supplies relevant information, such as descriptions of potential interventions, their benefits and side effects, and data supporting their efficacy in understandable language. The patient considers this information through the lens of their values and preferences that may affect engagement in treatment. Significantly, this focus on the patient's values and preferences extends the traditional informed consent process of examining potential risks, benefits, and alternatives for various health care interventions and personalizes the decision-making process.** Providers who practice from an SDM framework recognize that different treatment options come with

their unique set of benefits, harms, and uncertainties and that different patients will weigh these factors in different ways. Although the two most central players in SDM are the patient and the provider, other individuals often have a role in the process, including the patient's family members, other members of the treatment team, and those who have been treated for similar conditions (Joosten et al., 2008).

Among the best-known aspects of SDM is the concept of the decision aid, or an information tool that facilitates the decision-making process, often in the form of a pamphlet, grid, video, or interactive website or other electronic resource. Decision aids are frequently used to help patients distill and comprehend extensive and often complex health information. In general, decision aids (1) provide evidence-based information about a health condition and treatment options and (2) facilitate a process in which patients decide what is most important to them and consider ways to maximize benefits and minimize harm (Shafir & Rosenthal, 2012). **Consequently, decision aids are generally an important component of the SDM process, though they represent one part of a larger collaborative and interactive *interpersonal* process that is also informed by patient needs, experiences, values, and preferences.**

In more recent years, SDM has moved from concept to increasingly being implemented into clinical practice in a variety of health care contexts. Among several significant events that have fostered the widespread growth in SDM over the past two decades was the identification of key SDM principles and practices as part of specific recommendations issued by the Institute of Medicine in 2001 (National Academy of Sciences, 2001). In its seminal report on redesigning health care, the IOM included five recommendations that pertain to SDM:

1. Care is customized according to patient needs and values.
2. The patient is the source of control.
3. Knowledge is shared, and information flows freely.
4. Decision making is evidence-based.
5. Transparency is necessary.

Another key event that helped to cultivate SDM was its inclusion in the Patient Protection and Affordable Care Act (ACA). Moreover, several states have enacted legislation to promote implementation of SDM (Shafir & Rosenthal, 2012).

Although SDM is emphasized and now commonly practiced in general health and specialty care (particularly oncology) settings, its systematic adoption in mental health care has been sporadic and slow.

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Although SDM is emphasized and now commonly practiced in general health and specialty care (particularly oncology) settings, its systematic adoption in mental health care has been sporadic and slow. Recognizing and reflecting the slow adoption of SDM in mental health care delivery, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a report, based on expert consensus, designed to promote the incorporation of SDM into mental health care practice and research (SAMHSA, 2010). Among the expert recommendations for advancing SDM in mental health care was the development of models and materials for implementing SDM in mental health care targeted for mental health providers.

1.1. SDM MODELS

In recent years, a number of general SDM conceptual models have been developed to help inform understanding and implementation of SDM. In their review of 15 SDM models,

Stacey and colleagues (2010) identified 18 core concepts across four domains (Features of SDM Process, Individuals Involved in SDM, Factors Influencing the SDM Process, Outcomes of SDM). These domains and core concepts are summarized in Table 1.1.

TABLE 1.1.
DOMAINS AND CORE CONCEPTS IN SDM CONCEPTUAL MODELS

DOMAIN	CORE CONCEPT	DEFINITION OF CORE CONCEPT
Features of SDM Process	Equipoise	Recognition that a decision needs to be made
	Knowledge transfer and exchange	The communication of information from the health care provider to the patient treatment options and their procedures, side effects, and effectiveness
	Expression of values and preferences	Patient's identification of factors that they view as important and may influence their treatment decision
	Deliberation	The processing of information in light of the knowledge transferred and values and preferences considered
	The decision	Treatment option selected on the basis of deliberation
	Implementation of the decision	Patient and provider follow through with selected treatment
Individuals Involved in SDM	Patient	The individual with a health condition who is seeking treatment for the condition
	Provider	The trained health care professional who educates the patient about available treatments
	Decision coach	A trained health care professional who provides support to patients in the decision-making process to reduce decisional conflict
Factors Influencing the SDM Process	Establishing a partnership	The ability of the provider and patient to form a collaborative relationship for facilitating the decision-making process
	Health care system policies	Relevant policies in the agency or institution, including the training required to implement SDM, the time allotted to providers to deliver SDM, the process by which patients are identified for and referred to SDM, and reimbursement for time spent engaging in SDM
	Access to health information beyond that which was offered by the provider	Patient's resources, outside of those given by the provider, to learn more about their health condition, available treatments, and procedures, side effects, and efficacy of treatments
	Availability of decision aids to facilitate SDM	Written and interactive materials describing the health condition, potential treatments, and the procedures, side effects, and effectiveness of treatments
	Access to health care services	The availability of treatments for the patient's health condition, and the patient's ability to utilize those treatments

DOMAIN	CORE CONCEPT	DEFINITION OF CORE CONCEPT
Outcomes of SDM	Patient level outcomes	The impact of SDM on one or more patient level domains, including knowledge, attitude, engagement, well-being, and health status Examples: ▪ Understanding of treatment ▪ Confidence about treatment ▪ Uptake of treatment ▪ Satisfaction with selected treatment ▪ Adherence to treatment ▪ Quality of life ▪ Emotional distress
	Relationship level outcomes	The impact of SDM on the patient-provider relationship, including agreement on aspects of treatment
	Practitioner outcomes	The impact of SDM on provider-related beliefs and behaviors
	Health care system outcomes	The impact of SDM on health system-related domains, such as health care quality, costs, and throughput

Adapted from Stacey et al. (2010)

Across SDM models, the specific constructs included vary significantly. A summary of models and features included within each is presented in Table 1.2. Additional information is available in Stacey et al. (2010) as well as in individual articles cited describing specific models. Of note, these models are primarily based on the general medical care context.

TABLE 1.2.
COMPARISON OF SDM MODELS

MODEL	FEATURES OF THE SDM PROCESS	INDIVIDUALS INVOLVED IN SDM
Briss et al. (2004)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation ▪ The decision ▪ Implementation of the decision	▪ Provider ▪ Patient
Charles, Gafni, & Whelan (1997)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation ▪ The decision	▪ Provider ▪ Patient ▪ Additional health care providers[a] ▪ Family members or friends[a]
Eddy (1990)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ The decision	▪ Provider ▪ Patient
Elwyn et al. (2012; developed from qualitative research reported by Elwyn et al., 1999)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation ▪ The decision	▪ Provider ▪ Patient
Emanuel & Emanuel (1992)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation	▪ Provider ▪ Patient
Entwistle & Watt (2006)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation ▪ The decision	▪ Provider ▪ Patient
Légaré et al. (2011)	▪ Equipoise ▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation ▪ The decision ▪ Implementation of the decision	▪ Provider ▪ Patient ▪ Decision coach ▪ Other health care professionals[a] ▪ Family members[a]
Llewellyn-Thomas (1995)	▪ Knowledge transfer and exchange ▪ Expectations[a] ▪ Expression of values and preferences ▪ The decision	▪ Provider ▪ Patient ▪ Family members[a]
Makoul & Clayman (2006)	▪ Equipoise ▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation ▪ The decision	▪ Provider ▪ Patient

MODEL	FEATURES OF THE SDM PROCESS	INDIVIDUALS INVOLVED IN SDM
Myers (2005)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences (most central construct in this model) ▪ Deliberation ▪ The decision ▪ Implementation of the decision	▪ Provider ▪ Patient
O'Connor et al. (1998)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation ▪ The decision ▪ Implementation of the decision	▪ Provider ▪ Patient ▪ Family members and friends (in the way that they establish norms, apply pressure, provide support, and shape decision participation roles)[a]
President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982)	▪ Equipoise ▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation	▪ Provider ▪ Patient
Rothert et al. (1997)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ The decision ▪ Implementation of decision	▪ Provider ▪ Patient
Sheridan et al. (2004)	▪ Assessment of patient's health needs, eligibility for preventive services, and desired role in decision-making ▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ The decision ▪ Implementation of the decision	▪ Provider ▪ Patient
Stacey et al. (2008)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation ▪ The decision ▪ Implementation of the decision	▪ Provider ▪ Patient ▪ Decision coach
Towle & Godolphin (1999)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ Deliberation ▪ The decision ▪ Implementation of the decision	▪ Provider ▪ Patient ▪ Other health care professionals[a] ▪ Family members[a]
VandeVusse (1999)	▪ Knowledge transfer and exchange ▪ Expression of values and preferences ▪ The decision	▪ Provider ▪ Patient

Note: [a]Included as a component of the model, but was not identified by Stacey et al. (2010) as a core concept or consistent component across models.

Review of the components of each of the foregoing models reveals a number of notable themes, which are summarized below:

1. Each of the models includes two key components—knowledge transfer and exchange and expression of values and preferences.
2. Making "the decision" is specifically included in all but one of the models (i.e., Emanuel & Emanuel, 1992), in which it is implied.
3. Most models include a step for deliberation following knowledge transfer and exchange and discussion of values and preferences, as well as for the implementation of the decision.
4. The major "players" in all of these models are the provider and patient, although several models include important others in the decision-making process, including family members, friends, other health care professionals, and decision coaches.
5. A few models specifically include the establishment of a collaborative partnership between the patient and provider as an important factor influencing the SDM process; the central role of a collaborative partnership is implied in other SDM models.
6. Use of decision aids is explicitly referenced in approximately 25% of the models, although decision aids were clearly viewed as tools to facilitate the steps of SDM, rather than representing or replacing the process.

One widely cited contemporary SDM model, developed by Elwyn and colleagues (2012), offers particular applied utility for guiding the application of SDM principles in clinical practice and, consequently, has informed a number of recent SDM interventions. This model is based on a framework established through an iterative, expert consensus process (Elwyn et al., 2014). The framework specifically emphasizes patient engagement, patient education, elicitation of patient preferences, and decision-making that reflects input and preferences of the provider and patient. In particular, the model incorporates a simple yet elegant three-step process designed to promote "informed preferences" and treatment decision- making: (1) *choice talk*, (2) *option talk*, and (3) *decision talk*. The three steps of SDM incorporated into this model are described below and summarized in Table 1.3.

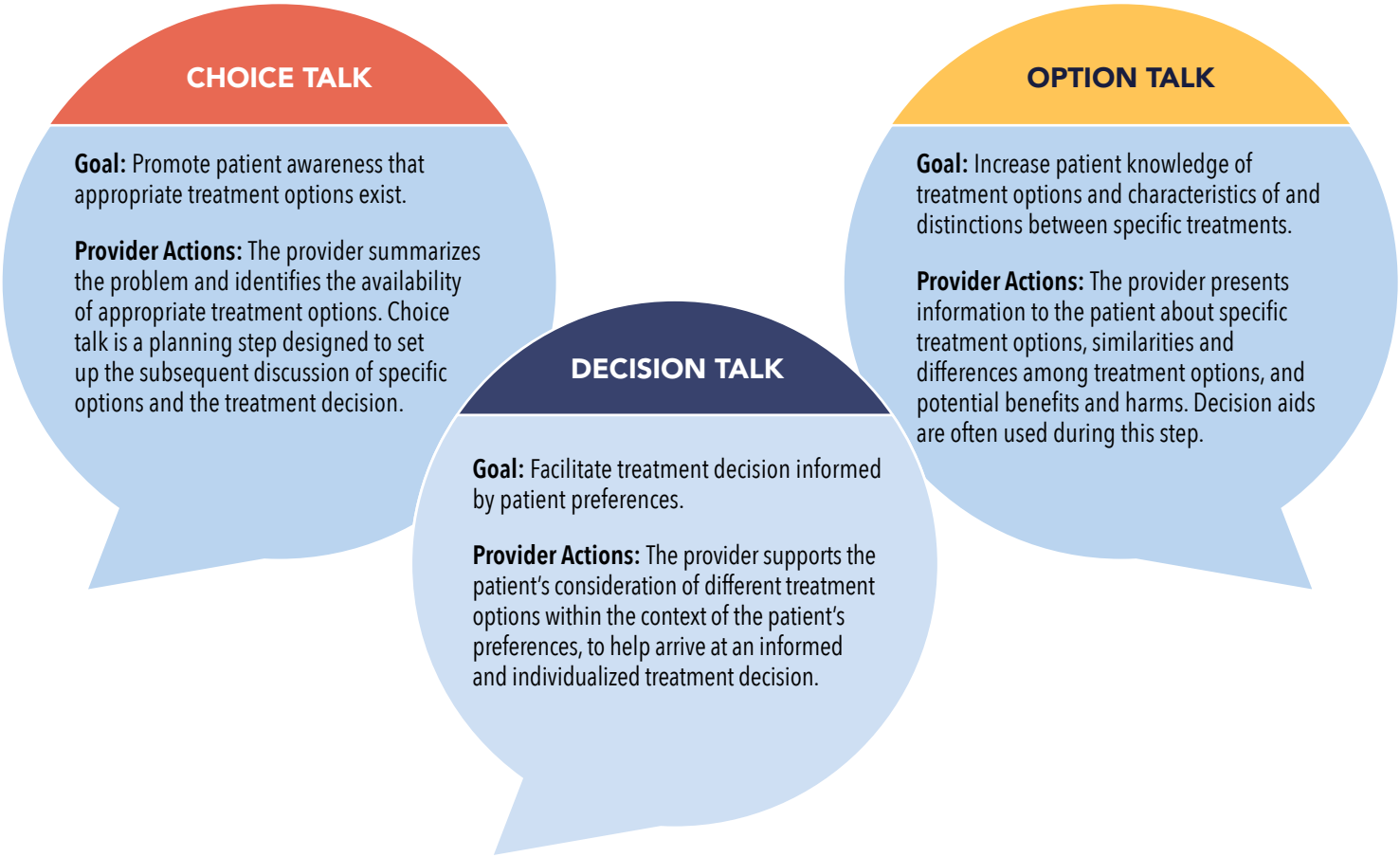
Choice talk focuses on helping patients to recognize that various treatment options are available. It may be considered as a "planning" step in the model. The process begins with the provider taking a step back, summarizing the problem, and inviting the patient to discuss what to do about the problem. The provider then presents initial information about treatment options available and emphasizes the importance of personal preference and the role of uncertainty for any treatment. Throughout the discussion, the provider checks in with the patient to ensure understanding, elicit questions, and confirm that the patient would like to continue the conversation.

Option talk focuses on providing more specific information about treatment options. During this discussion, the provider identifies key similarities and differences and the benefits and harms of the different treatment options. This process is intended to be collaborative and interactive, rather than purely didactic, such that the provider delivers information in small doses and regularly checks the patient's understanding of and reaction to the information. **The use of and reference to decision aids, such as a summary list or grid of treatment options, is encouraged for helping to distill and**

organize key information about treatment options. At the conclusion of this step, the provider often presents a final summary of the treatment options and then elicits a summary from the patient to assess comprehension and accuracy of understanding.

Decision talk focuses on identifying and considering patient preferences and moving to a decision. As part of eliciting patient preferences, the provider might ask what matters most to the patient. During the conversation, the provider inquires whether the patient is ready to make a decision or instead would prefer more time to contemplate options. When appropriate, the patient may be encouraged to take additional time to consider the information and review decision aids on their own before making a decision. Further, the model recognizes that some individuals may wish to discuss the information with others before coming to a decision.

TABLE 1.3.
ELWYN ET AL. (2012) SHARED DECISION-MAKING MODEL: GOALS AND PROVIDER ACTIONS



One additional model that is complementary to other models and deserves elaboration is the *Communication Model of Shared Decision-Making* (CMSDM) (Siminoff & Step, 2005). This model was not included in Table 1.2 above because it focuses less on the processes or steps of SDM (i.e., knowledge transfer and exchange, expression of values and preferences) and more on contextual factors that affect communication between the provider and patient, expanding on earlier work focusing on contextual factors noted above (Llewelyn-Thomas, 1995). One contextual factor is *patient-physician communication antecedents* (preexisting individual factors that could influence communication), which capture differences in sociodemographic characteristics (e.g., gender, culture, ethnicity),

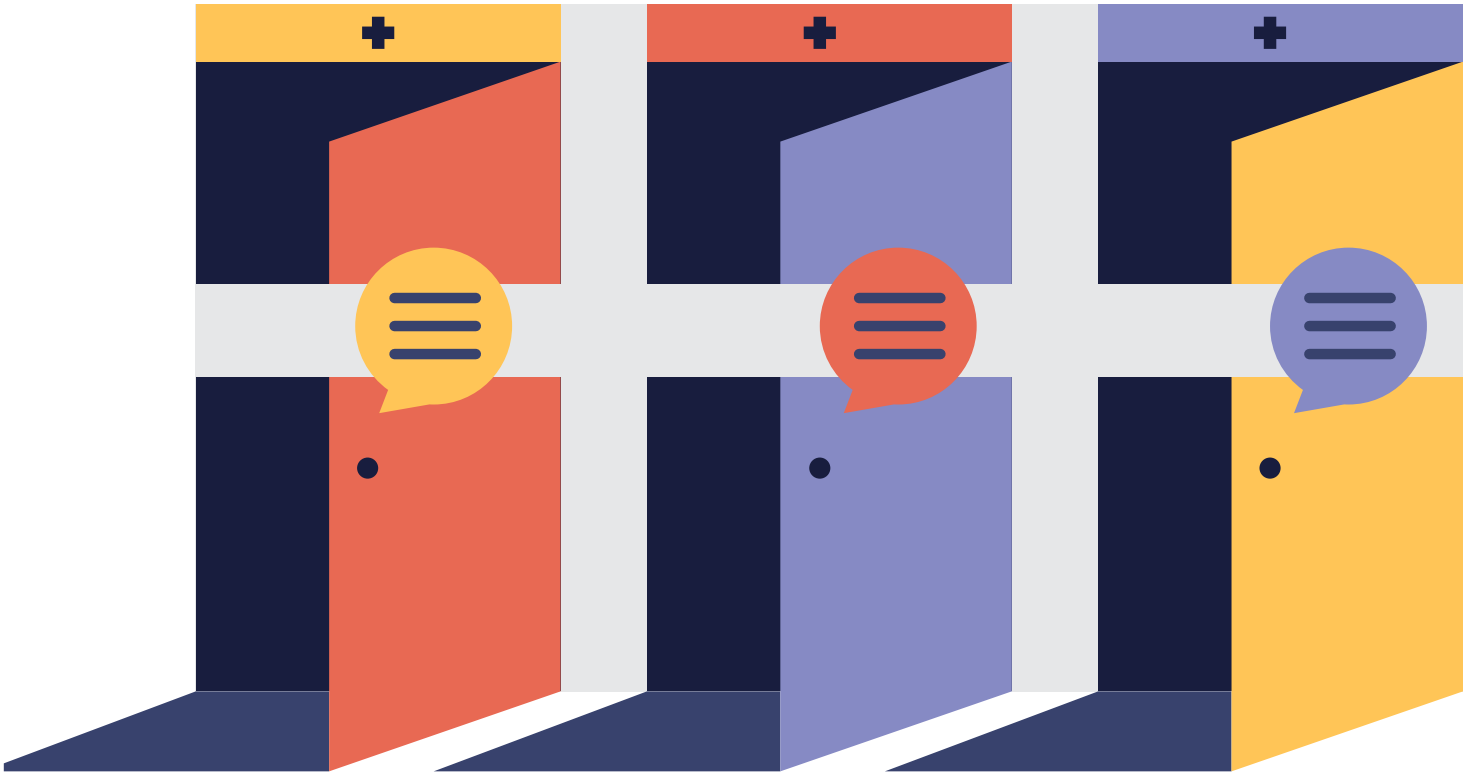
personality traits, and communication competence between the provider and patient. Cultural differences between the provider and patient, in particular, are important to acknowledge, as culture affects beliefs about illness, preferences for treatment, trust in health care providers, and perceptions of discrimination (Hawley & Morris, 2017). Another contextual factor identified in this model is the *communication climate* in which the communication occurs, including the amount of information available about the patient's condition, the severity of disease, the emotional state of the patient and provider, and the patient's preference about how much involvement they wish to have in the decision-making process. **One clinical implication of this model is the significance of diversity, including in the patient-provider dyad, in the SDM process. Further, the model explicitly recognizes that not all patients prefer a highly collaborative approach to SDM, but may wish for the provider to assume a more active and authoritative role—a preference that may be affected by cultural and other factors (e.g., Dowsett et al., 2000).** This important consideration notwithstanding, research and expert opinion indicate that most patients (including Veterans) desire additional information about their health conditions and treatment options and prefer to be actively involved in decision-making—a preference that has appeared to increase over time (Chewning et al., 2012; Harik, Hundt, Bernardy, Norman, & Hamblen, 2016; Watts, Zayed, Llewellyn-Thomas, & Schnurr, 2016). When information exchange and other SDM components are not desired, this may also be a reflection of low self-efficacy rather than disinterest in SDM (Légaré & Thompson-Leduc, 2014). In short, the CMSDM model's focus on contextual factors provides an important reminder that the SDM process should be individualized on the basis of the patient's unique and specific clinical presentation, individual characteristics, social and cultural background, needs, and style.

The SDM process should be individualized on the basis of the patient's unique and specific clinical presentation, individual characteristics, social and cultural background, needs, and style.

Over the past several decades, as SDM has made significant inroads in general and specialty medical care settings, there has been limited focus on SDM within the context of mental health care delivery (Duncan, Best, & Hagen, 2010; Morant, Kaminskiy, & Ramon, 2015). The development of conceptual models for SDM has focused almost exclusively on general health care settings. **At the same time, SDM offers great promise in promoting mental health treatment engagement and outcomes, and tenets of SDM are central to recovery-oriented and person-centered approaches to mental health treatment (SAMHSA, 2010). In fact, SDM has particular relevance for addressing significant (and often unique) barriers to seeking and engaging in mental health care, such as limited knowledge, negative attitudes (e.g., stigma, negative treatment perceptions), and few systematic processes for learning about and selecting among treatments in most mental health care settings.** In most cases, patients are referred to mental health treatment without the opportunity to learn about treatment options and directly influence the treatment decision-making process. Moreover, for many mental health problems, there is a wide variety of treatment options. And in no other health care context are certain treatments labeled and distinguished as "evidence-based" as in the field of mental health care. This makes for a dizzying and often overwhelming experience for individuals with mental health problems.

In most cases, patients are referred to mental health treatment without the opportunity to learn about treatment options and directly influence the treatment decision-making process.

Much of the attention to date on SDM in mental health care has focused largely on decision aids and education. However, as noted above, knowledge barriers are just one type of barrier that limits engagement in mental health care and that could be important targets of pre-treatment SDM processes. In fact, a recent review of research on SDM interventions in mental health care concluded that while information exchange is a central component of SDM, other key elements should be included and emphasized in SDM approaches in mental health care, including interpersonal trust and rapport, goal-setting,



While information exchange is a central component of SDM, other key elements should be included and emphasized in SDM approaches in mental health care, including interpersonal trust and rapport, goal-setting, identification of values and preferences, and motivational enhancement

identification of values and preferences, and motivational enhancement (Zisman-Ilani, Barnett, Harik, Pavlo, & O'Connell, 2017).

1.2. EMPIRICAL SUPPORT FOR SDM

In recent years, there has been increasing empirical attention devoted to SDM. Although still a relatively young empirical field, accumulating research reveals that the implementation of SDM in clinical care settings is associated with a number of positive outcomes, particularly outcomes related to patient knowledge and affective-cognitive domains (e.g., patient satisfaction, concerns about illness, decisional conflict, confidence in decision) (for reviews, see Shay & Lafata, 2015; Stacey et al., 2017). While not as extensive as the data on knowledge and affective-cognitive domains, there is a growing body of research demonstrating SDM to be associated with positive outcomes related to specific treatment-related behaviors (e.g., treatment adherence, active role in treatment, treatment decisions) (Shay & Lafata, 2015; Stacey et al., 2017). There has been more limited controlled research on and conclusive results related to the impact of SDM on patient outcomes. As a result, there has been a call by researchers for, and movement towards, greater examination of patient health and behavioral outcomes associated with SDM.

The small body of research on SDM for patients with mental health problems has focused mainly on SDM within the context of depression treatment. Although the relatively limited systematic research in this area restricts the extent to which broad conclusions can be made, findings provide cause for optimism. This is especially the case with respect to repeated findings of the positive role of incorporating patient treatment preference in the treatment process. Research on treatment decision-making for the treatment of depression has shown that incorporating patient preference for treatment is associated with greater treatment uptake (Dwight-Johnson, Unutzer, Sherbourne, Tang, & Wells, 2001). In addition, patient participation in treatment decision-making for depression has

SDM today is understood as more than a collaborative approach to communication and information exchange, but as a dynamic, interpersonal process for promoting informed choice, agency, and decision-making that is impacted by affective, cognitive, and other individual factors and preferences

been shown to be associated with significantly increased treatment adherence and, in turn, improved clinical outcomes (Loh, Leonhart, Wills, Simon, & Harter, 2007). Additional research has shown that patients who receive their preferred treatment have better outcomes in psychotherapy than patients who do not receive their preferred treatment, including greater reduction in symptoms (Chilvers et al., 2001; Kocsis et al., 2009), higher number of visits and reduced rate of dropout (Kwan, Dimidjian, & Rizvi, 2010), and higher patient ratings of the therapeutic alliance (Iacoviello et al., 2007; Kwan et al., 2010).

SUMMARY

Greater emphasis on the patient as an active participant in a process of *shared* treatment decision-making has increasingly replaced the longstanding notion of the patient as a passive and willing agent in a unidirectional communication exchange. In recent years, SDM has seen significant conceptual maturity, with many models and implementation frameworks developed to clearly define and operationalize the components of SDM and help guide SDM in different treatment contexts. Consequently, SDM today is understood as more than a collaborative approach to communication and information exchange, but as a dynamic, interpersonal process for promoting informed choice, agency, and decision-making that is impacted by affective, cognitive, and other individual factors and preferences and that often includes key individuals beyond the patient-provider dyad.

The evolution and advancement of the concept and process of SDM, coupled with the need to promote patient engagement and agency in many health care contexts, has contributed to the proliferation of the clinical application of SDM. SDM is now widely incorporated into many general and specialty medical settings, with increasing empirical evidence for its use, particularly regarding patient knowledge, satisfaction, and decision-making involvement and confidence, as well as growing empirical support related to treatment-adherence and engagement.

The foregoing notwithstanding, systematic adoption of SDM in the field of mental health care has been more limited. Nevertheless, research to date on the implementation of SDM in mental health care (mainly depression care) has yielded some consistent and encouraging findings, namely the positive impact of incorporating patient treatment preference on treatment uptake, adherence, and engagement. **These findings and the developments in SDM research and practice in other health care contexts suggest significant opportunities for leveraging principles and practices of shared treatment decision-making for increasing Veterans' uptake of and engagement in EBPs—and for expanding the concept and focus of SDM in mental health care beyond the focus on increasing knowledge to address key attitudinal, interpersonal, and other factors significantly impact treatment engagement in the mental health care context.** This is explored in more detail in the next section.

SECTION 2

Shared Decision-Making and Evidence-Based Psychotherapy

2

SHARED DECISION-MAKING AND EVIDENCE-BASED PSYCHOTHERAPY

Most Veterans (and non-Veterans) seek mental health care with limited knowledge of specific mental health treatments or accurate understanding or expectations of the treatment process. Limited understanding of mental health treatment and what treatment involves is complicated by the fact that, unlike many other fields, there is a wide variety of treatment options across different treatment modalities (e.g., psychological, pharmacological, psychological and pharmacological), and for some conditions, dozens of options. Further, crude and invasive techniques not too long ago used for treating mental health problems, and overly negative portrayals of mental illness and mental health treatment (particularly for Veterans and Military Service Members) in the media, contribute to inaccurate and often negative perceptions of mental health care. **At the same time, in most mental health treatment settings, patients begin mental health treatment without a systematic process in place to learn about different treatment options (including how they work, their effectiveness, and potential benefits and risks relative to their situations and experiences) and the opportunity for the informed patient to engage in preference-based discussion and directly contribute to the decision about which treatment to receive (Fukui, Matthias, & Salyers, 2015; Matthias, Fukui, & Salyers, 2017).** This combination of (1) limited and often negative understanding and perceptions of treatment and (2) lack of informed choice and engagement in treatment decision-making prior to the initiation of treatment sets up a clinical scenario with substandard odds for treatment initiation and success, especially for treatments that require active participation and engagement as a key component of the treatment. It should be no surprise, therefore, that many Veterans who can benefit from evidence-based psychotherapies do not receive these treatments or drop out prematurely.

On the other hand, let us envision what treatment initiation and engagement might look like if Veterans had the opportunity to learn about effective treatments and then themselves make the decision to begin treatment considering their personal situations, hopes, values, and preferences, all the while being supported by a caring provider. In addition to findings from the SDM literature of increased uptake and engagement associated with similar processes in other treatment contexts summarized above, initial efforts and research findings directly addressing this question within the specific context of Veterans receiving EBPs suggest that such processes for promoting SDM and patient engagement before treatment offer significant promise for increasing the number of Veterans who receive EBPs. These recent efforts, which to date have focused on promoting Veteran engagement in EBPs for PTSD within treatment settings in the VA health care system, are briefly summarized below.

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Recent efforts to engage Veterans in pre-treatment processes designed to promote informed choice and involvement in the treatment decision-making process prior to the initiation of PTSD treatment have included a variety of strategies that vary in the nature and extent to which they incorporate different SDM principles and processes (Hamblen et al., 2015). Most of these approaches consist of education-based groups and range from single-session orientation groups focused on psychoeducation about PTSD and treatments to multi-session preparatory groups that incorporate some broader elements of SDM, including use of decision aids and motivational enhancement. In addition, some VA facilities have incorporated skills-based preparatory groups for Veterans who may lack basic coping skills and psychological readiness for EBPs for PTSD.

Emerging research on pre-treatment education and treatment planning indicates that the opportunity to learn about specific treatments and be involved in the treatment decision-making process prior to treatment initiation is associated with significantly higher rates of initiating an EBP (DeViva, Bassett, Santoro, & Fenton, 2016; Hamblen et al., 2015; Harmon, Goldstein, Shiner, & Watts, 2014; Mott, Stanley, Street, Grady, & Teng, 2014; Watts et al., 2015) and high levels of patient satisfaction with the pre-treatment orientation experience (Schumm, Walter, Bartone, & Chard, 2015). In addition, research examining the impact of incorporating motivational enhancement strategies prior to the initiation of treatment suggests that pre-treatment motivational enhancement increases positive attitudes toward mental health treatment and session attendance and reduces attrition (Murphy, Thompson, Murray, Rainey, & Uddo, 2009; Murphy, Rosen, Cameron, & Thompson, 2002; Seal et al., 2012).

Virtually all pre-treatment processes for promoting patient knowledge and involvement in treatment decision-making to date were not developed directly based on or informed by specific SDM models or components, nor do many approaches incorporate much, if any, discussion of Veteran values and preferences, which is generally considered to be an essential component in the SDM literature. One exception is a brief SDM approach to promote Veteran involvement in treatment decision-making for evidence-based treatments for PTSD developed by Mott and colleagues (2014). This approach includes

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a 30-minute pre-treatment decision-making session and a PTSD treatment decision aid. Results of a pilot study indicate that 67% of Veterans who participated in the pre-treatment session expressed a preference for an EBP for PTSD, compared to 0% of Veterans in the usual care condition (Mott et al., 2014). While Veterans in both the SDM and usual care conditions initiated treatment at similar rates, more Veterans who participated in SDM (1) received an EBP and (2) participated in at least nine psychotherapy sessions, as recommended in clinical practice guidelines for PTSD.

In addition to emerging evidence demonstrating the positive impact of pre-treatment orientation and SDM processes for promoting Veteran engagement in EBPs, the systematic implementation of SDM prior to the initiation of EBPs is strongly recommended by clinical experts and researchers. In their systematic review of psychological treatments for depression, Farah et al. (2016) concluded, "A shared decision-making approach is needed to choose between non-pharmacological therapies based on values, preferences, clinical and social context (p. 220)." Similarly, following their recent examination of provider decision-making related to the implementation of evidence-based treatment for PTSD, Osei-Bonsu and colleagues (2017) concluded, "More active efforts are needed to…engage patients in the decision-making process to discuss the best treatment options" considering patient preferences and other patient factors (p. 221). In addition, a process of SDM for facilitating treatment decision-making for evidence-based treatments for PTSD is strongly recommended in the *2017 VA/Department of Defense (DoD) Clinical Practice Guideline for Management of PTSD and acute stress disorder* (VA & DoD, 2017). The guideline recommends that providers educate patients about the range of available and effective treatment options prior to initiating treatment and that specific treatment decisions be guided by a shared and informed decision-making process that involves active participation of both the provider and patient. The guideline notes that the "strong recommendation" is based on "the substantial literature supporting SDM in other conditions," as reviewed above. These recommendations add to our own call for such pre-treatment engagement processes to address key patient factors for promoting EBP uptake and delivery (Karlin & Cross, 2014a).

The systematic implementation of SDM for promoting patient engagement in EBPs—and mental health care, more broadly—is limited. General exceptions to this primarily consist of a range of education and treatment planning processes (mainly orientation groups) targeting EBPs for PTSD in treatment settings within the VA health care system. While noteworthy and forward-looking, these processes are widely variable and have generally not extended to EBPs for mental and behavioral health conditions beyond PTSD. There is significant need for a standardized process for promoting shared treatment decision-making and patient engagement, as well as standardizing treatment descriptions and resources, for mental and behavioral health conditions throughout the vast network of more than 160 medical centers and more than 800 community-based outpatient clinics in the Veterans Health Administration (VHA), as well as for health care systems and settings outside of VHA, where Veterans are increasingly seeking care.

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CONNECT

MOTIVATE

EDUCATE

EXPLORE

SET GOALS

CHOOSE

2.1. THE SDM SESSION

Building on significant developments in SDM research and practice in general health care settings and recent data, clinical experiences, and expert recommendations for incorporating SDM prior to the initiation of EBPs and other mental health treatments, we present a structured SDM process for promoting Veteran engagement in EBPs, known as the *SDM Session*. This approach incorporates and synthesizes key SDM principles and strategies based on a detailed review of SDM models and research findings summarized in the preceding sections. **Significantly, the SDM Session includes a broader conceptualization of and approach to SDM than is included in many existing SDM approaches used in mental health care to address important psychological and social components that are critical to patient engagement in the mental health care context (Zisman-Ilani et al., 2017).** This includes incorporation of motivational enhancement, consideration of Veteran values and preferences, and goal setting. Moreover, the clinical process of the SDM Session embodies key principles of patient-centered care and patient engagement incorporated into EBP protocols for Veterans, including important focus on collaboration, Veteran agency and autonomy, and patient feedback (Karlin & Cross, 2014a).

The SDM Session provides a standardized and systematic framework and language for educating and engaging patients in the treatment decision-making process. In this way, the process is designed to promote consistency—within and across patients—in how treatments are described and considered and for what to expect in the individual and interpersonal *process* of decision-making. At the same time, the standardized process emphasizes individualization and accounting for nomothetic factors that are critical to decision-making and engagement.

The SDM Session includes six key components:

1. **Connect:** Establish initial trust and interpersonal connection
2. **Motivate:** Assess and enhance motivation for treatment
3. **Educate:** Educate Veteran about EBPs and other treatment options
4. **Explore:** Explore values and preferences
5. **Set Goals:** Identify potential treatment goals
6. **Choose:** Select treatment or determine next steps

In most instances, the SDM Session is delivered as a single session, recognizing that extended SDM interventions may be too long for practically implementing in a variety of real world mental health treatment contexts. At the same time, the approach is designed to be flexible, with the length tailored to the needs and characteristics of the patient and specific treatment setting. Further, while the goal and expectation of the SDM Session, supported by existing research, is that most Veterans will choose to initiate an EBP or other mental health treatment at the end of the session, the approach also flexibly accounts for other potential outcomes and provides guidance and steps for addressing knowledge, attitudinal, skill, or logistical barriers to beginning treatment or that suggest a high likelihood of early termination if treatment is initiated.

Although our primary focus on and journey through the six steps of the SDM Session is for promoting Veteran informed choice and engagement in evidence-based psychotherapies, it is worth noting that the principles, processes, and components

of the SDM Session may be utilized for enhancing engagement and the overall treatment experience in other mental health—and non-mental health—treatment contexts and settings. In fact, the concepts and strategies incorporated in the SDM Session reflect central components and processes included in and recommended for a variety of health care contexts.

In the next section, we describe each of the components of the SDM Session in detail. In so doing, we illustrate the delivery of the SDM Session using a case example of a fictitious Veteran with depression and clinical dialogue interwoven throughout the six steps of the SDM Session. This case example reflects features and experiences common among Veterans presenting for treatment for depression. In addition, we present decision aids and other clinical resources for implementing the components of the SDM Session. **These accompanying clinical resources are electronically accessible through the Provider portal (www.mirecc.va.gov/visn19/treatmentworksforvets/providers), a public education website designed to promote awareness of and engagement in EBPs among Veterans and family members. Providers are encouraged to familiarize themselves with the Veteran portal of the website (www.mirecc.va.gov/visn19/treatmentworksforvets/), which includes interactive information and exercises to increase Veteran and family member knowledge of EBPs and the treatment process, promote motivation and hope, and help Veterans find treatment.** As we describe below in the discussion of the *Educate* step of the SDM Session, the information and exercises contained within the Veteran portal of the Treatment Works for Vets website may be incorporated into (or referred to during) the SDM Session for educating Veterans about EBPs and for identifying potential treatment goals to increase treatment motivation. Further, some Veterans will present for care (and for the SDM Session) after learning about EBPs through Treatment Works for Vets.

CASE DESCRIPTION: BOBBY

Bobby is a 52-year-old retired Army Warrant Officer who completed four tours in the Middle East—two in Iraq, and two in Afghanistan. He retired from active duty due to the consequences of service-connected injuries that began to accumulate, including migraines, nerve damage, and back and neck pain. He is unable to work due to these medical conditions and has 80% disability through the VA. Bobby and his family (wife and three children) recently moved into a small rental house after they lost their home to foreclosure. Bobby's wife works two jobs to "make ends meet" and frequently expresses dissatisfaction with the marriage and, more generally, their life together. His oldest child, age 20, was recently arrested for possession of marijuana with intent to sell, his second arrest in the past two years. Bobby describes his two younger children as "doing OK," although he worries about the impact of the move to the smaller house on the children, and he feels distant from them due to his medical and other struggles.

Bobby was referred to Mental Health by his neurologist who was treating his migraine headaches. Prior to the SDM Session, Bobby completed a psychodiagnostic evaluation session, which revealed that he meets criteria for major depressive disorder, with an onset soon after he announced his retirement. Bobby reported that he does not know what to do with himself now that he is retired, remarking, "I have no purpose now." Although he endorses sleep disturbance, such that he is often awake for several hours at a time in the middle of the night, he indicated that he gets a total of 10–12 hours of sleep per day because he takes frequent and lengthy naps during daytime hours. Bobby indicated that he has little interest in pursuing activities that he used to enjoy, such as playing drums and following NASCAR, and remarks that he has so much difficulty concentrating that he

probably would not be able to do these activities anyway. He stated that he has no intent to harm himself, although he commented that this could change if his wife were to leave him. Bobby denied a history of depression or symptoms of PTSD (despite experiencing combat-related injuries on two of his tours in the Middle East, and despite previously trying psychotherapy).

CONNECT

2.1.1. CONNECT: ESTABLISH INITIAL TRUST AND INTERPERSONAL CONNECTION

Developing a strong interpersonal connection with the patient—beginning at the very first encounter—is the foundation of shared decision-making. In fact, when not implemented within in the context of a supportive relationship, other elements of SDM often have limited impact (Astbury, Shepherd, & Cheyne, 2016). **Establishing interpersonal connection is especially significant in the context of individuals with mental health conditions for whom disengagement, avoidance, and detachment may be common (Morant et al., 2015). Moreover, establishing interpersonal connection is essential for helping to create trust and treatment motivation, which are necessary ingredients for treatment engagement.** Developing trust is particularly salient when working with Veterans for whom trust and comfort with mental health issues and formal treatment may be limited due to military culture, stigma, and past experiences with seeking treatment and navigating institutional policies and practices (Britt, Jennings, Cheung, Pury, & Zinzow, 2015; O'Donnell, Karlin, Landon, Dash, & Reed, 2018). **In fact, a strong patient-provider relationship is an especially important element in SDM in mental health care and one specifically desired among Veterans receiving mental health care (Eliacin, Salyers, Kukla, & Matthias, 2015; Zisman-Ilani et al., 2017).**

Establishing a foundation of interpersonal connection and trust in the SDM Session can help to set the stage for a strong alliance in treatment, which, in turn, may promote ongoing engagement and positive treatment outcomes.

In addition, the development and maintenance of a strong therapeutic alliance are essential components of successful delivery of EBPs (Karlin & Cross, 2014a; Kazantzis, Dattilio, & Dobson, 2017). Consequently, establishing a foundation of interpersonal connection and trust in the SDM Session can help to set the stage for a strong alliance in treatment, which, in turn, may promote ongoing engagement and positive treatment outcomes. Although evidence-based treatments are sometimes characterized as favoring strategies or techniques (*specific factors*) over the relationship or person behind the problem, EBPs, such as Cognitive Behavioral Therapy (CBT), were always intended to place significant emphasis on the therapeutic alliance and what are often called *common factors* (e.g., empathy, genuineness, positive regard). **Failing to emphasize important relationship factors does not represent EBP, but rather substandard delivery of EBP.** Approximately four decades ago, Dr. Aaron T. Beck, the "father" of CBT, emphasized the necessity of cultivating a warm and trusting relationship for successful delivery of CBT (Beck, Rush, Shaw, & Emery, 1979). This importance of the relationship in CBT is specifically reflected in the fact that a number of the items on the Cognitive Therapy Rating Scale, the gold standard measure of therapist competency in CBT, such as Feedback, Understanding, Interpersonal Effectiveness, and Collaboration, measure elements of common factors (Karlin & Cross, 2014b). When interpersonal connection declines or is threatened, shoring up the relationship should be a primary focus of treatment (Wenzel, Brown, & Karlin, 2011).

Intentional focus on promoting trust and establishing a strong interpersonal connection begins at the outset of the SDM Session, but is not just the initial step of this encounter. Rather, the process of promoting interpersonal connection is interwoven throughout the session. This component of the SDM Session is achieved through specific

focus on the relationship and use of verbal and nonverbal communication skills to connect with the Veteran and their experience, beginning at the initial greeting of the patient. More specifically, this involves the use of active listening and related skills, such as expressed empathy, warmth, and genuineness, to help to create an environment in which the patient feels heard, accepted, and understood. While likely familiar to most mental health providers, these skills take center stage and require explicit focus in the SDM Session. A list of key skills for promoting interpersonal connection during the SDM Session is presented in Table 2.1, along with descriptions, examples, and the purpose of each.

TABLE 2.1.
SKILLS TO PROMOTE INTERPERSONAL CONNECTION

SKILL	DESCRIPTION	EXAMPLES	PURPOSE
Paraphrasing	The provider restates in their own words what the patient just said.	PATIENT: "I've really been struggling recently." PROVIDER: "Things have been tough for you lately."	An active listening skill that demonstrates interest and understanding of content
Reflection	The provider communicates the *emotional content* of what the patient has communicated. Whereas paraphrasing focuses on the words the patient spoke, reflection focuses on the emotional meaning and impact of what the patient communicated verbally and nonverbally. This involves listening and watching for emotions.	PATIENT: "I don't know what to do *[looks exasperated and tears up]*. No matter what I do, nothing changes. I'm just stuck and nothing seems to help." PROVIDER: "I can see you're feeling hopeless and exhausted. You want to feel better, and you're trying, but nothing seems to change."	An active listening skill that demonstrates understanding of the patient's emotional experience
Summarizing	The provider pulls together information that the patient has communicated and makes a summary statement of the main points the patient has communicated.	PATIENT: *[patient discusses several difficult events in his life, states how he perceives that he lacks skills to manage how he feels, and notes little support from others]* PROVIDER: "So, maybe if I can summarize what I've heard you say so far, you've indicated that you're really struggling right now and that you don't have the tools you need to manage your depression. You also don't believe you have much support from others in your life."	An active listening skill that demonstrates ongoing attention and understanding of key points and themes
Expressed Empathy	The provider communicates a sense that they truly understand and appreciate the patient's internal experiences.	PROVIDER – VERBAL INDICATION: "It sounds like you have been feeling very frustrated and discouraged, which has led you to keep to yourself, causing you to feel even more discouraged." Avoid direct statements likely to be invalidating, such as "I know exactly how you feel" or "I understand completely." PROVIDER – NONVERBAL INDICATIONS: Change in tone of voice, facial expression, and/or posture to match the meaning of the patient's message.	Similar to reflections but captures emotional themes or overall internal reality of the patient without judgment

SKILL	DESCRIPTION	EXAMPLES	PURPOSE
Genuineness	The provider responds in an authentic and transparent manner, truly meaning what he is expressing. This may include appropriate self-disclosure. Genuineness involves congruence, or consistency, between what the therapist feels internally and how he externally communicates this, as well as congruence or proportionate response between the emotional content of the patient's message and the provider's response.	PATIENT: "I'm really messed up with all the emotional and health stuff I have going on, aren't I?" PROVIDER: *[in open manner and natural tone of voice]*: "I don't see it that way at all. Actually, I once had my knee replaced and, at the time, wondered if I'd get through that. What I do think is that you have a lot piled up in your life and you're having a hard time taking care of it all–and yourself. It's a lot for anyone to carry on their shoulders." Examples of low- and high-congruence provider communication: PATIENT: Describes witnessing his friends die in combat. PROVIDER (LOW CONGRUENCE): "That sounds hard" *[displays little emotion or nonverbal response]*. PROVIDER (HIGH CONGRUENCE): "I can only imagine what that must feel like. While I haven't been in quite that situation, I can appreciate the helplessness that would bring and the impact that would have afterward" *[displays a forlorn facial expression, a posture that communicates a willingness to talk more about a difficult topic, and a pause to allow the patient time to process and respond]*.	Designed to promote trust and comfort. Patients tend to be less forthcoming when the provider is perceived as impersonal, mechanical, inauthentic, or uncomfortable.
Warmth	Provider conveys a sense of caring, support, and concern for the patient through verbal and nonverbal messages.	PROVIDER – VERBAL INDICATION: "I'm really sorry you had to experience that, Rachel." PROVIDER – NONVERBAL INDICATION: Soft tone of voice, appropriate smile or other facial expression, direct but inviting eye contact, open posture	Promotes comfort, connectedness, and positive interpersonal climate
Open-Ended Questioning	Provider asks questions that require consideration and elaboration, rather than a simple "yes" or "no" response.	PROVIDER: "How would your life be different if you weren't depressed?" PROVIDER: "What was going through your mind in that situation?"	Promotes more active participation and deeper-level processing that can promote engagement and discovery
Confidence	Provider conveys through verbal and nonverbal channels that she is competent and optimistic that treatment will help the patient; involves use of articulate but comprehensible language and limiting of paraverbals (e.g., "um," "uh," "like").	PROVIDER – VERBAL INDICATION: "Fortunately, we've come a long way in our understanding and treatment of PTSD. And based on what you've told me and my experience working with Vets, I'm confident that treatment can help turn things around for you. Would it be okay if I share information about some treatment options for us to discuss together?" PROVIDER – NONVERBAL INDICATIONS: Upright and open posture, direct eye contact, even tone and cadence of voice	Promotes patient confidence and optimism; often especially important with Veterans when provider has not had military experience

The focus of the first several minutes of the SDM Session is spent facilitating the connection with the patient and setting the foundation for the SDM work before moving on to the specific "business" of SDM. In this way, the initial part of the SDM Session is focused on *concentrated connection*. As summarized in Table 2.2, this is accomplished through introductions, initial understanding of the patient's experience, and education about the purpose and goals of the SDM Session. During this discussion, the provider specifically and intentionally focuses on incorporating the interpersonal skills for promoting connection and trust described in Table 2.1.

TABLE 2.2.
STEPS AND CONSIDERATIONS FOR INITIATING THE SDM SESSION

1 WELCOME VETERAN

- Warmly and genuinely greet and welcome the Veteran.
- Consider introducing yourself using both your first and last name.
- Briefly describe your position within your treatment facility (in non-technical terms).
  - Consider sharing something else about yourself or make an informal comment to break the ice.
- Ask whether there is anything you can do to make the patient more comfortable.
- Ask the patient how they are doing, using elaboration to promote openness and disclosure, as appropriate.
  - Show genuine interest in the patient, give them interpersonal space, and provide an empathic response.

2 DISCUSS PURPOSE OF VISIT

- Express appreciation for coming in and inquire about patient's understanding of the purpose of the visit.
- Provide education about SDM Session.
  - Brief description and goals
  - Emphasize teamwork approach—both the patient's values and preferences and your opinion as a mental health expert will guide the treatment decision.
- Ask the patient whether there is anything at the outset the Veteran believes is important for you to know about them as you work together to identify the best treatment match.
- Ask the patient what role they would like to play in the decision-making process.

FIGURE 2.1.
SAMPLE SCRIPT FOR INTRODUCING THE SDM SESSION

Today, we'll be talking about different treatment options for you to choose from as part of a process called "shared decision-making." "Shared" means that I have valuable information for you about different treatment options, like what they involve and how effective they are. And, at the same time, you have valuable information about yourself, like what's important to you and what you hope to get out of treatment. We will pull this information together so that you can make a decision about the best treatment for you.

As you can probably tell, you'll get the most out of this session by openly sharing your thoughts as we talk—including your reactions to different options, how things do or do not apply to you, and asking questions.

I'm looking forward to working together to come up with a decision of what's best for you and your personal situation.

At the outset of the session, the provider takes an opportunity to warmly and genuinely welcome the Veteran and express pleasure at their meeting. The provider proceeds with introducing herself. One way to facilitate the "teamwork" approach of SDM and reduce any perceived power differential is to present yourself as an equal partner in this process. For example, you may consider introducing yourself with both your first and last name. Next, briefly describe in non-technical terms your role within your treatment facility. At this point, you may consider sharing something else about yourself that may demonstrate genuineness and transparency or making a casual comment (e.g., about the weather, season of year) to break the ice. Before proceeding, you may ask the patient if there is anything you can do to make them more comfortable (such as provide a glass of water, change in seating, provide additional lighting, offer a clipboard). Next, you may ask, generally, how the patient is doing to demonstrate interest and provide an opportunity for connection. The provider may follow-up with open-ended questioning to promote openness and disclosure, as appropriate. As the patient responds, it is important to remain fully present and to respond in a genuine, empathic manner, using active listening skills to connect with the verbal and nonverbal experience of the patient. **Above all, the goal at this point of the session is for the Veteran to view you as an interested, caring, and concerned ally.**

The next step of *Connect* involves discussion of the purpose of the session. This discussion begins with first thanking the Veteran for coming in and checking in to assess their understanding of the purpose of the visit. Next, the provider communicates the purpose and goals of the visit, emphasizing the teamwork approach that embodies the session. In so doing, the provider notes that both (1) the patient's values, goals, and experiences and (2) the provider's opinion and judgment will inform the decision about next steps. A sample script for introducing the SDM Session is provided in Figure 2.1.

Next, the provider inquires whether there is anything the patient believes is important for them to know to help identify the most appropriate next steps before proceeding, noting that there will be opportunities to explore this as the discussion ensues. This communicates, early on, the provider's interest in understanding the patient as a person and unique characteristics that may affect treatment decision-making.

The final part of this discussion involves asking the patient how involved they would like to be in the decision-making process, recognizing the fact that a small subset of Veterans wish not to have a highly active role in the treatment process. The answer to this question will not necessarily change the focus or structure of the session, but may help the provider calibrate their level of involvement in the session. Furthermore, it is important to note that some Veterans may initially indicate a preference for the provider to have greater influence on the treatment decision. If this is the case, the provider may abbreviate (but not eliminate) the *Educate* step and/or take a more active role in the *Choose* step of the SDM Session, but would generally not significantly affect the other steps of the SDM Session (i.e., assess and enhance motivation, explore values and preferences, identify potential treatment goals) unless specifically declined by the patient because these components may still help inform and influence treatment selection and patient engagement. In some cases, the initial indication of preference for a less collaborative decision-making process may be based on the fact that the Veteran is only accustomed to less collaborative decision-making processes and has not had any other experience, though when experiencing the SDM process may find that they value being involved in the process.

Although presented in a linear, stepwise fashion, it is important for the discussion during the *Connect* phase to be interactive and conversational to promote connection and help the Veteran ease into the process. Accordingly, it is important to speak slowly and clearly, as speaking quickly when presenting new information can be overwhelming and cause the patient to "shut down." In this vein, it is an important reminder that the primary focus of this step of the SDM Session is relational (interpersonal connection and trust) and that the primary goal of the overall process is patient engagement. Thus, the process and the patient's reaction to the process should be of greatest concern and attention at this point in the session. It is therefore important to be aware of subtle (and, at times, nonverbal) factors that might affect the developing relationship. Be sure to make eye contact and demonstrate that you are fully present with the patient. If appropriate initially and at other times during the exchange, use small doses of self-disclosure or anecdotes to further develop a connection and demonstrate a sense of understanding. **The message to communicate is, "I truly understand that you are suffering, and I want to work together so you can get the treatment you believe will work best for you."** Let's see what this initial exchange looked like for Bobby in the following excerpt from the beginning of his SDM Session:

The primary goal of the overall process is *patient engagement.*

EXCERPT
DR. TAMMY & BOBBY

DR. TAMMY: *[giving Bobby a heartfelt handshake, demonstrating warmth and genuineness]* Bobby, welcome, please come on into my office. I'm Dr. Tammy Young. I'm a psychologist here at the VA. You can call me Tammy if you'd like.

BOBBY: *[returning the handshake but looking uncomfortable and averting eye contact]* Um, sure, OK.

DR. TAMMY: *[motioning to an area of the office with two different chairs]* Please, have a seat. Choose whichever chair seems most comfortable to you.

BOBBY: *[sits down]*

DR. TAMMY: How was the weather outside when you came in? I was out only briefly earlier this afternoon and it was a lot warmer than I expected.

BOBBY: Yeah, they called for rain, but they're often wrong.

DR. TAMMY: Yes, I heard that too. Sure is nice when they are wrong in our favor!

BOBBY: No kidding.

DR. TAMMY: So, how are you today?

BOBBY: OK, I guess.

DR. TAMMY: *[providing space for Bobby to elaborate]* I understand things have been tough lately?

BOBBY: *[fidgeting]* Yeah, you could say that.

DR. TAMMY: *[asking an open-ended question to invite elaboration]* Tell me a bit more about it.

BOBBY: Oh, it just seems like nothing is coming together right now. Wife, kids, money. It's been a real downer lately. I think they told me I'm suffering from depression. *[pausing]* It probably wasn't hard for them to figure that out.

DR. TAMMY: *[demonstrating empathy in her facial expression as well as her tone of voice]* I'm really sorry to hear that. I appreciate how hard life can feel when many things seem to be going in the wrong direction all at once.

BOBBY: *[making eye contact for the first time]* I can't really think of a single thing in my life that is going *right* at the moment.

DR. TAMMY: *[paraphrasing empathically]* Mmm, it's a real a difficult time for you right now.

BOBBY: You can say that again.

DR. TAMMY: *[Continuing to demonstrate warmth and genuineness]* Well, I certainly want to help make things better for you, and I appreciate that you came in to discuss possible treatments for these issues. Tell me what your understanding is about the purpose of this visit.

BOBBY: I don't know, really. After I had that appointment, where I guess I was diagnosed with depression, they sent me to you.

DR. TAMMY: OK, I'm glad you're here. Today, we'll be talking about different treatment options for you to choose from as part of a process called "shared decision-making." "Shared" means that I have valuable information for you about different treatment options, like what they involve and how effective they are. And, at the same time, you have valuable information about yourself, like what's important to you and what you hope to get out of treatment. We can pull this information together so that you can make a decision about the best treatment for you. What do you think–would you be up for having a conversation about options?

BOBBY: *[shrugging his shoulders]* I guess. I didn't know there is more than one option. Sounds kinda confusing to me. *[pausing]* I'm not so good at making decisions right now.

DR. TAMMY: I hear you. Making decisions about treatment *can* be confusing and overwhelming. *[using appropriate self-disclosure to facilitate a connection and express empathy]* I, myself, was confused and overwhelmed with treatment options last fall when I tore my ACL.

BOBBY: Really? You tore an ACL? That happened to me a long, long time ago when I was in basic training. What did you do, a full ACL repair?

DR. TAMMY: Actually, no. It was only a mild tear, so my two options were physical therapy or a full ACL repair. I chose physical therapy.

BOBBY: *[shaking his head]* I would have done the opposite. Who wants to go through all of that physical therapy if you'll just have to have surgery down the line?

DR. TAMMY: *[providing validation]* I get where you're coming from. But I have a toddler at home to chase around, and I knew that having surgery at that time wasn't right for what was going on in my life. *[pausing and bringing the conversation back to Bobby]* Bobby, this is a perfect demonstration of what I'd like to do with you today, which is share available treatment options for you, and then hear from you what *you* think would work best in light of everything going on in your life. Just like I did with my treatment for my torn ACL. How involved would you like to be in the treatment selection process?

BOBBY: Can't you just tell me the one you would recommend?

DR. TAMMY: Well, I *could* tell you what I recommend…but truthfully, there is more than one good option for the treatment of depression. [demonstrating concern] And I truly want to respect your preferences and expertise on your own life circumstances. My style is such that I work with Vets in a teamwork fashion, with both of us contributing equally to decisions. I have information to give you about available treatments for depression. But you have valuable information about your own style.

BOBBY: *[pausing for a moment]* OK. I kind of like that. I'm not sure that a doctor ever asked me what I wanted before. Usually, they just give me a script and tell me to check back in three months.

DR. TAMMY: Oh, good. I'm glad you find this teamwork approach appealing. Before we begin, is there anything at the outset that is important for me to know as we work together to try to find the best treatment match for you?

BOBBY: I don't know, really. I guess that I just don't even really have a sense of what you all can offer me.

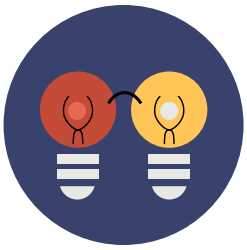
DR. TAMMY: Very important for me to know. In fact, today I can tell you very specifically what we have to offer you. How is this for a plan–what if we first talk a bit about your interest in treatment for depression? Then, I can give you some information about possible treatment options. I can get your feedback on aspects of the treatments that sit well with you and that don't sit well with you. Then, we can develop some possible goals and see if we can decide on an approach that makes the most sense for you.

BOBBY: *[frowning]* I'm not sure I want to commit to a treatment right now, though.

DR. TAMMY: *[leaning forward to demonstrate an openness to the patient's preference, respecting his autonomy]* Absolutely, it is ultimately your choice. We can talk about options, I can listen to your views of the options, and you can take more time to think about it if you'd like. I can even give you some materials to take home and review after you've had some time to reflect on our conversation. But you're in the driver's seat here.

BOBBY: OK, then. That's good.

MOTIVATE



Notice the very first interaction that the provider had with Bobby. She was warm, inviting, and open, and she demonstrated a desire to work with Bobby as equal members of a team. Dr. Tammy noticed that Bobby was feeling uncomfortable, so she invited him to choose his seat, which provided him an increased sense of controllability and predictability over the way in which the session would proceed, and she commented on the weather to "break the ice." Rather than asking yes/no questions, Dr. Tammy asked open-ended questions to help engage Bobby and forge a connection when he initially was not very responsive. Dr. Tammy reasoned that asking an open-ended question would give him a chance to elaborate and share on his own terms. When Bobby indicated that things at home were not going well, Dr. Tammy communicated empathy in a number of ways, such as by showing care and concern in her facial expressions and by softening her tone of voice to communicate that she appreciated how difficult life had been for him lately. As the conversation progressed, Dr. Tammy found a way to connect with Bobby on a personal level—when he expressed a sense of being overwhelmed by treatment options, she conveyed a sense of understanding of his experience through the use of appropriate self-disclosure, when she indicated that she went through a similar process of being overwhelmed with decision-making when she had to make a decision about treatment for her torn ACL. However, rather than focusing too much on her personal situation, she linked it back to the purpose of the SDM Session—to help Bobby make an informed decision about treatment for his depression, given that there were several treatment options available for him. When Dr. Tammy made it clear that there is more than one option for the treatment of depression, she was implementing what Elywn et al. (2012) refer to as *choice talk*. In other words, she was conveying to Bobby simply that a choice exists.

Interestingly, Bobby's reaction to the notion of SDM was to inquire whether Dr. Tammy could just make the decision for him. As mentioned previously, some patients, and Veteran patients, in particular, may initially suggest a preference to exercise this option. Before taking this at face value, Dr. Tammy explained her philosophy and her belief in the importance of functioning as equal members of a team. If Bobby had continued to indicate that he was uninterested in SDM, Dr. Tammy would have respected his wishes and not forced active involvement in the SDM process upon him. However, once she explained a bit more about the philosophy underlying SDM in relatable terms, Bobby responded favorably, remarking that he had not been asked before by other health care providers to participate in such a process. Despite this apparently small victory, Bobby followed up with a statement that he was unsure whether he wanted to commit to treatment at this time. Dr. Tammy responded in an open and nonjudgmental way, affirming his right to choose no treatment as a viable option and reiterating his control over the situation.

2.1.2. MOTIVATE: ASSESS AND PROMOTE MOTIVATION FOR TREATMENT

After working to initially establish a warm and supportive interpersonal context and provide information about the purpose and goals of the session, the next step of the SDM process involves assessing and enhancing the patient's motivation for treatment. It is important not to assume that a patient, even one who presents for treatment voluntarily, is truly motivated and ready for the treatment and change process (Norcross, Krebs, & Prochaska, 2011). Ambivalence about treatment is a natural part of the process of recovery, and patients often demonstrate ambivalence at many points during the course of treatment (W. R. Miller & Rollnick, 2013; Wenzel, 2013).

Ambivalence is not simply a problem to overcome or an indication of patient resistance, but something that is part of the very fabric of the experience of mental illness and of seeking treatment. Making motivation for treatment, or lack thereof, explicit and working to enhance treatment motivation through non-directive inquiry and exploration can help to increase treatment.

When patients present for treatment, they often struggle between reasons for staying as they are (e.g., they experience benefits, they doubt that they can change) and reasons for changing. Further, it is important to remember that patients with mental health problems often face many factors that impact the extent to which they internally embrace treatment, including low motivation, hopelessness, difficulties with organization and follow through, and stigma. Thus, ambivalence is not simply a problem to overcome or an indication of patient resistance, but something that is part of the very fabric of the experience of mental illness and of seeking treatment. Making motivation for treatment, or lack thereof, explicit and working to enhance treatment motivation through non-directive inquiry and exploration can help to increase treatment readiness and engagement. **In implementing this process, providers are encouraged to embrace ambivalence using an inquisitive, empathic, and non-directive stance, rather than simply viewing or approaching it as something to be changed or eliminated (W. R. Miller & Rollnick, 2013; Westra, 2012).**

The first part of *Motivate* involves exploring the patient's motivation for treatment. **This is accomplished through the use of non-directive questioning to explore the patient's beliefs about mental health treatment so that (often unidentified) attitudes, expectations, assumptions, and stereotypes about treatment that can affect the degree to which they will engage in the SDM Session, and subsequently in treatment, can be uncovered and modified, or at least shaped.** In many cases, beliefs and expectations toward mental health treatment are influenced by past treatment experiences. Therefore, inquiring about past experience with mental health treatment is an important part of assessing treatment beliefs and expectations.

Beyond uncovering negative perceptions of treatment that may moderate treatment motivation, the process of understanding negative treatment beliefs and expectations and the bases for these perceptions provides opportunities for (1) validating the patient's concerns and developing closer interpersonal connection and alignment, (2) understanding treatment elements or approaches that the patient does not believe to be helpful, and (3) identifying and highlighting other treatment strategies and approaches during the *Educate* step of the SDM Session. Understanding the bases of these beliefs is important both for informing treatment selection and for promoting hope and motivation toward other approaches.

Table 2.3 presents the steps for assessing treatment motivation, along with sample questions. Providers may introduce this step of the *Motivate* phase by stating, **"I'd like to ask you a few questions to learn a little bit more about your thoughts about treatment. Would that be okay?"**

TABLE 2.3.
STEPS FOR ASSESSING MOTIVATION FOR TREATMENT

Listening carefully to the patient's responses to these questions will provide insight into their belief system and views about treatment and the extent to which treatment may improve their lives. Left dormant and unaddressed, these beliefs and expectations are likely to portend more limited engagement in the SDM and treatment processes. On the other hand, uncovering negative or neutral beliefs and expectations about treatment produces important opportunities for updating inaccurate beliefs, expectations, and experiences through this and subsequent components of the SDM Session and, in turn, for increasing motivation and engagement.

After assessing the patient's experiences, beliefs, and expectations related to mental health treatment, the provider engages in non-directive questioning as part of an initial process to help *increase* motivation for treatment. This exchange centers on helping the Veteran to elucidate and recognize ways in which their mental health condition is interfering with their life and how their life would be different if the mental health problem is successfully treated. Specifically, this discussion begins by asking the patient to briefly identify the prominent symptoms or problems they have been experiencing. If this has already been discussed, the provider can offer a summary of the symptoms for the patient to affirm or add to. Then, the provider asks the patient to identify how these symptoms or problems have impacted their day-to-day life. Once the problems and their impact are identified, the provider asks the patient to envision how life would be different if treatment is successful. Specific steps and sample questions for guiding the initial motivational enhancement discussion are presented in Table 2.4. Providers may introduce this step by stating, **"Thank you for telling me a bit about your thoughts about treatment. I'd like to talk more about this in a few moments. If it's okay with you, I'd like to now talk briefly about the changes or symptoms you've been experiencing and how these have affected your day-to-day life. This will help us see how your life could look different. How does that sound?"**

TABLE 2.4.
STEPS FOR ENHANCING MOTIVATION FOR TREATMENT

STEP	SAMPLE QUESTIONS
1. Inquire about or summarize the prominent symptoms the patient has been experiencing.	"Since you've been experiencing [depression], can you tell me a bit more about what changes or symptoms you've noticed? These may be changes in your mood, your thoughts, or certain changes in behaviors or things you do or don't do."
2. Identify ways in which the patient's symptoms are causing problems in their life.	"Looking at your day-to-day life, how have these changes [or provide examples of specific symptoms] caused problems in your life?" "How have these changes interfered with your personal life or life at home? Your job? School? Your relationships?" "Has anyone noticed that changes in how you've been feeling are causing problems in your life? What have they noticed?"
3. Identify ways in which the patient's life would be different if treatment were successful.	"Now, looking at your life again, how would your life look different if you were no longer experiencing the symptoms of [depression]? "If your symptoms were to improve, what would you be doing differently?" "What would it be like to feel different?" "How would feeling different affect your work? School? Your romantic relationship? Your relationship with your children?" "If your symptoms were to lessen significantly, what area of your life would change most? How?" "What hopes or aspirations have you been putting off because you are struggling right now?"

It is important to note that the discussion of how life would be different if the patient's mental health condition is successfully treated is different from—and a precursor to—the identification of possible treatment goals, which occurs later in the SDM Session after specific treatments and the possibilities that treatments provide are discussed. While both are designed to instill motivation for treatment, the discussion of possible treatment goals during the *Set Goals* step of the SDM Session is more specific than, though may follow from, the discussion of ways in which life may look different during *Motivate*. In this and other ways, the structure and sequence of the SDM Session is specifically designed as a linear process with earlier steps leading into and helping to support and inform later steps.

In most cases, the motivational enhancement component of the SDM Session is a relatively brief exchange that helps set up and promote interest in discussion about specific treatments that offer real promise for changing the patient's situation, followed by discussion of possible treatment goals. If a patient endorses few negative beliefs or reservations about treatment, then the provider may spend more limited time discussing the second step of *Motivate* and proceed to the next step of the SDM Session.

In some cases, patients may appear highly motivated for treatment, which might suggest that the *Motivate* step be skipped entirely. We strongly encourage that this step be implemented with each patient, if nothing else than to strengthen or reinforce positive beliefs about treatment. Given the significant investment that treatment requires of patients, elucidating and strengthening positive treatment beliefs is likely to yield dividends even for patients who present as motivated for treatment.

Given the significant investment that treatment requires of patients, elucidating and strengthening positive treatment beliefs is likely to yield dividends even for patients who present as motivated for treatment.

In other cases, patients may have more deeply negative attitudes or entrenched beliefs that may benefit from additional focus on motivational enhancement. **When this is the case, motivational work may assume a more significant focus of the SDM Session and might require extending the SDM process to include one or more additional SDM Sessions, which is explored in greater detail in the discussion of the *Choose* step of the SDM Session** **(see Section 2.1.6).** Spending this additional time to promote "attitudinal readiness" for treatment is becoming increasingly recognized and recommended as important "front-end" preparatory work. At the same time, extending the SDM process significantly should generally be reserved for those with greater motivational (or other) barriers (e.g., very negative or entrenched beliefs about treatment), especially considering that subsequent steps of the SDM Session, which also address motivational issues, are likely to help promote more positive treatment-related perceptions for many patients. Thus, as the foregoing reveals, the assessment of the patient's baseline motivation for treatment by elucidating their beliefs, assumptions, and expectations for treatment is used to help inform the amount of time devoted to motivational enhancement work.

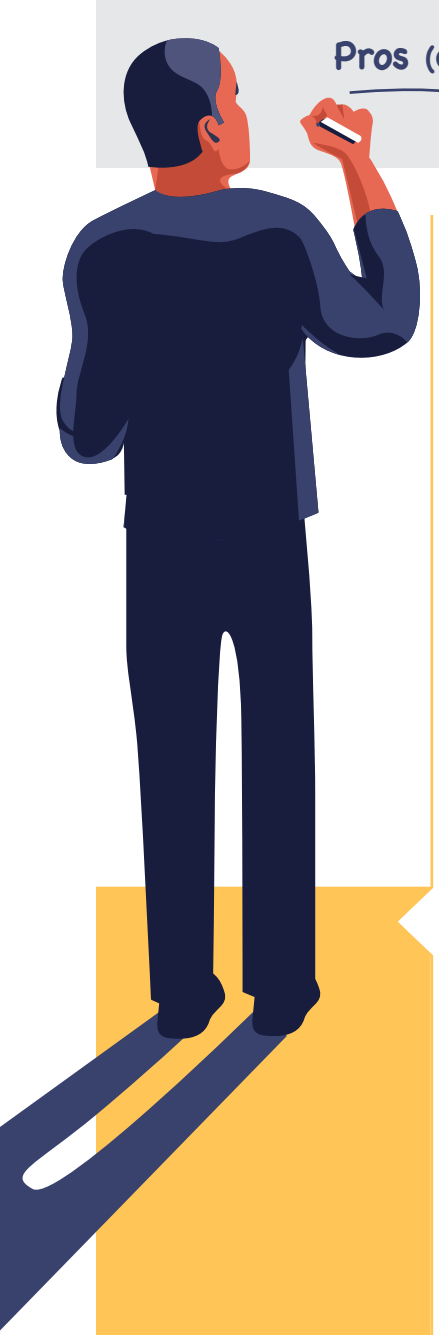
During this discussion, the provider should be on the lookout for and reinforce instances of *change talk*, or verbal indicators that the patient is unhappy with their current state or sees benefits to things being different. The provider may reinforce change talk by asking for *elaboration*, or requesting additional detail (W. R. Miller & Rollnick, 2013; Wenzel, 2013; Westra, 2012). For example, the provider may simply inquire "How so?" or "In what ways?" This helps to promote patient focus on the change possibility and, as they elaborate, they may see additional reasons for change that move the patient toward taking ownership over the change process. **In other words, when you detect change talk, you ask open-ended questions of elaboration to reinforce such talk and provide additional space for the patient to embrace such talk. In this type of exchange, the reasons for changing originate from the patient, rather than from the provider, which is likely to increase patient attention and buy-in and reduce resistance.** Research indicates that patients continue to articulate change talk when they are asked by a clinician to provide additional detail (Moyers & Martin, 2006; Moyers et al., 2007; Moyers, Martin, Houck, Christopher, & Tonigan. 2009).

Attempting to convince a patient to embrace change, or directly point at the merits of change, can serve to invalidate the patient's experience and perception and, in turn, threaten therapeutic alliance and engagement and cause the patient to further withdraw.

With patients who articulate little, if any, change talk or instead convey *sustain talk*, which refers to reasons for maintaining the status quo, there may be a natural pull to assume a more directive approach. However, assuming a more directive or "corrective" approach may only strengthen or reinforce their preexisting beliefs and attitudes, even when there is merit to the information or advice provided (W. R. Miller & Rollnick, 2013). Moreover, attempting to convince a patient to embrace change, or directly point at the merits of change, can serve to invalidate the patient's experience and perception and, in turn, threaten therapeutic alliance and engagement and cause the patient to further withdraw.

There are several strategies the provider may employ in instances where patients engage in sustain talk. First, the provider should allow space for the patient to articulate reasons why they are not ready for treatment, demonstrating respect for their views and autonomy. Second, the provider should use active listening, expressions of empathy and warmth,

FIGURE 2.2.
PROS AND CONS EXERCISE FOR ADDRESSING AMBIVALENCE ABOUT TREATMENT



and open-ended questions to demonstrate understanding of their situation and views. After demonstrating empathy and understanding, you may use *amplified reflection* to help the patient reconsider their views. Amplified reflection is a technique that involves repeating the patient's expression of sustain talk in a more intense or pronounced manner. For example, if a patient remarks, "I'm not sure this therapy stuff is for me," you might respond, "You do not think therapy can be helpful at all." When you engage in amplified reflection in this way, patients tend to move back toward at least subtle expressions of change talk when they are faced with an overstatement. Another technique that may be employed to help patients who are stuck start to move toward change talk is *double-sided reflection*. Specifically, double-sided reflection is used to help patients see the competing thoughts that they hold that cause them to be trapped. This involves repeating back to the patient the two sides of their thoughts connected by "and yet"—for example, "You know treatment has helped others, including some of your former Army buddies, and yet you think it cannot help you."

An additional strategy—and component of many EBPs, such as CBT and Problem Solving Therapy—that can be helpful for overcoming uncertainty or ambivalence about treatment is the simplified *Pros and Cons Exercise*. In this exercise, a line is drawn down the center of a piece of paper (or flip chart or white board), the top of the left column is labeled "Pros (Get treatment)," and the right column is labeled "Cons (No treatment/Stay as is)" (see Figure 2.2). The Veteran is then asked to identify and list the pros and cons of initiating treatment, completing one column before turning to the next. Either the provider or Veteran may complete the grid, preferably sitting side by side one another so that the exercise is completed collaboratively. During this step, it is important that the patient focus only on identifying pros and cons and not make evaluations or judgments about items on either side. After the lists on both sides are populated, the patient reviews and evaluates both columns, considering and comparing not the number of items on each side but the impact or significance of each item. It is important to note that at this stage of the SDM Session (prior to discussion of specific treatments and their effectiveness), many patients will have limited knowledge of existing treatment and the possibilities they afford. More detailed discussion about this will come later in the session and should not be the focus of the current exercise. At this point, what is important is that the Veteran consider the pros and cons of initiating treatment based on the notion that effective treatment is available (and will be described momentarily). For patients who are especially ambivalent about treatment or who would benefit from more time to consider the advantages and disadvantages of initiating treatment, the Pros and Cons Exercise may be recommended for completing on their own after session. This may also be further discussed with patients who would benefit from an additional SDM Session (see Section 2.1.6). We recommend that patients complete this exercise on their own only after they have been introduced to the exercise and at least partially completed the table. Finally, patients should be encouraged to keep the completed Pros and Cons table in their possession so that they can refer back to their reasoning for engaging in treatment as a reminder at later points in time.

The following dialogue illustrates how Bobby's SDM Session continued during the *Motivate* phase as Dr. Tammy inquires about Bobby's beliefs about and expectations for treatment.

EXCERPT
DR. TAMMY & BOBBY

DR. TAMMY: I'd like to ask you a few questions to learn a little bit more about your thoughts about treatment. Would that be okay?

BOBBY: Okay.

DR. TAMMY: First, can you tell me if you have ever received mental health treatment before?

BOBBY: Once when I came home in between my second and third tours.

DR. TAMMY: What did treatment consist of?

BOBBY: I don't know, really. Just talking back and forth.

DR. TAMMY: What was your experience like?

BOBBY: I can't say that I have an opinion either way.

DR. TAMMY: How long did you see your therapist for?

BOBBY: Three, maybe four, times.

DR. TAMMY: Three, maybe four, times. So just briefly, yes?

BOBBY: Yeah, that's right.

DR. TAMMY: How did treatment end? Did the two of you decide that your depression resolved, or did you just stop going?

BOBBY: I just stopped going.

DR. TAMMY: So you didn't believe it was helping?

BOBBY: No. All I did was update him on the past week. We didn't really *do* anything. It takes a lot for me to get to these appointments at the VA, so coming here just for that wasn't worth it to me.

DR. TAMMY: Did you see any problems with the treatment you received?

BOBBY: No problems, really, just that it wasn't really doing anything.

DR. TAMMY: So, it really wasn't something that was very helpful to you. I understand. Have you had other experiences with mental health treatment?

BOBBY: [shrugging] Just that my wife's on one of those meds, uh, antidepressants. It doesn't seem to do much for her.

DR. TAMMY: Ah, your wife is on an antidepressant. But you don't see any benefit from it?

Here, Dr. Tammy is paraphrasing to show that she is listening to Bobby and taking his observations seriously. She stayed close to his words in order to stay connected to his perspective and demonstrate that she understood what he was trying to communicate.

She was mindful not to directly challenge Bobby's impression that treatment was not helpful to him or his wife.

BOBBY: Not really. She's just as miserable as ever.

DR. TAMMY: Do you have the belief, then, that treatment for depression is not effective?

Because Bobby expressed a generally unfavorable view about depression treatment, Dr. Tammy extended Bobby's sentiments, which she checked out for verification. This is an example of the use of an amplified reflection described earlier, such that the provider not only expresses a statement that mirrors the main message that the patient is communicating, but does so in a more pronounced manner. In many instances, patients catch on to the more pronounced message and back away, as Bobby does below.

BOBBY: I don't know if I'd go that far. But I'm skeptical. It seems like a whole lot of appointments that are a big hassle for not a lot of benefit. And I'm kind of a private person; I don't really like to open up to others.

DR. TAMMY: I can understand that. It can be hard to share your thoughts and feelings with another person. How was it sharing your thoughts and feelings when you were in treatment in the past?

BOBBY: I dunno. I didn't really do that much, just basically gave an update on stuff that happened over the past week.

It is important to take the time to validate patients' reservations about therapy and difficulty trusting others with their very private experiences. Dr. Tammy took time out of her line of questioning to provide empathy and validation that it can be difficult to share thoughts and feelings with another person. Then, she attempted to learn more about Bobby's previous experiences in therapy to verify whether it was, indeed, the case that he had difficulty opening up or trusting a provider or had a negative experience in doing so.

DR. TAMMY: *[first summarizing, then setting the stage for education about available treatments, to come later in the SDM Session]* So, what I'm hearing from you is that you don't really see your wife's antidepressant medication having an effect on her mood, and that you did not see a lot of benefit from your previous course of talk therapy. I've heard this many times, that people discontinue treatment because they didn't believe that they were getting anything beneficial. Fortunately, we have some effective treatments that are quite active and focused, such that they are designed to *do* something. *[asking permission]* Would you be willing to hear about some of those?

BOBBY: I didn't realize that there is more than one treatment for depression. Well, maybe medicine and talk therapy, but those are it.

DR. TAMMY: Actually, there are several different types of talk therapy, each with a different focus, and we can put our heads together to figure out if one sounds appealing to you.

BOBBY: Well, OK then.

Notice here that Dr. Tammy was patient with Bobby when he was expressing somewhat negative experiences with previous treatment, and she validated his experience by noting similar experiences that others have shared. She gently indicated that there are treatment options available that are different from the one he might have received, but before launching into talking more about this, she first asked if he would like to discuss this. **Incorporating inquiries, including inquiries related to the discussion and process, can help to disarm patients and provide a sense of greater control and agency in the process. Further, asking for permission is a fundamental technique in many EBPs and communicates a respect for the patient's viewpoint and the spirit of collaboration.**

During the second step of *Motivate* (motivational enhancement), Dr. Tammy and Bobby explored how depression was affecting Bobby's day-to-day life and the benefits of overcoming depression.

DR. TAMMY: I realize that you did not have an ideal experience in your previous course of talk therapy, and also, that you're far from sure about participating in treatment now. How would you say your depression is affecting your life?

BOBBY: *[sighing]* I'm not really sure what part of this is depression and what part of this is retiring.

DR. TAMMY: *[reframing]* Well, what if we were just to refer to it as your current situation?

BOBBY: Current situation. Yeah, that's better. I don't know, things are not great.

DR. TAMMY: *[expressing empathy]* I'm gathering that, and I'm sorry to hear that. Can you tell me a bit more about what changes or symptoms you've noticed? These might be changes in your mood, your thoughts, behaviors, or things you do or don't do.

BOBBY: Everyone in my family–my wife, my kids, even my mother who lives in the next state–says I'm irritable with them. I can tell my wife and kids are steering clear from me.

DR. TAMMY: Is that OK with you?

BOBBY: It's the opposite of OK. They're all I have right now, now that I'm not working. But, I don't know, it just seems like every time I talk to them, it just goes so damn wrong. It's just easier to sleep.

DR. TAMMY: *[expressing more empathy]* Oh, that sounds really tough. I can just imagine how uncomfortable that makes the household.

BOBBY: Oh, you don't even know the half of it. It's like walking on eggshells.

DR. TAMMY: The sleeping, Bobby. Do you think that helps, or do you think that causes more problems?

BOBBY: *[pausing, acting as if he is caught slightly off guard]* That is a good question, Dr. Tammy. I'm not gonna lie, it's a big escape for me. *[sighing]* But my wife hates it. Don't get me wrong, she doesn't expect me to be working a full-time job, and she knows I put in more than my dues in the Army. But if I'm honest, I think it's making her respect me less.

DR. TAMMY: *[asking for elaboration using an open-ended question, keeping in mind principles of motivational interviewing]* In what way?

BOBBY: I'm only 52 years-old. Not 72. She doesn't want an old man for a husband. *[pausing, eyes becoming moist]* And I don't want to be 72 years-old either. I did a lot of good things in the Army, a lot to be proud of. Now, maybe I can't serve anymore with the injuries that have been piling up. But I damn well don't want to shrivel up and just sleep the rest of my life away.

DR. TAMMY: *[using a very warm, empathic tone of voice, expressing concern]* Bobby, I don't want that for you either. It sounds to me like you do want things to be different. Is that right?

BOBBY: *[nods head]*

DR. TAMMY: If your current situation were to improve, what would you be doing differently?

BOBBY: I'd be getting along better with people, my family especially. I guess I'd be more active in my life.

DR. TAMMY: *[conveying confidence]* Bobby, I have some treatment options that I think could be a good match for you. No question, you are going through perhaps what is the most significant transition in your life, from being a Warrant Officer in the Army and serving overseas to being retired. But what if there were some options for you to help you redefine what you can offer to your family and even to the community at this point in your life?

BOBBY: *[reverting to sustain talk]* I'm not sure that's possible. I feel like I'm at ground zero, and I'm not sure I have it in me to build something different.

DR. TAMMY: *[providing validation and respecting Bobby's autonomy]* I hear you, and no one is going to force anything on you. For whichever treatment you choose, if you choose one, you and your therapist will work together and at your pace. Am I right, though, in interpreting what you're saying that, all things being equal, you'd like things to be different?

BOBBY: *[softly]* Yeah.

EDUCATE

A key component of SDM involves empowering patients with information about potential treatment options to promote informed choice and agency in the treatment decision-making process.

This dialogue illustrates the "dance" between movement toward change and sustain talk. Although Bobby expresses significant dissatisfaction with many areas of his life, he also expresses pessimism by saying that he does not know if change is possible and if he has it "in him" to do anything differently. When Bobby verbalized sustain talk, Dr. Tammy did not engage in debate and try to convince him that he should embrace change. Rather, she indicated that she heard his viewpoint, reiterated that no one would force treatment on him, and reassured him that if he did seek treatment, then it would proceed at his own pace. However, at the same time, she asked a question that opened the door for additional change talk on the basis of the information that he expressed earlier in the conversation. Mental health providers who practice from a motivational enhancement perspective are cognizant to indicators of change that they express in the course of conversation. Providers should be aware of the change talk that patients express earlier in conversation so that patients can be reminded of it; however, at the same time, it should not be presented in a way that "boxes" patients into a corner or "confronts" them when they might make a contradiction. Rather, it is encouraged that when patients express change talk and follow with indications of sustain talk that providers approach these instances from a curious and nonjudgmental stance, asking for understanding to reconcile the statements and factors that might be at work in the interplay of change talk and sustain talk.

2.1.3. EDUCATE: EDUCATE VETERAN ABOUT EBPS AND OTHER TREATMENT OPTIONS

A key component of SDM involves empowering patients with information about potential treatment options to promote informed choice and agency in the treatment decision-making process. The discussion of specific treatment options corresponds to *option talk* in the Elwyn et al. (2012) SDM model. As part of this step of the SDM Session, **the provider identifies potential treatment options and presents verbally and in written form a summary of information about each treatment and what treatment involves, the treatment length and frequency, the risks of treatment, and the effectiveness of treatment.** To promote comprehension and alignment with the patient, it is important that the information is presented slowly and clearly, with periodic breaks to allow the patient to process the information and ask questions. The provider may also check periodically for understanding, including through occasionally eliciting summaries from the patient.

Patient decision aids and related resources for specific mental health conditions are available as part of this toolkit to help standardize the descriptions of mental health treatments and facilitate implementation of the *Educate* step of the SDM Session. These patient resources include the following:

1. **Treatment Options Grids:** Include key information about different treatment options listed side-by-side that is provided to patients as a visual guide during the discussion of potential treatment options. The ***Treatment Options Grids*** are printable electronic matrices that may be customized for individual patients and local use, including removing or adding EBPs or other treatments based on clinical considerations for specific patients and local treatment availability.

2. **Treatment Fact Sheet**: Patient education handouts providing additional information about specific treatment options. The ***Treatment Fact Sheets*** are designed to be provided to patients who are interested in learning more about specific treatment options after reviewing and discussing the treatments included

on the Treatment Options Grid. The Treatment Fact Sheets may either be reviewed in session or, more commonly, at home following the SDM Session.

3. **Treatment Works for Vets website**: Providers may introduce Veterans interested in learning more about EBPs to Treatment Works for Vets—a public awareness and information resource for Veterans and family members. This website provides information about EBPs using creative and animated design, character-based content, and interactive exercises. Providers may consider briefly showing the website to Veterans in the SDM Session and recommending they review the website and integrated animated videos depicting Veterans with mental health conditions and the treatment process at home following the session. In addition to descriptive information about EBPs, presented through interactive exercises and character-based content, Treatment Works for Vets includes an *Additional Resources* section that lists key research and evaluation articles documenting the efficacy and effectiveness of EBPs for different mental health conditions, including with Veterans, specifically, that may be of interest to some patients who wish to learn more about the EBPs and their effectiveness.

Each of these resources may be accessed through the Educate subpage of the Provider portal of the Treatment Works for Vets website (www.mirecc.va.gov/visn19/treatmentworksforvets/providers/#educate). Providers who work with Veterans with PTSD may wish to use the PTSD decision aid resources developed by the VA National Center for PTSD, which may be accessed at www.ptsd.va.gov/apps/decisionaid.

Although decision aids are a central component of educating patients about available treatment options, it is the human interaction and discussion with the patient that promotes deeper processing, personal application, and trust of information.

Providers may introduce the *Educate* step of the SDM Session by stating, **"There are now some good treatments available for the problems you've been experiencing, and I think there are some options that could really help you. Would you like to take a closer look at these together?"** Of course, it is important to tailor the introduction of this and other sections of the SDM Session so that the transition is natural and fits well with the content and process of the prior discussion. If the patient responds affirmatively to learning about possible treatment options, the provider may then give the patient the *Treatment Options Grid* for them to review as the provider describes each treatment. As noted above, the treatments listed as potential options for consideration on the *Treatment Options Grid* may be customized for local use and based on patient factors known to the therapist prior to the SDM Session.[1]

It cannot be overemphasized that, although decision aids are a central component of educating patients about available treatment options, it is the human interaction and discussion with the patient that promotes deeper processing, personal application, and trust of information. Thus, the discourse and a strong interpersonal connection are essential to the *Educate* process. The following strategies are recommended for guiding the collaborative discussion about treatment options:

1. Use the decision aids as a basis for educating and engaging the Veteran about available treatments.

2. Use active listening and related communication skills to maintain close interpersonal connection with the Veteran and demonstrate understanding of their reactions, questions, and concerns.

1 The Treatment Options Grids available on the Treatment Works for Vets website include interactivity, including removing or adding additional treatments, for customizing to individual patients.

3. Relate, as appropriate, your firsthand experience of what happens in treatment and the experiences of other Veterans.

4. Respond to questions and concerns based on your clinical experience and knowledge of the research literature in understandable language.

To allow for quick comprehension and discussion, the Treatment Options Grid includes only the core information about specific treatments. Providers should elaborate on key elements, as appropriate, and encourage questions from patients. Providers are encouraged to elaborate in their own words based on their clinical experience, knowledge, and awareness of the treatment experiences of other Veterans, as appropriate. Indeed, your first-hand experience of the treatment approaches can provide a valuable "personal touch" to the conversation. While it is, of course, important not to use absolute language that guarantees a positive outcome in discussions about treatments, it is important to use language that is encouraging and provides hope. Along these lines, information about, or personal experience with, the effectiveness of specific treatments with many Veterans can be valuable and relevant information for many patients.

The mission of the provider of the SDM Session is to provide personally relevant treatment information to enable informed choice within the context of a supportive and sensitive human interaction.

While considering each of the foregoing strategies for educating Veterans about potential treatment options, it is also important to consider that the process should be individualized to be consistent with the Veteran's style, existing knowledge, and the nature of the conversation and interpersonal environment established thus far in the SDM Session. **While knowledge acquisition is an important part of SDM, the SDM Session is more than an education session but an interpersonal process whose primary goal is interpersonal engagement.** Thus, the mission of the provider of the SDM Session is to provide personally relevant treatment information to enable informed choice within the context of a supportive and sensitive human interaction.

Furthermore, it is important to highlight that the focus of the *Educate* step is on increasing knowledge and understanding to promote informed choice, although the actual process of choosing is not part of this step. The emphasis in *Educate* is on ensuring that the Veteran has accurate and accessible information that, along with other factors to be discussed in the ensuing steps of the SDM Session, will allow for an informed and personalized treatment decision.

Let's turn back to Bobby and Dr. Tammy's discussion during the *Educate* step of their SDM Session. In reading the exchange between Bobby and Dr. Tammy, notice the way in which Dr. Tammy presents information in response to Bobby's reactions during the session. Rather than mechanically present information in a strict linear manner, she presents the information interactively, responding to Bobby's questions as he asks them. She also focuses discussion on parts of the decision aid that pique Bobby's interest. Throughout the exchange, Dr. Tammy demonstrates collaboration and responsiveness and links aspects of the discussion back to earlier discussion during the session.

EXCERPT
DR. TAMMY & BOBBY

DR. TAMMY: There are now some good treatments available for the problems you've been experiencing, and I think there are some options that could really help you. Would you like to take a closer look at these together?

BOBBY: Oh yeah? That's news to me. I just figured I'd have to start taking Prozac or something.

DR. TAMMY: Well, a medicine like Prozac *is* an option. But there are other options too. Is it OK if I share some specific information about treatment options?

BOBBY: Like what options?

DR. TAMMY: Talk therapy, or "psychotherapy" with a therapist–someone like me. In fact, there are certain talk therapies for depression now available that could be good treatment options for you.

BOBBY: You mean there's more than one? How many different ways are there to talk about your problems?

DR. TAMMY: *[giving Bobby a warm smile]* I know that may sound surprising and appreciate that it can be overwhelming to think about all of these options. Would you like me to help you sort them out?

BOBBY: I think you're gonna have to.

DR. TAMMY: I have some materials here to help us out. *[grabbing the Treatment Options for Depression Grid and handing it to Bobby]* The information on this sheet can be helpful to take a look at as we discuss some possible options. These four columns, here *[points]*, list different treatments for depression. And, the rows, here *[points]*, include questions about how treatment works, how long it lasts, any risks of treatment, and the effectiveness of treatment. Should we take a look at this together?

BOBBY: OK. I need to know what is involved before I agree to anything.

DR. TAMMY: Absolutely. The first three columns describe three talk therapy options. With these treatments, you would be matched with a therapist, and you would meet with that therapist on a regular basis to address your depression. Make sense so far? *[Here the provider stops to check in for understanding]*

BOBBY: I get that I would be meeting with a therapist. But, geez, I don't know. I'm a pretty private person, you know.

DR. TAMMY: *[providing validation]* I get where you're coming from. You mentioned this earlier, as well. In fact, many Vets have the exact same concerns. One of the nice things about talk therapy is that almost all of what is discussed in therapy is kept confidential, so you feel comfortable. The exceptions are instances where people may be a threat of harm to themselves or someone else and situations of child abuse. Most Vets like having someone they can talk to who they can trust.

BOBBY: Yeah, I see.

DR. TAMMY: *[sensing that Bobby continues not to be entirely comfortable with the idea of psychotherapy]* These are the exact types of concerns I was hoping that you'd be checking out with me today, Bobby. To make an informed choice about treatment, it is important that you have a good understanding of the options and what they mean for you, considering your own comfort level and personal life circumstances. By all means, when something comes up that you're not sure about, please stop me so that we can discuss it. *[Here the provider is inviting collaboration and questions of clarification.]*

BOBBY: OK, thanks, that sounds good.

DR. TAMMY: *[asking permission to continue]* Can I share a bit more about the different talk therapy options?

BOBBY: Yes, please do. I still don't understand how there can be more than one talk therapy. To me, talk therapy is talk therapy.

DR. TAMMY: Well, it is true that they all involve conversation between you and a therapist. But the first two options on this sheet *[pointing down to Treatment Options for Depression Grid]* are what we call "evidence-based psychotherapies." What this means is that multiple research studies have shown these therapies are effective for reducing symptoms of depression. Just like the way proven treatments for heart disease and diabetes are studied.

BOBBY: *[furrowing his brow]* This is interesting; it's like this clinic has done its homework to figure out the best treatment approaches for guys like me.

DR. TAMMY: *[smiling]* Yes, exactly. Would you like to hear more about them?

BOBBY: *[thinking to himself]* Yes, that would be helpful. *[again reviewing Treatment Options for Depression Grid]*

Here, Dr. Tammy begins describing the specific treatments to Bobby and calling Bobby's attention to the material on the Treatment Options for Depression Grid. As she described the treatments, she frequently checked in for understanding and asked questions to obtain feedback. In the process, she reinforced when Bobby responded in a way suggesting that he found aspects of the treatments to be attractive to him. In addition, she identified instances in which Bobby was having a negative reaction to aspects of the treatments so that she could provide clarification, as well as reassurance that his preferences would directly guide treatment selection. After learning more about treatment options, Bobby reflected on his newly acquired knowledge:

BOBBY: I wouldn't have ever guessed that I'd even be considering talk therapy. But some of what I'd be doing in them, I don't know, I think I could really use. I need to figure out how to make my life better, not just sitting on the couch watching TV and thinking about the past. I need to figure things out with my wife and son. There's so much damn tension there that you could cut it with a knife.

DR. TAMMY: I've really appreciated your openness to discussing talk therapy options with me.

BOBBY: I don't know, though, I was thinking that I really need medicine. *[pauses and looks down at the Treatment Options for Depression Grid]* It says here that I can also do combination treatment and get *both* medicine and talk therapy. Maybe that would be the most effective?

DR. TAMMY: Combination treatment is an option. A number of Veterans who come here for treatment take advantage of both medication and talk therapy. *[leading into discussion of Bobby's values and preferences]* Perhaps we can shift our discussion toward what's most important to *you*, so that you can make a decision that is most consistent with who you are and what you value?

BOBBY: Yes, let's do that. Because I'm still not sure where to go from here.

This dialogue illustrates the way in which providers can share information about available treatments, respond to patients' questions and concerns as they arise, and continue to build an interpersonal connection characterized by warmth, trust, and respect. In most cases, the discussion will not proceed in a linear manner, just as any interaction rarely does. Rather, the provider introduces the idea of choices, provides written material to serve as a guide for discussion and reference, reviews and elaborates on key elements, and takes note of and follows the patient when they ask a question or express a significant point or preference. When elaborating on information summarized in the Treatment Options Grid, it is important for providers to incorporate objective knowledge from the empirical literature and from their clinical experience.

Throughout the dialogue, Dr. Tammy responded (verbally and non-verbally) to Bobby's comments and patiently answered his questions, while also guiding the discussion forward. She simultaneously validated Bobby's concerns, provided information to help

The focus of the *Educate* step is to ensure that the patient has the knowledge about different treatments to subsequently allow for evaluation and informed choice, rather than to select a specific treatment at this point in the process.

resolve his concerns, and explained information from the scientific research literature in understandable terms. While Dr. Tammy remained open in her presentation of different treatment options, she made sure to provide enough information for Bobby to give EBPs specific consideration. This is especially important for treatments highly recommended in clinical practice guidelines and, in Bobby's case, in light of his desire to do something in treatment and address specific behavioral and other challenges in his life.

In the next step of the SDM Session, information about different treatments and their effectiveness is considered through the lens of the patient's values and preferences. Accordingly, the focus of the *Educate* step is to ensure that the patient has the knowledge about different treatments to subsequently allow for evaluation and informed choice, rather than to select a specific treatment at this point in the process. While some evaluation of specific treatments as they are presented is natural, if the discussion veers too far down the road of treatment selection, the provider may gently redirect the patient by reassuring them that they will come back to the selection of treatment after the patient has had an opportunity to learn about the different treatment options and consider what the treatments offer relative to what is important to them and what would work best in their lives. If, however, a patient expresses a strong preference for a particular treatment before all treatment options are discussed, going through the motions of discussing the remaining columns of the Treatment Options Grid may not be beneficial. At the same time, empowering patients in a process of informed choice presumes that patients have received sufficient information to make an informed decision. Therefore, in such instances, it is recommended that the provider ask the patient to elaborate on this preference and the basis for it. Based on the patient's response and consideration of whether important information has been discussed (e.g., patient made aware of recommended or first-line treatments for their condition—typically the first treatments discussed), the provider should exercise discretion over whether and to what extent to continue the discussion of additional treatments.

EXPLORE

2.1.4. EXPLORE: EXPLORE VALUES AND PREFERENCES

The two fundamental components of SDM are patient education about treatment options, the focus of the preceding step of the SDM Session, and the examination of those options by the patient based on their personal values and preferences, which is the focus of the current step of the SDM Session. **Explicit focus on patient values and preferences has become an increasingly prominent and significant theme in the SDM literature and is a core component of person-centered care. At the same time, SDM research incorporating coding of patient and provider interactions in health care, and mental health care visits, specifically, shows that preference-based discussion occurs less than science-based discussion (Fukui et al., 2015).** Thus, discussion of treatment options often has a tendency to veer toward exclusive provision of information.

The overarching goal of the *Explore* step of the SDM Session is to make what is important to the Veteran explicit and have this serve as a lens through which to consider and evaluate different treatment options. Consequently, the overarching question *Explore* seeks to address is "What is important to the Veteran, and how are the treatment options discussed consistent or inconsistent with this?" Specifically, along with the information provided in the *Educate* step about specific treatments, how they work, and their benefits and risks, this involves exploring and considering personal factors along one or more domains that are significant to the Veteran, including:

The overarching goal of the *Explore* step of the SDM Session is to make what is important to the Veteran explicit and have this serve as a lens through which to consider and evaluate different treatment options.

1. **Treatment focus and desired outcomes:** Short- and longer-term outcomes associated with the patient's problem areas and desired areas for change. This may include remission of certain symptoms, improved functioning in certain domains of life (e.g., interpersonal, behavioral, cognitive), or other personal or life changes. For many Veterans, knowing that treatments are supported by empirical evidence is an important factor (Schumm et al., 2015).

2. **Lifestyle, social, and cultural factors:** Personal and lifestyle factors that may impact treatment and treatment engagement. This may include social characteristics and preferences, cultural norms and preferences, preference for active vs. passive role in treatment, and practical and logistical issues (e.g., financial and physical accessibility of treatment, session attendance requirements).

3. **Negative consequences:** Potential negative consequences of specific treatments (or no treatment). This may include potential treatment side effects or discomfort associated with disclosure of personal information.

The factors identified above illustrate a range of potential factors that may be salient for patients. However, different factors will have significance and value for different patients. It is not expected that all of these considerations will be important to or relevant for all patients.

The process for considering patient values and preferences in the treatment decision-making process includes several steps and is summarized in Table 2.5, along with sample questions for implementing each. Providers may introduce *Explore* by stating, **"Perhaps we can shift our discussion toward what's most important to you, so that you can make a decision that is most consistent with who you are and what you value?"**

TABLE 2.5.
STEPS FOR CONSIDERING PATIENT VALUES AND PREFERENCES

STEPS	SAMPLE QUESTIONS
1. Elicit preferences that are important to the patient (follow up and provide examples, as needed).	"As we think about the different treatment options, what are the most important factors for you to consider?" "Do you have any other preferences about treatment that we should consider as we move toward a decision about treatment?"
2. Acknowledge and summarize what is important to the patient. If patient identifies many factors, ask the patient to prioritize the most important ones.	"It sounds like [X] is important for you. That really makes sense. I'm glad you mentioned that." "I have appreciated hearing more about what is important to you. From what you've said, it sounds like [X] and [Y] are really important. I think we should consider these factors as we make a decision about the best option for you." "You mentioned several factors, including…Which of these factors are most important to you?"

STEPS	SAMPLE QUESTIONS
3. Explore reactions to treatment options Use Socratic questioning and/or provide information to help guide patients and make connections between treatments and preferences.	"Considering what we've discussed so far, do you find that you connect with any of the treatments we reviewed? How so?" "Were any of the treatments that we reviewed difficult for you to connect with? How so?" "Was there anything about the treatments that concerns you in any way? Which ones, and why?" "You mentioned that you [spend a lot of time thinking negatively about yourself and staying home, which makes you feel worse. You also noted that you have a hard time making decisions about things]. Of the treatments we discussed, are there any that seem like they might help with these things?"
4. Summarize and request feedback.	"This has been a great discussion. It sounds like what is important to you is…And based on what we've discussed so far, [X] may be a good treatment option for you. Do I have that right so far?" "Before we proceed with the last parts of our discussion today, how do you feel about our discussion so far? Do you have any questions?"

Therefore, throughout the discussion about values and preferences, it is important to (1) identify what matters to the patient, (2) communicate that you are interested in and respect their values and preferences, and (3) convey that the values and preferences will be respected in the decision-making process.

The first step of the *Explore* process involves identifying factors that are important to the patient and that may be relevant to one or more treatment options. If the patient does not immediately identify specific preferences, the therapist may follow up with probing questions, such as "What do you hope to get out of treatment?" Or the therapist may provide examples by stating, "For example, some people prefer not to talk a lot about things that happened during their childhood or that occurred well in their past. Or for people whose problems are primarily related to relationships in their lives, what may be especially important for them is to learn ways to improve relationships." While it is important to consider patients' preferences, it is also important to consider that initial preferences for particular treatments or types of treatments may reflect limited understanding of specific treatments. For example, patients may initially express a preference for medication because they believe that psychotherapy involves talking about their childhood or resolving unresolved issues with individuals in their life. Thus, the *Explore* process provides an opportunity to uncover and modify inaccurate beliefs that may underlie certain preferences.

The second step of *Explore* involves acknowledging and summarizing what is important to the patient through the use of active listening skills, such as paraphrasing and expressed empathy, and summary statements. Providing acknowledgement of what is important to the patient demonstrates the value of what matters to them and that treatment will reflect their unique preferences. Therefore, throughout the discussion about values and preferences, it is important to (1) identify what matters to the patient, (2) communicate that you are interested in and respect their values and preferences, and (3) convey that the values and preferences will be respected in the decision-making process. The ultimate goal is for the patient to feel that the treatment decision reflects their active input and individuality.

In the third step of *Explore*, the provider explores the patient's thoughts about the treatment options presented considering the preferences and values identified by the patient. In so doing, the provider should inquire about the reasons why the patient may

feel more or less connected to particular treatment options to assess their understanding of the treatments and why the patient believes they are or are not consistent with their preferences and values. In addition, the provider may offer information to affirm or correct the patient's understanding and reasoning.

In some cases, patients may not, on their own, identify one or more treatments that they connect with. A useful approach to help support the patient in the process is Socratic questioning. **A technique commonly used in CBT and other evidence-based psychotherapies, Socratic questioning involves asking the patient questions to help lead them to self-discovery.** This may be particularly useful for helping patients make connections between their preferences and specific treatment options.

It is important to note that, while directly checking in on, discussing, and considering the patient's reactions to the different treatment options can be helpful after determining what is most important to the Veteran so that these factors are explicitly identified and used to filter treatment information, in some cases, the discussion about specific preferences may follow (or occur simultaneously with) the discussion of specific treatment options. This may especially be the case with patients who are readily aware of or hold strong preferences and may even express these during or immediately following the review of specific treatments. In addition, for some patients, such as those who may have more difficulty comprehending new information or with recalling or referring back to the treatment information, it may be beneficial to check in on the patient's reactions to the treatments before (and potentially after) proceeding with specific discussion about patient preferences. Consequently, the sequence presented here is intended to be flexible and may not follow a direct linear path as reflected in Table 2.5. **Rather, the provider should adapt and gently guide the discussion as appropriate for each patient, making sure to maintain a natural flow of conversation and keep important focus on Connection and collaboration, while seeking to bring personal values and preferences into the conversation.**

The final step of *Explore* involves tying together the discussion of values and preferences. This is achieved by first providing a clear summary of factors that are most important to the Veteran and the treatment option(s) the Veteran connects most with. The Veteran is not expected to select a specific treatment at this point, though in most cases it is expected that the Veteran may express particular interest in one or two treatment options that would be consistent with what is most important to them.

After summarizing the factors that are particularly important to the patient and the treatment option(s) the patient most connects with, the provider should confirm the accuracy of the summary with the patient. This is important to ensure that the patient and provider are in alignment and to see whether the patient is ready to proceed to the next step of the SDM Session. At this point, it is also a good opportunity to generally check in with the patient and request feedback as to how they feel about the discussion so far and whether it has been helpful.

The following dialogue illustrates the way in which Bobby's values and preferences were considered as he contemplated different treatment options for depression.

EXCERPT
DR. TAMMY & BOBBY

DR. TAMMY: *[leading into discussion of Bobby's values and preferences]* Perhaps we can shift our discussion toward what's most important to you, so that you can make a decision that is most consistent with who you are and what you value?

BOBBY: Yes, let's do that. Because I'm still not sure where to go from here.

DR. TAMMY: Understandable. Let's start with what's important to you. As we think about the different treatment options, what are the most important factors for you to consider?

BOBBY: *[pausing]* Well, that's a good question. *[thinking]* I guess it's important that I learn to deal with things better, now that I'm retired. I think I get more depressed when I don't deal well with life. You know, like things with my son and not having anything to really do. So I need to have a solution for that.

DR. TAMMY: *[making a note that specific talk therapy options might help him to achieve this goal]* It sounds like learning how to deal with life challenges is really important to you. Did you connect with any of the treatments that we've discussed so far, or does it seem that any of the treatments I described would be consistent with this preference?

BOBBY: Yeah. A few of them did. Especially that one that had to do with behavior. I forgot the letters.

DR. TAMMY: Oh, you mean Cognitive Behavioral Therapy, or CBT?

BOBBY: Yeah, that was the one. *[pausing]* But, I don't know, maybe it would just be easier to take a pill. If I'm mellowed out, then that would also help me to deal with life better.

DR. TAMMY: Well, medicine is certainly a reasonable approach in the treatment of depression. Is there something about Cognitive Behavioral Therapy, or talk therapy in general, that is inconsistent with your style?

BOBBY: Yeah, I think that's why I'm hesitating. I said before that I'm a private person. I really don't like to share my dirty laundry with others, especially strangers. I think talk therapy would be way out of my comfort zone.

DR. TAMMY: *[providing validation]* You're not the first person to say that. Maintaining privacy is something that many people value tremendously. It strikes me that, today, you've shared some personal information with me during the session. Do you feel that we've overstepped the boundaries of the maintenance of your privacy?

BOBBY: *[looking a bit surprised]* Actually, no. This has felt okay.

DR. TAMMY: What might that say about the way in which talk therapy would go?

BOBBY: *[continuing to look a bit surprised]* Are you saying that talk therapy would be like this?

DR. TAMMY: *[demonstrating respect for Bobby's concerns about opening up to a therapist]* Absolutely. You're in the driver's seat during talk therapy, such that you can choose to share as much or as little about your life as you'd like. Of course, talk therapy does tend to work best when the patient is pretty open about their life. But you can also work up to a level of openness as you develop trust with your therapist.

BOBBY: Hmmm. That's kinda interesting. I don't know, I thought I'd be talking about my past and stuff like that, and that I'd be leaving each session crying like a baby. I don't want that at all.

DR. TAMMY: Did you get the sense that would be the case with any of the talk therapy options I described to you?

BOBBY: *[looking at Treatment Options for Depression Grid]* No. Well, maybe general talk therapy a little.

DR. TAMMY: *[providing a summary in order to communicate that she has listened and understood what Bobby has been saying]* So what I've heard you say is that you'd like a treatment approach that helps you learn ways to deal with your life more effectively. But, at the same time, maintaining some sense of privacy is important to you. Do I have that right?

BOBBY: Yes, it's exactly right.

DR. TAMMY: Are there any other preferences or concerns that we should make sure we talk about as we move toward a decision about treatment?

BOBBY: The meds–I've heard that some people with depression have to take more than one medicine for it to really work.

DR. TAMMY: That is true on some occasions, but that's not the case for many people.

BOBBY: Well, that wouldn't be for me. I take so many meds now, I don't want to be completely zoned out like a zombie.

DR. TAMMY: *[paraphrasing]* Right now you wish not to add new medications to an already complicated medication regimen.

BOBBY: Yes, exactly.

DR. TAMMY: I think it's reasonable if you wish to start with talk therapy now. You can always talk with your therapist more about exploring medication treatment later on if you or she believes that may also be beneficial.

BOBBY: Good. That sounds more manageable right now.

DR. TAMMY: I'm remembering one other comment you made about these treatments that we should be mindful of. When I was describing Cognitive Behavioral Therapy, I had mentioned between-session work, and you responded that you don't want to have to write anything down

BOBBY: *[making a face]* Definitely not. It feels too much like school to me.

DR. TAMMY: I get that. It is true that some of the work done in Cognitive Behavioral Therapy involves written work, but there are ways to make it simple–and kinda fun when you get going. For example, you can focus on doing things differently–the behavioral piece–or you can find alternatives to writing, such as recording notes into your smartphone.

BOBBY: Oh, that's an option? I make notes to myself in my phone all the time.

DR. TAMMY: That's great. That will be an asset with whichever treatment you decide on. Any other factors that are particularly important to you that we should think about?

BOBBY: *[thinking and looking at the Treatment Options for Depression Grid]* I just really want treatment to work.

DR. TAMMY: So, it's important to you that there is research supporting the effectiveness of whatever treatment you choose?

BOBBY: Yeah, I think so. I mean, I didn't think about that before the appointment today. But if I'm going to do this, then I want to put my best foot forward and figure out the plan that's most likely to work.

DR. TAMMY: *[summarizing and requesting feedback]* Good point. We'll be sure to keep that in mind when we make a decision about treatment, Bobby. This has been a terrific discussion. It sounds like what is most important for you is to receive an effective treatment that will help you to deal with life. Although you're a private person, you see that some of the types of talk therapy, like CBT, may help you to meet your goals. And even though, when you first walked in, you expected me to recommend medication, you're realizing that there are other options and that you don't necessarily want to add more medications to an already complicated medication regimen. Do I have all of this right?

BOBBY: *[face brightening]* Yes, you got it.

DR. TAMMY: How do you feel about our discussion so far? Any questions?

BOBBY: No questions, really. *[Shaking his head]* If someone would've told me before today I'd be considering a talking therapy, I would've laughed at them. But this is different than I expected it to be.

SET GOALS

In this dialogue, Dr. Tammy elicited Bobby's preferences and explored how these fit with the discussion of treatment options. She engaged in active listening throughout the discussion and made sure to recognize and validate Bobby's concerns, including his concerns about opening up to others. In so doing, she also pointed out that many others have this same concern about talk therapy. This not only can serve to normalize Bobby's concern but can also convey to him that she is open to hearing potential negative reactions to various treatment options. At the same time, Dr. Tammy helped Bobby to re-examine his negative beliefs about opening up by prompting him, in a non-direct fashion, to look at his reaction to the current conversation. Later in the conversation, Dr. Tammy recalled several points that Bobby had expressed earlier in the SDM Session (i.e., that he does not engage in much goal-directed activity, that he spends much time dwelling on the past, and that he does not like writing), linked these observations with his preferences for treatment, and provided a general overview of ways in which these characteristics and preferences could be reflected in the treatment process. As the SDM Session progressed, Dr. Tammy wrote down key points and preferences that Bobby expressed and which she thought may have relevance for discussion and consideration at this point in the SDM Session. She concluded with a summary and asked for feedback to ensure that the two of them were thinking similarly about his preferences.

2.1.5. SET GOALS: IDENTIFY POTENTIAL TREATMENT GOALS

Helping patients to elucidate how therapy may be helpful to them can be a powerful motivator for treatment. Identifying personally relevant ways in which treatment could improve one's life can bring concepts of treatment and treatment effectiveness from a general, abstract level to a more meaningful, individual level and make treatment more real and accessible. Moreover, Veterans presenting for care often have unclear life goals, due to significant life changes or other factors, making treatment goals even less identifiable initially. Furthermore, identifying possible treatment goals can help the provider in offering and providing specific information about treatment options best suited to the patient.

Identifying personally relevant ways in which treatment could improve one's life can bring concepts of treatment and treatment effectiveness from a general, abstract level to a more meaningful, individual level and make treatment more real and accessible.

The *Set Goals* step of the SDM Session involves engaging Veterans in a collaborative process of *preliminary* goal setting to identify potential goals for treatment—to be refined and completed during the beginning phase of treatment—for increasing awareness and motivation and guiding treatment selection. This process is designed to bring treatment to the level of the Veteran's life and help the Veteran see, concretely, how treatment may benefit their personal situation. **Envisioning how a specific treatment may have utility in the patient's life can help to further increase motivation for and commitment to treatment. It can also instill hope that a patient's life can improve, which increases the likelihood that the Veteran will fully embrace the treatment that they choose.**

The discussion during the current step of the SDM Session is similar to but more specific and active than the general discussion about how life might be different that occurs in the *Motivate* step earlier in the session. Moreover, the goal-setting discussion during *Set Goals* may also follow from the discussion of what matters to the patient during the *Explore* step immediately preceding this part of the SDM Session. Given the evolving nature of the SDM Session and the fact that the identification of potential treatment goals may extend from more specific ideas discussed in earlier parts of the session, it is recommended that providers write down earlier comments that may help during the *Set Goals* step of the SDM Session, including instances of change talk, ways in which life might be different, specific symptoms or problem areas, and negative consequences of the mental health condition.

Providers may introduce the *Set Goals* step by inquiring, **"It is OK if we take a moment to talk, specifically, about what you want to get out of treatment?"**

Table 2.6 presents specific steps and sample questions for identifying potential treatment goals. The first step of the process is inquiring about potential treatment goals, with the purpose of identifying at least 1 or 2 meaningful goals that are relevant to the patient's life. Some Veterans will be able to readily articulate possible goals at this point in the SDM Session, whereas other Veterans may benefit from guided discussion. The questions listed in Table 2.6 for helping to elicit potential treatment goals are listed from more specific (focusing on specific goals or outcomes) to more general (focusing on problem areas) to reflect the fact that some patients may have difficulty initially identifying goals. In such instances, beginning at a more general level by asking questions about their problems or symptoms, which are typically readily accessible, and then working toward generating goals related to those problem areas, may yield greater success. Moreover, as discussed above, providers may use information discussed during earlier points of the SDM Session, such as the *Motivate* and *Explore* steps, as a starting point for the discussion of potential treatment goals. During the discussion of potential treatment goals, providers should explicitly note that the discussion of goals is primarily intended to help the Veteran see how treatment may be beneficial to them and that they will have an opportunity to develop more specific treatment goals (which these may be a good starting point for) at the outset of treatment.

TABLE 2.6.
STEPS FOR IDENTIFYING POTENTIAL TREATMENT GOALS

STEP	SAMPLE QUESTIONS
1. Elicit at least 1 or 2 potential treatment goals. Refer back to previous discussion, e.g., how life might be different (*Motivate*) and/or what matters to the Veteran (*Explore*).	More Specific (Goals) More General (Problems) ▪ "If treatment is successful, how would your life look different than it does today?" ▪ "What, specifically, are the most important things you would like to get out of treatment?" ▪ "What would you like to focus on in treatment?" ▪ "What are the most important problems to address in treatment?" ▪ "Many people who seek treatment for [depression] focus on ways in which these symptoms cause problems in big areas of their lives, such as their relationship with their spouse or children or in their jobs. Is there an area of your life that your symptoms are affecting that could be addressed in treatment?"
2. Link goals to treatments the patient is considering.	▪ "Do you think any of the treatments we discussed could help with [X]?"
3. Summarize and request feedback.	▪ "So, it sounds like we have identified a couple of possible goals that treatment may help with: [X and Y]. And from our discussion, it seems like [treatment] could be a good match for those goals. How does that sound to you? What are your thoughts about this discussion?"

During the discussion of potential treatment goals, the provider should apply their knowledge of the patient and use their clinical judgment to assess the appropriateness of potential treatment goals and help guide the patient to identifying goals that are reasonable and meaningful to the patient. Many readers of this toolkit are aware that the best treatment goals are those that are clear, specific, and behaviorally oriented, such that they can be measured and, therefore, used for assessing the impact of treatment over time. However, because the purpose of the current process is to help patients invest in the notion that treatment will be make a difference in their own life, it is not necessary for the treatment goals to be overly specific or stated in specific behavioral terms, just specific enough for to be clear, meaningful, and motivating to the Veteran.

While it is preferred for patients to identify treatment goals directly from their personal experiences, for patients who have difficulty identifying potential goals, the provider may present common goals of other Veterans who have had similar problems for the patient to consider and choose from. Hearing goals of other Veterans who have been in similar situations and received similar treatments can also be motivating to the patient. To introduce these goals, the provider may ask, **"Would you like to hear some common goals of other Veterans who have had similar problems?"** Providers may also bring up in session or recommend to Veterans the Veteran portal of the Treatment Works for Vets website, which contains interactive goal-setting exercises that include a number of common treatment goals of Veterans with specific mental health problems. A list of some of these treatment goals for depression and insomnia is presented in Table 2.7.

TABLE 2.7.
EXAMPLES OF POTENTIAL TREATMENT GOALS

DEPRESSION	INSOMNIA
I want to improve my mood.	*I want to sleep longer each night.*
I want to feel more hopeful about my future.	*I want to fall asleep sooner each night.*
I want to improve relationships in my life.	*I want to get through the day without worrying about whether I will sleep that night.*
I want to have things to look forward to.	*I want to feel more rested and less tired throughout the day.*
I want to feel better about myself.	*I want to concentrate and focus better.*

After identifying at least one or two potential treatment goals, the provider works to help link the goals to specific treatments. This may be done by asking the patient whether there are treatments that were discussed (particularly treatments that the patient may have expressed interest in during the *Explore* step of the session) that they believe could help the patient achieve one or more of their goals. In addition to inquiring of the patient, the provider may highlight or provide additional information or feedback regarding such treatments to the patient. This additional information and expert perspective can be helpful, especially with more specific goals, in light of the fact that the patient is likely just learning about specific treatments and may not have full awareness of how specific treatments may have utility and effectiveness or help to achieve specific goals. In addition, the provider may elaborate or offer specific examples of how the treatment can help with achieving identified goals, based on their experience and specific clinical work with Veterans.

The final step of *Set Goals* involves summarizing the patient's potential treatment goals and the discussion of specific treatments that may be helpful for achieving one or more of these goals. Following the summary, it is recommended that the provider check in with the patient to see whether they agree or have questions and to elicit feedback to hear the Veteran's reactions to the conversation and have a sense of where the patient is as they prepare to embark on the final component of the SDM Session.

Let's check back to see how the discussion of potential goals proceeded with Bobby and Dr. Tammy.

EXCERPT
DR. TAMMY & BOBBY

DR. TAMMY: *[summarizing the work done to this point in the SDM Session]* Bobby, we've covered a lot so far today. We talked about the way in which your depression is affecting your life, such as irritability with your family members, sleeping a lot, and not doing things in your life that give you a sense of joy and accomplishment. I've described the various treatment options to you, and I've heard your views about aspects of these treatments that are and aren't consistent with your style. Is it OK if we take a moment to talk, specifically, about what you want to get out of treatment for depression? What your goals might be? Doing this will help us to further narrow down your choices and could even help you to make a final decision about treatment. It will also help you anticipate the changes that are possible with treatment, which I hope will be encouraging to you.

BOBBY: I'm not sure what you mean about goals. I just want to feel better. And deal with life better.

DR. TAMMY: *[providing validation]* Those are good starting points, feeling better and dealing with life better. Can we look at each of those more closely? *[Bobby nods his head]* What would it look like to feel better?

BOBBY: *[scratching his head]* I'm not sure. *[pausing]* Well, sleep and feeling sluggish are big problems, I guess. It irks my wife to no end when she comes home from her first job and finds me sleeping in the middle of the day.

DR. TAMMY: Yes, sleep does sound like a big problem for you. If you were feeling better, what would your sleep be like?

BOBBY: I wouldn't be napping during the day. And I'd sleep through the night. No getting up in the middle of the night and pacing. Although, I'm not sure that's possible because my back pain often wakes me up in the middle of the night.

DR. TAMMY: *[providing empathy]* Mmm, back pain can certainly make it tough to sleep.

BOBBY: Yeah, if sure does.

DR. TAMMY: OK, so not napping and sleeping more at night would be a couple of signs that you're feeling better. It might not be realistic to expect that you will sleep through the entire night, given your back pain. I wonder what would be more realistic?

BOBBY: Maybe to sleep six, six-and-a-half hours straight without getting up. Any more than that, my back gets so tight that I have to get up and move around.

DR. TAMMY: Alright, we'll know you're feeling somewhat better when you're not napping during the day and sleeping six to six-and-a-half hours. What would you be doing during the day instead?

BOBBY: *[making a face]* My wife thinks I should get some sorta volunteer job.

DR. TAMMY: *[sensing that he is having an aversive reaction to his wife's suggestion]* What do you think? Do you want a volunteer job?

BOBBY: *[pausing]* I guess it's not a bad idea. But I wouldn't know where to find one.

DR. TAMMY: *[linking this possible goal to an activity that could be pursued in treatment]* Might talk therapy be a good place for you to figure that out?

BOBBY: Oh. I never thought of that.

DR. TAMMY: Any other way we'd know you are feeling better?

BOBBY: We talked about dwelling earlier. I'm constantly stuck in my own head. Even when I'm watching TV, I'm not really paying attention.

DR. TAMMY: What are you dwelling on?

BOBBY: Everything. How I've let my wife down. My kids down. All our financial problems.

DR. TAMMY: *[linking this problem to a target of treatment]* Do you think any of the treatments we discussed could address the dwelling?

BOBBY: *[consulting Treatment Options for Depression Grid]* Yeah, I think some of them would.

DR. TAMMY: You also mentioned wanting to deal with life better. What do you mean by that?

BOBBY: Well, I guess not snapping at my wife and kids so much. It seems like every little thing they do sets me off. Like the other day when…

Here, Bobby launches into a description of an argument with his oldest son. Many mental health providers who practice EBPs discourage lengthy, open-ended venting in sessions so that a systematic, targeted strategy can be applied to the problem at hand, which increases the likelihood that the patient will leave the session with something tangible to address the problem. At the same time, it is important that mental health providers allow space for patients to discuss issues of important to them and develop the sense that they are being heard. Thus, Dr. Tammy listens to the story without interruption to demonstrate that she cares about his concerns and to provide a positive experience with opening up about his feelings. **When providers conducting an SDM Session find themselves in a position in which the patient is providing great detail about a specific problem in his or her life, they (a) use nonverbal expressions to communicate empathy, (b) provide validation that the patient is enduring a difficult situation, (c) link back to the aims of the SDM Session, and (d) provide reassurance that the problem can be addressed in the context of treatment.** As the dialogue between Bobby and Dr. Tammy continues below, she reflected on the tension that Bobby experiences with his son, and she linked back to the treatment goal of "dealing with things better."

DR. TAMMY: *[providing empathy]* Bobby, it sounds like that argument created some tension that hung around in your home for some time.

BOBBY: Exactly. And if I could just learn to keep my cool, not fly off the handle, I think we could avoid a lot of these arguments.

DR. TAMMY: OK, we'd know that you were dealing with things better if you had fewer instances in which you lose your cool and lash out at your wife and children?

BOBBY: Definitely.

DR. TAMMY: Any other way we'd know you were dealing with things better?

BOBBY: I think I would be more motivated. Like even when I am sitting on the couch doing nothing, there are things I could be doing, like paying the bills or emptying the dishwasher. I think that's another reason why my wife gets so mad at me. She works two jobs, but then sometimes she's left with no choice but to do some of these other chores that I could be doing if I had more energy.

DR. TAMMY: *[paraphrasing]* So, you'd be more proactive with taking care of chores around the house?

BOBBY: Yeah, and maybe even doing some projects around the house. Our deck really needs to be repaired. It's probably too unstable to even walk on. I know how to fix it; I just have to do it.

DR. TAMMY: These all sounds like reasonable goals. *[summarizing]* You'd like to have more energy and deal with things better, and the ways we'd know you're doing that are by napping less, sleeping more at night, getting a volunteer job, dwelling less on problems in your life, snapping less at your wife and kids, and taking care of small chores and projects around the house, like maybe even the deck. What do you think of these as possible goals?

BOBBY: *[looking surprised]* Uh, wow. If I could do all of that, I'd be a much happier guy.

DR. TAMMY: *[checking out the possibility that Bobby is overwhelmed by these goals]* That's the overarching goal, Bobby. For you to be a happier man. Is there any aspect of these goals that is overwhelming?

BOBBY: *[pausing to think]* A little.

DR. TAMMY: *[providing reassurance]* That's understandable–you wouldn't tackle this all at once. You and your therapist will talk more about specific goals and prioritize ones that are most important to you. You can break them down into smaller pieces. As you reach specific goals, you'll be able to move on to new ones.

BOBBY: *[looking relieved]* I think I'll need to work at my own pace.

DR. TAMMY:Of course. In fact, that's best so that the gains you make in treatment stick with you in the long term.

BOBBY: I sure hope it sticks. Because things can't stay like they are right now. No way.

DR. TAMMY: If you choose to begin treatment, I can share these possible goals with the therapist you'll work with if you'd like?

BOBBY:Yes, please do. I'll probably forget a lot of what we just said.

CHOOSE

It is important to emphasize that the identification of potential treatment goals in the SDM Session is designed to support and instill hope during the process of treatment decision-making and is not intended to formally establish specific goals for treatment. In fact, if the patient chooses to initiate treatment, they will likely spend some time in the first or second session clarifying and finalizing treatment goals. This is especially the case in EBPs where the identification of measureable treatment goals is an important part of the initial phase of treatment. Within the context of the SDM Session, the purpose of identifying treatment goals is to make the prospect of treatment and what treatment may yield more specific and personally meaningful to instill hope. In addition, the identification of potential treatment goals may help to inform the selection of a specific treatment.

Finally, in addition to discussing potential goals during the *Set Goals* step of the SDM Session, providers may also introduce or refer Veterans considering an EBP to the interactive *Explore Your Goals* sections of the Treatment Works For Vets website can learn about common goals that are targeted in specific treatments, select the goals that are relevant to them, and learn more about how the treatment may help to achieve these potential goals. Users can print out or e-mail the goals they have selected to themselves. Veterans for whom the SDM process extends to a second session may bring to the next session the printout of potential goals they have selected between sessions.

2.1.6. CHOOSE: SELECT TREATMENT OR DETERMINE NEXT STEPS

The final step and culmination of the SDM Session is the selection of treatment or next steps. During this step, the provider guides the patient to make a decision about treatment or other possible next steps. This step aligns with *decision talk* in the Elwyn et al. (2012)

SDM model. Providers may introduce the *Choose* step of the SDM Session phase by stating, **"Now that we've had a chance to talk about different treatment options, what's important to you, and possible goals for treatment, let's make a decision together about treatment for you."** During this final step of the SDM Session, it is important to provide the Veteran with space to process and integrate information discussed in the previous steps of the session. A list of specific steps for implementing *Choose* is provided in Table 2.8.

TABLE 2.8.
STEPS FOR SELECTING TREATMENT OR DETERMINING NEXT STEPS

STEPS	SAMPLE QUESTIONS
1. Elicit patient summary.	"From *my* point of view, we've covered a lot of ground here today. Can you tell me in your own words what we have accomplished, from *your* point of view?"
2. Assess where patient is in decision-making process.	"Based on the information I gave you, as well as your preferences and goals, do you have a sense of the direction in which you'd like to proceed?"
3. Confirm patient preference for treatment or next steps. If needed: Help point out and tie together key information and patient remarks from earlier in session. Help patient decide between specific treatment options.	"So, it sounds like you're interested in [X]?" "I'd like to share with you some things that stood out for me in our discussion so far." "How about I list out the pros and cons of [treatments X and Y], based on what we've discussed, and you can tell me if you prefer one or the other?"
4. Assess patient's reasoning for preference.	"What is it that led you to that decision?" "What are the specific reasons you have chosen [X]?"
5. Assess and problem solve potential barriers to treatment.	"Is there anything that may get in the way of your being able to engage in [X]?"
6. Finalize plan.	"Shall we go ahead and schedule an appointment?"
7. Provide a concluding summary.	"It's been terrific to meet with you, [name of Veteran]. The purpose of our visit today was to make the best treatment decision for you, after looking at different options and considering what's important to you. I really appreciate what you've shared with me and how we've been able to work together to make this decision. That's a big step. Based on our discussion today, I'm confident that treatment will be very helpful to you."

Providing and eliciting summary statements, starting at the beginning of the *Choose* discussion, is recommended for helping to pull together key points discussed in previous steps of the discussion and to help guide the patient toward a decision. It is recommended that the provider begin the discussion by eliciting a summary from the patient. Based on the patient's response, the provider may add to the patient's summary or provide their own summary. Throughout the *Choose* discussion, the provider should use active listening and related skills to demonstrate understanding and alignment with the patient.

Providing and eliciting summary statements, starting at the beginning of the *Choose* discussion, is recommended for helping to pull together key points discussed in previous steps of the discussion and to help guide the patient toward a decision.

Despite the *Choose* step having a specific end goal (formulating a decision), another main purpose of the discussion, as with the overall SDM Session, is to promote interpersonal engagement, hope, and trust in the treatment process.

Next, the provider may use open-ended questioning to assess where the patient is in the decision-making process, considering the information discussed so far. By the time the discussion reaches the *Choose* step of the SDM Session, some Veterans will be close to or have already reached a decision about treatment options. In such instances, the discussion during the *Choose* step may involve solidifying or confirming the patient's decision. In other instances, the *Choose* step will involve more extended discussion to help the Veteran make an informed choice about treatment.

Some patients may have difficulty making connections between their preferences and goals and specific treatment options or deciding between two different options. In such situations, the provider may be more active in helping the patient to reach a decision, such as by helping to point out and tie together information and patient remarks from earlier in the session. For patients that have difficulty deciding between specific treatment options, the provider may help identify the pros and cons of specific treatment options as they relate to the patient's situation, preferences, and goals.

In some instances, patients may prefer for the provider to be more directly involved in the decision-making process. While providers should strive to include patients in the decision-making process as much as possible, the provider's expertise and experience are helpful in informing the decision about treatment or next steps. This is especially the case when the patient specifically desires provider expertise and in situations where one or more treatments are clearly more effective, clinically indicated, or highly recommended in clinical practice guidelines *and* the treatment(s) appears to fit with the patient's situation, preferences, and goals. At the same time, it is recommended that providers refrain from making the ultimate decision for the patient, but rather provide input, information, and reasoning that patients have the opportunity to accept or decline.

Once the Veteran expresses a preference for next steps, it is recommended that the provider inquire about the patient's reasoning for this decision to ensure understanding and assess the basis for this decision. If the patient provides limited information to assess the reasoning for their decision, the provider may elicit additional elaboration. Based on the patient's preference and stated reasoning for their preference, the provider can determine whether additional discussion may be needed. Otherwise, the provider and patient may proceed to confirm the decision. **Once the decision is confirmed, it is recommended that the provider assess and problem solve any logistical or related barriers to participating in treatment and proceed with finalizing the plan for next steps.**

After the treatment decision has been finalized and specific next steps identified, it is recommended that the provider deliver a concluding summary. These concluding remarks are designed to acknowledge the Veteran's participation and commitment in the SDM process and (when the next step is treatment) reinforce optimism for the treatment process ahead.

Although most Veterans empowered with information and understanding of how specific treatments may be personally beneficial will choose to begin a particular treatment, there are several other possible decisions that the patient and provider may come to at the end of the SDM Session. These different outcomes, listed from most to least common, are summarized in Table 2.9 and described below.

TABLE 2.9.
OUTCOMES OF SDM SESSION

1 **SELECT TREATMENT:** Veteran selects a treatment and schedules an initial treatment session.

2 **REVIEW AND FOLLOW-UP:** Veteran chooses to further review information about treatment options and/or consult with family members or others, with a specific plan for follow-up on patient's decision.

3 **INCREASE TREATMENT READINESS – EXTEND SDM SESSION:** Veteran and provider determine that Veteran could benefit from one or more additional SDM Sessions to address motivational, attitudinal, knowledge, or logistical treatment barriers.

4 **INCREASE TREATMENT READINESS – PREPARATORY SKILLS BUILDING:** Veteran and provider determine that Veteran could benefit from developing preparatory skills to promote psychological readiness prior to initiating treatment.

5 **NO TREATMENT SELECTED/ WATCHFUL WAITING:** Veteran declines treatment at the current time or elects "watchful waiting," and provider follows up within a specified period of time.

The decision to initiate a mental health treatment is an important decision and commitment that, for some Veterans, may require some additional time to reflect on the discussion during the SDM Session, review and absorb information about specific treatments, and consult with family members or other trusted individuals. For patients who express interest in or who appear to likely benefit from having additional time to review and consider the information discussed, the provider may give them the relevant Treatment Fact Sheets described above in the *Educate* section and/or refer patients to the Treatment Works for Vets website for information, videos, and interactive exercises about EBPs. (Detailed information about various mental health conditions and treatments is available in the *Additional Resources* section of the website.) Patients may review these materials, along with the Treatment Options Grid, on their own and/or discuss treatment options and the possibilities they offer with loved ones or others, with a specific plan for following up with the provider. It is recommended that the patient and provider schedule a follow-up SDM Session before the conclusion of the session so that the Veteran leaves with an identified time for the follow-up discussion and decision. If the Veteran is unable to schedule a follow-up in-person appointment during the SDM Session, the provider should, at minimum, schedule follow-up phone contact. The follow-up discussion should be scheduled within a short period of time (generally within one to two weeks) following the initial SDM Session to ensure recall and continuity of the discussion during the initial SDM Session.

In the exchange below, Bobby, the case we have been following to this point, chose to take home materials about the treatment options for further consideration before making a decision about treatment. This dialogue illustrates the way in which Dr. Tammy concluded the SDM Session, made a specific plan to meet for a follow-up session, and during that second appointment, facilitated reaching a treatment decision.

EXCERPT
DR. TAMMY & BOBBY

DR. TAMMY: OK, from my point of view, we've covered a lot of ground here today. Can you tell me in your own words what we have accomplished, from your point of view?

BOBBY: I learned a whole lot about depression. How it affects me, what to do about it.

DR. TAMMY: *[summarizing]* Exactly. We figured out the ways that depression is affecting you, personally, we discussed various treatment options, and we considered factors and goals that are important to you as we move toward a decision about treatment. How are you feeling about what we've discussed?

BOBBY: It's weird. One part of me is still very confused. But another part of me feels a little better. Like something can be done about what I'm going through.

DR. TAMMY: *[smiling]* I'm really pleased that you're feeling more hopeful about treatment of your depression. Based on the information I gave you, as well as your preferences and goals, do you have a sense of the direction in which you'd like to proceed?

BOBBY: *[shaking his head]* I'm still pretty torn. It seems like there are pros and cons of all the treatments.

DR. TAMMY: I agree with you. That's why we thought it would be important for you to meet with me today so that you could be involved in the decision-making process, because *you* know what's best for you.

BOBBY: I *do* know that I want to do treatment. Some sorta treatment. I wasn't sure of that when we sat down.

DR. TAMMY: *[smiling again]* That's terrific that you feel more sure about wanting to start treatment, Bobby. Can I share some things that have stood out for me in our discussion so far?

BOBBY: Yes, that would be helpful.

DR. TAMMY: Well, you came in thinking that medication and perhaps general talk therapy were the only options for treatment. However, when I described the full range of treatments available–and what they entail–you started to realize that some of the active and focused talk therapies had the potential to be a good match for you. You'd like to deal with life more effectively, improve your family relationships, and generally engage in life more than you are right now. And some of the talk therapies I described have the potential to help you to reach these goals.

BOBBY: Yeah, that's generally what I'm taking away from this. But I'd like to read more about the different treatments we talked about, and I usually talk to my wife or kids about these kinds of things.

DR. TAMMY: Of course. I have an idea. What if I were to give you some more detailed information about the treatments? You could take that information home, read it at your leisure, and even discuss it with your wife or kids. Then, you can make a decision at your own pace, when you are comfortable that you have enough information about the options.

BOBBY: *[looking relieved]* Yes, this is the best plan. Can I have information about all the talk therapies, except maybe general talking? I don't think I want to do that one.

DR. TAMMY: *[pulling out Treatment Fact Sheets for CBT, IPT, and ACT]* Here you go. Try these. You can also visit the Treatment Works for Vets website for more information about these treatments. Here's a card about the website. It's a really interesting site with videos and information for Vets about these treatments–different from other websites with information that you've probably seen before.

BOBBY: OK, these look real good.

DR. TAMMY: I'd like to schedule another visit with you so that we can review what you read and I can answer any additional questions that you might have. If you're still trying to decide which treatment option is best for you, I can help you to lay out the pros and cons of each one of them.

BOBBY: *[hesitating]* Um, yeah, sure.

DR. TAMMY: *[paying attention to Bobby's hesitation]* Am I sensing some hesitation?

BOBBY: No, well, yeah, a little. It's just that the VA is pretty far from my house, and my back cramps up when I drive here. [thinking] But I guess I'll be coming here for other treatment, anyway, so I better get used to it. And I like that you'll answer any other questions I have.

DR. TAMMY: *[noting the distance he must travel as a potential obstacle to discuss at the time of the next visit]* Let's schedule another visit at a time that works well for you, and we can talk more about the impact that the distance might have on your ability to participate in treatment.

BOBBY: OK. *[looking at the calendar on his smartphone]* I am back here in a week and a half to see the orthopedic doc. Can I see you the same day?

DR. TAMMY: *[smiling warmly]* Let's take a look at my schedule…

> The following dialogue between Bobby and Dr. Tammy occurred 10 days later, scheduled on the same day as Bobby's other medical appointment.

DR. TAMMY: *[smiling warmly and shaking Bobby's hand, as well as demonstrating genuine interest and recall of specific details that Bobby had shared in the previous session]* Great to see you again, Bobby. How was the drive today? Is your back feeling okay?

BOBBY: *[smiling]* Better than I thought it would be. Not bad.

DR. TAMMY: Oh, terrific, good to hear that.

BOBBY: Yeah, the orthopedic doc gave me some physical therapy exercises to do. He thinks that'll loosen up the muscles and relieve some of the pain.

DR. TAMMY: *[noting that this might mean that Bobby will have appointments with a physical therapist, which could be coordinated with mental health visits]* Does this mean that you'll have to come to the VA for physical therapy?

BOBBY: Yeah, every two weeks. I'm supposed to come more, but this is all I can handle.

DR. TAMMY: Good, I hope that physical therapy will allow to get some relief from your back pain.

BOBBY: I sure hope so.

DR. TAMMY: Do you remember what the purpose of today's visit with me is?

BOBBY: Yeah. We were going to keep talking about depression treatments. You had given me some sheets to read.

DR. TAMMY: Yes, exactly. Perhaps we can talk more about what you read and what further questions you might have? And then make a decision about treatment?

BOBBY: I'd like that. I'd like to give it a try.

DR. TAMMY: That's good news, Bobby. What more did you learn from the sheets I gave you?

BOBBY: I really liked the things I would be doing in that first treatment, the one that starts with C. *[fumbling with his papers to find the name of the treatment]*

DR. TAMMY: Do you mean CBT? Cognitive Behavioral Therapy?

BOBBY: Yes, that's it, Cognitive Behavior.

DR. TAMMY: Terrific. What do you like about it, in particular?

BOBBY: Well, when I read on the sheet the different things I'd be doing in therapy, it just seemed more like my style. And I like that it's worked with a lot of Vets.

DR. TAMMY: Which specific things seemed more like your style?

BOBBY: Every one of those check marks. I think I can use all of them.

DR. TAMMY: So you'd like to start Cognitive Behavioral Therapy?

BOBBY: Yes, go ahead and sign me up.

DR. TAMMY: I can certainly sign you up. Before we do that, I'm just curious if there are any lingering reservations about Cognitive Behavioral Therapy, anything that might get in the way of your being able to participate in treatment?

BOBBY: I don't have major issues. I did do some more research online, including that Treatment Works site and videos you told me about. I liked those. The descriptions of CBT made it seem like homework or practice is a big deal. At first, I didn't like that. But then I remembered that you said there are ways to do homework without having to write stuff down on paper.

DR. TAMMY: I'm glad you remembered that. We had talked about homework being something that you do differently, rather than something that you write. And we had also discussed alternatives to writing, like using your smartphone and voice recordings.

BOBBY: Yeah. I've been doing voice recordings in the time since I met with you. You know, reminders of stuff to do, stuff like that.

DR. TAMMY: *[pleased that Bobby was able to take something of therapeutic benefit from the SDM Session]* That's good to hear, Bobby. Do you have any other reservations about treatment?

BOBBY: Not really. *[hesitating]* The only thing is that I still wonder is if taking meds is important. My wife thinks my depression may need both talk therapy and depression.

DR. TAMMY: What do *you* think?

BOBBY: Well, it said on the sheet that CBT is effective for Veterans.

DR. TAMMY: Yes, CBT is supported by decades of research. And, a number of studies have shown in to be effective with Vets. For depression like yours, CBT and medication are about equally effective in the short term, though CBT is often more effective in the long-term. For some people, combined treatment can provide additional benefit. I know when we last met, you mentioned that you would prefer to start the talk therapy first, but medication is something you could consider in the future if you decide.

BOBBY: *[looking relieved]* Oh good, so that's an option if I need it?

DR. TAMMY: It sure is.

BOBBY: OK, well I don't want to jump on that bandwagon quite yet. My neurologist is going to prescribe yet another pill for my migraines. So, I just want to see where that C *[hesitating, looking up at Dr. Tammy]*

DR. TAMMY: *[smiling]* CBT. Cognitive Behavioral Therapy.

BOBBY: Right, CBT, where the CBT takes me before considering more meds.

DR. TAMMY: That's a reasonable course of action. *[pausing]* I had also been wondering if the distance from the VA would get in the way of attending regular CBT sessions, since you mentioned last time that your back cramps up on the ride here. But today, you said it wasn't so bad.

BOBBY: Yeah, it wasn't so bad. And I think if I can schedule appointments on days that I have other appointments scheduled, then I'm here for a while, and my back settles down before I have to get back in the car. It's worse when I'm only here for a half hour or an hour and then have to hop right back in the car.

DR. TAMMY: When you mentioned physical therapy, I was thinking that, perhaps, you could coordinate talk therapy appointments with physical therapy appointments.

BOBBY: Yeah, I was thinking the same thing. And then there are times when I have other appointments, like with the orthopedic doc, the neurologist, my GI doc *[trailing off]*. Man, I'm a mess!

DR. TAMMY: Well, I'm just pleased that you can get all your needs met together.

BOBBY: Don't I know it. So, I think I can get here OK.

DR. TAMMY: *[providing validation]* That's a good plan. You know, I'm curious, Bobby, we've met twice now to talk about treatment options for depression. Could I get some feedback from you on the degree to which you felt our meetings were helpful?

BOBBY: They were helpful. Definitely.

DR. TAMMY: Really glad to hear that. In what way were they helpful to you?

BOBBY: Honestly, I didn't know what to expect. Even though I'm here a lot, I don't really do that good with hospitals and medical stuff. But you were really patient and walked me through it. And the sheets of paper with the information on it, those were really helpful. I guess I said to myself, "If this is what talk therapy is going to be like, then this isn't so bad."

DR. TAMMY: That is something that I hoped you'd get from our meetings. I think you'll find something very similar when you start CBT. It has a strong focus on teamwork, feedback, and empowering Vets so they can learn skills to eventually serve as their own therapists.

BOBBY: Yeah, I did get that. I was probably more open to talk therapy in general just by going through something like it when we met.

DR. TAMMY: *[expressing warmth and the sense that she genuinely wants the best for Bobby]* I'm glad this has been a good experience for you so far. It's certainly been gratifying for me to help you through this process and get you set up with an effective treatment. Shall we schedule an initial CBT session, then?

BOBBY: Let's do it.

DR. TAMMY: Great, let's do that. It's been terrific to meet with you, Bobby. I really appreciate what you've shared with me and how we've been able to work together to make this decision. That's a big step. Based on our discussion, I'm confident that CBT will be very helpful for you.

Although the SDM Session is not psychotherapy, per se, it may often be the patient's first introduction to an experience akin to psychotherapy.

As illustrated in the preceding exchange between Bobby and Dr. Tammy, once patients make the decision to begin treatment, it is important to inquire about potential obstacles to engaging in treatment so that these are identified in advance. If potential obstacles to engaging in treatment are identified, the provider may then problem solve these obstacles with the patient.

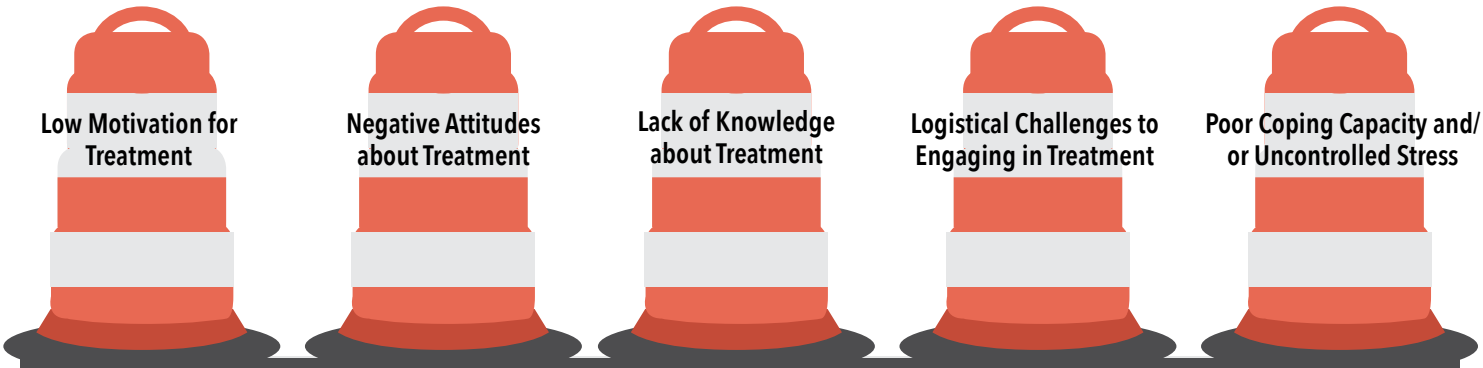
It is also important to highlight the conversation at the end of the exchange between Bobby and Dr. Tammy related to the way in which the SDM Session resembles a psychotherapy session. Although the SDM Session is not psychotherapy, per se, it may often be the patient's first introduction to an experience akin to psychotherapy. Accordingly, **implementing the active listening and related skills for facilitating the therapeutic alliance, as well as fundamental elements of EBPs, such as collaboration, feedback, and summarizing, can socialize patients into the psychotherapy process**

and provide a positive experience that may increase interest and engagement in psychotherapy. When appropriate, providers may point out explicitly to patients how the SDM Session encounter is similar in many ways to the psychotherapy process.

While most Veterans, at the end of the initial SDM Session or after further review of materials following the session, will be ready to select and engage in treatment, a subset of Veterans may have one or more ongoing barriers that have significant potential to impede treatment engagement (see Table 2.10). Some patients may present with particularly low levels of treatment motivation, negative treatment attitudes, and/or very limited or inaccurate understanding of treatment that may make it difficult for them to commit to or engage in treatment. Beginning treatment too soon, in these instances, is likely to result in early dropout. In addition, some patients may require additional time to address distance, scheduling, or other logistical barriers to regularly attending treatment. To address these barriers, the provider may schedule one or more additional SDM Sessions to engage in extended motivational enhancement, psychoeducation, and/or problem solving to increase treatment readiness. These sessions should follow as extensions of the SDM Session, maintaining an important focus on interpersonal connection and increasing hope, as well as reinforcing change talk.

Furthermore, some Veterans, particularly those in severe distress with limited baseline coping skills, may benefit from preparatory work to shore up basic skills and establish greater psychological readiness for treatment. This option is intended for a small subset of patients who, due to significant trauma or other particularly difficult life circumstances and limited coping skills, may have difficulty focusing on or engaging in active treatments. Appendices A1-A3 include additional information as well as ***Provider Tip Sheets*** and ***Patient Handouts*** for implementing foundational skills building with patients in these instances. Preparatory skills building is intended as a brief pre-intervention for promoting psychological readiness for treatment that generally lasts approximately two to four sessions, though is not limited to this range provided that the focus and goal is on promoting treatment readiness and preparation.

TABLE 2.10.
BARRIERS TO TREATMENT READINESS AND PRE-TREATMENT STRATEGIES



PRE-TREATMENT STRATEGIES				
Additional SDM Session(s): Focus on motivational enhancement and instilling hope	Additional SDM Session(s): Focus on motivational enhancement, psychoeducation, and instilling hope	Additional SDM Session(s): Focus on psychoeducation and preferences	Additional SDM Session(s): Focus on problem solving, motivational enhancement, and prioritizing of treatment	Preparatory skills building

Engaging in pre-treatment preparatory work, whether for addressing motivational, attitudinal, knowledge, logistical, or psychological skill needs, can be important front-end investments that may offer significant benefits to retention and outcome on the back-end.

Engaging in pre-treatment preparatory work, whether for addressing motivational, attitudinal, knowledge, logistical, or psychological skill needs, can be important front-end investments that may offer significant benefits to retention and outcome on the back-end. Further, the focus of this preparatory work is quite complementary with and may help with promoting early progress in EBPs, which often include psychoeducation, skills training, and problem solving—a point that should be emphasized with Veterans so they understand that while the preparatory work is not the treatment, per se, it will not impact or delay treatment progress. It is also important to frame this as a bridge to treatment. At the same time, preparatory work should be reserved and offered as a potential outcome of the initial SDM Session for Veterans for whom there is significant concern related to treatment engagement if one or more treatment barriers are not addressed, especially given that issues related to managing distress, increasing motivation, and other factors are often areas of focus in treatment, particularly in EBPs. The goal for all Veterans should be on beginning treatment as soon as the Veteran appears willing and able to participate in the treatment process. In situations where patients express some ambivalence about treatment but otherwise seem interested and appropriate for initiating treatment, the provider may suggest beginning with a trial of three or four treatment sessions, at which time the patient and provider can check in on how things are going and make a decision about whether to continue. This is a common strategy for promoting initial commitment to CBT and other EBPs.

The goal for all Veterans should be on beginning treatment as soon as the Veteran appears willing and able to participate in the treatment process.

In light of increasing recognition of the importance of readiness for engaging in EBPs and other mental health treatments, there has been recent attention devoted to developing structured approaches to the assessment and identification of treatment readiness. Although research in this area is still nascent, these developments may serve as useful tools for providers interested in incorporating greater structure or systematic assessment for identifying the degree of treatment readiness, particularly in cases where there is uncertainty related to a particular Veteran's readiness for treatment. Further, such tools may help to facilitate conversation about treatment readiness. One measure developed specifically for assessing readiness for psychotherapy is the Readiness for Psychotherapy Index (RPI; Ogrodniczuk, Joyce, & Piper, 2009), a 20-item measure of readiness for psychotherapy, which is free to use and may be accessed at www.mirecc.va.gov/visn19/treatmentworksforvets/docs/RPI.pdf. The RPI includes four distinct factors that assess different aspects of treatment readiness: Disinterest (treatment-related attitudes and motivation), Perseverance (ongoing commitment to treatment), Openness (openness and comfort with self-disclosure), and Distress (impact of problems). Items are rated on a 5-point Likert scale (1 = Strongly Disagree; 5 = Strongly Agree). Data on each of these domains of treatment readiness may provide useful information to guide efforts to enhance treatment readiness prior to initiation of treatment. For example, high scores on the Disinterest domain may suggest negative attitudes or low motivation for treatment that may support and help to inform some additional focus on motivational enhancement. Further, high scores on the Distress domain may support preparatory skills building to lower the impact and interference of problems that may diminish treatment engagement. Initial psychometric evaluation of the RPI yielded promising findings with respect to the convergent and discriminant validity of the measure (Ogrodniczuk et al., 2009).

A final possible outcome of the SDM Session is a decision not to pursue treatment at the current time. When the Veteran expresses this wish, it is especially important to understand the reasoning for this decision. If this is due to motivational, attitudinal, or other barriers, the provider should explore the patient's willingness to meet again to further discuss these issues, as described above. In so doing, it is recommended that the provider place particular focus on using active listening skills and non-directive questioning to support

and engage the patient in this discussion. The provider may also point out earlier instances of change talk or potential benefits of treatment identified earlier in the session that may suggest the value of continuing the conversation. Furthermore, if the patient is unsure about committing to treatment, but otherwise it seems appropriate, the provider may suggest—and recommend—that the patient initiate a trial of three or four treatment sessions.

If, at the conclusion of the session, the Veteran decides not to pursue treatment at the time, this decision should be accepted and respected. In such instances, the provider should acknowledge and express appreciation for the patient's current visit and note that the door is always open. It can be helpful for patients to hear that decisions are never final and situations often change. In addition, the provider should offer that they schedule a time to check in by phone to see how the patient is doing. Lastly, the provider should give the Veteran information about available resources the Veteran may access (including the Veteran and Military Crisis Line and online chat), if needed. A listing of such resources is available in the *Additional Resources* section of the Treatment Works for Vets website. The provider may wish to offer the Veteran the URL to this page (www.mirecc.va.gov/visn19/treatmentworksforvets/additional-resources.asp), along with educational information about the website.

In some cases, patients may not have significant clinical need warranting treatment at the end of the SDM Session. In such instances, the provider may suggest assuming a "watchful waiting" approach, in which the provider (or other mental health or primary care clinician) monitors the patient's symptoms over a period of time to see if the symptoms continue or worsen. If "watchful waiting" is selected, the provider may wish to schedule an in-person or phone appointment in approximately two to four weeks to check in with the patient. The patient should also be encouraged to contact the facility at any time if their symptoms worsen or they believe that treatment can be helpful. In addition, the provider may offer psychoeducation and self-help resources. A listing of mobile applications and web-based self-help resources for various conditions is available in the *Additional Resources* section of the Treatment Works for Vets website.

SUMMARY

The SDM Session provides a systematic process for empowering and engaging patients in the treatment decision-making process. Based on key principles and best practices of SDM and patient engagement, the SDM Session provides a structured, yet flexible, process for informing patients about treatment options within a highly supportive interpersonal context.

As the foregoing examination of each of the steps of the SDM Session reveals, the process follows an intentional and logical sequence such that successive steps of the process build on prior steps. For example, the initial focus on establishing interpersonal connection provides a foundation for then engaging in motivational enhancement. In addition, the sequence of the session proceeds from more general to more specific. For instance, the more general discussion of treatment expectations and how life may be different that occurs during *Motivate* proceeds to more focused discussion of specific treatments (*Educate)*, personal preferences (*Explore)*, and personally relevant goals (*Set Goals)* that is increasingly more meaningful at the level of the individual Veteran. Moreover, earlier steps of the process yield information that can often help inform and facilitate the implementation of later steps (see Figure 2.3). For example, the discussion of possible treatment goals may be informed by and pick up from earlier discussions of how life might be different and what matters to the patient. For this reason, we recommend that providers keep notes of key points made

during the course of the session that can be useful for further discussing later in the session, including but not limited to instances of change talk, preferences, and potential life changes.

FIGURE 2.3.
INDUCTIVE PROCESS OF THE SDM SESSION

The successful implementation of the SDM Session requires important balance of structure and flexibility, or strategies and process

The ***SDM Session Provider Checklist*** is a useful in-session tool to help guide providers in implementing each of the steps of the SDM Session (see Appendix A4). The *SDM Session Provider Checklist* provides a summary of each of the steps of the SDM Session, including specific strategies within each step and example questions.

While, on paper, the SDM Session reflects a stepwise process, the encounter is not intended to always unfold in a directly linear fashion in practice. Rather, the discussion should move naturally and fluidly, allowing for revisiting of earlier points of discussion, as needed, while following the guideposts of the session structure. Thus, the successful implementation of the SDM Session requires important balance of structure and flexibility, or strategies and process, just as skilled clinicians approach the delivery of EBPs (Wenzel et al. 2011). Further, the nature and extent of discussion of each step of the SDM Session should be individualized to each patient and where they are at baseline. Veterans present for treatment with different personal situations, styles, and preferences, as well as varying levels of knowledge and motivation, that may necessitate more or less discussion of different components of the SDM process.

When implementing the steps of the SDM Session, providers should not be overly focused on exhaustively covering each step or implementing the components in an overly rigid manner. This is especially important considering the significant focus of the session on achieving interpersonal engagement. Implementing the steps of the session or adhering to the *SDM Session Provider Checklist* in a mechanical fashion can be counterproductive to engagement and detract from the important focus on interpersonal connection.

The decision to initiate treatment and begin the difficult and uncertain work of individual change is one that requires interpersonal trust, connection, and acceptance of vulnerability. It is for this reason that the principles and strategies of *Connect* both begin and surround the SDM Session.

The key focus on interpersonal connection during the SDM Session cannot be overstated. Indeed, among the most important goals of the SDM Session is the establishment of a warm and trusting connection with the Veteran. Just as in EBPs (described in more detail in Section 3.1 below), the therapeutic relationship is an essential component to the clinical process and to patient engagement. This is especially the case in the SDM Session context of *initial* engagement. The decision to initiate treatment and begin the difficult and uncertain work of individual change is one that requires interpersonal trust, connection, and acceptance of vulnerability. It is for this reason that the principles and strategies of *Connect* both begin and surround the SDM Session.

The significant focus on process and interpersonal connection in the SDM Session urges that clinicians remain vigilant to the relationship and not move too far ahead of the patient in moving through the SDM steps. The provider should periodically elicit summaries or feedback to check in with the patient and assess their understanding of and engagement with the discussion. When there is indication that the patient is less interpersonally engaged or not aligned with the provider, it is recommended that the provider focus on *Connect*ing, including using active listening and related skills. If unsure of what to do at a particular point of the session, the provider may provide a summary, extending space for and listening carefully to the patient's response.

We hope the foregoing discussion has generated interest in implementing the SDM Session in clinics and facilities serving Veterans for increasing motivation, informed choice, and treatment engagement. Although designed as a brief and feasible process for implementing in real-world clinical settings, the SDM Session will require adaptations to existing processes in many settings. In the next section, we review the organizational requirements and key considerations to facilitate administrative planning and implementation of the SDM Session.

2.2. PUTTING SDM INTO PRACTICE: PRACTICAL AND LOGISTICAL GUIDELINES AND CONSIDERATIONS

This section provides practical and logistical requirements and guidelines for locally implementing the SDM Session. The information provided in this section is designed for clinicians, as well as for program managers and administrators who in many cases will assist with implementing administrative and workflow requirements. For facilities within the VA health care system, the information presented in this section will likely be especially useful for Local Evidence-Based Psychotherapy Coordinators at each VA facility who in many cases will be central to coordinating the process for locally implementing the SDM Session. Although the process for putting the SDM process in place is not complex, it does require important attention to issues such as the specific location of the SDM Session, patient flow, length, individual versus group modality, provider of SDM Session, and other considerations. Because of the considerable variability—in terms of specific services, patient populations, clinical processes, size, and structure—among the different settings and service systems (VA, other public systems, private systems) in which the SDM process may be implemented, we intend for the information provided in this section to serve as general guidelines and to be used flexibly to best fit local needs and circumstances.

Before turning to the specific organizational requirements and considerations for successfully implementing the SDM Session, it is important to note that the SDM Session (and preparatory skills building session (see Appendix A1), when indicated) should not

be construed by clinical or administrative staff as an administrative process or "extra step" that takes the place of or delays treatment, but rather as an integral part of the treatment process.

Below we describe the specific practical and logistical requirements for facilities and clinics to consider as they implement the SDM Session. These requirements are summarized in Table 2.11. In addition, an ***SDM Session Facility Implementation Checklist*** (see Appendix A5) is provided to help clinical and administrative staff implement and track SDM Session requirements in their settings.

TABLE 2.11.
PRACTICAL AND LOGISTICAL REQUIREMENTS FOR IMPLEMENTING THE SDM SESSION

ISSUE	DESCRIPTION	REQUIREMENTS	CONSIDERATIONS
Patient Flow	The pathway by which the Veteran reaches the SDM Session	Establish procedures for identifying and connecting Veterans to the SDM Session. Determine procedures that precede Veteran participation in SDM Session (e.g., psychodiagnostic evaluation).	Most Veterans will reach the SDM Session after being diagnosed with a mental health problem.
Location	Where the SDM Session is conducted	Determine location where the SDM Session will be conducted (e.g., general mental health clinic, specialty mental health clinic [e.g., PTSD Clinic], primary care).	In most instances, Veterans will participate in the SDM Session after being referred to or presenting to a general or specialty mental health setting. The SDM Session may be implemented in primary care or another setting where mental health needs are identified.
Staff Awareness	Awareness of the SDM Session among staff not directly involved in the delivery of the SDM Session	Provide awareness training and documented policies and procedures on the general purpose, function, and process of the SDM Session among staff not directly involved in the delivery of the SDM Session. Identify staff to provide awareness training, outreach, and support related to policies and procedures. In the VA health care system, the facility Local EBP Coordinator may provide training, outreach, and related support.	Awareness training should help promote understanding of the overall SDM Session and how it is being implemented in the clinical setting. Training should be made available for both clinical and administrative staff (including appropriate leadership and front-line administrative personnel). Training should help promote understanding that the SDM process is an integral part of the treatment process that can help maximize engagement and outcomes, rather than be seen as an extra step in addition to or separate from treatment.

ISSUE	DESCRIPTION	REQUIREMENTS	CONSIDERATIONS
Length	Duration and number of SDM Sessions	Establish guidelines for the duration and number of SDM Sessions.	Most Veterans will participate in one SDM Session and be prepared to choose a treatment by the end of the session. In some cases, Veterans may require an additional one or few sessions to promote treatment readiness. This may consist of (1) one or more SDM Sessions to address motivational, attitudinal, knowledge, or logistical barriers to treatment; or (2) preparatory skills building sessions to establish baseline skills or coping capacity. The duration and number of SDM visits vary depending on modality (individual vs. group) of SDM Session (see below).
Modality	Modality (i.e., individual, group) for conducting the SDM Session	Establish policies and procedures for individual vs. group modality for conducting SDM Session.	Most often, the SDM Session is delivered in individual format, though the modality is flexible and may be tailored to best fit the local clinical setting and patient population. The length of individual SDM Sessions is 50–60 minutes and generally lasts one session. The length of group SDM Sessions is generally 90 minutes and typically lasts one session for groups with 1–3 members and two sessions for groups with 4–6 members. Providers of group SDM Sessions should have experience with managing group process to ensure individualized attention to and participation of all group members. Care should be exercised throughout the session to maintain the SDM focus and process and ensure that the "shared" component of SDM is not lost. Group size should be limited to allow for collaborative and individualized decision-making. Group SDM Sessions may require multiple sessions, depending on group size, needs and characteristics of group members, number of available and potentially appropriate treatment options, and experience of the provider.

ISSUE	DESCRIPTION	REQUIREMENTS	CONSIDERATIONS
Provider	Qualifications of the individual who delivers the SDM Session and preparatory skills building sessions	Identify staff to deliver SDM Session.	The provider of the SDM Session is generally a mental health professional or trainee with sufficient knowledge of relevant treatment options and of the SDM Session. In some settings, the SDM Session may be delivered by one or a few designated individuals who have this as a specific focus of their work. In other settings, this may be a broader shared activity. In many cases, the provider of the SDM Session will not be the same individual who delivers the chosen treatment. It is not necessary or practical for the provider of the SDM Session to be proficient in the actual delivery of different treatment options; however, it is important that the provider be sufficiently knowledgeable to describe and discuss treatment options.
Scheduling and Documentation	Procedures for scheduling and documenting the SDM Session and preparatory skills building sessions	Develop procedures and guidelines for scheduling and documenting SDM Sessions and preparatory skills building sessions. Ensure availability of sessions of appropriate time length on scheduling grid for identified providers who deliver SDM Sessions or provide preparatory skills building sessions. Develop procedures for how and when Veterans are scheduled for chosen treatment option.	Scheduling should be flexible enough to allow providers to deliver additional SDM Sessions and preparatory skills building sessions, when indicated. Documentation of the SDM Session should include specific steps and strategies implemented, the patient's response and outcomes of the steps and strategies, and any obstacles encountered and ways in which these obstacles were addressed (see *SDM Session Documentation Template* [Appendix A6]). It is recommended that provider of selected treatment (if known) or treatment clinic be copied on or directly receive documentation of SDM Session to facilitate treatment initiation, engagement, and goal-setting. SDM Session documentation should have clearly identified label or code that is recognizable by treatment provider.
Follow-up	Procedures for following up with Veterans who do not choose a treatment at the end of the SDM Session	Establish guidelines for follow-up with Veterans who do not choose a treatment at the end of the SDM Session.	Guidelines for follow-up should include the modality of follow-up, the length of time between the SDM Session and follow-up, and the provider who will make the follow-up contact, if someone other than the provider of the SDM Session. Guidelines for follow-up will vary among clinics and facilities based on general clinic and facility policies for follow-up, patient population, staffing, and other factors. Guidelines should allow for patient preference and clinical judgment to inform the nature of follow-up.

ISSUE	DESCRIPTION	REQUIREMENTS	CONSIDERATIONS
Transition to Treatment	Procedures for transferring the Veteran to next step	Establish procedures for smooth transition and continuity following SDM Session.	Veterans who choose a treatment should leave the SDM Session with an appointment or specific plan for initiating treatment. When possible, the provider of the SDM Session should communicate to new provider key information about the SDM Session to facilitate new therapeutic alliance and care continuity. Treatment provider should acknowledge, reinforce, and build on patient's participation in the SDM Session.

A. Patient Flow. Identifying how patients reach the SDM Session is a key part of planning and implementation. The most common general pathway by which a Veteran reaches the SDM Session is as follows:

1. Patient is referred to or self-refers to a general or specialty mental health clinic for a suspected mental health problem. In many settings, an initial intake is conducted at this point to identify the general reason for seeking treatment and for assessing severity and safety. If emergent need is identified, appropriate actions are taken.
2. Psychodiagnostic evaluation is completed.
3. Patient is scheduled for SDM Session.
4. At the end of the SDM Session(s), patient makes a decision about treatment, and an appointment is scheduled with a provider who will deliver the treatment. (If patient requires preparatory skills building to increase psychological readiness for treatment, this is delivered either by the provider who delivers the SDM Session or another identified provider.)

Figure 2.4 presents a visual depiction of pathways leading to and immediately following the SDM Session. This illustration is intended as a general example. Specific pathways will vary and may be adapted to best fit local processes and procedures of the clinic or facility. In general, it is expected that patients will complete a psychodiagnostic evaluation prior the SDM Session, as the SDM Session focuses on treatment options for the particular mental health condition the patient is experiencing.

FIGURE 2.4.
EXAMPLE OF COMMON PATHWAYS TO THE SDM SESSION

Bobby, the case we have been following throughout the SDM Session in the previous section, was referred to the general mental health clinic at his local VA medical center by his neurologist, who was treating Bobby's migraine headaches. During Bobby's initial consultation with the neurologist, the neurologist observed that Bobby might be depressed and raised the possibility of connecting Bobby with the Mental Health Clinic. Bobby initially refused, saying that he did not feel he needed mental health treatment. However, during his follow-up appointment, the neurologist again commented on possible depression and encouraged Bobby a bit more directly to consider at least just an initial evaluation appointment at the Mental Health Clinic, with the rationale that depression and migraines are both treatable conditions and that addressing both would likely increase Bobby's overall well-being. The neurologist told Bobby where the Mental Health Clinic was located within the VA medical center, and after his Neurology appointment, Bobby stopped by. Bobby completed an initial intake and scheduled a psychodiagnostic evaluation for two weeks later.

Bobby completed the psychodiagnostic evaluation with a social worker in the Mental Health Clinic, and he was diagnosed with major depressive disorder. The social worker conducting the evaluation recognized that Bobby had limited knowledge of depression and briefly educated him about the nature and symptoms of depression and its impact on functioning and quality of life, which resonated with Bobby. The social worker recommended that Bobby participate in an SDM Session to learn about different treatment options available and determine which treatment fit best with his preferences. She emphasized that this was intended to allow Bobby to have important say in what treatment could work best. Bobby appreciated being provided with the opportunity to provide input into what treatment he would pursue, especially given that he knew very little about treatment and was not entirely convinced that treatment was for him. Bobby agreed to return the following week for the SDM Session, which is depicted in the preceding section.

B. Location. In most instances, SDM Sessions take place within general and/or specialty mental health clinics (e.g., PTSD clinic, substance use disorder clinic) or private practice setting. The SDM Session may also take place in other clinics or departments that identify and serve patients with mental health problems, such as primary care clinics.

In larger facilities with both general and specialty mental health clinics, the SDM Session may be implemented in multiple settings for different patients. For example, facilities, like many VA medical centers, with a general mental health clinic (that provides treatment for general mental health issues like depression and anxiety disorders), a substance use disorder clinic, and a PTSD clinic, may choose to implement the SDM Session within each clinic, particularly if the specialty conditions are diagnosed within the specialty clinics, as is often the case. Moreover, facilities with integrated mental health care in primary care may elect to implement the SDM Session within the primary care setting.

No special equipment is needed for conducting the SDM Session beyond copies of the decision support tools and clinical aids associated with this toolkit (e.g., *Treatment Options Grids, Patient Fact Sheets, Provider Tip Sheets, SDM Session Provider Checklist*). However, access to a computer with Internet can be helpful for introducing certain patients to the Veteran portal of the Treatment Works for Vets website.

C. Staff Awareness. To help ensure successful patient flow to and from the SDM Session and overall successful operation of the SDM Session, it is important to promote awareness of the SDM Session among appropriate staff within the clinic(s) where the SDM Session

is implemented, as well as other relevant clinical departments. This includes clinical and administrative staff (including appropriate leadership and front-line administrative personnel) not directly involved in the delivery of the SDM Session. To achieve this, it is recommended that awareness training and documented policies and procedures be available and provided to staff. The focus of this training and these materials should be on the SDM Session purpose, process, and pathways to illustrate the "big picture" of how the SDM will operate and function within the clinic, rather than focus on the detailed steps of the SDM Session, which is more appropriate for the provider of the SDM Session.

Furthermore, one or more staff members should be identified to provide awareness training and support for the development of appropriate clinic policies and procedures. In the VA health care system, the facility Local EBP Coordinator may provide training and related support, though one or more staff within each clinic where the SDM Session is implemented may also be identified to serve in this role.

D. Length. In most cases, the length of the SDM Session delivered in an individual format is 50–60 minutes and generally lasts one session. In some instances, Veterans may require additional work to promote treatment readiness. This may consist of one or more additional SDM Sessions to address motivational, attitudinal, knowledge, or logistical barriers to treatment or preparatory skills building sessions to address baseline skills deficits, such as difficulty managing negative affect or impulsivity. When the SDM Session is implemented in a group format (see below), the length of the session is generally 90 minutes and may require more than a single session to complete. In general, the SDM Session can be completed in one session for groups with one to three group members and two sessions for groups with four to six group members, though the exact number of sessions will be influenced by needs and characteristics of the patient population, number of treatment options, and experience of the provider.

Care should be exercised throughout the session to maintain the SDM focus and process and ensure that the "shared" component of SDM is not lost.

E. Modality. In most instances, the SDM Session is most effectively delivered in an individual context because this provides greater opportunity for openness and individualization during what is a highly individualized and personal process. However, the SDM Session is designed to be flexible to allow for best meeting the needs and circumstances of the local clinical setting and patient population. In some instances, implementation of the SDM Session in an individual format may not be feasible due to resource constraints or other factors. In addition to efficiency of resources, delivering the SDM Session in a group format may provide some Veterans a sense of identification and solidarity with others who are struggling with similar mental health problems. It also provides the opportunity to hear others' points of view and decisions about treatment, which could, in turn, enhance their treatment commitment and engagement. Clinics with both individual and group SDM Sessions may consider offering certain Veterans the option of choosing between the two formats.

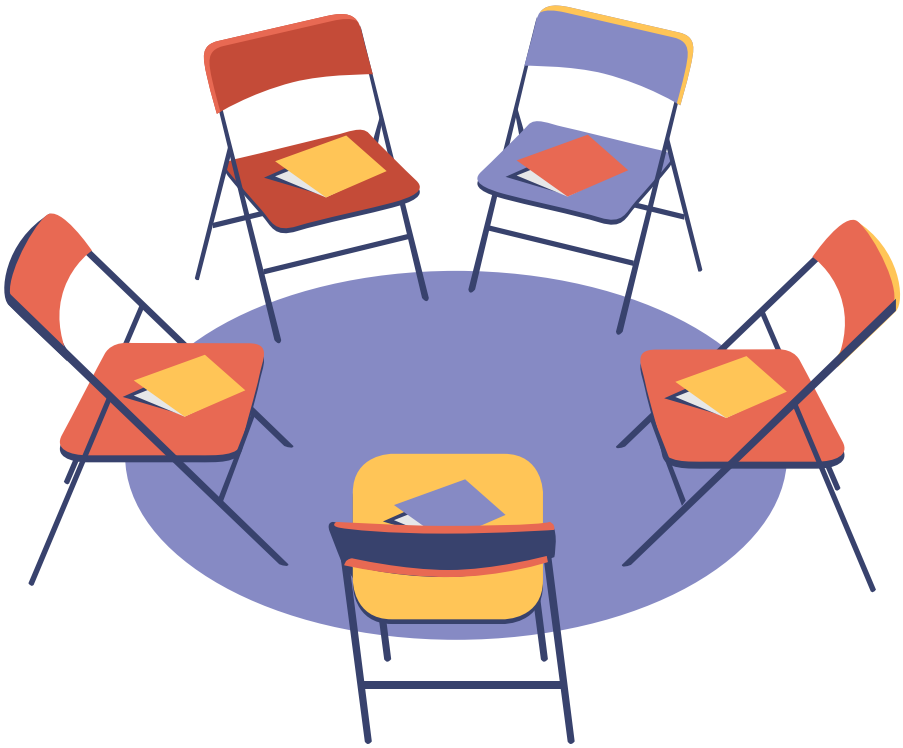
There are a number of important considerations for providing the SDM Session in a group format. **In particular, it is important that providers of the SDM Session have experience with managing group process to ensure individualized attention to and participation of all group members.** Care should be exercised throughout the session to maintain the SDM focus and process and ensure that the "shared" component of SDM is not lost. Otherwise, the SDM Session may turn into a purely psychoeducational or orientation group session that places primary focus on didactic presentation of information about different treatments. Accordingly, it is important that providers of group SDM Sessions follow the SDM Session agenda and be mindful of and devote sufficient attention and time to ensuring engagement, individualized application of information,

FIGURE 2.5.
SAMPLE SCRIPT FOR INTRODUCING THE GROUP SDM SESSION

Today, we'll be talking about different treatment options for you to choose from as part of a process called "shared decision-making." "Shared" means that I have valuable information for you about different treatment options, like what they involve and how effective they are. And, at the same time, you have valuable information about yourselves, like what's important to you and what you hope to get out of treatment. We will pull this information together so that you can make a decision about the best treatment for you.

As you can probably tell, you'll get the most out of this session by thinking about and sharing your reactions to the information I give you, discussing how it does or does not apply to you, and asking questions. I also find that members of the group benefit from hearing the comments and questions others have.

I'm looking forward to talking together and learning more about each of you so that together we can come up with a decision of what's best for you and your personal situations.



and collaborative decision-making with all group members. Of note, in the group context, providers should be sure to plan sufficient time for contemplating and discussing preferences and possible goals in the *Explore* and *Set Goals* steps, following the discussion of specific treatment options, before making a decision about next steps.

To promote group member participation during the SDM Session, providers are encouraged to use open-ended questions and summaries and actively encourage questions from and among group members. Providers may also specifically note the importance of active participation by group members and emphasize the "shared" nature of the SDM process at the commencement of the session. A sample script for doing so, which is adapted from the Sample Script for introducing the individual SDM Session, is provided in Figure 2.5.

It is recommended that the number of group members in the SDM Session be limited to approximately four to six (ideally four or fewer), to allow for greater intimacy, interactivity, and personal application of information. As noted above, for small groups (i.e., one to three group members), the SDM Session can typically be completed in a single session, though the specific number of sessions for a particular group will depend on the needs and characteristics of the group members, number of available and potentially appropriate treatment options, and experience of the provider.

In situations where one or more group members has difficulty engaging in the SDM Session or remains undecided about treatment at the end of session, the provider should schedule a follow-up SDM Session. If there is more than one member of a group who would benefit from follow-up and it appears appropriate, this may be scheduled as an additional group session. If in-person follow-up shortly after the initial session is not feasible, the provider may arrange to follow up by telephone to answer any remaining questions, facilitate *decision talk*, and make appropriate arrangements for treatment.

F. Provider. Providers of the SDM Session are generally mental health professionals or mental health trainees. In some settings, the SDM Session may be delivered by one or a few designated individuals who have this as a specific focus of their work. In other settings, including smaller clinics and facilities, this may be a broader shared activity across clinicians. Often, the provider of the SDM Session will not be the same individual who delivers the chosen treatment.

It is not required that providers of the SDM Session be proficient in the delivery of each of the EBPs and other treatments to be discussed during the SDM Session, though they should have sufficient knowledge of each treatment for describing and answering questions about how each treatment works, treatment components and the overall treatment process, length and duration of treatments, benefits and risks of treatments, and the efficacy of treatments. It is also desirable for the provider of the SDM Session to have examples of previous treatment experiences of Veterans to which they can refer. The provider of the SDM Session should also be sufficiently familiar with the structure and process of the SDM Session and the information, decision aids, checklists, and additional clinical resources included in this toolkit and through the Treatment Works for Vets website.

In addition to the identifying providers of the SDM Session, clinics and facilities should identify one or more providers who may deliver preparatory skills building sessions (see Appendix A1), when appropriate. In many cases, this may be the same individual(s) who deliver the SDM Session, though in other cases this may be one or more other identified providers.

G. Scheduling and Documentation. Clear procedures and guidelines for scheduling and documenting SDM Sessions and preparatory skills building sessions, when appropriate, are important for successfully implementing SDM Sessions and follow-up actions. This includes the availability of 50- to 60- or 90-minute sessions on the scheduling grid for identified providers who deliver SDM Sessions or provide preparatory skills building sessions. In addition, scheduling should be flexible enough to allow identified providers to deliver additional SDM Sessions and preparatory skills building sessions, when indicated. Furthermore, there should be clear procedures for how and when Veterans are scheduled for the initial appointment for the selected treatment and for who schedules this appointment (SDM Provider, clerk, etc.).

When documenting the SDM Session, the provider should record specific details about the session, including the purpose, specific steps and strategies implemented, the patient's response and outcomes of the steps and strategies, and any obstacles encountered and the ways in which these obstacles were addressed. In integrated health care settings where documentation among mental health providers is commonly shared, such as through an electronic health record, it is recommended that the provider of selected treatment (if known) or treatment clinic be copied on or directly receive (or receive notification of) documentation of the SDM Session to facilitate treatment initiation, engagement, and continuity. SDM Session documentation should have a clearly identified label or code that is recognizable by the treatment provider. An ***SDM Session Documentation Template*** that may be customized for local use is provided in Appendix A6.

H. Follow-up. Guidelines should be established for following up with Veterans who are unable to, or initially do not make a choice to, begin treatment by the end of the SDM Session. Considerations for follow-up include, but are not limited to, the method of follow-up (e.g., in person, phone, video teleconferencing), length of time between the SDM Session and the follow-up contact, and the provider who will conduct the follow-up

contact. Guidelines for follow-up will vary among clinics and facilities based on general clinic and facility policies for follow-up, patient population, staffing, and other factors. Guidelines should provide flexibility to allow for patient preference and clinical judgment to inform the nature of follow-up for specific cases.

I. Transition to Treatment. A smooth transition from the SDM Session to treatment (or to preparatory skills building sessions, if chosen and delivered by a different provider) is essential. When the patient has chosen a treatment, it is important that they have an appointment or specific plan for initiating treatment when they leave the SDM Session. As noted above, we encourage, when possible, that the provider of the SDM Session communicate to the new provider key information about the SDM Session to facilitate a new connection and contribute to the foundation of a strong therapeutic relationship and care continuity.

Upon meeting the new provider, it is recommended that the new provider acknowledge and reinforce the patient's participation in the SDM Session and decision to initiate treatment. When the treatment provider has access to specific information from the SDM Session, such as information related to values and preferences and possible treatment goals, the provider may inform the patient that they are aware of this information to help reassure the patient that they will not "start over" but rather springboard into treatment with a solid understanding of the patient's clinical presentation, views, values, and preferences that can help promote the efficiency and effectiveness of treatment. This final point of reassurance is important because Veterans often have the experience of "re-telling" their story to multiple providers, clinical administrators, and others. **It is essential that the SDM process not be seen as another hurdle or step to treatment but rather a process designed to promote treatment readiness and match to reduce the potential for premature termination or the need for multiple treatment attempts. In this way, the SDM process is intended to *increase* access to the most appropriate treatment and maximize the impact of treatment.**

SECTION 3

Promoting Ongoing Engagement

3

PROMOTING ONGOING ENGAGEMENT

The preceding sections of this toolkit have focused on the central importance of establishing a connection with the Veteran to promote *initial* engagement in and commitment to treatment. Beyond promoting initial engagement in treatment, a critical issue and opportunity in the delivery of EBPs (and other mental health treatments) is promoting *ongoing* engagement in treatment to maximize treatment gains. Research shows that at least 25% of patients drop out of EBPs and other mental health treatments (Fernandez, Salem, Swift, & Ramtahal, 2015). This figure is even higher for PTSD-focused EBPs (Hernandez-Tejada, Acierno, & Sanchez-Carracedo, 2017; Najavits, 2015). The current section of the toolkit focuses on two key clinical strategies that offer significant promise for promoting ongoing engagement in EBPs (and other mental health treatments): (1) the ongoing assessment and enhancement of the therapeutic alliance, and (2) the incorporation of principles and strategies of measurement-based care.

Beyond promoting initial engagement in treatment, a critical issue and opportunity in the delivery of EBPs (and other mental health treatments) is promoting *ongoing* engagement in treatment to maximize treatment gains.

3.1. THERAPEUTIC ALLIANCE

A key clinical strategy for promoting ongoing engagement and retention in treatment—including psychotherapy, specifically—is the establishment and maintenance of a strong therapeutic alliance. Increasing research has consistently demonstrated a moderately strong relationship between the therapeutic alliance and patient engagement and retention in psychotherapy (Sharf, Primavera, & Diener, 2010). Further, recent research focusing on Veteran patients in mental health treatment, specifically, has shown the therapeutic alliance to be significantly associated with patient engagement, a relationship that persisted even after adjusting for sociodemographic factors and length of time with providers (Eliacin et al., 2018).

In addition, over the past few decades, a fairly extensive body of research has accumulated examining the impact of the therapeutic alliance on treatment outcome. Findings from a meta-analysis revealed a consistent moderate relationship between the therapeutic alliance and outcome, independent of other variables (Martin, Garske, & Davis, 2000).

Among the best-known and empirically supported conceptualizations of the therapeutic alliance is the framework developed by Bordin (1979). According to this conceptualization, the therapeutic alliance consists of three components:

- *Goal:* Agreement on the goals of treatment
- *Task:* Agreement on the tasks of treatment
- *Bond:* The level of interpersonal bond, or connection, between the patient and provider

The therapeutic alliance reflects both an affective element (Bond), most commonly associated with the therapeutic alliance, as well as a cognitive-perceptual element related to the goals being worked on in therapy (Goal) and the specific strategies that are being used to help accomplish these goals (Task).

Thus, the therapeutic alliance reflects both an affective element (Bond), most commonly associated with the therapeutic alliance, as well as a cognitive-perceptual element related to the goals being worked on in therapy (Goal) and the specific strategies that are being used to help accomplish these goals (Task). By definition, therefore, a strong therapeutic alliance reflects strong agreement with the treatment focus and approach and a feeling of close connection with the provider. On the other hand, a weak therapeutic alliance reflects weak agreement with the treatment goals or approach and/or limited connectedness with the provider. The therapeutic alliance, therefore, is a phenomenon with multiple components, each of which has relevance to and important and actionable implications for treatment engagement. Patients who feel more connected to their provider and to the treatment process are generally less likely to drop out of treatment due to uncertainty, disagreement, or discordance with the treatment process. Further, in instances where closely aligned patients experience ambivalence or discord, such patients are often more likely to express and resolve their uncertainty or differing views due to established interpersonal trust and connection and due to the fact that feedback is specifically encouraged when the therapeutic alliance is an explicit focus of treatment.

It is significant to note that Bordin's (1979) conceptualization of the therapeutic alliance is transtheoretical and not tied to any particular therapeutic orientation, offering opportunities for application across a range of psychological treatments. Not surprisingly, it offers particular utility in the delivery of EBPs, which place specific focus on establishing measureable treatment goals (Goal) to guide treatment and assess progress, specific cognitive, behavioral, and/or interpersonal strategies to promote change (Task), and emphasize the therapeutic relationship (Bond).

There has been increasing empirical attention devoted to examining the therapeutic alliance within the context of EBPs, in particular, CBT. This research has revealed that the therapeutic alliance is associated with moderate increases in symptom reduction and increased patient adherence (Thompson & McCabe, 2012; Webb et al., 2012).

In light of the important role of the therapeutic alliance in the treatment of mental health problems—and EBPs, in particular—ongoing assessment of and attention to the therapeutic alliance has been incorporated into EBP protocols adapted for Veterans (Clougherty et al., 2015; DeMarce, Gnys, Raffa, & Karlin, 2014; Murphy et al., 2014; Walser, Sears, Chartier, & Karlin, 2015; Wenzel et al. 2011). Specifically, this includes regular administration of the *Working Alliance Inventory-Short Revised* (WAI-SR; Hatcher & Gillaspy, 2006), a 12-item patient-rated measure of the therapeutic alliance based directly on Bordin's (1979) three-part model of the therapeutic alliance. Consistent with Bordin's conceptualization, the WAI-SR includes three subscales: Goal (agreement on treatment goals), Task (agreement on the focus of therapy), and Bond (interpersonal bond between patient and therapist).

Evaluations of EBPs delivered to Veterans in real-world treatment settings by therapists newly trained in these therapies provide significant support for the utility and relevance of the therapeutic alliance in the delivery of EBPs. Specifically, results from these investigations reveal significant increases in Veteran ratings of the therapeutic alliance over the course of CBT for depression (Karlin et al., 2012), Acceptance and Commitment Therapy (ACT) for depression (Karlin et al., 2013; Walser et al., 2013), Interpersonal Psychotherapy (IPT) for depression, (Stewart et al., 2014), CBT for insomnia (Trockel, Karlin, Taylor, & Manber, 2014), and CBT for chronic pain (Stewart et al., 2015). This pattern of results holds true for both total scores on the WAI-SR, as well as scores on the three WAI-SR subscales—Goal, Task, and Bond. Moreover, evaluation of the therapeutic

alliance among older vs. younger Veterans receiving CBT revealed significant increases in the alliance over the course of treatment (Karlin, Trockel, Brown et al., 2015; Karlin, Trockel, Spira, Taylor, & Manber, 2015; Karlin et al., 2013) and positive association between the therapeutic alliance and depression outcomes (Karlin, Trockel, Brown et al., 2015). The relationship between the therapeutic alliance and depression outcomes was found to be more pronounced for older Veterans receiving CBT, suggesting the therapeutic alliance to be an especially important area of focus for this group (Karlin, Trockel, Brown et al., 2015). In the next section, we examine key issues in how to incorporate ongoing assessment of the therapeutic alliance in treatment and review a number of available measures to assist therapists interested in doing so.

The primary goal of incorporating ongoing assessment of the therapeutic alliance is to provide an explicit and systematic process for attending to, learning about, and, when indicated, refining the treatment process or approach.

3.1.1. ASSESSMENT OF THE THERAPEUTIC ALLIANCE

The primary goal of incorporating ongoing assessment of the therapeutic alliance is to provide an explicit and systematic process for attending to, learning about, and, when indicated, refining the treatment process or approach. **In this way, assessment of the therapeutic alliance is intended as a clinical and decision support process that provides valuable information to the therapist and ensures that specific focus is placed on the therapeutic relationship and the patient experience of the therapy process.** In addition, regular assessment of the therapeutic alliance provides important process benefits to the patient by communicating that their opinions of the therapeutic relationship and treatment process matter and that communication about such topics is not only acceptable, but encouraged.

Given the important emphasis in the current context on using the assessment of the therapeutic alliance for clinical feedback and decision support, less emphasis is placed on specific scores in and of themselves and more emphasis is placed on understanding what the scores represent for the patient both in the present and relative to past scores (e.g., improvements or declines). Further, the process of incorporating ongoing assessment of the therapeutic alliance is designed to provide structure for open conversation for how therapy is going from the patient's perspective, especially when (total, subscale, or item) scores reflect a low level of alliance or significant change from the previous scores.

Because therapeutic alliance measures assess the patient's experience of and reaction to treatment, they are typically administered at the *end* of session at spaced intervals in the early, middle, and latter points of the treatment process (e.g., 1, 4, 7, and 11), as opposed to measures of symptom severity and functioning, which are typically administered at the beginning of, or just before, each session.

It is recommended that therapists communicate the rationale for administering the therapeutic alliance measure at the outset of treatment so patients understand why and how the information will be used, including for informing the treatment process. In addition, we recommend that clinicians thank patients for providing their perspective about how treatment is going to reinforce the importance placed on feedback and its value in the treatment process. As noted above, the therapeutic alliance measure is generally administered at the end of session. Between sessions, the therapist reviews the patient's responses and notes any low scores or significant changes in scores from the past. Given the focus on using the therapeutic alliance measure as a feedback and decision support tool, examining for low scores or changes on specific items (and relevant and meaningful subscales, if appropriate) is encouraged, as opposed to placing exclusive

focus on the total score, as this will provide more specific insight into the patient's view of different aspects of the alliance that will also allow for more meaningful discussion with the patient, when indicated. At the next session, the therapist can note significant observations for discussion with the patient. The purpose of this discussion is to:

1. Confirm or clarify the therapist's understanding of the patient's response
2. Obtain additional information that may help promote understanding and guide decision-making
3. Discuss any implications or changes in light of the feedback

At the conclusion of the discussion, it is recommended that the therapist thank the patient for providing the feedback and being open to discussing it so that treatment can be as collaborative and successful as possible. The discussion of the feedback items from the therapeutic alliance measure often occurs at the start of the session after considering the nature and priority of other items, including issues the patient identifies. In CBT, for example, the observations from the therapeutic assessment measure may be raised as an item to be placed on the agenda. We recommend raising one, or no more than two, specific observations at a time.

Significant interest in the therapeutic alliance over the years (largely outside of the context of EBP delivery) has led to the development of a wide array of therapeutic alliance measures, many with desirable psychometric properties. Although there is no "right or wrong" choice or universal recommendation regarding the specific therapeutic alliance measure for ongoing use in treatment, the decision of which measure to use should be guided by careful consideration of a number of factors, in addition to psychometric status, including:

1. Feasibility and ease of patient use (Feasibility)
2. Focus of measure and nature of intended use in treatment (Applicability)
3. Ease and likelihood of clinician use (Probability)

These important considerations are described in more detail below.

One important factor to consider in selecting a therapeutic alliance measure involves how feasible and appropriate the measure is for the intended patient population and length of treatment. This includes consideration of the length of the measure, patient reading level and ability, and related practical and feasibility issues. When using in an ongoing manner throughout treatment, we recommend using one of several validated brief measures of the therapeutic alliance that now exist and that generally have psychometric properties that are comparable to longer measures. Use of a brief measure eases response burden and allows for more seamless integration into the treatment process.

Among the most frequently used and well-researched measures for assessing the therapeutic alliance and available in a short form is the *Working Alliance Inventory-Short Revised* (WAI-SR). As noted above, the WAI-SR has been incorporated into several EBP protocols adapted for Veterans and that are the focus of national dissemination and implementation within the VA health care system. Described in further detail below, the WAI-SR is a 12-item measure that operationalizes Bordin's (1979) three-part model of the therapeutic alliance (Goal, Task, and Bond) that we have found fits very well with many EBPs.

For patients for whom an even briefer measure of the therapeutic alliance may be appropriate, even shorter therapeutic alliance measures are available, such as the 5-item version of the *Agnew Relationship Measure* (Cahill et al., 2012) and the 4-item *Session Rating Scale 3.0* (Duncan et al., 2003), the latter of which includes items that are rated on a visual analogue scale that may be well suited for patients with significant reading difficulties (though may be challenging for individuals with difficulty with visual distance perception). At the same time, it is important to recognize that very brief measures (i.e., those with approximately 5 or fewer items) of the therapeutic alliance generally do not provide for as much breadth or yield as much information on specific aspects or nuances of the therapeutic alliance as even slightly longer abbreviated measures, though in certain contexts they may be appropriate.

When selecting among various measures of the therapeutic alliance, it is important to also carefully consider the focus of the measure and intended use in treatment. This is especially important given that different measures are based on different theoretical formulations of the therapeutic alliance. In fact, while there is often statistically significant correlation and overlap among measures (particularly related to the affective-relational element of the therapeutic alliance), the structure and specific focus of measures vary. Given that treatment goals and specific strategies are significant areas of focus for EBP and measurement-based care (discussed in Section 3.2), these domains often have utility for planning and decision-making in EBPs. On the other hand, if, for example, treatment focuses more on interpersonal or process issues or there are strains or ruptures in the therapeutic relationship (or potential risk of such), the therapist may wish to consider using a measure more focused on these domains, such as the Alliance Negotiation Scale (Doran, Safran, Waizmann, Bolger, & Muran, 2012).

Furthermore, it is important for clinicians to select a measure that they feel particularly comfortable with using in an ongoing manner and discussing with patients, rather than select a measure with which they do not fully understand or identify, which they may be less likely to use or meaningfully implement Veterans' feedback on. In addition to the content and focus of the measure, it is important that therapists feel comfortable with interpreting and using information from the therapeutic alliance measure they select. As part of this process, it is important to consider that some measures include negatively valenced or reverse-scored items, which if referred to quickly in session, could lead to challenges in interpretation if the therapist is not sufficiently familiar and comfortable with the measure. As presented here and important for patient engagement, the therapeutic alliance measure is designed to serve as a decision support tool. Therefore, it is essential that the clinician feel confident about using it as a tool for conversation with the patient and to help guide collaborative decision-making. Otherwise, its use and utility will be greatly diminished. In fact, it is the structure and process of systematically attending to and openly discussing the therapeutic alliance and therapy experience that are perhaps the most valuable aspects of incorporating therapeutic alliance measures into treatment.

In fact, it is the structure and process of systematically attending to and openly discussing the therapeutic alliance and therapy experience that are perhaps the most valuable aspects of incorporating therapeutic alliance measures into treatment.

As the foregoing reveals, the selection of therapeutic alliance measures should be done in a thoughtful manner that carefully considers the feasibility, applicability, and probability of use, in addition to psychometric status. In the paragraphs below, we review common therapeutic alliance measures developed for adults. Although measures of the therapeutic alliance include versions that assess patient, therapist, and/or observer perspectives, we focus here and in our clinical work and training on the administration of patient report alliance measures given that the patient experience is most significant in the context of patient engagement and in light of research suggesting that patient ratings of the alliance

are stronger predictors of engagement and outcome than therapist ratings (Ogrodniczuk, Piper, Joyce, McCallum, 2000; Owen & Imel, 2009). Further, requesting patient views of the treatment experience is consistent with the process of shared decision-making and the emphasis in CBT and other EBPs on regularly eliciting feedback from patients.

3.1.1.1. MEASURES OF THE THERAPEUTIC ALLIANCE

This section provides a review of commonly used therapeutic alliance measures with adults. Although not intended to be an exhaustive listing of therapeutic alliance measures, the section includes a representative listing of brief (and very brief) measures more suitable for ongoing use in routine care. The measures included in this section have generally acceptable psychometric properties; any notable deficiencies are identified in the description of the measure. In addition, several of the measures have been shown to be moderately correlated with treatment outcome. A summary of the measures included in this section, where they may be obtained, and comments and considerations for use is presented in Table 3.1, following the description of the individual measures.

This finding indicates that the interpersonal relationship with the therapist and specific aspects of the treatment are unique factors and provides further support for attending to *both* specific treatment elements and the relationship.

Working Alliance Inventory-Short Revised (WAI-SR): The WAI-SR (Hatcher & Gillaspy, 2006) is a 12-item self-report measure abbreviated from the original 36-item *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989). The WAI-SR includes three subscales (Goal, Task, Bond) that assess Bordin's (1979) three components of the therapeutic alliance. Items are rated on a 5-point Likert scale (1 = Seldom; 5 = Always). An example of an item in the Goal subscale is "____ and I collaborate on setting goals for my therapy." An example of an item in the Task subscale is "As a result of these sessions I am clearer as to how I might be able to change." An example of an item in the Bond subscale is "I believe ____ likes me." Items are summed to obtain a total score, as well as subscale scores.

The WAI-SR is among the most widely used measures of the therapeutic alliance and has been used and examined specifically within the context of EBP delivery. As described above, the structure of the WAI-SR, which includes assessment of both the interpersonal relationship and specific aspects of treatment (goals and tasks), fits well with the focus of EBPs. In addition, information on patient agreement (or lack thereof) with specific aspects of treatment provides valuable insight for making changes to the focus of treatment and change strategies, consistent with the tenets of measurement-based care, described in more detail in Section 3.2.

Significantly, some research suggests that the Goal and Task subscales of the WAI-SR are largely independent of the Bond factor in the delivery of CBT (Andrusyna, Tang, DeRubeis, & Luborsky, 2001). This finding indicates that the interpersonal relationship with the therapist and specific aspects of the treatment are unique factors and provides further support for attending to *both* specific treatment elements and the relationship.

Recent research examining the therapeutic alliance, as measured by the WAI-SR, with Veterans receiving mental health treatment revealed that the therapeutic alliance was positively associated with patient engagement, a relationship that persisted even after adjusting for sociodemographic factors and length of time with providers (Eliacin et al., 2018). As described above, the WAI-SR has been successfully incorporated into EBP delivery with Veterans throughout the VA health care system. The WAI-SR is free to use.

Agnew Relationship Measure-12 (ARM-12) and Agnew Relationship Measure-5 (ARM-5): The ARM-12 and ARM-5 (Cahill et al., 2012) are recently developed abbreviated 12- and 5-item versions, respectively, of the original Agnew Relationship Measure (ARM; Agnew-

PARTNERSHIP

BOND

CONFIDENCE

OPENNESS

CLIENT INITIATIVE

Davies, Stiles, Hardy, Barkham, & Shapiro, 1998). The original ARM is a 28-item self-report inventory designed to measure patient factors, therapist factors, and patient-therapist relationship factors impacting the therapeutic alliance. Similar to the WAI-SR, the ARM was developed to be generalizable to a variety of therapeutic orientations. Also similar to the WAI-SR, the ARM includes multiple dimensions of the therapeutic alliance. The ARM includes five subscales, with items rated on a 7-point Likert scale ranging from Strongly Disagree to Strongly Agree: (a) Bond (i.e., friendliness, support, acceptance, and understanding in the relationship; e.g., "I feel friendly towards my therapist"); (b) Partnership (i.e., jointly working on therapeutic tasks and toward therapeutic goals; e.g., "My therapist follows his/her own plans, ignoring my views of how to proceed"); (c) Confidence (i.e., optimism and respect for the therapist's ability; e.g., "I have confidence in my therapist and his/her techniques"; (d) Openness (i.e., comfort in expressing personal ideas and feelings without fear of embarrassment; e.g., "I feel I can openly express my thoughts and feelings to my therapist"; and (e) Client Initiative (i.e., empowerment—the client's sense that they can lead the direction of therapy; e.g., "I take the lead when I'm with my therapist.") Scores for items on each subscale are summed, with appropriate items reverse scored. A total score is not calculated.

Perhaps not surprising, the Bond, Partnership, and Confidence subscales have been shown to be highly correlated (0.86–0.91) with the Bond, Goal, and Task subscales of the WAI (Stiles et al., 2002). One notable psychometric finding in research on the ARM is the low internal consistency of the Client Initiative subscale.

The ARM-12 was constructed by selecting three items each from the Bond, Partnership, Confidence, and Openness subscales with high loadings on their respective factors on both patient and therapist versions of the instrument. This yielded two factors: (a) Core Alliance and (b) Openness. (The example ARM items noted above are included in the ARM-12). The Client Initiative Scale was not included in this brief version of the ARM due to its low internal consistency. The ARM-5 was constructed by identifying the five most discriminating Core Alliance items. Available psychometric data suggest that the ARM-12 and ARM-5 have acceptable psychometric properties (Cahill et al., 2012). The ARM-12 and ARM-5 are free to use.

Alliance Negotiation Scale (ANS): A newer addition to the collection of therapeutic alliance measures, the ANS (Doran, Safran, Waizmann, Bolger, & Muran, 2012) is a 12-item self-report measure designed to assess the negotiation component of the alliance, or the way in which the patient and provider work through disagreement and tension in the therapeutic relationship. This construct of negotiation is regarded by Safran and Muran (2000, 2006) as an important component of the therapeutic alliance in addition to Bordin's (1979) three components. The ANS includes both positively and negatively valenced items for tapping into the degree of negotiation in the therapeutic relationship.

The ANS consists of two subscales: (a) Comfort with Negative Feelings (e.g., "I am comfortable expressing disappointment with my therapist when it arises"), and (b) Flexible and Negotiable Stance (i.e., "My therapist is inflexible and does not take my wants or needs into consideration"). Items are rated on a 7-point Likert scale (1 = Never; 7 = Always). Appropriate items are reverse scored, and ratings on each item are summed to obtain a total score. Full-scale ANS scores have been shown to account for 56% of the variance in WAI scores. Correlations between the WAI and ANS indicate that there are elements of Goal, Task, and Bond across both ANS factors (Doran et al., 2012). The ANS is free to use.

***Helping Alliance Questionnaire-II (HAq-II)*:** The HAq-II (Luborsky et al., 1996) is a 19-item self-report measure that assesses aspects of the therapeutic alliance as described by Bordin (1979) and Luborsky (1976). Items are rated on a 6-point Likert scale (1 = Strongly Disagree; 6 = Strongly Agree), with some items reverse scored. Scores on each item are summed to obtain a total score. This version is a revision of the original Helping Alliance Questionnaire (HAq; Alexander & Luborsky, 1986), eliminating items that focused on early symptom improvement and adding items that pertained to patient-therapist collaboration and patients' perceptions of the therapist. An exploratory factor analysis yielded two distinct factors: (a) positive therapeutic alliance (e.g., "I feel the therapist understands me.") and (b) negative therapeutic alliance (e.g., "At times, I distrust the therapist's judgment."). The HAq-II focuses more on therapeutic relationship and process dimensions and less on specific treatment elements, incorporating one item (negatively valenced) assessing the patient's view of "the procedures" in therapy. The measure is longer than other brief therapeutic alliance measures and may be somewhat less feasible to administer in an ongoing manner throughout treatment. The HAq-II is free to use.

Session Rating Scale 3.0 (SRS 3.0): The SRS 3.0 (Duncan et al., 2003) is a 4-item measure of the therapeutic alliance designed specifically for clinical use. The very brief nature of the SRS 3.0 was designed to facilitate ease of administration on a session-by-session basis. The first three items of the SRS 3.0 assess the relationship, goals and topics, and approach or method, respectively, corresponding to Bordin's (1979) three components of the therapeutic alliance. The fourth item captures the patient's overall view of the current session. Each item is rated using a 10-centimeter visual analogue scale, with anchors depicting negative and positive ends of each construct. For example, the "Relationship" item ranges from "I did not feel heard, understood, and respected" to "I felt heard, understood, and respected." The SRS 3.0 is scored by summing the marks made by the patient on the visual analogue scale to the nearest centimeter, with 40 being the highest possible score. The authors of the measure suggest that any score lower than 36 overall, or 9 on any item, is worth considering for discussion with the patient. The very brief nature of the SRS 3.0 represents a tradeoff of feasibility over depth and may be most appropriate for patients who, because of reading or other challenges, have difficulty completing somewhat longer measures and who feel comfortable providing ratings using a visual analogue scale. The SRS 3.0 is free for personal use.

TABLE 3.1.
MEASURES OF THE THERAPEUTIC ALLIANCE

NAME OF MEASURE	CONSTRUCT ASSESSED	NUMBER OF ITEMS	WHERE TO OBTAIN IT?	FREE TO USE?	COMMENTS AND CONSIDERATIONS FOR USE
Working Alliance Inventory-Short Revised (WAI-SR)	Patient views of treatment goals and tasks, and the quality of the bond between the patient and therapist. Directly based on Bordin's (1979) three-part conceptualization of the therapeutic alliance.	12	wai.profhorvath.com/Downloads	Yes	The WAI-SR is among the most commonly used measures of the therapeutic alliance and is regularly used in EBP protocols adapted for Veterans and implemented throughout the VA health care system. Assessment of both the interpersonal relationship and specific aspects of treatment (goals and tasks) can provide useful decision support and facilitate shared decision-making during treatment.
Agnew Relationship Measure-12 (ARM-12) and Agnew Relationship Measure-5 (ARM-5)	The ARM-12 assesses patient views of quality of the bond between the patient and provider, degree of partnership (including agreement on goals and tasks), confidence in provider and treatment, and comfort with openness. The ARM-5 is a very brief measure that captures information related to bond, partnership, and confidence dimensions of the ARM-12.	12 and 5, respectively	www.mirecc.va.gov/visn19/treatmentworksforvets/docs/ARM_12.pdf www.mirecc.va.gov/visn19/treatmentworksforvets/docs/ARM_5.pdf	Yes (for personal use)	Similar to the WAI-SR, the ARM was developed to be generalizable to a variety of therapeutic orientations. Also similar to WAI-SR, includes some items assessing goals and tasks, in addition to relationship factors, though overall focuses in somewhat broader.
Alliance Negotiation Scale (ANS)	Comfort with negative feelings and flexible and negotiable stance to resolve disagreements between the patient and therapist about treatment tasks and goals.	12	Doran, J. M., Safran, J. D., & Muran, J. C. (2017). An investigation of the relationship between the Alliance Negotiation Scale and psychotherapy process and outcome. *Journal of Clinical Psychology, 73*(4), 449–465.	Yes	A newer therapeutic alliance measure designed to have specific focus on disagreement and tension in the therapeutic relationship.

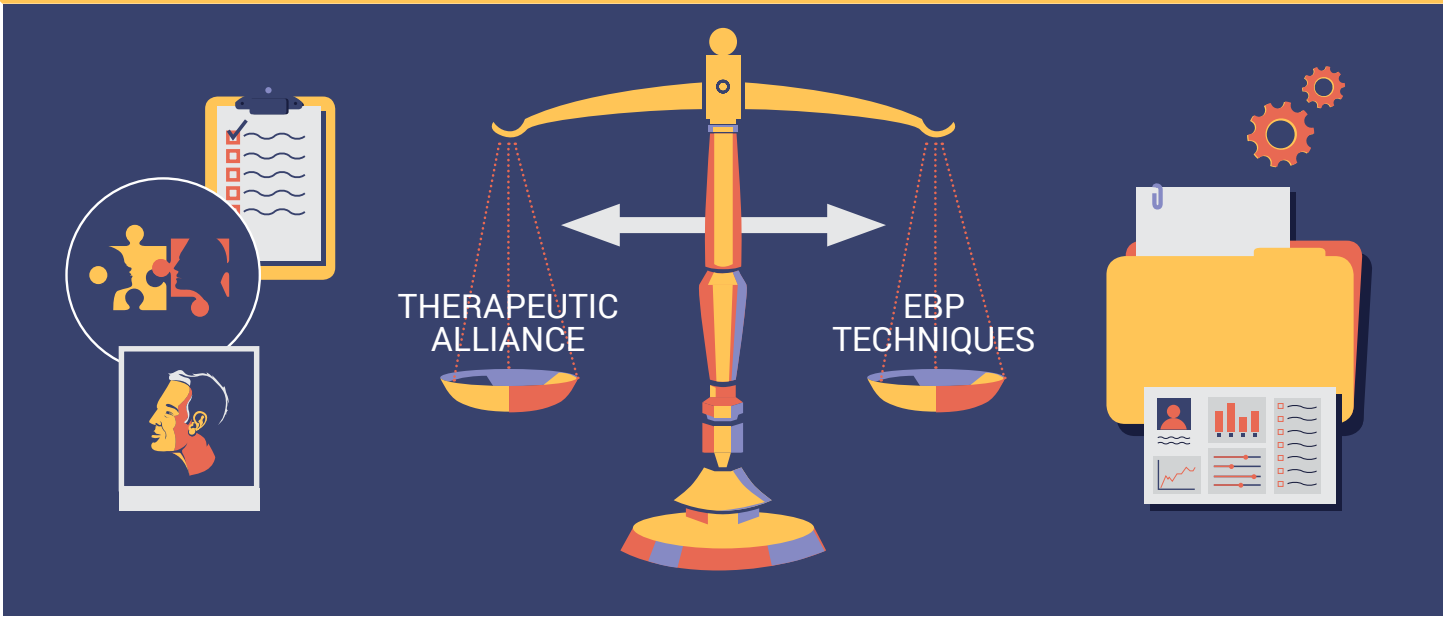
NAME OF MEASURE	CONSTRUCT ASSESSED	NUMBER OF ITEMS	WHERE TO OBTAIN IT?	FREE TO USE?	COMMENTS AND CONSIDERATIONS FOR USE
Helping Alliance Questionnaire-II (HAq-II)	Positive and negative feelings and perceptions of the therapeutic relationship and treatment process.	19	www.med.upenn.edu/cpr/assets/user-content/documents/HAQ2QUES.pdf	Yes	The HAq-II focuses more on therapeutic relationship and process dimensions and less on specific treatment elements, incorporating one item (negatively valenced) assessing the patient's view of "the procedures" in therapy. Given its length, the measure may be less feasible to administer in an ongoing manner in treatment.
Session Rating Scale, Version 3.0 (SRS 3.0)	Relationship, goals and topics, approach or method, and overall view of the current session.	4	Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R.,…, Brown, J., & Johnson, L. D. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, 3*(1), 3-12.	Yes (for personal use)	The SRS 3.0 was developed specifically for clinical, session-by-session use. It includes one item assessing each of the four domains captured by the measure. Its very brief nature and limited depth render it more appropriate when other measures may not be feasible, such as with patients with reading or related challenges. Should not be used with patients who are not able to provide or are not comfortable providing ratings using a visual analogue scale.

3.1.2 ENHANCEMENT OF THE THERAPEUTIC ALLIANCE

Although sometimes mischaracterized as less important in the delivery of EBP than other therapies, EBPs delivered well require important and ongoing attention to and cultivation of the therapist-patient relationship and related process requirements. Without the foundation of a strong therapeutic alliance, EBPs (or any therapeutic approach) bears little chance of successful outcome and is ripe for premature termination. **Therefore, successful delivery of EBPs requires balancing of alliance-focused behaviors (therapist behaviors designed to enhance the therapist-patient relationship) and technique-focused behaviors (therapist behaviors focused on specific skills or strategies), with the amount of directed attention to each varying over the course of session and treatment (see Figure 3.1).**

Although alliance-focused behaviors and technique-focused behaviors exist on a continuum, and require shifts, as appropriate, in the degree to which the therapist

FIGURE 3.1.
THE THERAPEUTIC ALLIANCE—EBP TECHNIQUE CONTINUUM



focuses on each, attention should always be placed on the therapeutic alliance such that treatment never reaches the far end of the techniques side of the continuum. This approach to EBP is very different from highly didactic or overly structured approaches to EBPs. Such directive approaches to EBP may account for misperceptions and mischaracterizations of EBPs as being mechanical and rigid. Neither of these characteristics are inherent properties of EBPs.

The outset of treatment, beginning with the initial encounter between the therapist and patient, provides a significant and important opportunity for focusing on the therapeutic relationship and establishing the basis for a strong alliance.

At certain points in the treatment process, primary or even exclusive attention is placed on the therapeutic relationship. This occurs most often in two instances—at the beginning of therapy and at times when the alliance may be weakened. At the beginning of therapy, much like the beginning of the SDM Session, it is important to focus on establishing a strong therapeutic alliance. This is achieved in several ways:

1. **Incorporate interpersonal connection skills for establishing a foundation for a strong therapeutic relationship and for promoting initial engagement.** The outset of treatment, beginning with the initial encounter between the therapist and patient, provides a significant and important opportunity for focusing on the therapeutic relationship and establishing the basis for a strong alliance. Significantly, this point in the treatment process sets the interpersonal climate for treatment and creates treatment expectations that may strengthen or weaken patient engagement. Accordingly, it is important that the therapist spend time focusing on establishing interpersonal connection and trust, much like the *Connect* step of the SDM Session. This involves using the same interpersonal connection skills incorporated in the *Connect* step of the SDM Session and presented in Table 2.1).

   Therapists are encouraged to review the *Connect* step of the SDM session, which is focused on increasing interpersonal connection and trust. As part of promoting interpersonal connection at the start of an EBP, the therapist should spend time on getting to know the patient and their views and expectations of treatment.

The therapist may highlight key information from the SDM Session for demonstrating understanding and enhancing continuity. If the therapist was the provider of the SDM Session, the therapist will likely need not spend as much time on this initial foundational step.

2. **Prepare the patient for the treatment process by providing psychoeducation and encouragement.** Prior to embarking on the treatment process, it is important to provide information about the structure, process, and focus of treatment to help prepare the patient to actively engage in the treatment process and promote alignment between the patient and the therapist. If the Veteran has received the SDM Session, some of this information will have been provided. However, in such cases, it is important to still review the treatment approach and the patient's role in treatment. To help facilitate and reinforce psychoeducation on the treatment being delivered, therapists may provide patients with the Treatment Fact Sheet for the EBP being delivered that is available on the Educate subpage of the Provider portal of the Treatment Works for Vets website (www.mirecc.va.gov/visn19/treatmentworksforvets/providers). Therapists may also introduce or refer patients to the information and videos about specific EBPs and the treatment process on the Veteran portal of the Treatment Works for Vets website. In addition to increasing Veteran understanding of the treatment structure, process, and focus of treatment, it is also recommended that therapists promote encouragement and optimism toward treatment and the therapist by briefly summarizing the effectiveness of the treatment, including with Veterans, and their own experience implementing the treatment with Veterans. The therapist may also express their belief that the treatment is likely to be beneficial for the patient. Finally, it is recommended that the therapist elicit and problem solve any questions or concerns about treatment before proceeding.

3. **Develop an individualized case conceptualization.** Development of an initial case conceptualization is an essential step for guiding treatment, but also has positive interpersonal and process effects, including enhancing understanding of the patient and demonstrating interest, value, and validation of their experience. Furthermore, deeper understanding of the patient that an individualized case conceptualization provides may provide valuable information to help guide the monitoring of or approach to the therapeutic alliance. For example, a patient with a history of isolating behaviors, social anxiety, interpersonal difficulties, or problems with trust may suggest placing greater attention to the alliance, particularly at the outset of treatment. In addition, because the case conceptualization helps to inform the selection of specific treatment strategies, it increases the likelihood that the approaches employed will be well suited for and agreeable to the patient.

4. **Establish individualized treatment goals.** Similar to the individualized case conceptualization, collaboratively establishing individualized treatment goals is important not only for guiding and monitoring treatment progress, but also sends an important message to the patient that the therapist cares about and is dedicated to what the patient wishes to get out of the treatment experience and creates common targets that the therapist and patient will work toward together. Further, as noted previously, agreement with treatment goals, as well as tasks, are important elements of major conceptualizations of the therapeutic alliance and are included in several therapeutic alliance measures. In addition, the development of treatment goals often helps to motivate and engage patients by communicating to the patient what is possible for achieving in therapy.

The establishment of treatment goals is similar to, but more specific than, the *Set Goals* step of the SDM Session, which focuses on identifying *potential* treatment goals for enhancing motivation and further individualizing the process of selecting treatment. The process of establishing collaborative treatment goals in EBP generally involves developing specific goals that are behaviorally oriented and measureable. Therapists may wish to refer to the *Set Goals* step of the SDM Session and specific steps for identifying potential treatment goals presented in Table 2.6 as a starting point for developing specific treatment goals. For Veterans who have completed the SDM Session, therapists should build on the discussion of potential treatment goals discussed during that session, if possible.

In addition to the heightened focus on the therapeutic alliance at the outset of therapy for establishing a strong foundation for treatment, primary focus on the therapeutic alliance is warranted when there is indication that the therapeutic alliance is or may be weakened. This may be determined based on the patient's responses on a therapeutic alliance measure, such as one of the measures described in Section 3.1.1.1., that is regularly incorporated into the treatment process or based on information communicated by the patient during session. In addition to direct communication from the patient related to the alliance or experience of treatment, changes in session attendance or level of engagement may also indicate an opportunity for strengthening the alliance. If there is uncertainty about the strength of the alliance, the therapist may wish to administer a therapeutic alliance measure in addition to the regular administration schedule (e.g., Sessions 1, 3, 7, 11), which is intended as a minimum. Therapists may also request feedback, an important therapist behavior for regularly incorporating in EBPs, during or at the end of session to learn more about how the patient feels about therapy. For example, the therapist may ask "How has [today's session or treatment] been helpful/not helpful?" What are your thoughts about our work together so far?" or "What other feedback do you have for me?" Therapists are encouraged to openly discuss the patient's views of the alliance and ways in which the patient's views and experience may be improved. Therapists should use information to make appropriate adjustments, which may include (1) focusing more on the treatment process and connection with the patient to shore up the relationship, (2) adjusting treatment goals, and/or (3) modifying treatment strategies or treatment approach.

Throughout most of the main phase of treatment, there is approximately equal and simultaneous attention to techniques and the relationship, such that the therapeutic relationship serves as the vehicle through which specific treatment strategies are delivered. This involves intentionally focusing on both the "what" (specific techniques) and the "how" (the manner in which the techniques are implemented) as treatment is delivered. The focus on the "how" involves avoiding overly directive or didactic approaches to implementing techniques or teaching skills and, instead, using active listening and related interpersonal connection skills, as well as incorporating specific alliance-enhancing strategies emphasized in EBPs.

As treatment approaches the final phase, which often includes one or more sessions that focus on skill consolidation or relapse prevention, specific focus on the relationship is important for reinforcing and sustaining treatment gains and for increasing the likelihood that the patient will seek treatment in the future, if this should ever be needed. In addition to active listening, the focus on the relationship at this stage often involves acknowledging the patient's progress and commitment to treatment, which may include a reflection on the patient's journey in treatment and genuine expression of empathy, respect, and enthusiasm for the patient's efforts and experience.

Table 3.2 provides a summary of the focus on the therapeutic relationship vs. specific techniques at different phases of the treatment process.

TABLE 3.2.
FOCUS ON THE THERAPEUTIC RELATIONSHIP DURING THE EBP TREATMENT PROCESS

PHASE OF TREATMENT	FOCUS ON THERAPEUTIC RELATIONSHIP VS. SPECIFIC TECHNIQUES	STEP	SPECIFIC SKILL OR ACTION	ADDITIONAL COMMENTS
Early	Relationship > Techniques	▪ Establish a foundation for a strong therapeutic relationship.	▪ Incorporate interpersonal connection skills.	
		▪ Prepare the patient for the treatment process.	▪ Provide psychoeducation and encouragement. ▪ Elicit and problem solve any questions or concerns about treatment.	
		▪ Develop an individualized case conceptualization.	▪ Create cognitive, behavioral, interpersonal, or other formulation relevant to the treatment to guide treatment and facilitate treatment process.	
		▪ Establish individualized treatment goals.	▪ Collaboratively establish specific and measurable treatment goals for guiding and monitoring treatment and for conveying positive messages of collaboration and encouragement.	For Veterans who have completed the SDM Session, therapists should build on the discussion of potential treatment goals during *Set Goals* step of SDM Session.
Middle	Relationship = Techniques	▪ Place approximately equal and simultaneous attention on techniques and relationship, intentionally focusing on both the "what" (specific techniques) and the "how" (the manner in which the techniques are implemented) as treatment is delivered.	▪ Focus on the "how" involves avoiding overly directive or didactic approaches to implementing techniques or teaching skills, instead using active listening and related interpersonal connection skills, as well as incorporating specific alliance-enhancing strategies emphasized in EBPs.	Specific alliance-enhancing skills include Feedback, Collaboration, and Guided Discovery.

PHASE OF TREATMENT	FOCUS ON THERAPEUTIC RELATIONSHIP VS. SPECIFIC TECHNIQUES	STEP	SPECIFIC SKILL OR ACTION	ADDITIONAL COMMENTS
Middle – Upon Indication of Weakened Therapeutic Alliance	Relationship > Techniques	▪ Place greater or primary focus on the treatment process. ▪ Use information from Veteran to make appropriate specific adjustments to treatment and/or process.	▪ Specific adjustments include (1) increasing interpersonal connection, (2) adjusting treatment goals, and/or (3) modifying treatment strategies or approach.	If strength of alliance is uncertain, re-administer therapeutic alliance measure or request feedback. Feedback may be elicited by asking, "What are your thoughts about our work together so far?" or "What other feedback you have for me?"
Late	Relationship = Techniques	▪ Place specific focus on relationship for reinforcing and sustaining treatment gains and increasing likelihood the patient will seek treatment in the future, if needed.	▪ Engage in active listening, acknowledging the patient's progress and commitment to treatment. ▪ Reflect on the patient's journey in treatment and express empathy, respect, and enthusiasm for the patient's efforts and experience.	

Reflecting the importance placed on the therapeutic alliance, the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980), the gold standard measure for assessing therapist competence in CBT (which has been adapted for assessing competence in a number of other EBPs), includes a number of specific domains that relate directly to the therapeutic relationship and process skills (Karlin & Cross, 2014b). These components, which represent almost half of the competency domains assessed on the CTRS, include *Understanding, Interpersonal Effectiveness, Feedback, Collaboration,* and *Guided Discovery*. The first two components—*Understanding* and *Interpersonal Effectiveness*—involve communication strategies that comprise specific interpersonal connection skills. The remaining components involve clinical competencies for engaging patients in the therapy process that are highly emphasized in CBT and other EBPs. Descriptions and clinical considerations for each of these five core EBP competencies for enhancing the therapeutic alliance are provided in Table 3.3. As is likely evident, these competencies are also highly consistent with shared decision-making and components of the SDM Session described earlier in this toolkit.

TABLE 3.3.
CORE EBP COMPETENCIES FOR ENHANCING THE THERAPEUTIC ALLIANCE

COMPETENCY	DESCRIPTION	CLINICAL CONSIDERATIONS
Understanding	The ability of the therapist to grasp and communicate the patient's "internal reality" and effectively use active listening skills in so doing	Communicated verbally and nonverbally using active listening and related skills (e.g., reflection, summarizing, expressed empathy, periodic head nods; see Table 2.1) throughout the session. Used not only to convey understanding of a specific comment or experience, but understanding of the patient's overall experience.
Interpersonal Effectiveness	Degree of warmth, concern, confidence, genuineness, and professionalism displayed by the therapist	Communicated verbally and nonverbally using active listening and related skills throughout the session. Important for establishing early on in the treatment process.
Feedback	Extent to which the therapist elicits and responds to verbal and nonverbal feedback throughout the session	Implemented at appropriate points (on average, 1–2 times) during the session and at the end of session for assessing what was most helpful about the session.
Collaboration	The degree to which the therapist is able to collaborate with the patient and work as a team in identifying and addressing problems both the therapist and patient consider important	Involves encouraging the patient as much as possible to be actively involved in the approach to and process of treatment. This is best accomplished through indirect methods, such as offering choices, open-ended questions, acknowledgement, and positive reinforcement.
Guided Discovery	The use of non-directive, open-ended questioning to help the patient explore problems and reach their own conclusions, rather than use of didactic or persuasive approaches	A powerful technique for promoting insight, awareness, and deeper engagement. Guided Discovery is often used for helping patients learn and apply new CBT strategies and make new discoveries. Therapists should approach Guided Discovery with a curious stance.

Feedback and open discussion of the patient's reactions in the therapy room reflect important opportunities for enhancing the therapeutic alliance and promoting patient engagement.

The core EBP competencies described in Table 3.3 represent significant opportunities for promoting the therapeutic relationship and enhancing the overall therapeutic environment. These actions, which are interwoven throughout treatment, are not treatment-specific and may be implemented across a number of EBPs.

As described previously, open discussion of the patient's views toward treatment and any specific concerns the patient may have is highly encouraged in EBP so that these can be addressed and resolved. **It is, for this reason, that eliciting patient feedback is considered an essential part of CBT and other EBPs that should occur each session. In practice, eliciting feedback is infrequently implemented in EBPs and other treatments and is a skill that is often overlooked in psychotherapy training.** Thus, feedback and open discussion of the patient's reactions in the therapy room reflect important opportunities for enhancing the therapeutic alliance and promoting patient engagement. In some instances, this may involve discussion of the therapeutic relationship itself. **In fact, some of the most powerful moments in treatment are those when the therapeutic relationship is the subject of the work done in session.** Beyond allowing for enhancing the therapeutic relationship, open discussion of the relationship, when indicated, provides the therapist an opportunity to model the tenets of the EBP in real time and provides a corrective learning experience that the patient can apply to relationships outside of the session. For example, if a therapist delivering CBT senses (e.g., through nonverbal cues) that the patient is having an adverse reaction to something in session, the therapist may check in with the patient

regarding their observation. If the patient responds that they have concerns, it is important for the therapist to demonstrate openness to this feedback and to spending some time addressing it. Such a response communicates to the patient that the therapist is truly interested in collaboration and feedback and that the patient's views and feelings are valued. In this scenario, the therapist may say, "I see that you are frowning, and I'm wondering what your reaction is to what I just said." In this way, the therapist is modeling the process of checking out the evidence that may or may not support the therapist's assumptions.

Commenting on the therapy process need not be reserved for negative experiences. If a therapist suspects something positive is occurring in the therapeutic relationship, the therapist may bring this up in discussion as well. Similar to the therapist's statement in the previous scenario, the therapist in the current scenario would make an observation and ask for additional information about that reaction. For example, the therapist may state, "I'm noticing you're smiling right now. Tell me what is running through your mind." If the patient indeed makes a positive comment about the therapeutic relationship (e.g., "I don't have many people in my life who get me like you do."), the therapist may respond with a genuine sentiment (e.g., "I'm glad I'm able to do so. It's gratifying for me to see the progress you've made so far.") Depending on the specific circumstances, the therapist may extend the impact of the situation by, for example, encouraging the patient to fully experience the positive affect associated with the interaction, asking the patient what they learned about themselves or about relationships, or encouraging the patient to contemplate the way in which they may apply this experience to relationships outside of session.

Bobby, the case we have followed in the toolkit to this point, initiated CBT for depression. Although he demonstrated moderate levels of motivation and engagement across the first five sessions, he cancelled an appointment and then failed to attend the rescheduled appointment. Bobby's therapist recalled the sense that they had ended the fifth session on an uneasy note. He had not provided time for discussion of feedback at the end of the session and later speculated that Bobby might have had an adverse reaction to something that happened in session, a speculation that became stronger when Bobby failed to attend the rescheduled appointment. The therapist decided to personally call Bobby, inform him that he had missed him at his last two appointments, and indicate that he was looking forward to resuming working together in the next couple of weeks. Bobby agreed to schedule another therapy session in two weeks when he planned to be at the VA for another medical appointment.

At the beginning of the next therapy session, Bobby's therapist obtained a mood check from Bobby and asked for feedback on the most recent session. The following dialogue ensued.

EXCERPT
THERAPIST & BOBBY

THERAPIST: *[bridging from the previous session by eliciting feedback not elicited last session]* I'd like to get some feedback on our last session, which occurred five weeks ago now. What did you end up taking away from that session?

BOBBY: I don't know. I have to be honest, I'm not sure that I'm feeling all of this.

THERAPIST: *[demonstrating an openness to feedback]* Oh, I'm sorry to hear that Bobby. I'd like to hear more about that. Can you tell me more about what does not feel right to you?

BOBBY: *[averting eye contact]* I don't know, really.

THERAPIST: *[eliciting additional feedback]* Is there something that rubbed you the wrong way in the previous session, or something that you thought I got wrong?

BOBBY: *[hesitating]* Well, yeah, I didn't like how the last session ended.

THERAPIST: *[providing validation]* You know, Bobby, I also had the sense that we ended on a note that was less comfortable than the notes we had ended on in previous sessions. I couldn't put my finger on what it was, though. Did you have a negative reaction to something I said?

BOBBY: Not exactly…well…maybe. It's just that I was talking about things with my wife, and it seemed like all of a sudden, you looked at the clock and said we're out of time.

THERAPIST: *[responding with a non-defensive stance]* I do remember that I mentioned that we were nearing the end of the session time. It seems that when you said that, you had the sense that I was closing off discussion of the relationship with your wife. Tell me, what did that mean to you that I said that?

BOBBY: *[looking down, sheepishly]* I don't know, I guess that you really don't give a shit about what I am going through, just like everybody else.

THERAPIST: *[continuing to demonstrate an openness to feedback, as well as noting that Bobby had identified an important thought that could be worked with in CBT]* Ah, so when I mentioned that we were near the end of session, what jumped into your mind was that I don't care what you are going through.

BOBBY: Yeah, that's right.

THERAPIST: *[asking permission]* Is it OK with you if I share my perspective of that point in our session?

BOBBY: Sure.

THERAPIST: *[summarizing]* In my mind, I thought that we had drawn a conclusion about the issue with your wife. With our time coming to a close, I had hoped to point out all of the conclusions that we had reached throughout the session to make sure you could take them home with you and make use of them. It sounds like I was mistaken, though, and that you had more to share about your wife. I apologize for my misperception.

BOBBY: *[sighing, making eye contact for the first time]* Well, I guess we did come to a conclusion, actually. We had come up with a new way of responding to my wife when she makes those accusations about me being lazy.

THERAPIST: *[demonstrating curiosity]* Oh, so you think a conclusion was drawn?

BOBBY: Yeah, I guess it was.

THERAPIST: *[asking a question in the spirit of Guided Discovery]* What else might have been going on between the two of us that led you to leave with such a negative reaction?

BOBBY: I don't know, I think I just wanted to vent more about the way my wife treats me. It really eats at me after a while.

THERAPIST: *[providing validation]* I appreciate that there is a lot of tension in that relationship, Bobby. I also understand that when the tension is at its worst, that it really affects your mood.

BOBBY: You can say that again.

THERAPIST: So you've mentioned this desire to vent. I'd just like to be sure we're on the same page with that. Do you have the sense that it would be beneficial to have opportunities to vent or let this stuff out?

BOBBY: Um, I don't know, I actually don't think venting is very helpful. I like that you and I come up with a plan for solving the problems in my life.

THERAPIST: So, it was more of an issue that, in that moment, you felt a need to vent, and I was going in a different direction?

BOBBY: Yeah, that's it.

THERAPIST: *[circling back to Bobby's thought that his provider doesn't care in the spirit of Guided Discovery]* Does that mean to you that I don't care?

BOBBY: *[pausing]* No, no I know you care. Like that time I was feeling really hopeless and even suicidal, you called me back right away when I left you that message. That meant something.

THERAPIST: I'm glad, Bobby. *[demonstrating genuineness*] It was important to me to be able to provide support to you during that difficult time.

BOBBY: Yeah, it was real helpful.

THERAPIST: *[extended the discussion further using Guided Discovery]* I'm wondering if this happens again–if something happens in our session, and you again have the thought that I don't care–how would you respond to that thought?

BOBBY: *[looking thoughtful]* I'd remember that you really do care.

THERAPIST: *[playing "Devil's Advocate"]* What if it were the case that you feel very strongly that you need space to express your thoughts and feelings, and you have the sense that I am going elsewhere? How will you remember that I care?

BOBBY: *[pausing and thinking]* I guess I have to do the same thing that you have been teaching me–looking at the evidence and seeing that there really isn't any strong evidence to say that you don't care.

THERAPIST: *[reinforcing Bobby's application of cognitive restructuring skills]* I think that's a terrific idea. *[pausing, and asking permission]* Can I share with you a second idea to consider as well?

BOBBY: *[nods head]*

THERAPIST: Would you be willing to speak up when you have more to say? Just in case I haven't picked up on your cues?

BOBBY: Yeah, I can do that.

THERAPIST: Oh good, I'm glad to hear that. *[expressing genuineness and a collaborative stance]* I truly do want to hear from you if you have more to say, or if you think I'm prematurely switching topics or ending the conversation before you're ready. After all, we're equal members of a team, right?

BOBBY: *[looking relieved]* Yes, you're right.

THERAPIST: *[asking for feedback in a way that consolidates learning]* What are you taking away from our conversation so far, Bobby?

BOBBY: A lot, actually. First, I like that you talked about this with me. Most of the time, it seems like, when I work with doctors, it's their way or the highway. I'm always on the edge of my seat, just waiting for them to tell me that I'm doing something wrong or that they don't want to work with me anymore if I'm not making progress.

THERAPIST: And now you see this experience as being different?

BOBBY: Well, yeah. I pretend like I don't give a shit if my doctors care about me. But I guess deep down I do. Especially when it's someone I have opened up to.

THERAPIST: *[providing validation]* I hear you, Bobby. I certainly like to have the sense that my doctors care about me as well…You said you are taking a lot from our conversation. What else?

BOBBY: Also that I don't have to quit coming just because you and I have a disagreement, or if I don't like something that happened. *[demonstrating more learning that he has achieved in CBT]* I tend to be very all-or-nothing in my thinking and in my actions. If something turns me off, then boom, I'm gone.

THERAPIST: Was that the case with our therapy, such that if I hadn't called you, would you have been gone?

BOBBY: Honestly? Yeah.

THERAPIST: *[continuing to solicit feedback]* Now that you're back, how do you feel about therapy?

BOBBY: I'm glad you called me. And I'm glad that I gave it another chance. I probably wouldn't have admitted it before, but I've learned a lot in here already. It probably would have been a bad decision for me to stop coming here.

THERAPIST: *[smiling warmly]* I'm glad you're "back," Bobby. I'm looking forward to our continued work together.

BOBBY: Well, thanks doc. Me too.

THERAPIST: *[moving toward the generalization of learning]* Would it be OK with you if we spent our remaining time considering ways in which we can apply what you've just learned to other relationships in your life?

BOBBY: Yeah, I think that sounds like a good plan.

In the preceding dialogue, Bobby's therapist demonstrated openness to feedback and an intentional focus on cultivating the therapeutic relationship at several points. First, the therapist used a standard CBT technique—a bridge from the previous session focused on eliciting feedback—to check in with Bobby regarding his experience of the previous session. When Bobby indicated that he was not "feeling all of this," rather than becoming defensive or immediately trying to convince Bobby of the benefits of treatment, the therapist demonstrated genuine interest in Bobby's experience in therapy. When Bobby initially expressed that he did not know what he found to be aversive, his therapist "put himself out there" and inquired directly about the possibility that it was his (the therapist's) behavior that was off-putting. Bobby was able to provide more detail in response to this question, communicating his view that his therapist moved toward wrapping up the session when he was in the midst of expressing something important about the relationship with his wife. Bobby's therapist stated that he had a similar memory, reflected Bobby's concern about the incident, and extended the discussion by asking Bobby what this incident meant to him. Here, the therapist is enacting an important principle of CBT—identifying thinking associated with a negative mood state—directly within the context of the therapeutic relationship.

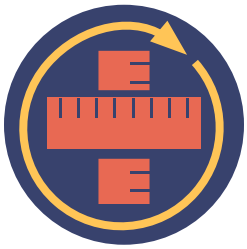
During the remainder of the dialogue, Bobby's therapist simultaneously maintained a focus on the therapeutic relationship and specific CBT tasks. He shared with Bobby his perspective of his motivation for mentioning that the session was coming to a close. When he did this, Bobby realized that the therapist's viewpoint was largely accurate—that a conclusion about the relationship with his wife *had* indeed been reached, and that it was understandable that the therapist would proceed as if that discussion had come to a close. Nevertheless, the therapist believed it was important to model taking responsibility for one's part in a miscommunication, so he apologized to Bobby for not picking up on the cues that Bobby wished to vent. He took that notion one step further by involving Bobby collaboratively in the structure and direction of therapy moving forward.

As the dialogue progressed, Bobby's therapist gently and non-defensively applied the cognitive restructuring technique of examining evidence to evaluate the idea that he did not care about Bobby. Bobby readily identified a previous interaction in which the therapist demonstrated a great deal of care and concern—when Bobby called him during a particularly difficult moment, and the therapist was very responsive. The therapist extended the discussion to consider how Bobby will remember this evidence in the event that he has a similar reaction to the therapist and experiences a high level of negative affect. They continued their discussion by considering the way in which this therapy relationship is different from Bobby's relationships with other therapists, providing space for Bobby to draw tangible conclusions about this experience, and extending the learning to other relationships. Throughout the discussion, Bobby's therapist was warm, genuine, open-minded, and non-defensive.

Many mental health providers find it uncomfortable to address negative feedback from a patient or to confront problems in the therapeutic relationship. At times, therapists may face the prospect of a *rupture* in the therapeutic relationship, defined as "tension or breakdown in the collaborative relationship between patient and therapist" (Safran, Muran, & Eubanks-Carter, 2011, p. 80). **As demonstrated in the previous dialogue, EBP providers address ruptures in the therapeutic relationship in a manner that is sensitive and respectful, that models the core tenets of the treatment, and that allows the client to have an important learning experience (Newman, 2007).** In fact, Strauss et al. (2006) found that the successful repair of a rupture in the therapeutic relationship was associated with better outcomes following treatment, suggesting that ruptures can actually enhance the therapy experience if they are directly and appropriately addressed. However, doing so requires interpersonal flexibility and effectiveness and careful attention to the therapeutic relationship. Qualitative data suggest that rigid adherence to techniques when faced with a rupture in the therapeutic relationship results in poorer outcomes than adopting a flexible stance (e.g., Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996).

Placing intentional and systematic focus on the therapeutic alliance presents a significant opportunity for promoting Veteran engagement in EBPs.

In short, placing intentional and systematic focus on the therapeutic alliance presents a significant opportunity for promoting Veteran engagement in EBPs. Although highly consistent with and central to high-quality EBP delivery, the therapeutic alliance is infrequently an ongoing and explicit focus in practice. Throughout this section, we have presented specific processes and strategies for assessing and enhancing the therapeutic alliance in the delivery of EBPs, with a focus on practical and actionable steps for feasibly incorporating and individualizing in treatment. We hope this information is helpful to clinicians interested in more fully realizing the potential of individualized, evidence-based, person-centered care for enhancing the Veteran experience in therapy. In the next section, we describe opportunities for incorporating principles and strategies of measurement-based care for enhancing patient engagement and outcomes.



Measurement-based care includes, though goes beyond, routine outcome assessment or monitoring by providing an important feedback loop that is used for confirming or making mid-course adjustments or corrections to specific treatment strategies or to the focus of therapy.

3.2. MEASUREMENT-BASED CARE

In addition to regular assessment of and clinical attention to the therapeutic alliance, reviewed in the previous section, ongoing assessment of and attention to patient outcomes, through a process of *measurement-based* care, is a key clinical strategy for enhancing patient engagement and treatment effectiveness. **Measurement-based care involves the ongoing assessment of the patient's clinical status and response to therapy over the treatment course and the use of these data to inform clinical decision-making, including potential changes to the treatment approach.** In this way, measurement-based care includes, though goes beyond, routine outcome assessment or monitoring by providing an important feedback loop that is used for confirming or making mid-course adjustments or corrections to specific treatment strategies or to the focus of therapy. Measurement-based care has been shown in increasing research to yield enhanced clinical and process outcomes (Scott & Lewis, 2015; Tarescavage & Ben-Porath, 2014). Although, it is very infrequently incorporated into the delivery of mental health care (Goodman, McKay, & DePhilippis, 2013; Jensen-Doss et al., 2018). Findings from a recent survey of mental health providers revealed that only 14% used standardized measures of progress at least monthly, and only 5% used such measures every 1-2 weeks; further, more than half reported never using standardized progress measures (Jensen-Doss et al., 2018).

Significantly, the ongoing assessment of outcomes and process of measurement-based care are highly consistent and compatible with the delivery of EBPs, which emphasize the use of data and experience to guide treatment. In fact, research examining clinician attitudes toward incorporating ongoing and monitoring in treatment has shown that providers with a CBT have more favorable attitudes toward these practices (Jensen-Doss et al., 2018). Most EBPs include routine administration of one or more

measures for assessing and tracking patients that are embedded into the treatment structure and seamlessly integrated into the therapy process. Most frequently, this includes regular administration of brief self-report symptom measures (and often more informal processes, like a brief mood check[2]) that are typically administered immediately before or at the beginning of each therapy session. In addition to symptom measures, outcome monitoring may also include administration of brief measures assessing other outcome domains, such as functioning, well-being, and quality of life.

When used most effectively, data gathered from the patient are used for providing information back to the therapist and patient *and* for informing how treatment unfolds. These data provide a valuable window into the patient's inner world and life—currently and over time—that can have an important impact on treatment. **In many instances, data from routine assessment measures may reveal consistent and/or significant improvement in one or more domains that may help to confirm or validate the treatment approach.** In addition, empirical information provided to the patient demonstrating improvement may help to further promote motivation and engagement in treatment. For example, seeing decreases in scores on symptom measures often enhances hope among patients and instills confidence that the work they are putting into treatment is making a difference. In some instances, without empirical data, patients may not recognize gains they have made. For example, patients with severe depression or negative cognitive biases may not fully recall the depths of the depression they experienced at the outset of treatment or recognize important gains that have been made on the road to achieving specific treatment goals. In these instances, empirical data, furnished by the patient, can be illuminating.

When used most effectively, data gathered from the patient are used for providing information back to the therapist and patient *and* for informing how treatment unfolds.

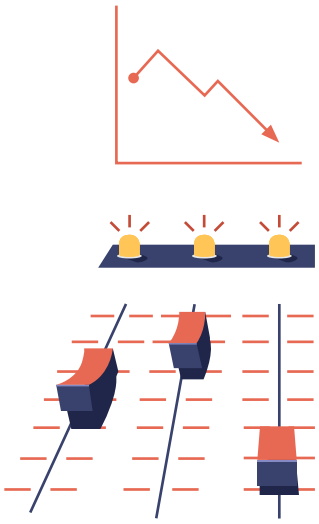
Data from routine assessment measures can be especially informative when indicating no change in or worsening of the patient's status—information that may not always be readily apparent in the absence of such data. Patients may not disclose lack of improvement or worsening of symptoms, functioning, or well-being in discourse for various reasons, including, but not limited to, having limited awareness of the decline, having discomfort associated with talking about their problems or not improving, or not wanting to disappoint the therapist. In such instances, ongoing outcome assessment provides a mechanism for this information to surface and be openly discussed.

Lack of improvement or negative treatment response revealed by outcome measures may be due to one or more patient or therapist factors. Patient factors that may contribute to lack of improvement include low motivation; limited understanding of treatment/treatment strategies or the rationale of such; and limited coping capacity or heightened stress**.** Therapist factors include inadequate understanding or conceptualization of the patient's problems; treatment goals that are less relevant, of lower priority, or are overly broad; challenges with implementing or adapting specific treatment strategies; inappropriate balance between the therapeutic alliance and specific treatment strategies; and selection or sequencing of treatment strategies that

2 A brief mood check is a subjective rating of the patient's mood over the past week (or since the last session) that is verbally requested from the patient, typically at the outset of the session. The mood check is generally reported on a 1–10 scale, where 1 = best possible mood and 10 = worst possible mood. The mood check can be used for assessing general mood and/or specific of mood or mood symptoms (e.g., sadness, irritability, anxiety, anger, etc.). For example, the therapist may ask, "How would you rate your level of anxiety over the past week on a scale of 1–10, where 1 = lowest possible anxiety and 10 = greatest possible anxiety?" The brief mood check may be used in addition to a brief symptom measure for beginning discussion of the patient's status, or in lieu of a brief symptom measure if the patient is unable to complete the measure for a particular session.

are less relevant to or appropriate for the patient. With respect to the latter, this may include, for example, implementing *in vivo* exposure exercises with patients who lack basic coping skills or applying cognitive strategies to severely depressed patients who may benefit from an initial focus on behavioral strategies, such as behavioral activation and activity scheduling.

In instances where data from patient measures consistently indicate the patient is not improving—or has declined—on key domains, it is important for the therapist to consider reasons for such, based on available outcome data and other information (e.g., from the patient, other key informants) and to make adjustments, as appropriate. Adjustment may involve changes or refinements to the understanding of or approach to the patient's problem or to the treatment process. Table 3.4 summarizes patient and therapist factors that may contribute to limited or reduced treatment outcomes, along with associated indicators and clinical considerations. While this is not intended to be an exhaustive enumeration of factors and associated indicators and clinical considerations that may underlie limited patient response to treatment, one or more of these factors, indicators, and considerations are relevant in many situations.



As Table 3.4 reveals, in many cases, adjustments for enhancing patient response to treatment may not only involve changes to the overall treatment approach but to how the treatment is implemented. Furthermore, adjustment to specific treatment strategies or sequencing thereof may vary depending on the specific treatment. Many EBPs are multi-component treatments that provide flexibility for tailoring and sequencing treatment components to maximize outcomes. For example, CBT for depression incorporates specific cognitive and behavioral treatment components that may be sequenced and simplified (e.g., use of coping cards or *Catch It, Check It, Change It* approach vs. *5-Column Thought Record*) based on various factors, such as the nature and severity of the presenting problem, level of cognitive functioning, patient preference, and other factors (Wenzel et al., 2011). Other treatments follow a more linear path but should still incorporate treatment and process considerations and adjustments in the presence of repeated data demonstrating limited patient response or engagement.

The process of identifying and addressing factors that may contribute to limited patient response involves hypothesis formulation and testing on the part of the clinician. As part of this process, therapists are encouraged to openly share and discuss the implications of outcome and process measures and more informal feedback with patients. Oftentimes, this open discussion will yield valuable information for enhancing understanding and formulation of the patient's problems and for informing treatment process characteristics (e.g., therapeutic alliance, pace, structure) and sequencing and selection of specific treatment strategies. This process also conveys an important message to the patient that their input and response to treatment are highly valued and prioritized by the therapist, and it is consistent with an SDM approach to EBP delivery.

As a general guide, therapists are encouraged to, at minimum, check in with patients and to consider exploring adjustments to specific treatment strategies or the implementation of strategies (e.g., ensure patient understands rationale, simplify treatment strategies), changes to the treatment approach, or augmentation of treatment (e.g., referral for psychopharmacotherapy) if clinically significant symptoms do not improve (or should worsen) after several (e.g., three) sessions, when improvement would have been expected. Of course, in some cases, it may be expected for specific treatment strategies (e.g., exposure exercises in PTSD and anxiety treatments) to yield no immediate improvement in symptoms, or even worsen symptoms,

TABLE 3.4.
FACTORS CONTRIBUTING TO LIMITED OR NEGATIVE TREATMENT RESPONSE AND ASSOCIATED INDICATORS AND CLINICAL CONSIDERATIONS

LEVEL	FACTOR	INDICATORS	CLINICAL CONSIDERATIONS
Patient	Low motivation	Expression of limited hope or confidence in treatment; inconsistent session attendance/limited participation in treatment or completion of homework	Engage in motivational enhancement (see Motivate section of SDM Session); provide psychoeducation about treatment and rationale for treatment; problem solve practical barriers to treatment
	Limited understanding of treatment/treatment strategies or rationale	Inability to demonstrate skill or explain rationale in session; inconsistent attendance or limited participation in treatment or completion of homework	Elicit summaries to assess understanding; provide psychoeducation on underlying model and rationale for treatment strategies
	Limited coping capacity/ heightened stress	Increased or high levels of stress/negative emotions; limited focus; new or increased stressors or disorganization in patient's daily life; inability to follow through with treatment strategies	Focus on increasing coping skills (see Appendix A1); re-evaluate treatment approach
Therapist	Inadequate understanding or conceptualization of patient problems	Incomplete case conceptualization; strategy successfully implemented with limited change in patient outcomes	Further develop/update case conceptualization
	Treatment goals that are less relevant, of lower priority, or overly broad	Goals described in general (non-measureable) terms; goals do not match problems and situations reported by patient; goals addressed with limited change in patient outcomes and no indication of other contributing factors; limited patient agreement on goals as reported on therapeutic alliance measure	Refine/re-prioritize treatment goals
	Challenges with implementing or adapting specific treatment strategies	Therapist challenges with pacing and/or structure of sessions; treatment strategies not tailored to patient problems and situations; therapy sessions have limited focus; patient has difficulty learning skills or implementing new skills outside of session that does not appear due to patient factors	Attend to pacing/structure and fidelity; simplify/limit treatment focus to one or few specific strategies and tailor treatment strategies to patient; use summaries, when appropriate
	Too much or too little focus on the therapeutic relationship vs. specific treatment strategies	Low or reduced level of agreement reported on relational/bond and/or task components of therapeutic alliance measure	Increase emphasis on therapeutic alliance or strategies, as indicated (see Section 3.1)
	Selection or sequencing of treatment strategies that are less relevant to or appropriate for the patient	Reduced or low patient agreement on treatment tasks as reported on therapeutic alliance measure or through verbally elicited feedback; treatment strategies implemented with limited change in patient outcomes and no indication of other contributing factors	Consider adjustments to sequence/selection of treatment strategies or approach

More important than the specific measures to adopt is the *process* of feedback and ongoing discussion and input between the patient and therapist that the incorporation of these measures provides.

whereas in other instances, such as treatment of depression, some degree of positive response or activation would be hoped for within this general timeframe. Changes may also be considered if scores on symptom or other measures demonstrate an overall flat or negative non-consecutive trend over a longer period, as well as at other times suggested by feedback from or discussion with the patient.

The processes described in this section for incorporating ongoing outcomes assessment and principles of measurement-based care offer significant promise for enhancing patient engagement and outcomes. The next section provides an overview of key measures across different outcome domains for, and specific guidance on, implementing these important processes in the delivery of EBPs. Before turning to the selection of specific measures, it is significant to emphasize that more important than the specific measures to adopt is the *process* of feedback and ongoing discussion and input between the patient and therapist that the incorporation of these measures provides.

3.2.1. ASSESSMENT OF PATIENT OUTCOMES

This section reviews a number of brief measures that may be integrated into the delivery of EBPs for monitoring and openly communicating about patient outcomes and incorporating principles and strategies of measurement-based care. The patient outcome measures included in this section include a number of brief, psychometrically validated instruments that offer practical utility for ongoing use in EBPs.

The types of measures included in ongoing outcome assessment and incorporated in this section include measures of symptom change—the most commonly incorporated measure for routine outcome assessment—as well as measures of functioning and well-being/quality of life. Measures of symptom change are typically administered every session. Measures of functioning or well-being/quality of life, which are often not as sensitive to week-to-week change, are more optional and often completed less frequently, such as at baseline (Session 1), every three or four sessions thereafter, and final session. If specific aspects of functioning or well-being/quality of life are a significant and ongoing focus of treatment or related to specific treatment goals, the therapist may wish to monitor these domains more frequently.

When possible, ongoing outcome assessment measures are administered immediately before the therapy session or at the beginning of the session. Patients may be asked to arrive at least 5–10 minutes before the session appointment time to complete the measures in the waiting room. Prior to administering the measures, it is important that the therapist briefly review the measures and the process and rationale for completing these questionnaires throughout the therapy process.

The therapist should collect and review completed measures at the beginning of the therapy session, both for reviewing the Veteran's specific responses and for communicating value for the patient's effort in completing the measures. In reviewing the patient's responses, it is important to look both at the total score and the scores on particular domains or items (including any items that tap into acute distress or suicidality). In reviewing scores, it is important to look at both the actual scores and for significant changes (decline or improvement) from previous scores. Elevated scores on particular domains of focus or significant changes from the past should be discussed with the patient and may help inform the focus of the session. For example, the therapist may note the following after reviewing a patient's score on the Patient Health Questionnaire-9 (PHQ-9), a brief measure of depression, "Your score of a 20 indicates that you're feeling

very depressed and more so than in past weeks. Is that the case?" This discussion may reveal significant changes in the patient's life, difficulty the patient had applying strategies learned in previous sessions, or unknown or undisclosed information that is relevant to the patient's condition.

Similar to the selection of measures for assessing the therapeutic alliance, discussed in Section 3.1.1, the selection of one or more measures for routine outcome assessment during treatment should involve consideration of several factors. First and foremost, it is important to consider issues of fit and feasibility with the specific patient population and treatment. This includes considering the focus of the measure with respect to the primary problem (symptomatic and functional) being treated, as well as considering the length of the measure and the reading level and ability of the patients with whom the measures will be used. Fortunately, there now exist a variety of validated brief measures for assessing different outcome domains that allow for reducing response burden and seamless integration into the therapy process. Nevertheless, even among the array of brief measures that exist, there is, in some cases, variability in the number of items across measures. This is especially important to take into account within the context of outcome measures (particularly measures of symptom change) that are administered each session.

With some patients, such as those with lower educational background, vision or reading challenges, or specific preferences for shorter questionnaires, clinicians may wish to use measures that offer even greater brevity and simplicity. Further, it is important to consider other individual factors, such as key sociodemographic characteristics (e.g., age, ethnicity), that may suggest the selection of certain measures for specific patients. For example, specific measures of depression and anxiety have been developed for older adults that offer greater simplicity (e.g., simplified wording, Yes/No response choices in lieu of Likert scale response choices) and that have been specifically normed on older adult samples. Such measures may serve as particularly appropriate choices for more frail or medically impaired older adults and for older adults for whom reading and responding may require greater effort. With respect to ethnicity, it is important to consider that some outcome measures, particularly newer measures, may have less psychometric validation research with specific ethnic groups. Moreover, the availability of validated translations of measures varies across measures, though established translations are available for a number of the most commonly used outcome measures.

Furthermore, the length and complexity of outcome measures are important to consider beyond the fit with the patient and time required. These issues are also important in relation to the time and effort of the clinician in reviewing symptom change measures at the beginning of the therapy session. Measures that are longer or more complex may pose more significant challenges for therapists to scan and discuss, when needed, in the moment during session.

Given the nature of review and use of outcome measures in session, and the intended use for decision support, it is especially important that therapists select measures that will provide clinical utility and that they feel particularly comfortable using in an ongoing manner for quickly gathering and discussing information about the patient's status and implications for treatment. We recommend that therapists familiarize themselves with, and even try out, one or more measures described below before systematically adopting them into their clinical practice.

In some cases, the decision of what outcome measure to use may be influenced by factors external to the therapist and patient. For example, some facilities or systems may have

established procedures (and licenses) for using certain measures. In addition, some EBP protocols specify the use of certain symptom measures, though for many treatments there is flexibility. When treatment protocols do note specific measures to be used, this often relates more to measures of primary symptoms.

Specific measures for assessing symptom change, functioning, and well-being/quality of life are described below. The measures included in this section have generally acceptable psychometric properties; any notable deficiencies are identified in the description of the measure. A summary table describing each measure and where to obtain each is included following the discussion of measures for each domain (see Tables 3.5 and 3.6).

Self-report measures of symptom change are most commonly utilized for ongoing assessment of outcomes in treatment.

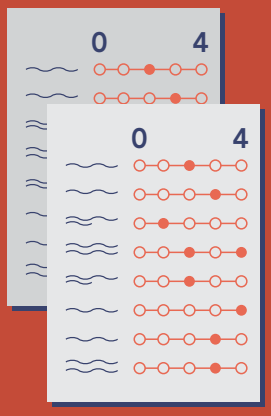
3.2.1.1. MEASURES OF SYMPTOM CHANGE

Self-report measures of symptom change are most commonly utilized for ongoing assessment of outcomes in treatment. In recent years, there has been a proliferation of self-report symptom change measures, yielding hundreds of measures assessing symptoms across a wide variety of mental and behavioral health conditions. This section describes a number of commonly used and empirically established measures of symptom change that offer clinical and practical utility and are feasible for incorporating into the delivery of EBPs and supporting measurement-based care. The measures included are brief, generally simple to complete by Veterans in a short period of time, target symptom profiles commonly reported by Veterans, and are generally either freely available or commonly used in facilities that serve Veterans. In some instances, newer measures representing promising innovations for supporting measurement-based care are included and noted as such. Some established measures developed for the specific purpose of monitoring outcomes, such as the Outcomes Questionnaire-45 (Lambert et al., 2013), the Symptom Checklist-90 (Derogatis, 1983) and its shorted Brief Symptom Inventory (Derogatis, 1993), and the CORE-OM (Evans et al., 2000), are not described in this section because they are lengthier or broader than measures typically used with Veterans and included for routine use in EBPs. Specific measures for assessing, respectively, symptom change, functioning, and well-being and quality of life are described below.

DEPRESSION

Patient Health Questionnaire-9 (PHQ-9): The PHQ-9 (Kroenke, Spitzer, & Williams, 2001) is a 9-item measure of depression severity based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; American Psychiatric Association, 1994) depression criteria. Items assess the degree to which specific symptoms of depression have been present over the past two weeks. Items are rated on a 4-point Likert scale (0 = Not at All; 3 = Nearly Every Day). Scores on each item are summed to obtain a total score. The PHQ-9 is the most widely used screening instrument for depression and is derived from the mood disorders module of the Primary Care Evaluation of Mental Disorders (PRIME-MD), which includes brief measures of depression, anxiety, alcohol, eating, and somatoform disorders. Although the timeframe for recall stated in the instructions refers to the past two weeks, the measure has been used for measuring depression symptoms weekly. The PHQ-9, and all measures based on the PRIME-MD, are free to use.

Clinically Useful Depression Outcome Scale (CUDOS): The CUDOS (Zimmerman, Chelminski, McGlinchey, & Posternak, 2008) is a newer measure of depression that includes 18 items rated on a 5-point Likert scale (0 = Not at All True; 4 = Almost Always



True) assessing the degree to which symptoms across the DSM-IV depression spectrum were present during the past week. Responses to each item are summed to obtain a total score. The CUDOS was specifically developed to serve as a tool that could be feasibly incorporated into routine clinical practice. Reflecting this goal, the CUDOS is reported to require less than 15 seconds to score. The expanded range of the CUDOS relative to briefer measures, due to the greater number of items and broader Likert scale, can be useful for tracking improvement over time. At the same time, the measure is reported to generally take less than three minutes to complete. A study of 50 depressed patients in an outpatient setting conducted by the primary developer of the measure revealed a preference among patients for completing the CUDOS rather than a longer measure, as well as high ratings of acceptability for completing at every session, with more than 90% of patients reporting a willingness to do so (Zimmerman & McGlinchey, 2008). In addition, the CUDOS has been shown to have particularly high sensitivity for detecting remission from depression, exceeding that of the PHQ-9 (Zimmerman, Walsh, Friedman, Boerescu, & Attiullah, 2017). The CUDOS is free to use.

Beck Depression Inventory-II (BDI-II): The BDI-II (Beck, Steer, & Brown, 1996) is a 21-item measure of depression that is widely used in clinical practice and in the delivery of EBPs, specifically. And it is among the most widely researched depression measures. For each item, patients select from a series of four statements, choosing the statement that best describes them over the past two weeks. Responses to each item are summed to obtain a total score. The BDI-II consists of two broad factors: cognitive-affective symptoms and somatic-vegetative symptoms. The BDI-II items and response choices are lengthier than some other brief depression symptom measures. At the expense of some additional response burden, the measure has been shown to be particularly sensitive to change and to detecting different levels of depression severity across a variety of ethnic samples. In addition, items provide information that map on well to and may provide clinical utility for CBT and related treatments. For example, at the more negative end of the score range of many items, responses reflect negative or extreme cognitions related to oneself, the world, or the future and are often a focus of treatment. This relates to Beck's conceptualization of depression as being related to a "negative cognitive triad" (negative beliefs about the self, the world, and the future), which serves as a theoretical foundation for many EBPs. The BDI-II is available for purchase, though is often available at treatment facilities for use by individual providers.

Geriatric Depression Scale-Short Form (GDS-SF): The GDS-SF (Sheikh & Yesavage, 1986) is a 15-item measure of depression developed specifically for older adults. The measure is an abbreviated form of the 30-item Geriatric Depression Scale (Yesavage et al., 1982-1983). Items are rated on a Yes/No basis to reduce response burden. Scores on individual items are summed to obtain a total score. The GDS-SF excludes physical symptoms of depression due to the potential of "somatic bias," or attributing of physical issues related to physical health conditions or aging-related phenomena (e.g., slowing) to depression, which may overestimate the severity of depression. The GDS-SF is typically verbally administered by the clinician, which can be less efficient in ongoing assessment for monitoring treatment outcome, though it can also be completed in writing by the patient. The GDS-SF is free to use.

ANXIETY

Generalized Anxiety Disorders-7 (GAD-7): The GAD-7 (Spitzer, Kroenke, Williams, & Löwe, 2006) assesses symptoms of generalized anxiety disorder (GAD) and is the GAD measure analogue to the PHQ-9 depression measure described above. Like the PHQ-9,

items are rated on a 4-point Likert scale (0 = Not at All; 3 = Nearly Every Day). Scores on individual items are summed to obtain a total score. Of note, the GAD-7 has been shown to be highly sensitive to gains made in treatment (Dear et al., 2011). Although the GAD-7 was developed to assess symptoms of GAD, it has been shown to have good sensitivity and specificity as a screener for panic disorder, social anxiety disorder, and posttraumatic stress disorder (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007). Furthermore, the GAD-7 can be useful for assessing and monitoring generalized anxiety symptoms that may be comorbid with depression or other mental health conditions. For this reason, it is sometimes used along with other symptom measures as part of ongoing outcome assessment. The GAD-7 is free to use.

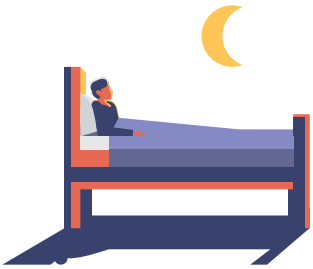
Clinically Useful Anxiety Outcome Scale (CUXOS): The CUXOS (Zimmerman, Chelminski, Young, & Dalrymple, 2010) is a newer, general measure of anxiety. The measure is not intended to be used for assessing or diagnosing specific anxiety disorders. The CUXOS includes 20 items rated on a 5-point Likert scale (0 = Not at All True; 4 = Almost Always True) assessing the degree to which anxiety symptoms were present during the past week. Individual item responses are summed to obtain a total score. The CUXOS is significantly longer than the most widely utilized measure (GAD-7) for ongoing assessment of anxiety (20 vs. 7 items), offering a tradeoff of greater breadth and range versus brevity. Although, like the CUDOS depression measure (described above) and created by the same authors, the CUXOS was specifically developed to be a feasible tool for incorporating into routine clinical practice for monitoring outcome. A psychometric evaluation of the instrument conducted by the developers of the measure revealed that the measure took less than 1.5 minutes, on average, to complete in an outpatient setting and required less than 15 seconds to score (Zimmerman et al., 2010). The CUXOS was designed to be useful for monitoring symptoms of anxiety that may be comorbid with depression, as well as for individuals seeking treatment for an anxiety disorder. Given this, the CUXOS may be administered along with other symptom measures as part of ongoing outcome assessment. Due to its recent development, the CUXOS has been less extensively evaluated than other brief anxiety measures, though available data suggest it to be a valid and reliable measure of anxiety that is sensitive to change. The CUXOS is free to use.

***Geriatric Anxiety Inventory (GAI)*:** The GAI (Pachana et al., 2007) is a general measure of anxiety developed specifically for older adults. The measure includes 20 items with a simplified "Agree/Disagree" response format. The GAI includes few physical symptoms of anxiety to minimize potential overestimation of anxiety that could occur with older patients with significant somatic symptoms due to medical or age-related issues in late life. Although psychometric analyses to date have supported the validity and reliability of the measure, there has been limited research examining the use of the GAI with ethnic minority elders. The GAI is available for purchase.

POSTTRAUMATIC STRESS DISORDER (PTSD)

PTSD Checklist for DSM-5 (PCL-5): The PCL-5 (Weathers et al., 2013) is a 20-item measure that assesses the frequency with which patients experience the 20 DSM-5 (American Psychiatric Association, 2013) symptoms of PTSD. The measure is used for PTSD screening, provisional PTSD diagnosis, and monitoring of symptom change during and in follow-up to PTSD treatment. Items on the PCL-5 are rated on a 5-point Likert scale (0 = Not at All; 4 = Extremely). Items 1–5 correspond to Cluster B PTSD symptoms (i.e., intrusions); items 6–7 correspond to Cluster C symptoms (i.e., avoidance); items 8–14 correspond to Cluster D items (i.e., negative alterations in cognition and mood); and items 15–20 correspond

to Cluster E items (i.e., alterations in arousal and reactivity). Of note, the PCL-5 is different than the previous version of the measure, which corresponded to DSM-IV PTSD criteria. A total score may be calculated by summing up the responses to individual items. Cluster severity scores may be calculated by summing the responses to individual items within a cluster. Research to date provides support for the use of the PCL-5 for detecting clinical change over time. The measure is widely used throughout the VA health care system and in other settings for PTSD screening and monitoring, and it is incorporated for symptom monitoring into EBPs for PTSD, such as Prolonged Exposure and Cognitive Processing Therapy. The PCL-5 is free to use.



INSOMNIA

Insomnia Severity Index (ISI): The ISI (Morin, 1993; Morin & Espie, 2003) is a 7-item measure that assesses severity of sleep disturbance. Items are rated on a 5-point Likert scale with different anchors depending on the nature of the question. Items assess problems in the three main domains of insomnia (i.e., difficulty falling asleep, difficult staying asleep, waking too early), as well as satisfaction with sleep, stress about sleep, and life interference. Scores on individual items are summed to obtain a total score. A total score of 10 or higher is indicative of insomnia in a community sample (Morin, Belleville, Bélanger, & Ivers, 2011). The ISI has repeatedly been shown to be sensitive to treatment response. The ISI is commonly used for assessing change in CBT-I and other insomnia treatments and was adopted for ongoing symptom monitoring in the CBT-I treatment protocol adapted for Veterans (Manber et al., 2014). The ISI is free to use with Veterans.

SUBSTANCE USE DISORDERS

Although the practice of measurement-based care has been slower to implement in many substance use disorder (SUD) treatment settings relative to specific mental health treatment contexts (Goodman et al., 2013), symptom monitoring is deemed to be a central component of SUD treatment and is recommended by the Institute of Medicine (IOM, 2006). In recent years, there has been increasing focus in SUD treatment on moving beyond symptom monitoring to incorporating principles and practices of measurement-based care, which is reflected in the recent development of several new measures for integrating into and guiding ongoing SUD care.[3] While psychometric evaluation of these measures is ongoing, the increasing emphasis on measurement-based care and development of new measures to advance such represent important innovations in the field of SUD treatment.

Brief Addiction Monitor (BAM), Brief Addiction Monitor-IOP (BAM-IOP), and Brief Addiction Monitor-Consumption (BAM-C): The BAM (Cacciola et al., 2013) is a newer measure that was specifically developed to support measurement-based care in specialty substance use disorder treatment settings and is widely-used within the VA health care system. The BAM contains 17 items that assess the severity of alcohol and drug use and recovery and includes both risk and protective factors relevant to substance use. Items include open ended, Likert-type, and dichotomous (Yes/No) response choices. The BAM assesses substance use during the past 30 days. A version of the measure designed for more frequent administration in intensive outpatient treatment settings (BAM-IOP) and is used in some other outpatient

3 In addition to subjective self-report measures, which are the focus of the current section, the adoption of objective measurement of substance use is often integrated into SUD treatment, including as part of psychological interventions (see, e.g., Dougherty et al., 2015).

settings is available that includes the same items as the BAM, but with a 30-day or 7-day timeframe. The instrument was initially described to have three factors: Recovery Protection, Physical & Psychological Problems, and Substance Use & Risk. However, greater emphasis is placed on clinician interpretation of and attention to individual item scores, rather than factor scores or total score. Limited psychometric data on the BAM have been reported beyond the initial psychometric analyses conducted by the authors of the instrument. A 4-item version of the measure—the Brief Addiction Monitor-Consumption (BAM-C)—is available that assesses only substance use (consumption) and excludes items related to consequences of or recovery from substance use. The BAM-C is primarily intended for use in non-SUD treatment settings where there is interest in monitoring consumption of substances.

The BAM, BAM-IOP, and BAM-C may be clinician-administered or completed through patient self-report. All versions of the measure are free to use. A variety of free clinical support materials designed to facilitate use of the measure are available from the Philadelphia Center of Excellence in Substance Addiction Treatment and Education (CESATE), including graphing templates, guidance on use in measurement-based care, and treatment planning content aligned with the *2015 VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders* (VA & DoD, 2015).

Short Inventory of Problems-Revised (SIP-R): The SIP-R (Kiluk, Dreifuss, Weiss, Morgenstern, & Carroll, 2013) is a revised version of the SIP (Blanchard, Morgenstern, Morgan, Labouvie, & Bux, 2003), which was adapted from the Drinker Inventory of Consequences (Miller, Tonigan, & Longabaugh, 1995) for assessing consequences of alcohol and drug use, rather than alcohol use alone. The SIP-R was developed and implemented as an outcome measure in several multi-site randomized clinical trials examining the effectiveness of Motivational Enhancement Therapy and Motivational Interviewing techniques (Kiluk et al., 2013). The SIP-R is a 17-item instrument that assesses negative consequences of substance use, which have been shown to be associated with frequency and severity of use and have been shown to be sensitive to change over time. Items measure consequences related to social, physical, interpersonal, intrapersonal, and impulse control functioning, providing information that may be clinically useful for treatment planning and for guiding ongoing treatment in the delivery of psychotherapy. Items assess negative consequences associated with substance use over the past 3 months, though the SIP has been used to assess shorter periods of time (e.g., 30 days). Items are rated on a 4-point Likert scale, ranging from "Never/Not at all" to "Daily or almost daily/Very much." The SIP and SIP-R do not include items that assess recovery-protective behaviors. The SIP has been shown to have good internal and test-retest reliability, strong concurrent and predictive validity, and sensitivity to change (Alterman, Cacciola, Ivey, Habing & Lynch, 2009; Bender, Griffin, Gallop & Weiss, 2007; Feinn, Tennen, & Kranzler, 2003). Initial psychometric evaluation conducted by the developers of the SIP-R provided support for the use of the measure within a large sample of patients seeking outpatient SUD treatment (Kiluk et al., 2013). The SIP-R is free to use.

Alcohol and Drug Outcome Measure (ADOM): The ADOM (Pulford et al., 2010) is a newer, clinician-administered measure of alcohol and drug use developed in New Zealand for the specific purpose of promoting routine monitoring of outcomes in real-world clinical practice settings and for informing treatment. The ADOM consists of 20 items that assess (1) the nature and frequency of substance use, (2) lifestyle and well-being, and (3) satisfaction with recovery. Items assessing frequency of use inquire about substance use during the past four weeks. Items include open ended, Likert-type, and dichotomous (Yes/No) response choices. A Feedback Wheel, on which clinicians can plot and visually

present scores for providing and discussing feedback is available. The ADOM is mandated by the New Zealand Ministry of Health for all community-based outpatient adult addiction services. There is initial empirical support, primarily from New Zealand, for the measure's psychometric properties, sensitivity to change, and clinical utility (Pulford et al., 2010; Newton-Howes & Stanley, 2015; Wheeler, Websdell, Galea, & Pulford, 2011). The ADOM is free to use.

Leeds Dependence Questionnaire (LDQ): The LDQ (Raistrick et al., 1994) is a 10-item, self-administered measure of substance dependence designed to have specific utility as an outcome measure. The LDQ assesses symptoms of psychological, rather than physiological, dependence, which can have important implications and utility for treatment planning and assessing and promoting change in treatment (Galecki, Sherman, Prenoveau, & Chan, 2016). Items are rated on a 4-point Likert scale (0 = Never; 3 = Nearly Always). The measure excludes items that assess recovery-protective behaviors and risks related to substance use. The measure has been validated with individuals diagnosed with dependence on a variety of substances (primarily alcohol and opiates) and has been shown to be sensitive to change (Heather, Raistrick, Tober, Godfrey & Parrott, 2001; Kelly, Magill, Slaymaker, & Kahler, 2010; Raistrick et al., 2014; Tober, Brearley, Kenyon, Raistrick, & Morley, 2000). An item-level examination of the LDQ in a large sample of patients in outpatient SUD treatment found that the LDQ to be most accurate and precise at the mid to lower range of psychological dependence in this patient group (Galecki et al., 2016). The LDQ is free to use.

TABLE 3.5.
MEASURES OF SYMPTOM CHANGE

NAME OF MEASURE	NUMBER OF ITEMS	WHERE TO OBTAIN IT?	FREE TO USE?	COMMENTS AND CONSIDERATIONS FOR USE
DEPRESSION				
Patient Health Questionnaire-9 (PHQ-9)	9	www.phqscreeners.com	Yes	The PHQ-9 is the most widely used measure for depression screening that is increasingly used for monitoring treatment response. Items directly map on to diagnostic symptoms. The measure's brief nature and simple response format make it easy to complete and use in repeated fashion, particularly for those who may have difficulty with somewhat longer measures. At the same time, its briefer nature relative to other measures offers somewhat less range than longer measures. In multi-disciplinary practice settings, it offers the advantage of being well-known to other providers.

NAME OF MEASURE	NUMBER OF ITEMS	WHERE TO OBTAIN IT?	FREE TO USE?	COMMENTS AND CONSIDERATIONS FOR USE
Clinically Useful Depression Outcome Scale (CUDOS)	18	www.outcometracker.org	Yes	A newer depression symptom severity measure, the CUDOS was specifically developed to serve as a tool for monitoring depression symptoms over time in routine clinical practice. The CUDOS is longer than the PHQ-9 and includes a broader Likert scale, which provides the benefit of greater breadth for tracking ongoing improvement. The measure is reported to generally take less than 3 minutes to complete, and initial data indicate high acceptability among a small group of patients. At the same time, its greater length may increase response burden for some patients. The CUDOS represents an intriguing option for therapists interested in a somewhat broader yet generally practical measure for tracking depression symptom change that is freely available and easily accessible.
Beck Depression Inventory-II (BDI-II)	21	www.pearsonclinical.com/psychology/products/100000776/beck-family-of-assessments.html#tab-details	No	The BDI-II is widely used in mental health treatment settings, and in the delivery of EBPs, specifically. BDI-II items and response choices are lengthier than other brief depression symptom measures. At the expense of some additional response burden, the measure is particularly sensitive to change and to detecting different levels of depression severity. Items also yield information that maps on well to and may provide clinical utility for CBT and other EBPs. Unlike the other depression symptom measures listed here, the BDI-II is only available for purchase, making it less accessible than other alternatives in some settings.
Geriatric Depression Scale-Short Form (GDS-SF)	15	web.stanford.edu/~yesavage/GDS.html	Yes	Developed specifically for assessing depression symptom severity in older adults, the GDS-SF includes a simplified (Yes/No) response format and excludes physical symptoms that may be associated with aging or physical health conditions and may overestimate depression severity. The dichotomous response choice format yields more restricted range. However, the GDS-SF is a good choice for more frail older adults, those with significant medical or physical health conditions, or for those who may have more difficulty with other item response formats (e.g., Likert scale).
ANXIETY				
Generalized Anxiety Disorder-7 (GAD-7)	7	www.phqscreeners.com/	Yes	The GAD-7 is a widely used measure of symptoms of generalized anxiety disorder (GAD) that is part of the same set of measures as the PHQ-9. In addition to GAD, the measure has been shown to have good sensitivity and specificity as a screener for other anxiety disorders. The measure has been shown to be highly sensitive to treatment gains and is often used for monitoring general anxiety symptoms that may co-occur with depression or other mental health conditions, in addition to response to treatment for GAD. The GAD-7 is brief and easy to administer on a repeated basis.

NAME OF MEASURE	NUMBER OF ITEMS	WHERE TO OBTAIN IT?	FREE TO USE?	COMMENTS AND CONSIDERATIONS FOR USE
Clinically Useful Anxiety Outcome Scale (CUXOS)	20	www.outcometracker.org	Yes	The CUXOS is a newer measure that was developed specifically for the purpose of ongoing monitoring of anxiety symptoms in routine treatment. Unlike the GAD-7, the CUXOS is a broad measure of anxiety symptoms that was not developed for assessing or diagnosing specific anxiety disorders. The CUXOS was specifically designed to be useful for monitoring symptoms of anxiety that may be comorbid with depression, as well as for individuals seeking treatment for an anxiety disorder. The CUXOS is significantly longer than the GAD-7 and other anxiety symptoms measures, offering a tradeoff of greater breadth and range versus brevity. The CUXOS may be a good choice with patients who have significant anxiety symptoms that are not limited to worrying and related symptoms associated with GAD that are the focus of the GAD-7 and for whom the length does not present a response burden. While research to date has indicated it to be a valid and reliable measure of anxiety that is sensitive to change, the CUXOS has been less extensively evaluated than other measures given its recent development.
Geriatric Anxiety Inventory (GAI)	20	www.gai.net.au	No	The GAI is a general measure of anxiety developed specifically for older adults. It includes few physical symptoms of anxiety to minimize potential overestimation of anxiety that may occur in the presence of significant somatic symptoms due to physical or medical issues in late life. The measure includes a simplified (Agree/Disagree) response format to ease response burden. Like the CUXOS, the GAI was not developed for assessing or diagnosing specific anxiety disorders. The GAI is being increasingly used in research and practice settings with older adults, and psychometric data to date have supported the validity and reliability of the measure, though there has been limited research examining the use of the GAI in ethnically diverse samples. The dichotomous response choice format yields more restricted range. However, the GAI may be a good choice for more frail older adults, those with significant medical or physical health conditions, or for those who may have more difficulty with other item response formats (e.g., Likert scale). Unlike the other anxiety symptom measures listed here, the GAI is only available for purchase and not yet widely available in health care systems, making it less accessible than other alternatives.
POSTTRAUMATIC STRESS DISORDER				
PTSD Checklist for DSM-5 (PCL-5)	20	www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp	Yes	The PCL-5 is a widely used measure of PTSD symptoms implemented throughout the VA health care system and other settings for PTSD screening, provisional PTSD diagnosis, and monitoring of symptom change during and in follow-up to treatment. The PCL-5 is incorporated for symptom monitoring into EBPs for PTSD, such as Prolonged Exposure and Cognitive Processing Therapy.

NAME OF MEASURE	NUMBER OF ITEMS	WHERE TO OBTAIN IT?	FREE TO USE?	COMMENTS AND CONSIDERATIONS FOR USE
INSOMNIA				
Insomnia Severity Index (IS)	7	www.myhealth.va.gov/mhv-portal-web/insomnia-severity-index1 Morin, C. M., & Espie, C. A. (2003). *Insomnia: A clinical guide to assessment and treatment.* New York, NY: Kluwer Academic/ Plenum.	Yes	The ISI is a widely used measure of insomnia severity that is brief and simple to complete. Its brief nature, strong psychometric properties, and sensitivity to treatment response render it a frequent self-report measure of choice in CBT-I and other insomnia treatments.
SUBSTANCE USE DISORDERS				
Brief Addiction Monitor (BAM), Brief Addiction Monitor-IOP (BAM-IOP), and Brief Addiction Monitor-Consumption (BAM-C)	17, 17, and 4, respectively	Both the BAM measure and free clinical resources developed by the Philadelphia CESATE to support use of the BAM may be accessed at: https://www.mentalhealth.va.gov/communityproviders/clinic_sud.asp (After clicking above link, click "Assessment" tab, then click "Screening for Addiction Problem Severity")	Yes	The BAM is a newer measure of alcohol and drug use and recovery developed specifically to support measurement-based care in specialty SUD treatment settings. The measure's wide use in the VA health care system render it increasingly familiar to Veterans seeking SUD care. The BAM assesses substance use during the past 30 days. The BAM-IOP, which contains the same items as the BAM, includes items that ask about the past 7 days. Focus is placed on interpretation of individual BAM and BAM-IOP item responses as opposed to use of aggregate scores. The length of the BAM and BAM-IOP, developed for the broader purpose of informing clinical decision-making and not solely outcome monitoring, may make it challenging for administering with some patients on a weekly session basis in outpatient psychotherapy. Although, the instrument is briefer than some other measures designed specifically to support measurement-based care. Limited psychometric data are reported beyond initial analyses conducted by the authors of the measure. The BAM-C, a 4-item version of the BAM that assesses only use of substances, offers feasibility for frequent administration; although, since it measures only consumption, it provides more limited information to inform treatment. For this reason, the BAM-C is intended more for use in non-SUD treatment settings where there is interest in monitoring substance consumption but where a substance use problem is not the focus of treatment (e.g., pain clinic, Hepatitis C Virus clinic). If used in a SUD treatment context, the measure may be paired with administration of a longer measure at less frequent intervals to provide information beyond consumption for informing treatment. A variety of applied clinical resources are available at no cost to support clinical implementation and interpretation of the BAM.

NAME OF MEASURE	NUMBER OF ITEMS	WHERE TO OBTAIN IT?	FREE TO USE?	COMMENTS AND CONSIDERATIONS FOR USE
Short Inventory of Problems-Revised (SIP-R)	17	www.mirecc.va.gov/visn19/treatmentworksforvets/docs/SIP_R.pdf	Yes	The SIP-R assesses negative consequences related to substance use, which are often associated with frequency and severity of substance use and have been shown to be sensitive to change over time. Items examine social, physical, interpersonal, intrapersonal, and impulse control functioning, which are often highly relevant to EBP. The measure may be used during initial assessment to aid in treatment planning as well as over time to monitor progress and revise the treatment plan as indicated. Unlike some other measures, the SIP-R does not include items that assess recovery-protective behaviors, which may help to inform treatment. Initial psychometric evaluation of the measure provided support for the use of the instrument within a large sample of patients seeking outpatient SUD treatment, building on past research on the SIP.
Alcohol and Drug Outcome Measure (ADOM)	20	www.tepou.co.nz/resources/alcohol-and-drug-outcome-measure-adom/458	Yes	The ADOM is a newer measure of alcohol and drug use that assesses the nature and frequency of substance use, lifestyle and well-being, and satisfaction with recovery. Developed specifically for regular monitoring of outcomes and for informing treatment in community practice settings, the ADOM includes a Feedback Wheel, on which clinicians can plot and visually present scores for providing and discussing feedback. The 20-item measure and clinician-administered format are generally more appropriate for administration on a periodic (e.g., monthly as opposed to weekly) basis; further, items related to frequency of use assess substance use during the past 4 weeks. When used to facilitate diagnosis, it is important to consider that the ADOM includes assessment of legal involvement and excludes assessment of craving (whereas the DSM-5 diagnostic criteria include craving and excludes legal problems). Unlike many other measures, the ADOM specifically assesses housing stability, which may provide information that is important for treatment and recovery. The ADOM is intended for use in outpatient SUD treatment settings, rather than residential or inpatient treatment settings. There is initial empirical support, primarily from New Zealand, for the measure's psychometric properties, sensitivity to change, and clinical utility. While a promising measure for facilitating measurement-based SUD care, use of the measure is still in an early stage, particularly with diverse patient populations.

NAME OF MEASURE	NUMBER OF ITEMS	WHERE TO OBTAIN IT?	FREE TO USE?	COMMENTS AND CONSIDERATIONS FOR USE
Leeds Dependence Questionnaire (LDQ)	10	www.emcdda.europa.eu/attachements.cfm/att_3954_EN_leeds.pdf	Yes	The LDQ is a brief measure of substance dependence developed specifically to assess symptoms of psychological, as opposed to, physiological dependence. In existence for more than 2 decades, the LDQ was designed to have utility as an outcome measure and has been shown to be sensitive to change during treatment. The measure's brevity offers feasibility for frequent administration. Like the SIP-R, the LDQ does not include items that assess recovery-protective behaviors, which may help to inform treatment. The measure also excludes items that assess for risks related to substance use, such as impairments in health, sleep, and mood, which may also help to guide treatment. Its brevity and sensitivity to change make the LDQ attractive for routine outcome monitoring, though it provides less information for use for measurement-based care than some other available measures.

3.2.1.2. MEASURES OF FUNCTIONING

The assessment of individual functioning provides information on the degree to which patients are able to fulfill necessary and desirable roles and tasks in their everyday lives.

The assessment of individual functioning provides information on the degree to which patients are able to fulfill necessary and desirable roles and tasks in their everyday lives.

Although information regarding specific symptoms and psychological domains represents primary areas of focus for monitoring and targeting throughout treatment, data with respect to patient functioning in one or more domains can provide valuable insight into patients' abilities that extends beyond the symptom level. This is especially the case when patients report low levels of functioning in one or more areas at the outset of treatment that may be related to psychological symptoms. Measures of functioning vary in the specific functional areas assessed though generally assess functioning in vocational, educational, relational, health, and/or recreational/leisure domains. Below is a description of several brief measures of functioning that may be administered at selected intervals of treatment to supplement data yielded by symptom severity measures.

Outcome Rating Scale (ORS): The ORS (Miller, Duncan, Brown, Sparks, & Claud, 2003) is a 4-item functioning measure designed for session-by-session administration developed in tandem with the Session Rating Scale, a brief measure of the therapeutic alliance (see Section 3.1.1.1.). The ORS was developed to serve as a brief alternative to the Outcome Questionnaire 45.2 (Lambert et al., 1996). The ORS assesses functioning in the following domains: (a) Overall (i.e., general sense of well-being), (b) Individually (i.e., personal well-being), (c) Interpersonally (i.e., family, close relationships), and (d) Socially (i.e., work, school friendships). Each item is rated using a 10-centimeter visual analogue scale. The ORS is scored by summing the marks made by the patient on the visual analogue scale to the nearest centimeter, with 40 being the highest possible score. Some research has supported the measure's sensitivity to change during treatment. The ORS is free for personal use.

Sheehan Disability Scale (SDS): The SDS (Sheehan, Harnett-Sheehan, & Raj, 1996) is a 5-item measure of functioning in which patients indicate the degree to which three domains of their life—work, social life or leisure, and home life or family—are affected by

psychological symptoms. The first three items, in which patients report level of disruption in each of these three areas, are rated on an 11-point Likert scale (0 = Not at All; 10 = Extremely) using a visual analogue scale. Scores in each life domain can be considered separately and aggregated into a total score, though there is no recommended cut score for the total score. A score of 5 or higher on any of the three domain questions is deemed to reflect significant functional impairment. Two additional items assess the number of lost and unproductive days that were associated with symptoms in the past week. The SDS is available for purchase.

World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0): The WHODAS 2.0 (World Health Organization, 2000), which replaces earlier versions of the measure, is a widely used measure of functioning and disability (available in self-report, interviewer-administered, and proxy versions) that is available in a short form composed of 12 items and a long form composed of 36 items. The WHODAS 2.0 measures functioning in six domains: (1) Cognition (understanding and communicating with the world); (2) Mobility (moving around); (3) Self-care (hygiene, dressing, eating, and staying alone; (4) Getting along (interacting with other people); (5) Life activities (domestic responsibilities, leisure, work, and school); (6) Participation (joining community activities). Each item describes a particular task or ability, and respondents rate their difficulty with the task in the past 30 days on a 5-point Likert scale (1 = None; 5 = Extreme or Cannot Do). Subscale and total score are calculated by averaging responses and transforming them to a standard scale. The WHODAS 2.0 and previous iterations of the measure have been psychometrically established in extensive research across many countries. Much of this research has been within the context of depression treatment during which the measure has been shown to be sensitive to change. The WHODAS 2.0 is free to use.

TABLE 3.6.
MEASURES OF FUNCTIONING

NAME OF MEASURE	NUMBER OF ITEMS	WHERE TO OBTAIN IT?	FREE TO USE?	DOMAINS ASSESSED
Outcome Rating Scale (ORS)	4	Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D. A. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*(2), 91–100.	Yes (for personal use)	Overall, individual, interpersonal, and social functioning
Sheehan Disability Scale (SDS)	5	www.davidvsheehan.com	No	Extent to which psychological symptoms disrupt work/school, social life, and family life/home responsibilities
World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)	12- and 36-item versions	www.who.int/classifications/icf/whodasii/en/	Yes	Cognition, mobility, self-care, getting along, life activities, and participation

3.2.1.3. MEASURES OF WELL-BEING AND QUALITY OF LIFE

In addition to their perceptions of their functional status, patient perceptions of their well-being and quality of life can provide useful information at selected points in treatment to supplement information related to specific symptoms in some instances.

In addition to their perceptions of their functional status, patient perceptions of their well-being and quality of life can provide useful information at selected points in treatment to supplement information related to specific symptoms in some instances. Well-being and quality of life are closely related constructs and are often referred to interchangeably in the literature. Well-being has been conceptualized in two ways: *hedonic* and *eudaimonic* (Cooke, Melchert, & Connor, 2016). The *hedonic* formulation emphasizes pleasure and happiness as underlying well-being. Measures that assess *hedonic* well-being assess life satisfaction and positive and negative affect. A number of these measures are ultra-brief, sometimes including a single item. The *eudaimonic* formulation, which has its roots in positive psychology, conceptualizes well-being in terms of achievement of one's individual potential and optimal functioning, though specific factors of measures in these areas vary. The most common factors assessed by such measures include mastery of one's environment, purpose or meaning in life, and positive relationships (Cooke et al., 2016). It is important to note a number of measures assessing well-being, particularly ultra-brief measures, have limited or no reported psychometric data.

Although there are many available definitions, quality of life is generally considered to be broader than well-being and incorporates aspects of both well-being and life satisfaction with respect to various aspects of life, including, but not limited to, physical, psychological, and social domains. Unsurprisingly, psychological and social domains often show greater change in psychological treatment. Below are descriptions of several brief and easily accessible well-being and quality of life measures that may be incorporated into treatment. For a detailed review of such measures, see Cooke et al. (2016).

Satisfaction with Life Scale (SWLS): The SWLS (Diener, Emmons, Larsen, & Griffin, 1985) is a well-established 5-item measure of *hedonic* well-being that provides a global assessment of life satisfaction. Unlike other broader measures of well-being, the SWLS includes a single factor (life satisfaction). Items are rated on a 7-point Likert scale (1 = Strongly Disagree; 7 = Strongly Agree). Individual items are summed to create a total score. Cut points are provided to facilitate interpretation. Further, normative data are available (Pavot & Diener, 2009). Examples of items include "I am satisfied with my life," "So far I have gotten the important things I want in life," and "If I could live my life over, I would change almost nothing." The SWLS has been shown to detect change in life satisfaction over the course of treatment. The SWLS is free to use.

Flourishing Scale (FS): The FS (Diener et al., 2010) is a newer measure of well-being, consistent with the *eudaimonic* conceptualization of well-being, that assesses self-perceived success in key aspects of life, including relationships, self-esteem, purpose, and optimism. The FS includes 8 items that are rated on a 7-point Likert scale (1 = Strongly Disagree; 7 = Strongly Agree). Examples of items include, "I lead a purposeful and meaningful life," "My social relationships are supportive and rewarding," and "I am engaged and interested in daily activities." Individual item scores are summed to create a total score, though responses to individual items may be used to ascertain and discuss patients' perceptions of their well-being in specific areas. Scoring instructions provide that "A high score represents a person with many psychological resources and strengths". The FS is free to use.

Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form (Q-LES-Q-S): The Q-LES-Q-S (Endicott, Nee, Harrison, & Blumenthal, 1993) is a 16-item measure in which respondents rate the degree of enjoyment or satisfaction in 14 different life domains

(e.g., social relationships, housing situation, physical health), as well as satisfaction with medication they are taking and an overall life satisfaction and contentment rating. Items are rated on a 5-point Likert scale (1 = Very Poor; 5 = Very Good). Items 1–14 can be summed to obtain a total score, and item 16 can be used as a single-item measure of overall life satisfaction. Psychometric data are available and provide support for the full 60-item version, though limited specific data have been documented for the abbreviated version. Data on the measure have indicated it to be sensitive to change during treatment. The Q-LES-Q-S is free to use.

World Health Organization Quality of Life-Brief Version (WHOQOL-BREF): The WHOQOL-BREF (Skevington, Lofty, & O'Connell, 2004) is a 26-item measure that assesses quality of life in four domains: (a) physical, (b) psychological, (c) social relationships, and (d) environment. Each item is associated with a set of anchors rated on a 5-point Likert scale (1 = Very Dissatisfied; 5 = Very Satisfied). Appropriate items are reverse scored, and ratings on each item are summed to obtain a score in each of the four domains. Raw scores are transformed into a scale between 0 and 100. The WHOQOL-BREF has been subject to extensive psychometric evaluation. The WHOQOL-BREF is free to use.

TABLE 3.7.
MEASURES OF WELL-BEING AND QUALITY OF LIFE

NAME OF MEASURE	NUMBER OF ITEMS	WHERE TO OBTAIN IT?	FREE TO USE?	DOMAINS ASSESSED
Satisfaction with Life Scale (SWLS)	5	internal.psychology.illinois.edu/~ediener/SWLS.html	Yes	Global life satisfaction
Flourishing Scale (FS)	8	internal.psychology.illinois.edu/~ediener/FS.html	Yes	Success in key aspects of life, including relationships, self-esteem, purpose, and optimism
Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form (Q-LES-Q-S)	16	www.outcometracker.org/library/Q-LES-Q-SF.pdf	Yes	Enjoyment and satisfaction in 14 life domains, as well as overall satisfaction and contentment
World Health Organization Quality of Life-Brief Version (WHOQOL-BREF)	26	depts.washington.edu/seaqol/WHOQOL-BREF	Yes	Satisfaction in four domains: 1. Physical 2. Psychological 3. Social Relationships 4. Environment

Conclusion

This toolkit was developed to advance significant opportunities for promoting the reach and impact of EBPs with Veterans. Despite unprecedented developments to make EBPs more widely available to Veterans throughout the nation and the accumulation of data from real-world treatment settings demonstrating the effectiveness of these therapies with Veterans, many Veterans who can benefit from these treatments fail to receive them, yielding many unfortunate missed opportunities. In this toolkit, we have introduced specific clinical processes and procedures for promoting initial and ongoing engagement of Veterans in treatment that offer significant opportunities for addressing knowledge, attitude, and other patient factors that have limited the uptake and delivery of EBPs.

Building on significant developments in SDM research and practice, we have presented a structured yet flexible process for empowering and engaging Veterans in the treatment decision-making process. **Incorporating core elements and components of SDM, the SDM Session is a dynamic process for promoting informed choice, motivation, and agency within a highly supportive interpersonal context that accounts for key psychological variables and individual preferences that impact treatment decision-making.**

The six steps of the SDM Session—*Connect*, *Motivate*, *Educate*, *Explore*, *Set Goals*, and *Choose*—set the Veteran and provider on a collaborative and inductive journey whereby earlier steps of the process help to inform and facilitate the discussion of later steps. When the provider *connects* with the patient, she creates an interpersonal climate of support and trust that serves as a foundation for and facilitates other SDM Session components. When the provider *motivates* the patient for treatment, she helps the Veteran recognize reasons for changing, consequences of not treating their mental health problem, and life beyond their mental health condition. When the provider e*ducates* the patient about potential treatments, she works to promote informed choice by describing the focus of specific treatments and the treatment process, potential benefits and harms, and effectiveness of treatments. When the provider *explores* the patient's values and preferences, she identifies what is truly important to the Veteran. When the provider works with the Veteran to *set goals* that may be the focus and product of treatment, she helps to concretize and individualize the potential benefits of treatment for further increasing motivation and guiding the final treatment decision. Empowered with information about treatments and choice, considered through the lens of personal values, preferences, and goals, the patient and provider *choose* a treatment or next step, together arriving at a decision for positive

The six steps of the SDM Session—*Connect*, *Motivate*, *Educate*, *Explore*, *Set Goals*, and *Choose*—set the Veteran and provider on a collaborative and inductive journey whereby earlier steps of the process help to inform and facilitate the discussion of later steps.

Incorporating specific focus on the therapeutic alliance and measurement-based care allows for better individualizing treatment and incorporating the patient's experience and feedback in the treatment process, benefits consistent with the goals and tenets of both shared decision-making and evidence-based psychotherapy.

change. Similar to the delivery of EBPs, the discussion throughout the SDM Session is designed to proceed naturally and fluidly, with the provider simultaneously assuming a curious yet guiding role.

In addition to providing a systematic process for promoting initial engagement in treatment, we have identified and described specific clinical processes and strategies for increasing *ongoing* engagement in treatment. This first of these processes involves ongoing assessment and enhancement of the therapeutic alliance. Although often misunderstood and mischaracterized within the context of EBPs, the therapeutic alliance is a critical component to the delivery of EBPs that requires important—and sometimes greater or exclusive—attention. **Ongoing assessment of the therapeutic alliance in treatment, through the use of one of a number of brief and feasible measures described herein, provides an explicit process for understanding, monitoring, and discussing the Veteran's views of treatment and the treatment process, including the goals and strategies of treatment and the connection with the therapist.** This information, in turn, is used to help inform the relative focus placed on specific treatment strategies vs. the therapeutic relationship or other refinements to the treatment process. Specific alliance-promoting actions and competencies are identified in this toolkit to assist therapists in enhancing the therapeutic alliance throughout treatment.

The second process introduced in the toolkit for promoting ongoing engagement in treatment involves the integration of principles and strategies of measurement-based care. In this process, the therapist integrates brief outcome measures to track the patient's status and response to treatment over the treatment course. This provides the therapist and patient with real-time insight that may be used to guide treatment and make mid-course adjustments.

Significantly, incorporating specific focus on the therapeutic alliance and measurement-based care allows for better individualizing treatment and incorporating the patient's experience and feedback in the treatment process, benefits consistent with the goals and tenets of both shared decision-making and evidence-based psychotherapy. Together, these clinical processes represent important and largely untapped opportunities for increasing patient engagement and adherence and, in turn, maximizing the experience and outcomes of treatment.

Although specifically intended and well-suited for EBPs, the clinical processes and strategies for promoting initial and ongoing treatment engagement described in this toolkit offer potential utility for promoting engagement of Veterans in other types of mental health services. Accordingly, this toolkit may serve as a resource for bringing SDM, the systematic focus on the therapeutic alliance, and the integration of measurement based-care more directly and broadly into the practice and provision of mental health care.

It is our sincere hope that this toolkit provides useful ideas, strategies, and tools to clinicians, program administrators, and clinical leaders dedicated to providing the best care possible to Veterans. By promoting initial and ongoing engagement in individualized and effective treatment, we have a significant opportunity to improve the reach, impact, and experience of mental health care among Veterans.

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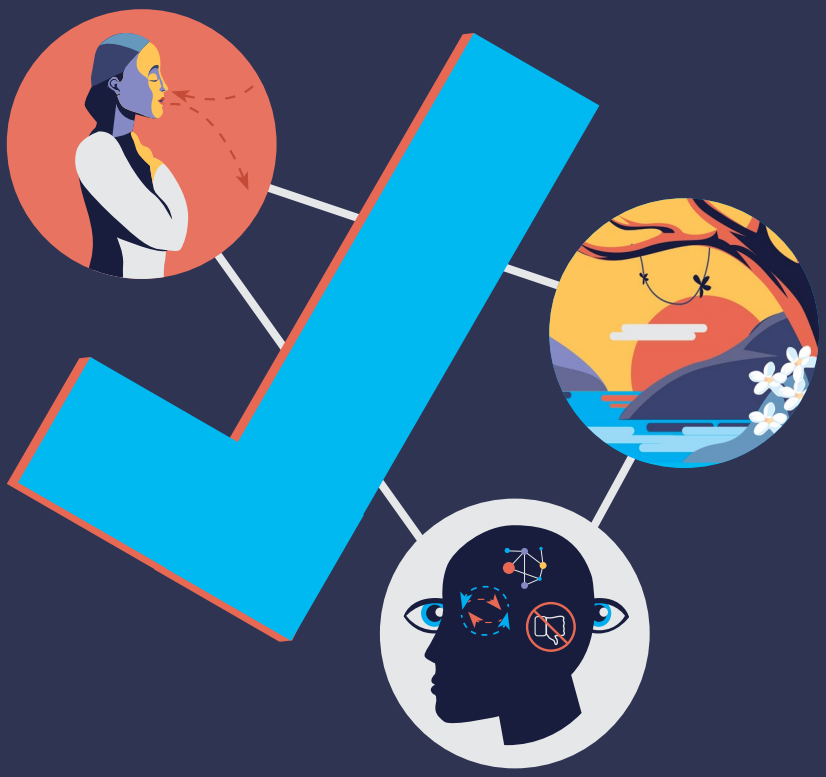
APPENDIX A1

Preparatory Skills Building to Increase Treatment Readiness



PREPARATORY SKILLS BUILDING TO INCREASE TREATMENT READINESS

Research indicates that Veterans are more likely to choose an EBP after having an opportunity to learn about them and their potential utility

In Section 2 of this toolkit, we have presented a structured yet flexible process of shared decision-making (SDM), beginning prior to the initiation of mental health treatment, for promoting informed choice and agency among Veterans in the treatment decision-making process. By empowering Veterans with information about specific treatments and their potential utility and fit with their personal goals, values, and preferences during the SDM Session, this process is intended to promote Veterans' initial and ongoing engagement in evidence-based psychotherapies (EBPs). In most instances, Veterans will reach the final step of the SDM Session presented in this toolkit choosing to initiate a specific EBP. Indeed, research indicates that Veterans are more likely to choose an EBP after having an opportunity to learn about them and their potential utility (DeViva, Bassett, Santoro, & Fenton et al., 2016; Mott et al., 2014; Schumm, Walter, Bartone, & Chard, 2015; Watts et al., 2015). In some cases, however, Veterans may express ambivalence or not appear ready to participate in an EBP (or other mental health treatment). **This lack of treatment readiness may be due to limited understanding of treatments, negative treatment attitudes or beliefs, or logistical or practical barriers (e.g., time or physical access challenges).** As noted in the discussion of the final step of the SDM Session (see Section 2.1.6) and summarized in Table 2.10, such knowledge, attitudinal, and logistical challenges may benefit from additional discussion and problem solving in one or more SDM Sessions.

Veterans who report or demonstrate limited readiness to initiate or fully engage in EBPs due to psychological skill deficits may benefit from learning core coping skills prior to initiating or choosing to initiate an EBP.

For other Veterans, low treatment readiness may be related to having limited foundational coping skills or experiencing a number of simultaneous and overwhelming stressors and challenges that make it difficult for them to fully attend to and engage in the treatment process. In fact, research suggests that the quality of affect management skills may be among the most important factors affecting Veterans' readiness for EBPs for PTSD (Cook, Simiola, Hamblen, Bernardy, & Schnurr, 2016). Furthermore, increasing research reveals that responding to negative mood states in maladaptive ways, such as through emotion suppression and avoidance, can inhibit recovery (Berking et al., 2013; Ehring, Tuschen-Caffier, Schnuelle, Fischer, & Gross, 2010; Morrow & Nolen-Hoeksema, 1990). Consequently, Veterans who report or demonstrate limited readiness to initiate or fully engage in EBPs due to psychological skill deficits may benefit from learning core coping skills prior to initiating or choosing to initiate an EBP. Beyond promoting skills for coping with difficult internal or external experiences in the patient's life, increasing coping capacity may also increase confidence in the treatment process and personal agency and potential for change. Accordingly, this section presents an optional set of strategies and resources for building coping skills for patients whose engagement in treatment may be compromised due to limited coping capacity. **In addition to the direct benefit of increasing coping skills, the process of preparatory skills building (PSB) can enhance self-efficacy to**

manage negative emotions and provide a flavor of EBP treatment that may increase interest in and motivation for treatment.

As noted in the toolkit, it is important that PSB (and other preparatory work), when indicated, not be implemented or perceived by patients or staff as an additional administrative process or step that delays treatment, but rather as an integral front-end investment in the treatment process designed to increase treatment engagement, retention, and outcomes. **Indeed, the focus of skill building and related preparatory work with Veterans prior to the initiation of treatment is complementary with and may help to promote early progress in EBPs.** At the same time, PSB (and other preparatory work, when indicated) should be considered as a potential outcome of the SDM Session for specific patients who may have difficulty engaging in treatment if basic psychological skill needs (or other treatment barriers) are not addressed. Below, we describe specific considerations and strategies to facilitate the identification of such patients by providers.

Table A1.1 provides a list of indicators that suggest PSB may be warranted. If a Veteran reports or demonstrates one or more of these indicators, the provider of the SDM Session may explore this possibility further with more specific questioning related to specific behaviors and circumstances.

TABLE A1.1
INDICATORS OF POTENTIAL APPROPRIATENESS OF PREPARATORY SKILLS BUILDING

			
Veteran reports or demonstrates having limited adaptive coping skills in the midst of significant, uncontrolled stress.	Veteran appears distracted or overwhelmed by life stressors, suggesting possible difficulty engaging or focusing in treatment.	Veteran demonstrates a high level of negative affect that takes the form of anger, hostility, agitation, extreme anxiety, or severe irritability or dysphoria that impacts functioning and interpersonal engagement.	Veteran refuses EBP (or other treatment) despite meeting criteria for a mental or behavioral health condition, and disinterest does not appear to be due to knowledge, attitudinal, or practical or logistical barriers.

In some cases, it may be readily apparent from discussion with the patient, reports of others, or clinical documentation that a Veteran has limited coping skills or frequently engages in maladaptive behaviors to deal with stress. In other situations, it may be difficult to determine a patient's repertoire of coping strategies from discussion with the patient or informants or other available information. **For Veterans for whom additional information related to coping strategies used by the Veteran may be useful for informing whether PSB prior to the initiation of treatment may be indicated, providers may consider administering a structured measure of coping strategies and/or of treatment readiness (the latter of which generally assesses treatment readiness factors beyond psychological skill needs** [see Section 2.1.6.]**).** One brief measure of coping skills developed for clinical use and widely available is the Brief COPE (Carver, 1997), an abbreviated version of the original COPE instrument (Carver, Scheier, &

Weintraub, 1989). The Brief COPE is a widely used and well-validated measure that assesses the frequency with which individuals use a range of adaptive and maladaptive coping strategies. The instrument includes 28 items, each representing a specific coping strategy, rated on a 4-point Likert scale (1 = "I haven't been doing this at all"; 4 = "I've been doing this a lot"). The Brief COPE is free to use and may be accessed at: www.psy.miami.edu/faculty/ccarver/sclBrCOPE.html.

Another measure of coping skills that may be useful in informing whether PSB may be indicated for promoting treatment readiness is the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004). The DERS is a well-validated, 36-item measure of the extent to which the respondent has difficulty regulating their emotion. The measure includes six subscales that allow for assessing the degree to which the respondents use certain types of coping skills. More recently, two abbreviated 18-item versions of the DERS—the DERS Short Form (DERS-SF; Kaufman, Xia, Fosco, Yaptangco, Skidmore, & Crowell, 2015) and the DERS-18 (Victor & Klonsky, 2016)—have been developed and offer greater feasibility for use in non-research (clinical) contexts. The two measures, developed at approximately the same time, differ only slightly. Initial psychometric evaluations conducted by the respective developers of the abbreviated measures found the instruments to perform similarly to the original version of the measure (Kaufman et al., 2015; Victor & Klonsky, 2016). Both measures are free to use. The DERS-SF may be accessed at: www.researchgate.net/publication/286385930_DERS-SF_scoring_and_measure. The DERS-18 may be accessed at: www2.psych.ubc.ca/~klonsky/publications/DERS18_measure.pdf.

When there is information to suggest that the Veteran is unlikely to engage in treatment due to limited adaptive coping skills, the provider may present the option of learning skills to improve the Veteran's ability to cope, which, in turn, may help to improve the experience and impact of treatment. It is important to note that the presence of few adaptive coping skills, on their own, is generally not an indication that the Veteran requires PSB. Indeed, many patients present for treatment with few coping strategies. **Rather, PSB is most appropriate in the presence of very limited adaptive coping capacity combined with a high degree of stress or significantly impaired attentional, affective, or interpersonal functioning likely to inhibit engagement in treatment.**

When the provider suspects a patient may benefit from PSB sessions prior to the initiation of treatment, they might explore this with the Veteran by stating something like, "I can see that things are very difficult for you right now and that you might not feel ready to fully participate in treatment or make a decision about treatment. I do have one additional option for you, which I think has the potential to be a good match for your needs right now. Would you like to hear about it?" The provider may then state, "Some Veterans find that they benefit from learning effective skills for coping with stress and difficult circumstances in their lives as they prepare to engage in treatment. This is something that can generally be taught in just a few sessions and can improve the experience and impact of treatment."

When initially introducing PSB to the Veteran, it is important to introduce the purpose of PSB as an opportunity to prepare the Veteran to get the most out of treatment. Providers are encouraged to also describe the ways in which other Veterans with similar clinical presentations benefited from an initial focus on promoting treatment readiness. The provider should document the offering of the PSB and patient's response in the SDM Session progress note.

Bobby, the patient we have followed throughout the SDM Session, was ready to commit to an EBP after participating in two SDM Sessions and reviewing information with his wife

in between the sessions. However, it is not difficult to imagine that he could have been less ready to commit to and engage in treatment had he been exhibiting more acute emotional distress if, for example, his wife had initiated a separation and demanded that he leave the house. In this scenario, the exchange with Dr. Tammy might have looked very different, and he very well might have benefited from PSB to acquire skills to manage emotional distress before deciding upon and committing to a specific course of treatment. Consider the following dialogue in this scenario, occurring after Dr. Tammy provided and discussed with Bobby the Treatment Options for Depression Grid and began to ask Bobby about his values and preferences.

EXCERPT
DR. TAMMY & BOBBY

BOBBY: *[giving Dr. Tammy a blank stare]* I'm sorry, I just can't think about this right now.

DR. TAMMY: *[conveying a sense of empathy and gentleness]* You have a lot on your mind right now. It's understandable that all of this is overwhelming, especially when other areas of your life feel overwhelming.

BOBBY: *[looking down]* Yeah. I just really don't know what I'm gonna do. *[beginning to escalate]* I mean, how could she do that to me? I just retired, I'm trying to get my life on track, and she drops this bombshell. How am I supposed to get back on my feet with no income and no place to live? I'm just, I'm just dealing with so much, I don't even know where to start!

DR. TAMMY: Perhaps we should table discussion about these different treatments until things have settled down and you can really think about the different options?

BOBBY: Yeah, that would be best, I'm just getting confused by them.

DR. TAMMY: *[reasoning that Bobby clearly needs intervention for his depression even if he is not in a place to choose a specific treatment]* I have an idea of a way to help you to feel less overwhelmed so that you can be in a better position to tackle these problems that you face. Would you be up for hearing my idea?

BOBBY: *[looking dejected]* It's worth a shot, I guess.

DR. TAMMY: I wonder if you would be willing to learn some effective skills for managing the stress and confusion you are experiencing. These tools you could learn in just a few sessions. This can also give you a sense of what treatment might look like and give you a head start if you choose to begin one of the treatments we started to talk about.

BOBBY: You're saying there's something you can teach me in a few weeks that would help me handle things better?

DR. TAMMY: Yes, they're tools that can help you feel more in control over how you feel and more prepared to face problems in your life. They would likely also be helpful in treatment that would follow.

BOBBY: What kinda tools?

DR. TAMMY: They are specific relaxation skills, like meditative breathing and muscle relaxation exercises, that research has shown to be effective. Many Veterans I've worked with have found them to be quite useful. See, they help to calm the mind and body when you become upset. When used regularly, they also work to lower one's day-to-day "emotional temperature" so you generally feel more clear-headed and centered.

BOBBY: *[looking skeptical]* I'm not sure I'll *ever* be able to calm down with all that is going on.

DR. TAMMY: *[providing validation]* You *do* have a lot on your plate, Bobby. That's why I'm wondering if it would benefit you to participate in something that will arm you with some tools that will help you get through this difficult time.

BOBBY: Maybe I should do that. Because I don't feel like I have any tools at all. I'm having trouble keeping my head above water here and don't think I'd be ready to commit to months of treatment at the moment.

DR. TAMMY: *[demonstrating care and concern, along with confidence that preparatory skills will allow him to more fully embrace treatment]* My hope is that when you gain some benefit from the tools we have to teach you, you'll have just a little taste of what can be done in the talk therapies we discussed. Then, you'll likely be in a better position to select treatment.

BOBBY: Yeah, I get it. Kind of like baby steps.

DR. TAMMY: Yes, exactly.

In this dialogue, Dr. Tammy recognized from both verbal and nonverbal indicators that Bobby was feeling very overwhelmed and confused due to current life stressors. His difficulty focusing, uncertainty, and heightened stress suggested to Dr. Tammy that Bobby may not be ready to initiate or fully engage in extended treatment, something confirmed by Bobby when he said he was not sure about committing to treatment. Dr. Tammy, therefore, suggested the option of PSB and how this may be useful to Bobby at the present time for quickly gaining control over how he feels and making him feel more prepared to commit to and get more out of treatment. Throughout this discussion, she expressed empathy and validation, and asked for permission to share options and suggestions without imposing them on him. Earlier in the session, Dr. Tammy assessed for safety, which revealed that Bobby was not an imminent risk to himself or others. In addition, Dr. Tammy offered Bobby the option of psychotropic medication evaluation while pursuing PSB, which Bobby said he would consider.

A1.1. IMPLEMENTING PREPARATORY SKILLS BUILDING

A1.1.1. THE PSB PROCESS

The implementation of PSB is designed to be tailored to the specific needs, baseline coping skills and abilities, and preference of the Veteran.

The implementation of PSB is designed to be tailored to the specific needs, baseline coping skills and abilities, and preference of the Veteran. The flexibility incorporated into the PSB process described herein is designed to account for the fact that not all Veterans have the same needs or respond in the same way, and at the same rate, to specific coping strategies. **PSB is generally intended to be brief—typically, a few PSB sessions is sufficient for patients to acquire tangible skills to reduce, to some degree, their level of psychological distress and increase self-efficacy to manage stress that puts them in a position to be more prepared and confident to participate in treatment.** At the outset of and throughout the PSB process, it is important that the Veteran recognize that the goal of PSB is to increase their ability to manage how they feel and put them in a position where they feel more ready and confident to fully participate in treatment.

In general, it is recommended that providers focus on no more than one or two skills in a single session. Many patients become confused and overwhelmed trying to learn and practice multiple skills simultaneously. **Moreover, as described in more detail below, the focus of the PSB session is on more than merely teaching a skill but also involves providing and ensuring the patient understands the purpose and rationale for using the skill.** In addition, time is spent discussing the personal application of the skill and identifying and problem solving any potential barriers to using the skill to maximize the likelihood that the Veteran will use the skill when needed. When several skills are covered in a single session, the focus becomes more on teaching and less on personalizing the application of the skill and considering what it will be like to use the skill in the Veteran's

daily life. Further, covering too much in a single session can often result in the patient not fully understanding the rationale for each skill and not having enough time for practice in session. The mantra "less is more" is very relevant to effective teaching and learning of preparatory coping skills, particularly when *less* allows for *more* concentrated focus on individualizing and promoting the utility, application, and use of specific skills.

Table A1.2 presents the steps for implementing PSB sessions. **As the steps in Table A1.2 reveal, the PSB session involves more than just psychoeducation or skills training. Rather, the session consists of a collaborative and individualized process for identifying, teaching, and examining the personalized application of coping skills within the context of a warm and supportive interpersonal environment.** Following from the SDM Session, important focus is placed on interpersonal connection at the outset of and throughout the session. This is important for further establishing trust, engagement, and maximal learning.

TABLE A1.2
STEPS FOR IMPLEMENTING PREPARATORY SKILLS BUILDING SESSIONS

1 WELCOME VETERAN

- Warmly and genuinely greet and welcome the Veteran.
- Consider introducing yourself using both your first and last name and briefly describe position within treatment facility (if provider was not the provider of SDM Session).
  - Consider sharing something else about yourself or make an informal comment to break the ice.
- Ask whether there is anything you can do to make the patient more comfortable.
- Check in with the patient on how they are doing.
  - Use active listening and related skills (e.g., expressed empathy, warmth, genuineness) to help to create an environment in which the patient feels heard, accepted, and understood.

2 BRIDGE FROM SDM SESSION

- Demonstrate understanding of and continuity from SDM Session.

3 DISCUSS PURPOSE OF VISIT

- Inquire about patient's understanding of the purpose of the current visit.
- Summarize purpose and rationale of PSB.
- Invite questions and confirm agreement.

4 IDENTIFY COPING SKILL TO FOCUS ON IN SESSION AND PROVIDE RATIONALE

5 TEACH AND PRACTICE SKILL IN SESSION

(refer to *Provider Tip Sheets*)

6 ELICIT AND PROVIDE FEEDBACK

- Request feedback on process and experience.
- Review change in pre-post SUDS ratings (if applicable).
- Provide positive and constructive feedback on patient's learning of the skill.

7 IDENTIFY HOW AND WHEN TO USE SKILL AND DEVELOP PRACTICE PLAN

(refer to *Practice Plan Summary Form*)

- Identify specifics of how and when skill can be used.
- Develop Practice Plan for practicing skill outside of session.
- Ensure understanding of Practice Plan, problem solve potential barriers, and assess likelihood of follow-through.

8 ELICIT FINAL SUMMARY AND SESSION FEEDBACK

9 DISCUSS NEXT STEPS

At the start of the PSB session, intentional focus is placed on warmly welcoming the Veteran and making the Veteran feel comfortable, similar to the outset of the SDM Session. If the provider of the PSB session is someone other than the provider of the SDM Session, the beginning of the session will involve specific focus on initial introduction and establishing rapport. During this early part of the session, the provider briefly checks in on how the patient has been feeling since the SDM Session, demonstrating interest, empathy, and support, similar to what occurs during the *Connect* step of the SDM Session. The provider may request a simple mood check rating to help quantify the patient's current level of emotional distress. This may be done by asking, for example, "On a scale of 0 to 10, with 0 being no distress and 10 being the most distress you can imagine, how would you rate your current level of distress?"

After welcoming the Veteran, the next step is to bridge the SDM Session and current session, demonstrating understanding of and continuity from the SDM Session. The bridge from the previous session is simply a summary of key points from the previous session that help set the stage for the current session. The provider may begin this discussion by eliciting a bridge from the patient, such as by asking, "What do you recall about the last session?" or "What stood out for you about the last session?" The provider should then provide their own summary, acknowledging the patient's experience in and contribution to the SDM Session. This should include a brief summary of the patient's reasons for initially seeking treatment and the decision to schedule the PSB session. As mentioned in the toolkit, it is recommended that, in instances where the provider of the PSB session was not the provider of the SDM Session, the provider of the PSB session review the note of the SDM Session prior to the PSB session.

For PSB sessions following the initial PSB session, the bridge will consist of a summary of the last PSB session. In this instance, it is recommended that the provider request the bridge from the patient to learn what they recall from the previous session and what was helpful or not helpful about the session. To do this, the provider may ask one of the following questions:

1. What do you recall from the last session?
2. What stood out for you about the last session?
3. What was helpful to you about the last session?

Next, prior to embarking on the work of building coping skills, it is important to ensure that the Veteran has an accurate understanding of the focus and goals of the PSB process. To do this, the provider should first ask the patient about their understanding of the current session, by inquiring "What is your understanding of the purpose of the current session?" or "What is your understanding of what we'll be doing now?" The provider then provides a summary of the purpose and rationale of the PSB session. After doing so, the provider should check in with the patient to see if they have any questions and to confirm their continued agreement with this plan.

After ensuring understanding of and commitment to the purpose of the PSB process, the provider works to identify the coping skill (discussed in further detail in the next section) to focus on in the current session. The identification of the skill to focus on should be determined primarily by the provider, though it is strongly recommended that the provider obtain the Veteran's input and agreement on the chosen skill. In some cases, the provider may wish to present the Veteran with a couple of options from which to choose, after briefly describing each. The selection of specific skills should be based on several

The selection of specific skills should be based on several factors, including, but not limited to, the patient's existing coping skills and abilities, complexity of the skill, patient preference, and other personal factors, such as nature of the Veteran's current distress or impaired attentional, affective, or interpersonal functioning and current maladaptive coping tendencies

factors, including, but not limited to, the patient's existing coping skills and abilities, complexity of the skill, patient preference, and other personal factors, such as nature of the Veteran's current distress or impaired attentional, affective, or interpersonal functioning and current maladaptive coping tendencies. In general, however, we recommend beginning with at least one to two more basic, fundamental skills at the bottom of the hierarchy presented below (e.g., Basic Relaxation Skills), as these are among the easiest coping skills to learn and provide an opportunity for fairly quickly increasing mastery and self-efficacy. By reducing physiological arousal, these skills may also facilitate the implementation of higher-order skills in the hierarchy.

When describing each of these skills to patients, the provider should be sure to give the patient the rationale for its use and discuss how it may be helpful to the patient. We also encourage providers to speak to the effectiveness of the skill and how it has been helpful to other Veterans, when possible. The provider may also note that the Veteran is likely to find that certain tools work better for them and their personal situation than others.

The next step of the session involves teaching the selected skill to the Veteran and providing an opportunity to practice in session. Prior to implementing the specific steps of each skill, the provider gives an overview of the exercise and what to expect. Immediately before walking the Veteran through the specific steps of the skill, the provider introduces the ***Relaxation Skills Practice Log*** (see Appendix A3), which is used for recording and tracking the level of stress or discomfort prior to and after each use of Basic Relaxation Skills (and may also be used with Guided Imagery), described below, as well as for recording any comments regarding the experience of using these skills (e.g., how it was helpful, when it was used, challenges to using skill, etc.). Using the *Relaxation Skills Practice Log,* the provider next elicits a current subjective units of distress scale (SUDS) rating of 0–10 from the Veteran, where 0 = No stress or discomfort/totally relaxed, and 10 = Highest possible stress or discomfort. This number should be entered on the *Relaxation Skills Practice Log* under the column labeled "Rating Before (0–10)." **To set realistic expectations and encourage ongoing practice, we typically begin the teaching of specific skills by noting it takes some time and practice to truly grasp the skill and that the benefit derived from the skill typically increases as patients become more adept at using the skill.** Next, the provider reviews each of the specific steps of the skill and demonstrates specific components, as appropriate. ***Provider Tip Sheets*** to guide the teaching of preparatory skills and incorporating scripts for teaching preparatory skills are included in Appendix A2. We recommend that providers become familiar with each skill before teaching them to patients. As the Veteran implements each step, the provider should closely observe the Veteran to ascertain how well they seem to implement each step. The provider should repeat specific steps or the overall exercise, as necessary. At the conclusion of selected exercises (i.e., those designed to promote relaxation), the provider elicits a current SUDS rating of 0–10. This number is then entered on the *Relaxation Skills Practice Log* under the column labeled "Rating After (0–10)."

Following the teaching and practicing of the skill, the provider elicits feedback from the patient on their experience of learning and implementing the skill for the first time. This includes initially inquiring about how well the patient was able to implement the steps, expressing interest in both successes and challenges in doing so. If the patient responds with a general response, such as "It was okay" or "It was good," the provider should follow up with a prompt, such as "Which parts did you find you were able to do?" and "Were there any parts you found more challenging?" Then, the provider inquires if the patient found the skill to be helpful and, if so, in what way. For selected skills, the provider

then refers the patient to the *Relaxation Skills Practice Log* to review the change, if any, in the patient's SUDS rating following the exercise relative to the SUDS rating immediately before the exercise. If the patient reports that they had difficulty learning the skill or did not find it to be helpful, the provider may offer reassurance, reminding the patient that, like with any skill, it becomes easier and more effective with practice. The provider may also note to the Veteran that they will have an opportunity to practice the skill again in session, if appropriate.

After reviewing the Veteran's feedback, the provider then offers positive and constructive feedback on the patient's learning of the skill. When providing feedback, it is important to identify at least one or two items for positive feedback for providing reinforcement, based on the provider's observation and careful listening to the patient's description of their experience, even if the Veteran had difficulty with the overall skill. This may relate to specific elements of the skill or the patient's efforts to learn the skill. **We recommend providing positive feedback before providing constructive feedback.** When providing constructive feedback, identify specific suggestions to help patients more successfully learn and implement the skill (e.g., keep eyes closed during Meditative Breathing, acknowledge intruding thoughts that enter and redirect thinking back to the sound, temperature, and movement of one's breath). The provider should normalize challenges the patient experienced when initially attempting to learn the skill. Specific difficulties or challenges the patient experiences that the provider is aware of during the exercise may also be addressed during the exercise so the patient has an opportunity to correct this while implementing the exercise. When patients have significant difficulty in their initial attempt to learn the skill, providers may consider practicing parts of the skill or the overall skill again in session if time permits (and during the next session).

After eliciting and providing feedback on the process and experience of initially learning the skill, the provider and the patient collaboratively work to identify how and when the skill might be useful in the Veteran's life to facilitate individualized application and maximize utility of the skill for the Veteran.

Once the provider and patient have identified how and when the skill may be most useful to the Veteran, the next step involves the development of a Practice Plan for practicing the skill following the session. **The Practice Plan should be specific and achievable to promote the likelihood that the Veteran will complete the Plan.** The Practice Plan should include the name of the skill, a brief summary of how the skill can be helpful to the Veteran, when the skill will be practiced, and where this will occur. We find that including this specificity and having the patient write this down increases the likelihood of follow-through. A ***Practice Plan Summary Form***, which may be provided to the patient to record the details of the agreed-upon Practice Plan, is provided in Appendix A3. Before finalizing the Plan, it is important that the provider ensure the patient fully understands the Plan, the rationale for practicing the skill, and the steps for implementing the skill. To assess the patient's understanding, we recommend that the provider request that the patient provide a verbal summary of the

plan, the rationale for practicing the skill, and the steps for implementing the skill. Once the patient has demonstrated understanding of the skill, the provider should assess and problem solve any potential obstacles that may get in the way of the patient following through with the Practice Plan. **Once any notable obstacles have been identified and the likely impact reduced or eliminated, the provider should assess the likelihood that the Veteran will implement the Practice Plan.** This may be done by requesting a rating from 0% to 100% of how likely the Veteran believes it is they will practice the skill as identified in the Practice Plan by the Veteran. If the likelihood is less than 90%, the provider should continue to identify obstacles and problem solve ways to overcome them, such as by changing aspects of the time or location of when the skill will be practiced, engaging in additional practice of the skill in session, and/or simplifying the practice of the skill.

Once the utility and personal application of the skill for the Veteran is clear and the Practice Plan is developed, the provider moves toward ending the session by eliciting a final summary and session feedback. **The purpose of the final summary and feedback is to check in with and help consolidate the patient's understanding and recognition of what was covered in session and provide an opportunity for the Veteran to offer input on the PSB process.** To request a summary, the provider may ask, "Can you recap what we covered today?" or "What do you take away from what we covered today?" In some instances, the Veteran's response to the summary request will include feedback about what was particularly helpful or not helpful about the session. If the Veteran does not comment on this, the provider may follow up by asking, "What was most helpful about our session today?" and "Was there anything that was not helpful about today's session?" **Concluding the session with a request for feedback from the Veteran demonstrates ongoing priority placed on the Veteran's perspective and experience and maintains a dynamic of collaboration and shared control that is highly consistent with shared decision-making.**

The final step of the session involves the collaborative discussion of next steps. In many instances, such as the end of the first PSB session, the next step will involve scheduling another PSB session to follow up and build on initial skill learning and use. **In fact, we generally recommend having at least one opportunity to follow up with patients after initially learning a new skill to see how well the Veteran was able to practice and use the skill outside of session.** This may also involve having the Veteran implement the skill in the next session to provide additional practice and opportunity for the provider to see how well the Veteran has grasped the skill.[4]

When the provider believes that the patient has made sufficient progress in learning and applying one or more preparatory skills and is more prepared to initiate treatment, the provider may check-in with the Veteran to see if they feel ready to do so. In some instances, the provider may wish to administer or re-administer a measure of coping skills, such as the Brief COPE or DERS (described earlier in this section), or a measure of treatment readiness, such as the Readiness for Psychotherapy Index (described in Section 2.1.6), to help inform the decision about readiness for treatment. In the discussion of next steps, the provider should reiterate that the PSB process is designed to prepare the patient to get the most out of treatment and that the work in treatment will build on the work they have accomplished during the PSB process.

4 Of note, the coping skills that are incorporated in the PSB process are fairly generalizable to and consistent with a variety of EBPs and other treatments; as a result, additional follow-up and practice may also continue with treatment, as opposed to ending at the conclusion of the PSB process. In fact, patients should be encouraged to continue the skills they have learned as part of the treatment process.

As the Veteran and provider approach the end of the PSB process, the provider works to (1) consolidate the patient's learning and (2) facilitate discussion of specific next steps. The consolidation of learning is accomplished by eliciting a final summary and feedback, providing an opportunity for the Veteran to communicate and reflect on the skills that they acquired, restate the rationale and purpose of the skills, and convey how the Veteran plans to use the skills in their life. Next, the provider facilitates discussion of next steps. If the PSB provider was the provider of the SDM Session, or if the PSB provider has access to the clinical documentation of the SDM Session provider, they may summarize key points and preferences discussed during the SDM Session and pick up from the *Choose* step of the SDM Session (see Section 2.1.6.) or at the step that seems most appropriate at the current time for the Veteran. Oftentimes, it may be helpful to provide a review of treatment options discussed during the *Educate* step of the SDM Session. The following dialogue illustrates how this discussion unfolded between Bobby and his PSB provider (Dr. Tammy) following three PSB sessions.

EXCERPT
DR. TAMMY & BOBBY

DR. TAMMY: *[providing a summary and eliciting feedback]* Bobby, when you and I first met each other last month, you were going through a difficult time in your life, and it was tough for you to think through the specific types of depression treatments and decide to begin treatment. Do you feel like the tools we've discussed over the past few weeks have better prepared you to manage these difficulties?

BOBBY: Yes they have, they definitely have. I'm learning to deal with all of this stress better than I was doing before.

DR. TAMMY: *[moving toward the consolidation of Bobby's learning]* Tell me what you've learned from these visits.

BOBBY: *[hesitating]* Well, I learned that I can manage more stress than I thought I could. If I use one of the tools when my stress starts to get out of control, it keeps me from going over the edge.

DR. TAMMY: And when your stress is managed more effectively, when you're not going over the edge, are you able to make better decisions? Take care of yourself better?

BOBBY: Oh yeah, there's no question there. Before these visits, I would just lose it on my wife, and it just made things so much worse. That's why she kicked me out of the house.

DR. TAMMY: *[asking an open-ended question]* So what's different now?

BOBBY: Now I usually catch myself when I'm starting to get out of control. And I can use the tools that you gave me to keep myself in check.

DR. TAMMY: *[inviting another elaborate response]* Tell me the way in which you've used the tools.

BOBBY: That relaxation stuff is real good. I think it's helping me fall asleep more quickly.

DR. TAMMY: *[providing validation]* Great, Bobby. Why do you think that is?

BOBBY: Part of the problem used to be that my mind started racing as soon as my head hit the pillow. The breathing helps me focus on something else, and it's a lot better to focus on relaxation than it is to focus on all of my crazy thoughts.

DR. TAMMY: *[paraphrasing]* So it sounds like you've gotten some benefit from the Meditative Breathing?

BOBBY: Yeah, I also use the breathing right before I have a conversation with my wife. Sometimes it can get ugly with her. But I really want to go into these conversations with my head on straight. I don't want the marriage to end.

DR. TAMMY: I know you don't, Bobby. So, breathing helps you to stay calm and centered before you talk to her?

BOBBY: Yeah.

DR. TAMMY: And it helped?

BOBBY: Definitely. Like the other day, we were going to talk about how often I should see the kids now that I am not living in the house. Anything involving the kids really gets me going. But I did a breathing exercise before calling her, and I was able to keep my cool during the conversation.

DR. TAMMY: And did the conversation go the way you wanted it to go?

BOBBY: Not entirely. But it could've been a lot worse. And I didn't do anything to piss her off, which is new for me. [chuckling]

DR. TAMMY: That does sound different from what you had been describing. That's good to hear. Have you been using any other tools we discussed?

BOBBY: The mindful exercises. I use one of the apps you suggested just about every day now.

DR. TAMMY: *[paraphrasing]* So you've continued to practice the Mindfulness Meditation?

BOBBY: Yeah, and to be honest, I'm kinda surprised. I never did any of that mindfulness stuff before and wasn't sure it was for me when you started telling me about it. But you said it's helped a lot of people and I like checking out new apps, so I gave it a whirl a few times and kinda liked it.

DR. TAMMY: And, it has been helpful to you?

BOBBY: Yeah, my wife's been kinda surprised, but it helps me say focused. It helps my thinking, kinda like the breathing, in a way.

DR. TAMMY: How so?

BOBBY: Well, ya know, I tend to think about things in the past a lot or worry about the future–like things I did that upset my wife and family or what it'll be like if my wife leaves for good. The mindful tools help to keep my thinking in check and keep more focused. I set an alarm that rings each day to remind me to stop and slow down…I'm definitely not cured, and sometimes I only do it for maybe 20 seconds, but it helps, ya know?

DR. TAMMY: Yes, that makes complete sense. It sounds like the Mindfulness Meditation and Meditative Breathing have helped your mind and body slow down and be a bit more present.

BOBBY: Yeah, that's it.

DR. TAMMY: *[smiling]* I'm happy to hear that, Bobby. Was there anything else from what we've talked about that has been helpful?

BOBBY: Uh…oh, looking at how factual my thinking is.

DR. TAMMY: *[smiling]* Great. And how did that tool, Cognitive Reappraisal, work for you?

BOBBY: Sometimes that one is harder to use when I'm really wound up. But I think if I just take a breath first and am calmer, then I can look at how I am looking at situations. Look at looking…that sounds kinda weird, but you know what I mean. *[pausing]* I know my thinking is one of my main problems, so this helps when I can do it. But, honestly, I'm still not great at that, though. My anger still gets the best of me sometimes.

DR. TAMMY: So, it sounds like looking at how you think about things before taking your initial interpretation as fact has been helpful, but it's not something that comes very easily or naturally yet. That's quite understandable, Bobby. In fact, I hear that a lot. Given that we've only worked together for a few sessions, I'd say that you've done as well as I would have hoped thus far. I'm quite confident that with ongoing practice and the opportunity to build on these skills in treatment that they'll become even more helpful.

BOBBY: That sounds good.

DR. TAMMY: Bobby, as you know, our work together in developing effective coping skills was designed to help prepare you to feel more ready and confident to begin treatment. I'm wondering, given what we just discussed, what are your thoughts now about beginning one of the talk therapies we had discussed?

BOBBY: I feel more ready. I won't lie to you; I'm glad I'm on meds too now. I think they've helped as well. But coming in here and meeting with you, I also think that's been helpful. I can do more of something like this in talk therapy?

DR. TAMMY: *[smiling warmly]* Yes, indeed, and in a way that is even more tailored to you and your depression.

BOBBY: Oh, good. I don't really remember the different options, though. My mind was kind of in a fog when we first started talking about all of this.

DR. TAMMY: I'd be happy to discuss the options with you again. I can answer any questions you might have, and we can consider the factors you think make these treatments a good or not so good match.

BOBBY: OK, I'd like that.

In the preceding dialogue, Dr. Tammy engages Bobby in a discussion and reflection on the PSB process using a series of non-directive questions. During the discussion, she incorporates active listening to continuously engage Bobby in the conversation and emphasize key information and feedback provided by Bobby about the experience and impact of learning preparatory skills. In addition, Dr. Tammy intentionally labels specific skills Bobby describes (i.e., Meditative Breathing, Mindfulness Meditation, Cognitive Reappraisal). After Bobby describes the benefits that he has seen from participating in PSB, Dr. Tammy provides her perspective of how the PSB process has been helpful to Bobby. Throughout the course of the discussion, Dr. Tammy focuses on communicating warmth and facilitating interpersonal connection. At the end of the discussion, Dr. Tammy reinitiates the focus on SDM, offering to again review different treatment options and help Bobby move toward a treatment decision considering his values and preferences.

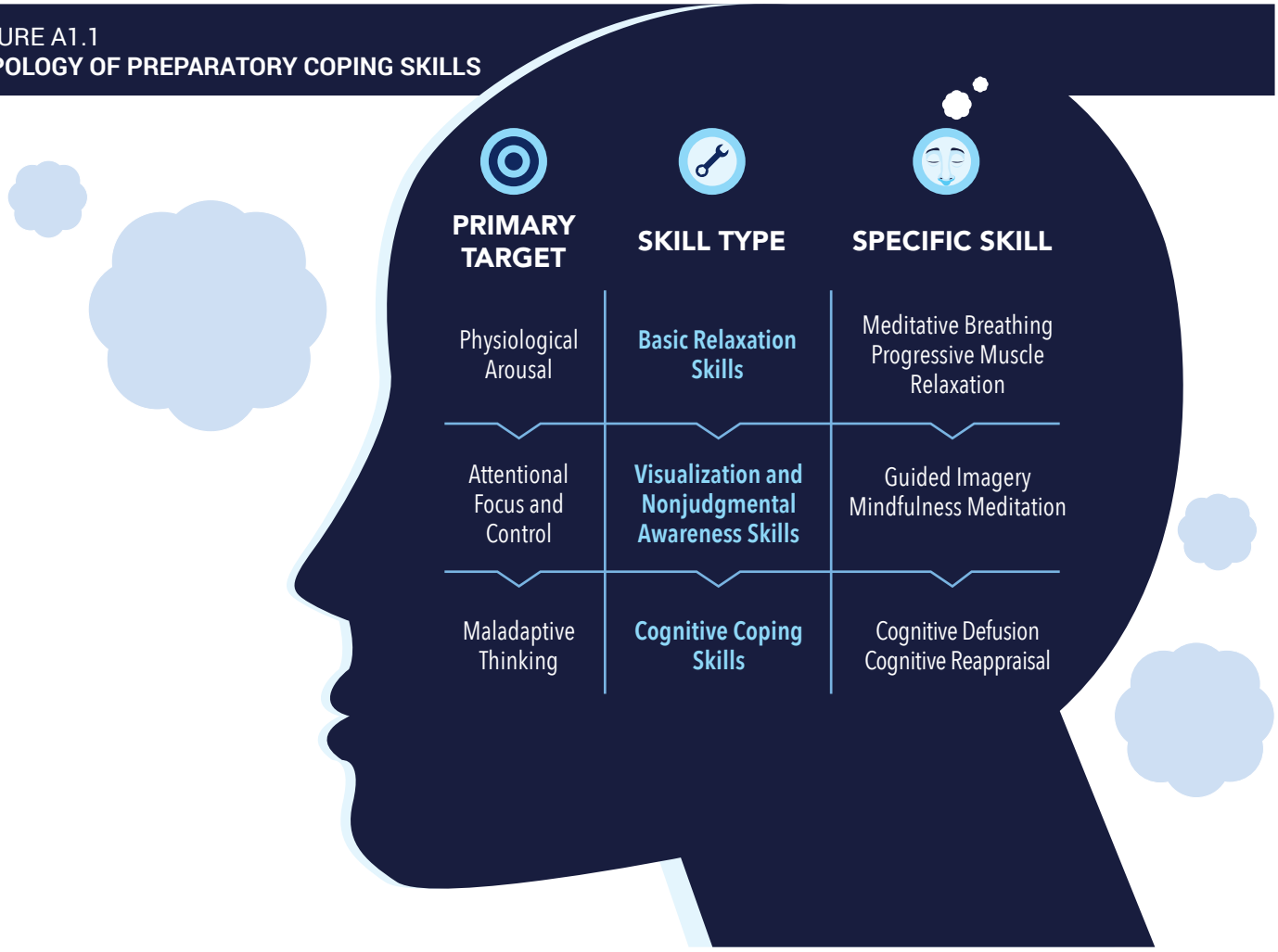
A1.1.2. PREPARATORY COPING SKILLS

A typology of specific skills for incorporating into PSB sessions is presented in Figure A1.1. **This framework includes specific skills with different primary functions, including skills to reduce physiological arousal (Basic Relaxation Skills), skills to promote attentional focus and control (Visualization and Nonjudgmental Awareness Skills), and skills to cope with maladaptive thinking (Cognitive Coping Skills).** These sets of skills are categorized hierarchically, based on complexity, beginning with more basic, behaviorally based relaxation skills followed by increasingly more complex cognitive coping skills.[5] Moreover, the sequence of skills reflects skills that can be used quickly to

5 Although beyond the scope of this toolkit, it is important to acknowledge that the coping skills presented in Figure A1.1 do not work exclusively on the Primary Target area listed and often involve multiple functional mechanisms and benefits (e.g., physiological, cognitive, behavioral). For example, Meditative Breathing reduces physiological arousal by activating the parasympathetic nervous system. At the same time, this skill also helps to quiet the mind (and, consequently, the body) by redirecting one's thinking on to one's breathing.

counteract physiological responsiveness to amygdala activation before proceeding to skills that require cognitive resources to implement once the patient has achieved reduction in physiological arousal (Berking & Whitley, 2014). When individuals experience increased or overactive amygdala activation, they often demonstrate pronounced reflexive emotional reactions that interfere with the ability to respond reflectively and adaptively. Patients who acquire skills in more than one domain may "chain" skills together when they notice significant negative affect, first applying skills to decrease amygdala activation and, once negative affect has decreased, to apply skills that require more cognitive resources (Berking & Whitley, 2014).

FIGURE A1.1
TYPOLOGY OF PREPARATORY COPING SKILLS



The skills in Figure A1.1 include skills that have clear empirical support and offer utility for patients across a range of mental and behavioral health conditions, both as part of a larger treatment package and as standalone skills. In addition, the skills listed include strategies that are feasible and useful for incorporating in a pre-treatment, preparatory context. Moreover, the skills are consistent with and often included as part of EBPs[6] and are commonly used by clinicians in a variety of contexts, including with Veterans, specifically. **Findings from a randomized controlled trial revealed that an abbreviated set of emotion regulation skills including many similar skills (e.g., muscle relaxation,**

6 When used in the context of PSB or similar pre-treatment context, the coping skills described herein are designed to enhance skills for adaptive coping in a manner that is broader than a symptom-type or condition that is the specific focus of treatment or antecedent of the condition (Berking et al., 2013).

breathing relaxation, nonjudgmental perception of emotions, and acceptance of emotions) increased the efficacy of CBT for depression (Berking et al., 2013). Further, research has shown that such skills predict alcohol consumption during and after CBT for alcohol use (Berking, 2011), and predict subsequent reduction of symptom severity during depression treatment (Radkovsky, McArdle, Bockting, & Berking, 2014). Recently, Miles et al. (2016) included training in relaxation skills and cognitive coping skills (including both skills for promoting nonjudgmental awareness and changing thoughts) in a 3-hour emotion regulation skills training session for reducing impulsive aggression in Veterans with PTSD.

Consistent with the hierarchical ordering presented in Figure A1.1, the implementation of PSB skills generally begins with Basic Relaxation Skills before proceeding to Visualization and Nonjudgmental Awareness Skills (which are highly compatible with Basic Relaxation Skills) and then to Cognitive Coping Skills. Because Basic Relaxation Skills are usually quick acting, relatively simple to learn and practice on one's own, and provide tangible evidence of impact, we find teaching such skills early on to patients provides an opportunity for early success and for increasing a patient's sense of self-efficacy and control over their emotions and physical sensations.

As noted in the description of the steps for implementing PSB sessions in the preceding section, the selection of specific skills to implement for a particular patient during the PSB session is designed to be flexible for addressing the specific needs and preferences of the Veteran and for maximizing the likelihood that one or more skills implemented will be useful to and employed by particular patients. **The selection of specific skills within and across specific skills types is based on several factors, including but not limited to the specific nature of the patient's coping challenges and preparatory skill needs, existing coping skills, skill complexity, and patient preference.** For example, patients who have particular challenges with acute stress or are highly reactive may particularly benefit from learning relaxation skills for reducing physiological arousal. With such individuals, providers may focus more on promoting the depth of skills within this domain at least until patients demonstrate proficiency in these skills. Further, the more behaviorally oriented Basic Relaxation Skills and Visualization and Nonjudgmental Awareness Skills are often more appropriate for patients with more limited cognitive abilities or language skills. Reflecting the brief nature and pre-treatment context of PSB, Veterans, in most instances, will receive a subset of the skills listed in Figure A1.1.

In implementing skills for reducing maladaptive thinking, providers typically choose *either* Cognitive Defusion or Cognitive Reappraisal, given the fundamental differences between these approaches in how one relates to one's thoughts. Determining whether to focus on one skill vs. the other should consider several factors, including the familiarity of the skill(s) to the provider, patient preference, and/or interest expressed by the Veteran, if any, in a specific treatment as well as the availability of treatments consistent with one or both approaches at the treatment facility. In some instances, a Veteran participating in PSB may have expressed interest during the SDM Session in possibly participating in a particular treatment, such as CBT, once the Veteran felt more prepared to begin treatment. If this is the case, it may be more appropriate to consider incorporating Cognitive Reappraisal during the PSB session, as this is more consistent with a CBT treatment orientation. Similarly, if a treatment facility does not provide Acceptance and Commitment Therapy (ACT) and it is likely that the patient would receive CBT, the provider of the PSB session may wish to consider incorporating training in Cognitive Reappraisal skills.

Although thoughtful consideration of potentially useful and appropriate skills for specific patients is recommended over a universal, one-size-fits-all approach, there will inevitably be situations where patients do not respond to a particular skill, even after practice. Consequently, the process sometimes involves "informed trial and error." In light of this, providers may cue patients to this possibility in advance by noting that, while the specific skills selected for the PSB process are proven techniques, different individuals often have a preference for different skills. In doing so, providers should emphasize the importance of identifying one or more skills that work well for the patient and that the Veteran will implement in their life and in treatment.

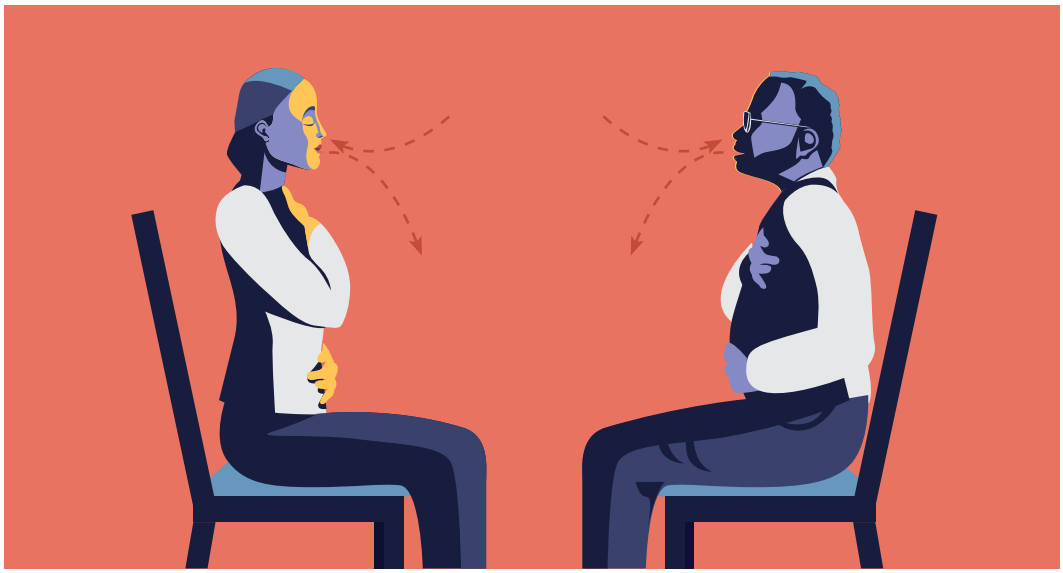
Finally, it is important to note that the skills included in this PSB protocol are not intended to be an exhaustive listing of skills that providers may choose to implement as part of PSB. Indeed, with some patients, other skills may be useful for promoting treatment readiness. For example, training in grounding techniques is often useful prior to or at the outset of PTSD treatment. Consequently, providers may consider incorporating other skills in the PSB process. In so doing, we encourage providers to consider issues of efficacy, as well as feasibility within a pre-treatment context, and fit with EBPs (and other treatments).

In the sections below, we provide descriptions of the PSB skills incorporated in this PSB protocol and listed in Figure A1.1. ***Provider Tip Sheets*** for facilitating the teaching of these skills are provided in Appendix A2.

A1.1.2.1. BASIC RELAXATION SKILLS

Relaxation skills are among the most straightforward for patients to practice and implement and generally have quick and noticeable effect.

As noted above, relaxation skills are among the most straightforward for patients to practice and implement and generally have quick and noticeable effect. Providers should encourage Veterans to use one or more of the Basic Relaxation Skills both for reducing acute stress in stress-provoking situations and in an ongoing manner for lower one's "emotional temperature." The latter use of Basic Relaxation Skills can have the effect of improving mood and increasing one's stress tolerance threshold by, for example, lowering levels of cortisol, the stress hormone, and stimulating the parasympathetic nervous system.[7]



7 Recent research reveals that Nonjudgmental Awareness Skills and Cognitive Coping Skills, described below, also stimulate the parasympathetic nervous system and often lead to specific neurophysiological changes, including changes in the amygdala and prefrontal cortex.

A1.1.2.1.1. MEDITATIVE BREATHING

Meditative Breathing is a core relaxation skill that patients can cultivate to develop a sense of controllability during states of agitation or arousal and to achieve a general sense of calm. This skill involves two components—diaphragmatic (or abdominal) breathing and a meditative component. First, the provider teaches the patient how to engage in diaphragmatic breathing (a process also referred to as "breathing retraining"). **Prior to teaching the skill (and relaxation skills in general) to the patient, it is important for the provider to briefly educate them about the underlying rationale and physiology, rather than just teaching the skill.** Patients are taught that diaphragmatic breathing, or breathing from the belly, involves a deeper, healthier way of breathing. Most people breathe from the chest or thoracic cavity (known as thoracic breathing), which is a much shallower type of breathing. Patients should be informed that the two types of breathing have very different physiological effects on the body. Diaphragmatic breathing activates the parasympathetic nervous system, turning off the body's stress response (sympathetic nervous system) and resulting in a slowing of one's heartbeat and lowering of blood pressure. Shallow breathing, on the other hand, often contributes to stress and activation of the sympathetic nervous system.

Meditative Breathing is a core relaxation skill that patients can cultivate to achieve a sense of controllability during states of agitation or arousal and achieve a general sense of calm.

After educating the Veteran about the rationale, function, and effects of diaphragmatic breathing, the provider demonstrates thoracic vs. diaphragmatic breathing by placing their right hand on their stomach and left hand on their chest and inviting the patient to do the same, observing which hand moves with each type of breathing. Next, the provider leads the patient through the diaphragmatic breathing exercise, instructing the Veteran to inhale through the nose, causing the belly to expand and fill with air, hold for three seconds, and then exhale through the mouth. Because diaphragmatic breathing is typically very new to most individuals and replaces habitual thoracic breathing, the provider should note that this skill may feel unnatural at first but becomes much easier with dedicated practice. Table A1.3 summarizes the steps to teach diaphragmatic breathing. In addition, a tutorial on diaphragmatic breathing and its effects on the stress response system is available in the Breathe2Relax mobile application developed by the Department of Defense (DoD) National Center for Telehealth and Technology. The app is free to use and may be accessed at: www.t2health.dcoe.mil/apps/breathe2relax.

A second component of Meditative Breathing involves adding a simple meditative element. After the patient is taught diaphragmatic breathing, they are then instructed the meditative component. Before leading the patient through this, the provider should describe this component so the patient can anticipate what to expect and natural challenges they may encounter (e.g., intrusion of thoughts). Then, the provider asks the patient to sit straight up in a comfortable position, close their eyes, and begin engaging in diaphragmatic breathing, inhaling through their nose and exhaling out of their mouth. While doing so, they are instructed to focus on their breathing and to redirect their thinking back to their breathing (including the sound, rate, temperature of each breath of air), when they find their mind wanders. The provider guides the patient through the exercise, with periodic and soothing reminders to "focus only on your breathing" and to notice the sound, temperature, and path of each breath. The provider periodically notes that "if your mind wanders, gently guide your thinking back to your breathing."

A ***Provider Tip Sheet*** for facilitating the implementation of each of the steps of Meditative Breathing can be found in Appendix A2. In addition, the following are two brief web-based Meditative Breathing training recordings that are freely available and may be downloaded

TABLE A1.3.
STEPS TO TEACH DIAPHRAGMATIC BREATHING

1	2	3	4
Educate the patient about diaphragmatic breathing and contrast it to shallow chest (thoracic) breathing. ▪ Explain body's fight or flight response and activation of sympathetic nervous system, difference in breathing chemistry and physiological effects on body of diaphragmatic vs. thoracic breathing (e.g., thoracic breathing contributes to stress and activation of sympathetic nervous system; diaphragmatic breathing activates parasympathetic nervous system, slowing heartbeat, and lowering of blood pressure).	*As you demonstrate, ask the patient to place the right hand on the abdomen and left hand on the chest. Then have the patient engage in thoracic breathing followed by diaphragmatic breathing, and observe which hand moves with each.*	*Lead the patient through the diaphragmatic breathing exercise, instructing him or her to inhale through their nose, hold for three seconds, and exhale through the mouth.*	*Encourage the patient to practice diaphragmatic breathing in the same manner outside of session.*

that providers may recommend for patients to listen to at home or for incorporating in session for practicing the meditative component of meditative breathing:

- UCLA Mindful Awareness Research Center – Breathing Meditation: www.marc.ucla.edu/mpeg/01_Breathing_Meditation.mp3
- Excel at Life – Mindful Breathing: www.excelatlife.com/mp3/mindfulbreathing.mp3

A1.1.2.1.2. PROGRESSIVE MUSCLE RELAXATION

Progressive Muscle Relaxation (PMR) is an empirically supported skill in which patients tense and then relax various muscle groups to reduce muscle tension and achieve a sense of calm

Progressive Muscle Relaxation (PMR) is an empirically supported skill in which patients tense and then relax various muscle groups to reduce muscle tension and achieve a sense of calm (Bernstein, Borkovec, & Hazlett-Stevens, 2000). PMR targets increased muscle tension that accompanies amygdala activation, which is often interpreted by patients as a sign of danger (Berling & Whitley, 2014). Specifically, PMR involves tensing of different muscle groups for approximately five to seven seconds, followed by gradual relaxation of muscle group and focus on the sensation of warmth and relaxation for approximately 30 to 40 seconds. The provider leads the patient through each muscle group while the patient is in a seated position, though the provider may note that the patient may engage in the exercise at home while lying on their back. As the provider leads the Veteran through the exercise, they may state, "Now I'd like you to make a fist with your right hand, holding it as tight as you can, holding and focusing on the tension,…continuing to hold and focus on the tension" and "Now I'd like you to release your fist, letting go of all the tension out of your fingertips, feeling the warmth that emerges when you let go of the tension and focusing on it as it dissolves away." Like diaphragmatic breathing, patients practice relaxation for homework in between sessions.

PMR is generally contraindicated in individuals with arthritis or physical pain that may be exacerbated by systematic muscle tensing. With such individuals, an alternative approach that has been shown to be effective is to instruct the patient to imagine tensing and relaxing specific muscle groups. A ***Provider Tip Sheet*** for facilitating the implementation of

PMR can be found in Appendix A2. In addition, the following are two brief Web-based PMR recordings that are freely available and may be downloaded that providers may recommend for patients to listen to at home or for incorporating in session for practicing PMR:

- Dartmouth College Health Service: media.dartmouth.edu/~healthed/p_muscle_relax.mp3
- University of Southern California Center for Work and Family Life: cwfl.usc.edu/training/audio/relaxation/andrea_muscles.mp3

A1.1.2.2. VISUALIZATION AND NONJUDGMENTAL AWARENESS SKILLS

The next set of PSB skills—Visualization and Nonjudgmental Awareness Skills—are highly compatible with and build on Basic Relaxation Skills.[8] **Like Basic Relaxation Skills, they often provide immediate and observable reductions in stress; however, the focus of Visualization and Nonjudgmental Awareness Skills is on promoting attentional control on the present moment and diverting one's thoughts away from negative judgment.** The two Visualization and Nonjudgmental Awareness Skills included in this section—Guided Imagery and Mindfulness Meditation—have similar characteristics but also notable differences in technique, focus, and complexity. Guided Imagery, which most often involves envisioning a detailed scene of nature or similar peaceful scenario described by the provider or other narrator, is in some respects a more basic version of Mindfulness Meditation that requires very little effort, skill, or practice and is, therefore, quite simple to learn and implement. For this reason, it can serve as a building block or alternative to Mindfulness Meditation for some individuals. Although Guided Imagery has existed for decades and has been widely used and shown to be effective in EBPs and other mental health and non-mental health (e.g., sports performance and rehabilitation) contexts, Mindfulness Meditation has received more extensive and rigorous empirical examination, with a spate of studies in recent years demonstrating the significant utility and efficacy of Mindfulness Meditation for a variety of mental health and other issues, as well as additional studies currently underway. Whereas Guided Imagery generally focuses more on external scenes, Mindfulness Meditation often involves focusing attention on internal

8 The meditative component of Meditative Breathing is consistent with and provides a simple introduction to and foundation for Visualization and Nonjudgmental Awareness Skills.

experiences, sensations, and aspects of self, and it utilizes specific techniques. Mindfulness Meditation requires repeated practice and discipline to maximize impact and utility. However, many freely available and highly usable applications are now available that make the practice of Mindfulness Meditation more accessible and feasible.

Guided Imagery is a technique in which a guide (provider or recorded voice) describes in great detail vivid, soothing mental images for the patient to imagine with their eyes closed, focusing their attention and maximizing their sensory experience.

A1.1.2.2.1. GUIDED IMAGERY

Guided Imagery is a technique in which a guide (provider or recorded voice) describes in great detail vivid, soothing mental images for the patient to imagine with their eyes closed, focusing their attention and maximizing their sensory experience. Examples of calming images used in Guided Imagery exercises include scenes of a beach, waterfall, rainbow, meadow, and mountainside. The narrative in Guided Imagery exercises includes significant detail to maximize the imaginal sensory experience, including references to sights, sounds, temperatures, textures, smells, and tastes. A ***Provider Tip Sheet*** for facilitating the implementation of Guided Imagery can be found in Appendix A2. In addition, Guided Imagery recordings are freely available online and may be downloaded for recommending to patients to listen to at home or for incorporating in session. For example, Excel at Life provides a number of Guided Imagery recordings describing many different scenes, which may be accessed at: www.excelatlife.com/downloads/relaxation/audios.htm.

A1.1.2.2.2. MINDFULNESS MEDITATION

For thousands of years, the practice of mindfulness has served as a powerful tool for increasing attentional focus and living in the present moment. In recent years, practitioners of modern medicine have embraced mindfulness for helping patients to manage stress, cope with illness and medical procedures, and promote overall healthy living. Mindfulness practice has been incorporated into many different areas of health care, including oncology, chronic pain and disease, sports medicine, and pre- and post-surgical contexts. Moreover, mindfulness practice has recently been adopted by employers to promote employee well-being and organizational performance. Within mental health, mindfulness has received significant interest and attention over the past three decades. More recently, mindfulness practice has increasingly been incorporated as a specific component or adjunct to treatment and has been shown, in some contexts, to be a promising standalone intervention, with additional research currently underway.[9]

Mindfulness practice generally involves three components: (1) remaining focused on the present, rather than ruminating over the past or anxiously anticipating the future, (2) being intentional in whatever activity is being pursued, and (3) being nonjudgmental, refraining from affixing labels like "good" or "bad" to one's experience

Mindfulness practice generally involves three components: (1) remaining focused on the present, rather than ruminating over the past or anxiously anticipating the future, (2) being intentional in whatever activity is being pursued, and (3) being nonjudgmental, refraining from affixing labels like "good" or "bad" to one's experience (Kabat-Zinn, 2003). Mindfulness Meditation involves the specific practice of mindfulness that can be easily taught and incorporated into Veterans' lives. The goal of these exercises is to help cultivate mindful awareness of the present moment and increase attentional control. This, in turn, promotes acceptance of emotional experience, sensation, and thought, facilitating adaptive responses to negative emotion and coping with stress and physical pain.

Mindfulness Meditation practices and guided exercises exist for many different areas of focus and individual needs (e.g., general stress, anxiety, sleep, self-compassion,

9 Although a core component of ACT and other acceptance-based therapies, Mindfulness Meditation is often compatible with and sometimes incorporated (e.g., as a behavioral strategy) into other treatments, such as CBT.

happiness, frustration, blame, guilt) and may be tailored to individuals' experiences. Some Mindfulness Meditation exercises have features in common with and build on the more general Meditative Breathing exercise described above; however, whereas Meditative Breathing is focused on promoting relaxation, Mindfulness Meditation is focused on increasing awareness. Relaxation may be a by-product of Mindfulness Meditation, but it is not the primary outcome targeted.

Prior to introducing Mindfulness Meditation, it is important to explain the purpose of and rationale for mindfulness practice, noting the benefits of nonjudgmental awareness and acceptance of internal experiences (e.g., emotions, thoughts, sensations) on both mental and physical health. This includes but is not limited to increased affect tolerance, adaptability, and overall coping capacity, as well as improved concentration and focus, which can help with getting the most out of treatment. Ultimately, through mindful practice, patients may come to see thoughts and feelings as transient experiences. This can help to decrease identification with a momentary affective state, facilitating greater self-understanding and self-compassion. In noting the benefit of mindfulness, the provider may specifically note the effectiveness of mindfulness with Veterans, referring to either clinical experience and/or empirical research. For instance, mindfulness-based interventions have been shown to reduce symptoms of anxiety, PTSD, depression, and suicidal ideation and improve mental health functioning in Veterans (Polusny et al., 2015; Serpa, Taylor, & Tillisch, 2014).

When initially introducing Mindfulness Meditation, it can be useful to ask the Veteran what, if anything, they know about mindfulness. Getting a sense of the patient's preexisting knowledge and beliefs can help with knowing how much and what to emphasize in the rationale and introduction. Some individuals have a highly inaccurate understanding of mindfulness and meditation, often mistaking them for something religious or mystical. Although it has its roots in Eastern philosophy and practice, Mindfulness Meditation is largely utilized as a skill in mental health prevention and treatment and is not promoted in most health arenas as either religious or mystical, but secular (i.e., not regarded as religious, spiritual, or sacred). As well, patients may express more openness and confidence in practicing Mindfulness Meditation after engaging in the previously described coping skills, such as Meditative Breathing and Progressive Muscle Relaxation. In fact, Mindfulness Meditation can be introduced as a skill designed to build on the previously introduced skills, although it is important to remind the patient that mindfulness is not about achieving a relaxed state; rather, it is about being aware.

After describing the purpose, rationale, and benefit of Mindfulness Mediation, it is important to assess the patient's receptivity to learning and practicing this skill. Next, the provider introduces the patient to the practice of mindfulness. One strategy for doing so is the Raisin Exercise. A brief overview of the exercise is provided below. The following online demonstrations on how to conduct the Raisin Exercise are also available:

- http://www.mbsrtraining.com/mindfully-eating-a-raisin-exercise/
- https://ggia.berkeley.edu/practice/raisin_meditation

In this exercise, the provider provides a raisin to the patient and asks them to describe the appearance of the raisin in as much detail as possible, noting the color, shape, size, texture, etc. As the patient does so, the therapist may ask the Veteran to notice any thoughts running through their mind, but to do so without judging the thoughts, merely noticing them for what they say. Next, the provider invites the Veteran to experience and

Being aware places one in a position to take thoughtful and intentional action— to choose rather than react.

describe the raisin using the sense of smell and then doing so with touch and taste (finger, lips, tongue), ending the exercise by noticing what it is like to have just eaten the raisin. Following the exercise, the provider should discuss the experience of the exercise with the Veteran and link this experience to the power of mindfulness and attentional control. The provider may also discuss with the Veteran how they may use their senses in this way and live life more mindfully in their daily life— from walking down the street to the experience of sounds to the tastes of foods, and so on—linking the senses explored using the raisin to how senses can be used in everyday mindful living.

At the conclusion of the exercise, the provider should explore the Veteran's reactions to the exercise. In this discussion, comments will generally center around how interesting it is to taste, touch, and experience a raisin more fully in the moment. However, from time to time, a patient completing the exercise may have more neutral (e.g., "It was no big deal") or negative (e.g., "What is the point of doing this? How is this going to solve my problems?") reactions. In these situations, reiterating the rationale regarding the power of awareness is often useful. In addition to restating the benefits of nonjudgmental awareness skills on mental and physical health, the provider may share with the Veteran how growing the practice of awareness supports self-knowledge and understanding, which, in turn, invites better choices than if one were to walk around in the world unaware and not present. Indeed, in such a state of non-awareness, we tend to simply react to the world and events. Being aware places one in a position to take thoughtful and intentional action— to choose rather than react.

Following the Raisin Exercise, the provider introduces the Veteran to a beginning Mindfulness Meditation exercise, such as one of the exercises listed in Table A1.4, which the provider may lead the Veteran through or implement through use of a recorded guided exercise. Table A1.4 includes corresponding web-based audio recordings that may be played in session and provided to the Veteran for practice at home. It is not expected that providers review or share each of these, but rather choose from the options to best match the style and fit for the Veteran and provider.

TABLE A1.4.
EXAMPLES OF BEGINNING MINDFULNESS MEDITATION EXERCISES

PRIMARY FOCUS	LENGTH (MINS.)	SOURCE
Body Scan (Female Guide)	3	Greater Good Science Center www.mindful.org/a-3-minute-body-scan-meditation-to-cultivate-mindfulness/
Body Scan (Female Guide)	10	Tara Brach www.tarabrach.com/ten-minute-basic-guided-meditation-practice/
Body Scan (Male Guide)	29	Jon Kabat-Zinn https://www.youtube.com/watch?v=15q-N-_kkrU
Breadth, Sounds, and Body (Female Guide)	12	Excel at Life marc.ucla.edu/mpeg/02_Breath_Sound_Body_Meditation.mp3
Sounds and Thoughts (Male Guide, British Accent)	8	Mindfulness: Finding Peace in a Frantic World http://cdn.franticworld.com/wp-content/uploads/2012/02/Sounds-and-thoughts-meditation-from-book-Mindfulness-Finding-Peace-in-a-Frantic-World-128k.mp3

PRIMARY FOCUS	LENGTH (MINS.)	SOURCE
Breath (Male Guide)	10	John Kabat-Zinn www.youtube.com/watch?v=8HYLyuJZKno
Breath/General Mindfulness Meditation (Male Guide)	20	Jon Kabat-Zinn https://www.youtube.com/watch?v=524RMtfHKz8

It is strongly recommended that providers carefully review and become familiar with the exercises and recordings before selecting one to use with patients. Prior to implementing the exercise, the provider should briefly describe the exercise to the patient so they know what to expect and invite the Veteran to communicate any reservations, provide permission to forego any aspects of the exercise, and seek agreement before proceeding.

At the conclusion of the Mindfulness Meditation exercise, the provider should discuss the Veteran's reactions to the exercise and explore how they might incorporate these practices and exercises into their daily life. Many high quality, free mobile applications now exist that make it simple to practice and incorporate Mindfulness Meditation in one's routine, with many applications able to provide a reminder at specific times and offering brief exercises that may be completed virtually anywhere. In addition, several apps include Mindfulness Meditation exercises for a range of applications and that, in some cases, progressively build on each other so that the user may engage in an individually tailored program that best suits their needs. Further, several apps include guides or teachers of different genders and accents, with some allowing the user to select those that best fit their preferences. Providers are encouraged to become familiar with different apps and to review in session one or more that appear to be a good fit for particular patients. Table A1.5 provides examples of Mindfulness Meditation mobile applications that may be considered for recommending to or using with patients, ranging from more basic or introductory applications to those that include more extensive content and features. All of the apps listed are free to download and include free content, though they vary in the extent of free material available.

Finally, it is important to note that caution should be exercised prior to introducing Mindfulness Meditation to Veterans with significant unresolved trauma, especially those with very limited basic coping skills. For these patients, it is typically more appropriate in the preparatory skills context to shore up more basic coping skills, such as grounding, and other preparatory skills (or Mindfulness Meditation exercises and scenes) that do not involve exposure to internal or other experiences that may trigger significant trauma reactions, especially with providers who do not have significant experience implementing Mindfulness Meditation with such patients or working with unresolved trauma.

A ***Provider Tip Sheet*** for facilitating the implementation of each of the steps of Mindfulness Meditation can be found in Appendix A2.

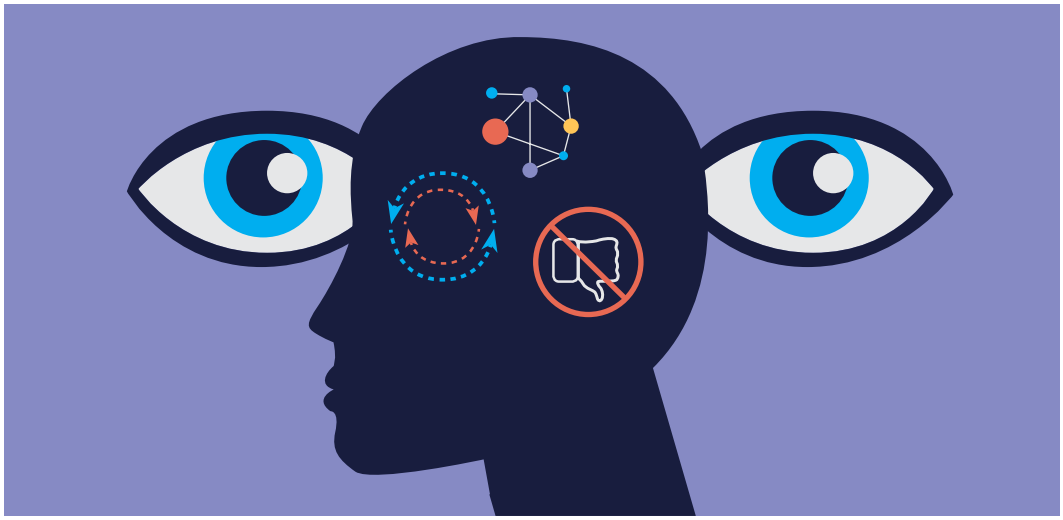
TABLE A1.5.
EXAMPLES OF MINDFULNESS MEDITATION MOBILE APPLICATIONS

NAME	WHERE TO FIND IT	COMMENTS
Mindfulness Coach 	mobile.va.gov/app/mindfulness-coach	Developed by the VA and DoD, this app provides mindfulness education, exercises, and mindfulness tracking logs to monitor progress. The app also allows users to set reminders for engaging in mindfulness exercises. All content is free. A good simple to use app for introduction to mindfulness meditation. Available for iPhone (Android coming soon).
Stop, Breathe, Think 	www.stopbreathethink.com	This mindfulness, meditation and compassion-building app is simple and easy to use. The app provides information on mindfulness, its benefits, and what to expect when engaging in exercises. It includes brief information on physiological processes underlying stress and the science of mindfulness. The app includes approximately 30 free guided exercises, led by different teachers, and cover different general themes. The app provides a tool for tracking meditation activity and mood. Users may also earn stickers for their progress. Additional content is available for purchase. A good option for those who wish to learn more about mindfulness and may not be fully motivated or who would benefit from greater structure and simplicity. Available for iPhone, and Android devices.
Aura 	www.aurahealth.io	This mindfulness app provides daily 3-minute, non-repeating meditation recommendations. Personalized experience is provided based on information provided about the user's age, level of stress, optimism, and interest in mindfulness. Daily meditation recommendations are based on current mood. Daily 3-minute meditations are free. Access to longer meditations is available for purchase. A good option for those interested in a single, brief daily meditation experience and personalized recommendations. Available for iPhone, and Android devices.
Headspace 	www.headspace.com	This app includes hundreds of themed sessions, allowing users to focus the application of mindfulness for specific aspects of their experience, such as stress, sleep, and performance. The app uses well-designed metaphors to help promote understanding of the practice of mindfulness and includes a playful interface. Includes limited free content and additional content for purchase. A good choice for regular mindfulness practice applied to different aspects of life and for those who prefer a rich user experience, particularly if cost is not a concern. Available for iPhone, and Android devices.
Insight Timer 	www.insighttimer.com	This meditation app features over 4,500 free guided exercises from over 1,000 teachers. Users choose from among the different exercises and teachers, rather than receive step-by-step recommendations. Users may customize intervals and background sounds. The app also includes podcasts and presents a community feel, providing information on how many others are meditating at the current time. All content is free. A good choice for those who wish to have access to deep (and free) content across many different themes and for those who may be interested in the social media elements of mindfulness offered by the app. Available for iPhone, and Android devices.

A1.1.2.3. COGNITIVE COPING SKILLS

Cognitive Coping Skills, the third and highest-order set of skills in PSB, involve specific and distinct strategies for relating to and managing unhelpful or extreme thoughts that impact emotions and well-being—Cognitive Defusion and Cognitive Reappraisal. Cognitive Defusion involves increasing awareness of thinking and noticing thoughts as thoughts, as opposed to statements of literal truth, and "defusuing," or disentangling, oneself from these thoughts without trying to change or avoid them. Cognitive Reappraisal, on the other hand, involves changing the meaning one makes of a situation or the trajectory of their thoughts. Because Cognitive Coping Skills are often initially more challenging to learn and can be facilitated by foundational skills to reduce physiological arousal and increase attentional focus and control, they are generally taught in PSB after one or more skills in the previous two sections are covered. As noted above, because Cognitive Defusion and Cognitive Reappraisal involve key differences in how one relates to their thoughts, and given the brief nature of PSB, providers will generally choose to include one or the other during PSB.

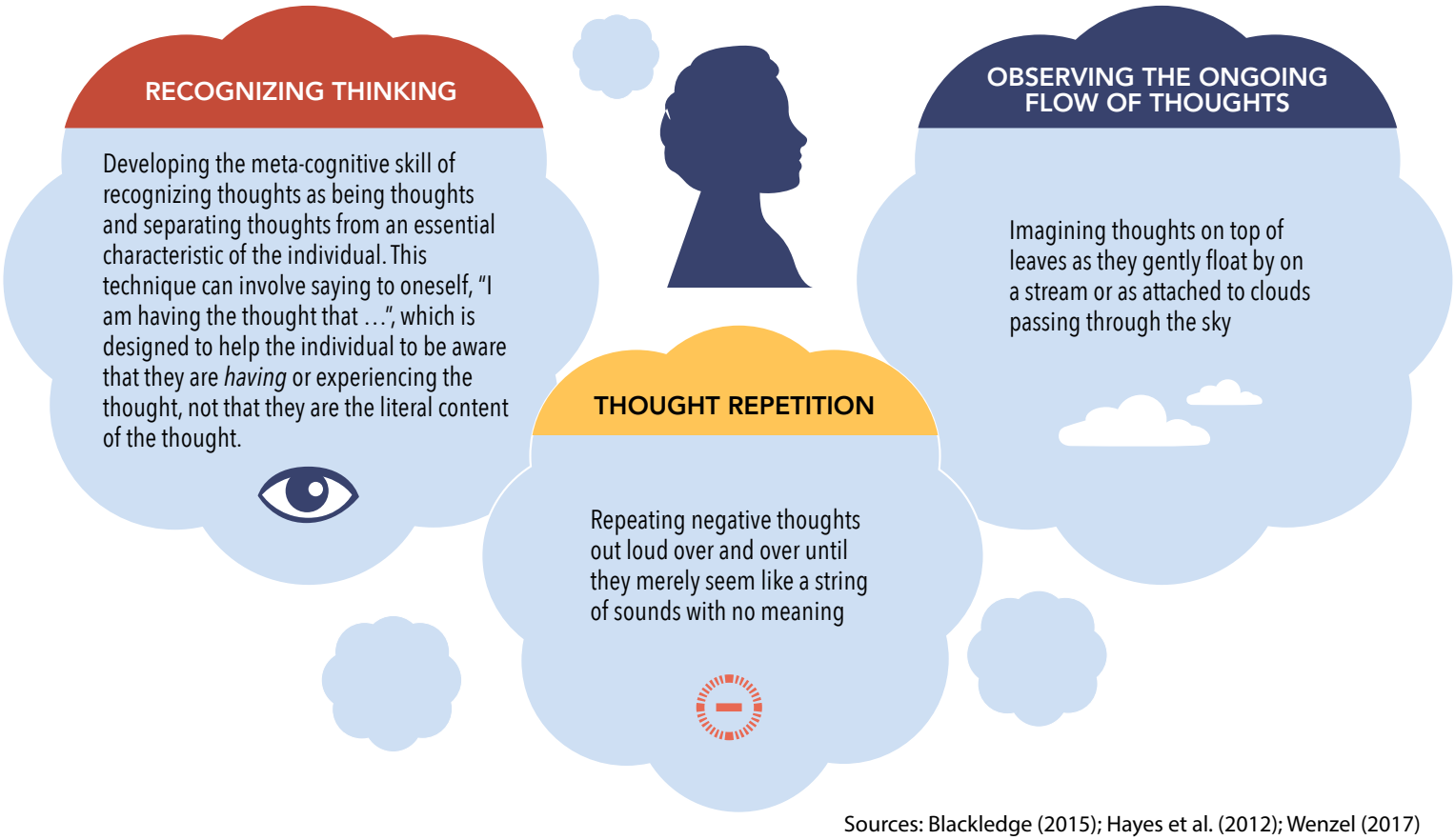
Cognitive Defusion involves specific techniques designed to help individuals observe the process of thinking and notice thoughts as thoughts, rather than take them as fact or allow them to overly influence behavior



A1.1.2.3.1. COGNITIVE DEFUSION

Cognitive Defusion involves specific techniques designed to help individuals observe the process of thinking and notice thoughts as thoughts, rather than take them as fact or allow them to overly influence behavior (Hayes, Strosahl, & Wilson, 2012). Cognitive Defusion helps patients to become less "fused" with their thinking by teaching them to look *at* thoughts instead of *from* thoughts, viewing thoughts as thoughts rather than literal truths (Harris, 2009). In this way, Cognitive Defusion teaches patients a new way of relating to their thoughts. The strategy does not involve changing or reshaping the content of maladaptive thoughts but engaging in mindful observation and disentanglement from these thoughts. Cognitive Defusion is a central strategy of ACT and has also been shown to have utility and to be effective as a standalone stress management technique. Cognitive Defusion can be used in conjunction with Basic Relaxation Skills, as well as with Mindfulness Meditation, as part of helping patients to engage in nonjudgmental awareness of their thoughts, situation, and surroundings and to remain in the present moment. Veterans who take particularly well to Mindfulness Meditation and the concept of nonjudgmental awareness may be especially well-suited to learning and using Cognitive Defusion. Table A1.6 presents several common Cognitive Defusion techniques. A ***Provider Tip Sheet*** for facilitating the implementation of Cognitive Defusion techniques can be found in Appendix A2.

TABLE A1.6.
COMMON COGNITIVE DEFUSION TECHNIQUES



Sources: Blackledge (2015); Hayes et al. (2012); Wenzel (2017)

Cognitive Reappraisal is a strategy that involves adjusting or reframing the meaning one gives to a situation in order to alter their emotional response

A1.1.2.3.2. COGNITIVE REAPPRAISAL

Cognitive Reappraisal is a strategy that involves adjusting or reframing the meaning one gives to a situation in order to alter their emotional response (Gross, 1998). Although often used synonymously with cognitive restructuring, Cognitive Reappraisal is a more basic technique that lends well to use as a general coping strategy. Cognitive restructuring, a central strategy of CBT, involves changing maladaptive thoughts by systematically identifying and examining the validity and function of thought, as opposed to the more basic process of reappraising or reframing of the situation. Learning Cognitive Reappraisal skills can provide Veterans with foundational cognitive coping ability that can be useful for subsequently learning cognitive restructuring or extending in CBT or other treatment. Because cognitive restructuring is a more complex skill that often requires more extended time for Veterans to learn and implement, it is generally not recommended for incorporating into the PSB context.

Providers may teach Cognitive Reappraisal to patients by indirectly guiding patients in reappraising a specific situation in their lives and demonstrating how they appraise—and reappraise—situations that affect how they feel. Through the use of Guided Discovery, the provider helps the Veteran to develop new perspective on or a new way of looking at the situation. First, the provider identifies a scenario where the patient formulated an extreme or narrow appraisal resulting in a strong negative reaction. Next, the provider inquires about the emotional or other (e.g., physiological) effect of the patient's appraisal in order

to help the patient gain awareness of the impact of their thinking on how they feel. Using non-directive questioning, the provider then helps the patient develop a new, modified, or broadened appraisal of the situation based on the *facts* of the situation, being mindful not to convince the patient or reject their thoughts and feelings about the situation. After helping the patient through the process of reappraisal, the provider highlights the patient's alternate or broadened view of the situation and the resulting change in the Veteran's emotional reaction. A ***Provider Tip Sheet*** and ***Cognitive Reappraisal Worksheet*** for facilitating the implementation of Cognitive Reappraisal can be found in Appendix A2 and Appendix A3, respectively.[10] These resources may be particularly useful for providers and/or patients for whom more structure in implementing Cognitive Reappraisal would be valuable. Let's look at part of how Cognitive Reappraisal unfolded in the PSB session with Bobby and Dr. Tammy.

EXCERPT
DR. TAMMY & BOBBY

BOBBY: *[escalating]* My wife is going to leave me! I'm going to be all alone, with no one to take care of me as my health gets worse and worse.

DR. TAMMY: *[first providing empathy and validation before implementing an intervention]* There's no question that things are really challenging between you and your wife, Bobby, and I wish that were not the case. *[Pausing, then setting up a general framework for implementing Cognitive Reappraisal]* But I wonder if we could take a step back and take a look at these statements that you're saying to yourself to see if there might be another, perhaps more helpful, way to view the situation. Would you be willing to explore this with me?"

BOBBY: More helpful? What do you mean? I'm not even living in the house right now!

DR. TAMMY: You're right, you're not living in the house right now. *[Recalling that Bobby had told her that his wife wanted a trial separation and would go to couple's therapy before deciding on a divorce, but also recognizing that Bobby is jumping to an upsetting conclusion that is perpetuating his emotional distress]* And does that guarantee that your wife is leaving you?

BOBBY: Well, no, I guess.

DR. TAMMY: *[asking another question that would facilitate a more accurate appraisal of his life situation]* What is the most accurate or factual way to view what's happening with your marriage?

BOBBY: *[pausing]* I guess that she's so mad at me that she wants a trial separation. That we might get divorced, but maybe not.

DR. TAMMY: *[asking a third question that facilitates reappraisal of the idea that Bobby will be all alone]* And if you did get divorced, would you truly be all alone?

BOBBY: I guess not. I have my kids. Well, my oldest is still figuring out his life, and I can't count on him for much. But I have the younger ones. And my sister the next town over, I guess.

10 An alternative approach—***Catch It, Check It, Change It***—may be used for helping patients develop new or modified appraisals (see Appendix A3). This approach is similar to that described in the *Provider Tip Sheet* and presented in the *Cognitive Reappraisal Worksheet*, but includes a specific step for examining initial thoughts, making it a bit more complex. Although sometimes used as an approach for simplifying cognitive restructuring, a more complex cognitive strategy, this approach may be considered for facilitating Cognitive Reappraisal with Veterans who are adept at monitoring and evaluating their thoughts.

DR. TAMMY: *[asking questions to demonstrate the effects of extreme and unhelpful thinking, and the effects of a more balanced perspective]* When you say to yourself, "My wife will leave me, and I'll be all alone with no one to take care of me while my health declines," what is the effect on you?

BOBBY: It's awful. I'm scared shitless.

DR. TAMMY: I can see having the thoughts "My wife is going to leave me! I'm going to be all alone" makes you quite scared.

BOBBY: Yes! Very much so.

DR. TAMMY: Does it make you more or less likely to interact calmly with your wife?

BOBBY: *[looking dejected]* Less. It's like I have this mix of rage and desperation, and I just end up yelling at her. But that just makes things worse.

DR. TAMMY: Yes, I can see that. So what if you were to say to yourself, instead, "My wife and I are separated, but we're gonna try couple's therapy before deciding on a divorce. And even if we do get divorced, I will not be alone because I'll have my kids and my sister." What effect would that have on you?

BOBBY: I guess it calms me down a bit.

DR. TAMMY: So which type of thinking is preferable?

BOBBY: The second one. I get how that's more real.

DR. TAMMY: *[consolidating learning]* Can you put the second one in your own words? I don't want to put words in your mouth.

BOBBY: *[taking a breath]* Yeah, I'll try. I guess I could say something like, "Things with my wife aren't good right now, though she hasn't left for good. And she's laid out things for me to improve on, which is up to me. I also have other people in my life."

DR. TAMMY: Great. How about we write this down *[referring to the right-hand column of the Cognitive Reappraisal Worksheet]*. In addition to helping you "step back" and look at the situation based on the facts, using this form can help you remember this new way of looking at the situation when you start to become upset about your wife in the future.

BOBBY: Yes, let's do that.

DR. TAMMY: We've done something very important here, Bobby. Using the skill of Cognitive Reappraisal, we looked at your thinking about a specific situation–the conclusion that your wife is going to leave you, and that you'll be all alone–that is upsetting to you. But before taking your thoughts as fact, we looked at the situation and came up with another way of viewing it–that things aren't great with your wife, but not what you initially told yourself. Sticking to the facts of the situation, you came to see that your wife may not leave you and that you're not alone. As a result, it seems now you're feeling a bit more calm and centered.

BOBBY: *[looking surprised]* Yeah, I guess I am.

DR. TAMMY: Do you buy this, Bobby, that questioning how you look at situations before taking your initial thought as fact can help you to approach stressful situations in a more factual, helpful way?

BOBBY: Maybe, yeah. As long as I can think straight.

DR. TAMMY: That's a good point, Bobby. I wonder if it would be helpful to use one or both of the other skills you've learned–deep breathing or muscle relaxation–before using Cognitive Reappraisal to think things through so that you can bring down your level of emotion and think straight.

BOBBY: I think that sounds like a decent plan.

DR. TAMMY: Should you write down "Use deep breathing and muscle relaxation" to remind yourself?

BOBBY: Yeah, that would be good.

DR. TAMMY: *[follows along with Bobby]* So, how will you recognize when this tool, Cognitive Reappraisal, would be useful?

BOBBY: When I get thinking real negative.

DR. TAMMY: What can you stop and ask yourself in order to figure out a more helpful way of thinking?

BOBBY: Well, when it came down to it, you basically asked me if what I was thinking was based on the facts, or if there is another way to look at the situation.

DR. TAMMY: Yes, that's right. Whether you were considering all of the facts, and whether there were any facts you were forgetting about.

BOBBY: I guess, sometimes, I get tunnel-visioned on everything I think is wrong.

DR. TAMMY: *[providing empathic understanding]* We all do that sometimes. When this happens, it can be helpful to recognize when we are falling into that pattern, question ourselves, and acknowledge all the facts.

BOBBY: I guess I'll have to practice that.

In this example, Dr. Tammy took care not to instruct Bobby or tell him what to think. Nor did she focus on systematically examining his cognitions, as is done in cognitive restructuring. Instead, she used non-directive questioning to gently guide Bobby to consider a more complete perspective of the situation that it was a foregone conclusion that his wife was leaving him and that he would be all alone. In addition to helping him broaden his thinking, she also encouraged him to consider the effects of thinking in this manner. As Bobby reframed his thinking, Dr. Tammy prompted him to put his own words on the new way of thinking to assess his understanding and in recognition of the fact that his words are more likely to resonate with him. Dr. Tammy also took care to define the skill for Bobby and describe the rationale for its use. Because Bobby, like many Veterans, expressed concern that he might have trouble "thinking straight," Dr. Tammy suggested that he first use relaxation skills to calm himself and then apply Cognitive Reappraisal when his level of emotional intensity had dropped. She also talked with him about ways he can recognize when Cognitive Reappraisal would be useful and basic ways to help him gain perspective.

It is important to note that, in addition to facilitating patient engagement in the process of Cognitive Reappraisal, the non-directive, Guided Discovery approach to modeling and teaching this skill, described and illustrated above, allows the provider to gauge the Veteran's reaction to the process of shifting or shaping their interpretation of a situation and its emotional impact before deciding whether to invest additional time on the skill. It is also recommended that the provider check in with the Veteran to see what they think about more carefully considering their views of situations before taking them as fact, as Dr. Tammy did when she inquired, "Do you buy this, Bobby, that questioning how you look at situations before taking your initial thought as fact can help you to approach stressful situations in a more factual, helpful way?" Based on the patient's response during the Guided Discovery process and their reflection on the process, the provider can decide whether to continue further or to consider an alternate strategy.

The scenario with Bobby presented above illustrates a more complex life situation—the separation of Bobby and his wife—in which Cognitive Reappraisal may be introduced to, at least somewhat, reduce emotional intensity. In this scenario, there was a "kernel of truth" to Bobby's initial meaning-making of the situation that his wife would leave him and that he would be all alone. This is usually the case. Most initial appraisals, even if incomplete or

extreme, have some small element of truth that becomes magnified or twisted. In Bobby's case, his wife had requested a trial separation, so completely changing Bobby's appraisal would not have been appropriate and may have felt dismissive. Instead, working with the facts of the situation, Dr. Tammy helped Bobby to shape his thinking in a manner that was realistic and accessible to Bobby, which, in turn, altered the emotional impact of the stimulus. In less extreme scenarios, Cognitive Reappraisal can be used with patients to identify new ways of or factors for explaining a situation that had not been considered. This may, for example, include helping patients to consider external (rather than internal) or mitigating factors that may help to explain specific situations. For instance, reflecting the negative cognitive bias of depression, a patient with depression may react to lower-than-desired performance in a given situation by associating the performance with personal inadequacies, rather than other factors. Cognitive Reappraisal is also often very helpful with highly anxious patients for reframing their interpretations of physiological symptoms of anxiety. Such individuals often perceive physiological arousal symptoms, such as elevated heart rate, as signs of danger or serious health problems. In these situations, the provider may help the patient to develop more accurate meaning of the physiological symptoms they experience. In situations where the patient misinterprets physiological symptoms of anxiety, it is recommended that the provider also educate or remind the patient of the function and purpose of the stress response ("fight or flight") system, likely discussed initially during the introduction of Basic Relaxation Skills, which may help with reframing initial extreme appraisals of such symptoms.

As reflected by each of the foregoing examples, the overarching goal of Cognitive Reappraisal is to help the patient to develop skills to step back and gain additional perspective and meaning for situations they experience. As the highest skill on the PSB skill hierarchy presented herein, Cognitive Reappraisal is somewhat more complex than the skills described previously and requires practice inside and outside of session for effectively applying in one's life. However, it has been shown to be teachable in very brief intervention and related contexts. In PSB, Cognitive Reappraisal is most appropriate and feasible for addressing one or more identified situations and interpretations that significantly impact the Veteran's current psychological functioning and readiness for treatment. Cognitive Reappraisal may be considered for patients who express extreme, maladaptive, or incomplete thinking that appears to contribute to current distress.

In considering whether to include Cognitive Reappraisal in PSB for particular patients, it is important to recognize that accessing and altering cognitions is typically more challenging for patients with more intense negative affect (Gotlib & Joormann, 2010). Significantly, recent research suggests that self-compassion, or "the compassionate response towards one's own suffering," facilitates the effective use and impact of Cognitive Restructuring in patients with major depression (Diedrich, Hofmann, Cuijpers, & Berking, 2016, p. 2). In light of these findings, providers may wish to consider incorporating guided self-compassion (a type of Mindfulness Meditation available through web-based recordings and mobile applications identified in Appendix A1.1.2.2.2.) prior to implementing Cognitive Reappraisal with Veterans with significant depression or negative affect (Diedrich et al., 2016), or to otherwise consider alternate PSB strategies with such patients. In addition, research indicates that Cognitive Reappraisal is often less effective with patients experiencing acute stress or anger (Zhan et al., 2017). **Accordingly, Cognitive Reappraisal is recommended after patients have learned other skills for reducing arousal and promoting attentional control.** Collectively, these findings support the sequential use of PSB strategies identified in this toolkit.

SUMMARY

The concepts of treatment readiness and pre-treatment preparatory skills building, specifically, represent important innovations in the delivery of mental health care.

Through the process of preparatory skills building, providers work to enhance treatment readiness among selected Veteran patients with limited psychological coping capacity and resources. The PSB process and specific preparatory skills described above are designed to increase Veterans' confidence and ability to successfully engage in treatment. The concepts of treatment readiness and pre-treatment preparatory skills building, specifically, represent important innovations in the delivery of mental health care. **The approach to PSB described herein is designed to build on the SDM Session and its important focus on empowerment and interpersonal connection. Reflecting this dual emphasis, PSB providers maintain important focus on both the content and process—the "what" and the "how"—of the PSB session, such that skills are taught within a warm and engaging interpersonal environment.**

Consistent with an emphasis on content and process, an important emphasis of the PSB process is the explicit focus on discussing how patients will use each skill, identifying and problem solving any potential barriers to using the skill, and discussing the purpose and rationale of specific skills with the patient to maximize the likelihood that the Veteran will use the skill. The emphasis on individualizing and promoting the utility, application, and use of specific skills should take precedence over focusing on quantity of skills.

The selection of preparatory skills is designed to be tailored to the patient within the hierarchy of skills presented in this PSB protocol, rather than be prescriptively assigned. The selection of specific skills is based on the needs, current distress or impaired functioning, baseline coping skills and abilities, and preferences of the Veteran, generally beginning with Basic Relaxation Skills and proceeding up the hierarchy. During the PSB process, providers are encouraged to function as scientist-practitioners, such that they use various types of data to inform the duration, sequencing, and selection of PSB skills, much like is done in the delivery of EBPs (Wenzel, 2013). This includes data related to the effectiveness and successful application of skills derived from qualitative and quantitative information reported by the patient, provider observations during session, and reports of others (e.g., family member, providers), when available. In this way, PSB sessions are delivered in a structured, thoughtful, and data-informed manner. Over the course of the PSB process, providers are encouraged to revisit earlier skills in the hierarchy to reinforce and solidify skills and address specific challenges to applying these skills outside of session.

Meditative Breathing, Progressive Muscle Relaxation, Guided Imagery, Mindfulness Meditation, Cognitive Defusion, and Cognitive Reappraisal represent foundational skills with empirical support, offer potential utility in a pre-treatment context for addressing various mechanisms of coping, and are generalizable for patients with a range of mental and behavioral health conditions. At the same time, this list is not intended to be an exhaustive enumeration of skills providers may consider. Additional skills may be considered for specific patients, though it is recommended that these include skills with empirical support, as well as theoretical and clinical utility for use within a pre-treatment, preparatory context.

Although preparatory skills have the potential to confer relatively immediate benefit to patients, their full potential is often realized following repeated practice and, when indicated, when incorporated and extended in treatment. Accordingly, at the outset of the PSB process, providers set the expectation for practicing the skills outside of session to derive even greater benefit. In addition, while it is important to convey optimism and enthusiasm when setting the stage for PSB, it is also important to explicitly note at the

PSB provides more generalized foundational skills designed to promote general coping capacity to enable the patient to better engage in, and get the most out of, the treatment

outset of the PSB process that the skills are not intended as full treatment and, as such, will not have the full impact of a more extended treatment process designed specifically to treat the target condition. PSB provides more generalized foundational skills designed to promote general coping capacity to enable the patient to better engage in, and get the most out of, the treatment process. **As the PSB process unfolds, it is important for the specific function of PSB as a bridge to treatment to remain in view and guide next steps.**

It is hoped that the PSB approach described in this toolkit provides a useful and feasible structure and framework for empowering and engaging Veterans with core psychological skill needs and for moving them along the continuum of treatment readiness. Through this focused, yet individualized, process designed to promote skills, confidence, and agency, PSB, paired with the SDM Session, provides an important early clinical opportunity for increasing the uptake and impact of EBPs among those who are often least likely to benefit from these treatments.

Through this focused, yet individualized, process designed to promote skills, confidence, and agency, PSB, paired with the SDM Session, provides an important early clinical opportunity for increasing the uptake and impact of EBPs among those who are often least likely to benefit from these treatments.

APPENDIX A2

Preparatory Skills Building

Provider Tip Sheets

Provider Tip Sheet

MEDITATIVE BREATHING

PART 1: DIAPHRAGMATIC BREATHING

STEP 1: PROVIDE THE PATIENT WITH PSYCHOEDUCATION ABOUT MEDITATIVE BREATHING

- "I'd like to talk with you about an effective strategy for managing stress and strong emotions, like anxiety and anger. When we are under acute stress, the brain activates what is called the 'sympathetic nervous system.' This is like an accelerator that increases heart rate, blood pressure, and respiration, and constricts blood vessels to prepare the body to deal with the perceived threat. This is sometimes referred to as the 'fight-or-flight' response, as these physical changes provide greater strength for battle and help increase our speed for escape. This is an evolutionary response that worked well in the days of cavemen who had to deal with major physical threats. The challenge is that the many stressors of today's world also activate this response when it is not needed. This breathing exercise that I will teach you helps to keep the fight-of-flight response in check."
- "This skill is also helpful for reducing your overall 'emotional temperature' so that it takes more to really affect you. So, in this way, Meditative Breathing is a powerful preventative tool that we recommend regularly incorporating into your life even if you are not experiencing acute stress."

STEP 2: INTRODUCE DIAPHRAGMATIC BREATHING

- "This skill involves two parts. The first part that I will review with you is called 'diaphragmatic', or 'abdominal', breathing. This is a new way of breathing for most people. Most people engage in what is called 'thoracic', or 'chest', breathing. This is because it involves breathing by moving air in and out of the thoracic cavity, which is the hollow space behind your chest. Thoracic breathing is a shallow type of breathing that results in exhaling too much carbon dioxide and breathing in too much oxygen."
- "'Diaphragmatic breathing,' on the other hand, involves breathing with your diaphragm, the large muscle near the abdomen at the bottom of the lungs. Breathing with the abdomen provides for deeper breathing and results in a healthier ratio of oxygen to carbon dioxide that helps to induce calm. This type of breathing sends a signal to the brain that activates the '*parasympathetic* nervous system'. This part of the nervous system cools down the body by slowing heart rate, dilating blood vessels, and relaxing the muscles. It functions kind of like the radiator in a car."
- "Let's take a look at the difference between diaphragmatic breathing using your abdomen and shallow breathing using your chest muscles."

  Provider should put their right hand on your belly and left hand on your chest. Ask the patient to do the same.

  Demonstrate shallow breathing, ensuring that your chest expands and contracts and that your shoulders are moving up and down. Ask the patient to do the same. The patient should notice their left hand (chest) move, which reflects thoracic breathing, while their right hand stays still.

  Demonstrate diaphragmatic breathing to the patient, ensuring that your belly is expanding and contracting. Ask the patient to do the same. The patient should notice their right (belly) move, which reflects diaphragmatic breathing, while their left hand stays still.

STEP 3: OBTAIN THE PATIENT'S BUY-IN TO ENGAGE IN DIAPHRAGMATIC BREATHING

- "Now, let's practice diaphragmatic breathing together. How does this sound to you?"
- "Do you have any questions?"

STEP 4: ELICIT BASELINE SUDS RATING AND HAVE PATIENT RECORD IN COPING SKILLS PRACTICE LOG

- "Before we get started, can you tell me how much stress you now feel on a 0-10 scale, with 0 being 'no stress' and 10 being 'the most stress you can imaging feeling'?"
- "OK, let's write this down on the Relaxation Skills Practice Log."

STEP 5: PREPARE THE PATIENT TO BEGIN THE EXERCISE

- "Let's start by having you sit up in a confortable position, with your legs straight and feet on the floor."
- "Ready to begin?"

STEP 6: LEAD THE PATIENT THROUGH DIAPHRAGMATIC BREATHING

Lead the Veteran through the exercise by instructing them to inhale through the nose, hold for three seconds, and exhale through the mouth. Have the Veteran keep their right hand on their belly and left hand on their chest for them to monitor whether they are breathing from their chest or abdomen. Practice for about 5 minutes.

- "Keep your right hand on your belly and left hand on your chest during the exercise."
- *Repeat the following prompt:* "Breathe in through your nose, gently pushing your belly out, hold for 3 seconds, and breathe out through your mouth, returning your belly to its normal state. Take comfortable breaths as you breathe."

Monitor the patient to check for understanding.

STEP 7: DEBRIEF

- "What was the experience like for you? What did you notice?"
- "Most people find that as they practice this skill, it becomes even more effective. Would you be willing to practice this outside of session?"

To support the Veteran in practicing diaphragmatic breathing and learning more about its effects on the stress response system, you may consider recommending the Veteran download the Breathe2Relax mobile application, developed by the Department of Defense National Center for Telehealth and Technology. The app is free to use and may be accessed at: www.t2health.dcoe.mil/apps/breathe2relax.

PART 2: **MEDITATIVE COMPONENT**

STEP 8: **INTRODUCE MEDITATIVE COMPONENT**

- "Earlier I mentioned that Meditative Breathing has two parts. The first part is learning how to breathe more deeply using diaphragmatic breathing, which we've reviewed. The second part involves adding the meditative element. This is a very powerful tool that helps people get through difficult moments in life. It's also a skill that is very helpful when you're not experiencing acute stress for reducing your emotional temperature, especially when used regularly."
- "As part of this exercise, I will invite you to close your eyes and engage in deep, comfortable breathing, again inhaling through your nose and out through your mouth. As you do so, I will ask you to focus only on your breathing, following the sound and movement of each breath. As you learn to breathe from your abdomen, this will be how you breathe. For now, however, I don't want you to worry too much about that. I just want you to focus on the rhythm and flow of breath, so that your breathing is your reference point. At times, you will find that your mind will wander. You may think about different things in your life or even about this exercise. When this happens, I want you to note it and re-direct your thinking back on to your breathing. Continue in this way throughout the exercise. My voice will guide you through the exercise."

STEP 9: **OBTAIN THE PATIENT'S BUY-IN**

- "How does this sound to you?"
- "Do you have any questions?"
- "Are you willing to give this a try?"

STEP 10: **PREPARE THE PATIENT TO BEGIN THE EXERCISE**

- "OK, let's start by again having you sit up in a confortable position, with your legs straight and feet on the floor. Relax the muscles in your neck, arms, and legs."
- "Ready to begin?"

STEP 11: **LEAD THE PATIENT THROUGH MEDITATIVE BREATHING**

Lead the Veteran through the exercise, as follows, using a soothing, but natural tone of voice:

- "Go ahead and close your eyes. Take a confortable deep breath in through your nose and out through your mouth *[pause]*. Again, in through your nose and breathe out through your mouth. Focus your thinking on your breathing. Notice the sound of each breath as it enters your nose, and then as it exits your mouth."
- "If your mind tends to wander and you begin to think about something else, just redirect your thinking back on to your breathing."
- "Breath in through your nose and out through your mouth. Follow the air as you breathe in, and then as you breathe out *[pause]*. Notice the temperature of the air as it enters the tip of your nose *[pause]*. Follow the path of each breath."

Repeat prompts approximately every 30 seconds for about 8-10 minutes, alternating focus on sensations related to the breathing (e.g., sound, rate, rhythm, temperature, flow). To conclude the exercise, state the following:

- "In a moment, I will count down from 10. As I do so, I will ask you to very slowly open your eyes. As I reach 1, and with your eyes open, notice how you are feeling without feeling a need to speak for a few moments."

Note: Occasionally, a patient may report feeling lightheaded during the exercise. If this is the case, it may reflect that the patient is breathing too fast or too forcefully. Remind the patient to take slow, comfortable breaths.

STEP 12: **DEBRIEF**

- "What was the experience like for you? What did you notice? Did you find that your mind tended to wander? What did you do?"
- "How helpful was this in helping you to relax?"

  Elicit final SUDS rating and have patient record on the Relaxation Skills Practice Log.
- "Can you tell me how much stress you now feel on a 0-10 scale, with 0 being 'no stress' and 10 being 'the most stress you can imaging feeling'?"
- "OK, let's write this down on the Relaxation Skills Practice Log."
- "Most people find that as they practice this skill, it becomes even more effective. Would you be willing to practice this outside of session?"

  Work with the patient to identify the specific way in which they will practice Meditative Breathing outside of session, including (1) frequency of practice, (2) time of day, and (3) location. Use the Practice Plan Summary Form (see Appendix A3) to record details of the Veteran's plan for practicing the skill outside of session.

  The following are two brief, freely-available web-based audio recordings that may be recommended to patients for practicing Meditative Breathing outside of session:

  - *UCLA Mindful Awareness Research Center – Breathing Meditation:* www.marc.ucla.edu/mpeg/01_Breathing_Meditation.mp3
  - *Excel at Life – Mindful Breathing:* www.excelatlife.com/mp3/mindfulbreathing.mp3
- "Is there anything that may get in the way of your being able to do this? Do you have any questions?"
  - *Problem solve potential barriers, as appropriate.*

Source: Karlin, B. E., & Wenzel, A. (2018). *Evidence-based psychotherapy shared decision-making toolkit for mental health providers*. Waltham, MA: Education Development Center, Inc.

Provider Tip Sheet

PROGRESSIVE MUSCLE RELAXATION (PMR)

STEP 1: PROVIDE THE PATIENT WITH PSYCHOEDUCATION ABOUT PMR

- "Progressive muscle relaxation is a simple skill that has been shown by research to be effective in reducing stress and producing a feeling of physical relaxation. It involves tensing various muscle groups, one by one, and then relaxing them. My voice will guide you through the process. As you tense each muscle group, I will ask you to focus on the tension you feel. Then, as you relax the muscle, I will ask you to observe the difference you feel."
- "After we complete the exercise, we will talk about the effect it had on you and ways to practice this in your life outside of this session."

STEP 2: OBTAIN THE PATIENT'S BUY-IN

- "How does this sound to you?"
- "What questions might you have?"
- "Would you like to give this a try?"

  Note: PMR is generally not recommended for individuals with arthritis or physical pain that may be exacerbated by systematic muscle tensing. With such individuals, you may implement PMR by instructing the patient to imagine tensing and relaxing specific muscle groups.

- "Do you have physical pain or a condition such as arthritis that may make it hard to tense different muscles?"

STEP 3: ELICIT BASELINE SUDS RATING AND HAVE PATIENT RECORD IN COPING SKILLS PRACTICE LOG

- "Before we get started, can you tell me how much stress you now feel on a 0-10 scale, with 0 being 'no stress' and 10 being 'the most stress you can imaging feeling'?"
- "OK, let's write this down on the Relaxation Skills Practice Log."

STEP 4: PREPARE THE PATIENT TO BEGIN THE EXERCISE

- "Let's start by having you sit up in a confortable position, with your legs straight and feet on the floor."
- "If it is comfortable with you, many people find this works best if they close their eyes during the exercise. If not, that's okay, you can keep your eyes open and focus on each muscle group as I describe them."

  For each muscle group, encourage the patient to tense their muscles for 5-7 seconds and focus on the feeling of tension. Then, instruct the patient to slowly release the tension and take careful notice of the difference between the tensed and relaxed state for about 30 seconds. It is recommended to do this two times for each muscle group.

- "During the exercise, I will ask you to hold and focus on the sensation of tension as you tense each muscle group. Please try to devote your full attention to the tension you feel. Then, as you slowly release the tension, I will ask you to

focus on how differently this feels. While you should feel some slight discomfort from the tension, please let me know if at any point you feel any pain."

- "Ready to begin?"

STEP 5: LEAD THE PATIENT THROUGH PROGRESSIVE MUSCLE RELAXATION

- "OK, let's begin."
- *Hands and forearms*: "Starting with your hands, make fists with both hands and pull the fists up on your wrists."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- *Biceps*: "Make fists and bend your arms up to touch your shoulders." OR "Push your elbows down against the chair."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- *Forehead: "*Lift your eyebrows as high as they can go."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- *Upper cheeks and nose:* "Squint your eyes and wrinkle your nose."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- *Lower cheeks and jaws:* "Bite down hard and pull back the corners of your mouth."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- *Neck and throat:* "Pull your chin down toward your chest."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- *Chest, shoulders, and upper back:* "Pull your shoulder blades together."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- *Abdominal region:* "Pull your stomach in, making it hard."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- *Thighs:* "Hold your legs out and tense your thighs."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- *Calves:* "Pull your toes toward your head." OR "Put your tip-toes on the ground and tense your calves."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- *Feet:* "Point and curl your toes, turning your foot inward."
  - "Notice the tension and what this feels like…Hold it…Now relax. Focus on how this now feels."
- "Now, take a minute to notice how you're feeling throughout your body."
- "In a moment, I will count down from 10. As I do so, I will ask you to very slowly open your eyes. As I reach 1, and with your eyes open, notice how you are feeling without feeling a need to speak for a few moments."

STEP 6: **DEBRIEF**

- "What was the experience like for you? What did you notice?"
- "How helpful was this in helping you to relax?"

  Elicit final SUDS rating and have patient record on the Relaxation Skills Practice Log.

- "Can you tell me how much stress you now feel on a 0-10 scale, with 0 being 'no stress' and 10 being 'the most stress you can imaging feeling'?"
- "OK, let's write this down on the Relaxation Skills Practice Log."
- "How willing are you to do this outside of session?"

  Work with the patient to identify the specific way in which they will practice PMR outside of session, including (1) modality (e.g., web-based recording, mobile phone application, recording of your voice, written instructions, (2) frequency of practice, (3) time of day, and (4) location. Use the Practice Plan Summary Form (see Appendix A3) to record details of the Veteran's plan for practicing the skill outside of session.

  The following are two brief web-based PMR recordings that are freely available and may be downloaded that providers may recommend for patients to listen to outside of session or for incorporating in session for practicing PMR:

  - *Dartmouth College Health Service:* www.media.dartmouth.edu/~healthed/p_muscle_relax.mp3
  - *University of Southern California Center for Work and Family Life:* www.cwfl.usc.edu/training/audio/relaxation/andrea_muscles.mp3

- "Is there anything that may get in the way of your being able to do this? Do you have any questions?
  - *Problem solve potential barriers, as appropriate.*

Source: Karlin, B. E., & Wenzel, A. (2018). *Evidence-based psychotherapy shared decision-making toolkit for mental health providers*. Waltham, MA: Education Development Center, Inc.

Provider Tip Sheet

GUIDED IMAGERY

STEP 1: PROVIDE THE PATIENT WITH PSYCHOEDUCATION ABOUT GUIDED IMAGERY

- "I'd like to introduce you to another exercise for promoting a sense of calm and well-being called 'Guided Imagery'. Guided Imagery is a simple technique, supported by research, that involves imagining oneself in a relaxing scene as the scene is described in detail. Re-focusing your thinking on to relaxing images allows for calming the mind and, in turn, your body."
- "As part of this exercise, I will ask you to close your eyes, if you are comfortable doing so, and follow my voice as I guide you through a peaceful scene, such as a particular scene of nature that many people find relaxing, almost like an 'imaginal vacation.'"

STEP 2: OBTAIN THE PATIENT'S BUY-IN

- "How does this sound to you?"
- "What questions might you have?"
- "Would you like to give this a try?"

Note: It can be useful to inquire as to the types of scenes or stimuli (e.g., beach, forest, meadow, cabin in the woods) that the patient associates with being most relaxing and to tailor the Guided Imagery exercise to this preference.

- "Very good. I'm wondering if you there are particular aspects of nature that you find most relaxing or appealing, for example, the beach, a forest, a cabin by the lake or the snow, the mountainside, and so forth. I'd like to make sure this is something that you're really able to connect to. It's okay if you don't have a preference."

STEP 3: ELICIT BASELINE SUDS RATING AND HAVE PATIENT RECORD IN COPING SKILLS PRACTICE LOG

- "Before we get started, can you tell me how much stress you now feel on a 0-10 scale, with 0 being 'no stress' and 10 being 'the most stress you can imaging feeling'?"
- "OK, let's write this down on the *Relaxation Skills Practice Log*."

STEP 4: PREPARE THE PATIENT TO BEGIN THE EXERCISE

- "Let's start by having you sit up in a confortable position, with your legs straight and feet on the floor. Relax the muscles in your neck, arms, and legs, feeling the tension slowly leave your body. In a moment, we'll begin describing a scene. Please follow the scene as it is described. Pay attention to the sights, sounds, temperature, textures, and tastes that may be described."
- "Now, go ahead and take a deep breath in through your nose, hold it, now exhale through your mouth. Again, in through your nose and out through your mouth. Good."

STEP 5: **LEAD THE PATIENT THROUGH GUIDED IMAGERY**

Lead the Veteran through the exercise, describing the scene in detail. The following are best practices for doing so:

- *Use a soothing tone of voice, speaking slowly and pausing periodically to allow the patient to fully envision and experience the scene*
- *Use sufficient detail to better enable the patient to envision specific stimuli*
- *Invoke multiple scenes (sight, sound, smell, taste, and touch), as appropriate, to maximize sensory experience by occasionally describing different aspects of the sensory experience*
- *With patients with a history of trauma, avoid introducing elements or surroundings that may trigger memories of the traumatic event*

Alternatively, you may play one of a variety of recorded Guided Imagery scenes that are available. Basic Guided Imagery scripts that may be read in session and a range of recordings are freely available online, such as the following:

- *Scripts*: www.hubpages.com/health/Guided-Imagery-Forest-Script
- *Recordings*: www.excelatlife.com/downloads/relaxation/audios.htm

- "In a moment, I will count down from 10. As I do so, I will ask you to very slowly open your eyes. As I reach 1, and with your eyes open, notice how you are feeling without feeling a need to speak for a few moments."

STEP 6: **DEBRIEF**

- "What was the experience like for you? What did you notice?"
- "How helpful was this in helping you to relax?"

  Elicit final SUDS rating and have patient record on the Relaxation Skills Practice Log.

- "Can you tell me how much stress you now feel on a 0-10 scale, with 0 being 'no stress' and 10 being 'the most stress you can imaging feeling'?"
- "OK, let's write this down on the Relaxation Skills Practice Log."
- "How willing are you to do this outside of session?"

  Work with the patient to identify the specific way in which they will practice Guided Imagery outside of session, including (1) modality (e.g., web-based recording, mobile phone application, recording of your voice), (2) frequency of practice, (3) time of day, and (4) location. Use the Practice Plan Summary Form (see Appendix A3) to record details of the Veteran's plan for practicing the skill outside of session.

- "Is there anything that may get in the way of your being able to do this? Do you have any questions?"
  - *Problem solve potential barriers, as appropriate.*

Source: Karlin, B. E., & Wenzel, A. (2018). *Evidence-based psychotherapy shared decision-making toolkit for mental health providers*. Waltham, MA: Education Development Center, Inc.

Provider Tip Sheet

MINDFULNESS MEDITATION

STEP 1: PROVIDE THE PATIENT WITH PSYCHOEDUCATION ABOUT MINDFULNESS MEDITATION

Note: Exercise caution prior to introducing Mindfulness Meditation to Veterans with significant unresolved trauma, especially those with very limited basic coping skills. For these patients, it is typically more appropriate in the preparatory skills context to focus on other coping skills that do not involve exposure to internal or other experiences that may trigger significant trauma reactions, especially for providers who do not have significant experience implementing Mindfulness Meditation with such patients or working with unresolved trauma.

- "I'd like to review another skill with you. It involves learning a very effective skill called 'mindfulness'. Have you heard of 'mindfulness' before? What have you heard?"

- "Basically, 'mindfulness' refers to paying attention to what's going on in the present moment—and doing so without judging what you notice, just observing. This may include paying attention to what's going on *inside* of you—being aware of your thoughts, feelings, and physical sensations. For example, you might pay attention to your breathing, noticing the air moving in and out of your body; or you might pay attention to the experience of specific tastes, such as the flavor and texture of a grape or the sweetness of a ripe watermelon. It also includes paying attention to what's going on *outside* of you, using your five senses—for example, being present to and observing the sights and sounds on a sunny day in your backyard, such as the chirping of the birds, the green of the leaves, the blue in the sky, the smell of the dew. This kind of paying attention is about being grounded in the moment rather than being lost in thought."

- "The specific *practice* of mindfulness, which involves certain kinds of exercises to help you apply mindfulness in your life, is called, 'Mindfulness Meditation.'"

- "Have you heard of this before? What comes to mind when you hear 'Mindfulness Meditation'?"

  Assess the patient's knowledge and beliefs, and process the patient's response. Listen for receptivity or bias related to the concept of meditation. If the patient has specific preconceptions about the practice of mindfulness as presented here, you may note that people often confuse this daily awareness practice with formal meditation practices designed to achieve a higher state of consciousness. Use and adapt, as appropriate, the rationale below to increase the patient's understanding and receptivity.

- "Mindfulness Meditation involves the specific practice of mindfulness and has been subject to many years of research. This scientific research has shown that Mindfulness Meditation has many positive benefits. It can help people cope with stress, anger, and other difficult emotions. It can help build tolerance for stress and other difficult emotions, so it takes more to get you upset. Mindfulness Meditation has also been shown to improve health and physical functioning, including improved sleep, reduced pain, and improved immune functioning. It's also been shown to improve other aspects of life. For instance, it can sharpen concentration, allowing greater focus in different areas of your life. Together, the emotional, psychological, and physical benefits of Mindfulness Meditation make it a great skill to learn and practice. As you might suspect, the benefits are greatest when it is practiced regularly and made part of your regular routine."

- [*If appropriate, add*]: "Although it takes practice, the good news is that Mindfulness Meditation builds on some of the coping skills we have already covered, like the Meditative Breathing exercise. Unlike those skills, Mindfulness Meditation is not specifically about relaxation, although this can be a consequence. Rather, it's about being more present and aware, which is not always relaxing."

- "If you are interested in learning Mindfulness Meditation, there are two beginning exercises I can guide you through to get you started and give you a sense of what it is and how it looks in practice. After we complete these exercises, we'll talk about what you noticed. Then, if you wish to continue, I'll provide you with information and tools to help you to continue to learn and practice outside of session."

STEP 2: **OBTAIN THE PATIENT'S BUY-IN**

- "How does this sound to you?"
- "What questions might you have?"
- "Would you like to give this a try?"

Note: Many Mindfulness Meditation exercises invite the patient to close their eyes. Patients with a history of trauma or general preference to keep their eyes open may do so. Invite these patients to gently focus on the floor or other spot in front of them.

STEP 3: **GET PATIENT INTO MEDITATION POSTURE**

- "Okay, as you prepare to begin Mindfulness Meditation exercises, it's helpful to do a couple of things. First, choose your body position. Sitting in a chair, in a firm but not rigid position with both feet on the floor, is generally best. When you practice at home, I would do the same. You may choose to lie down at home, but if you do, be sure you're able to stay alert. If you routinely fall asleep, move back to the chair. Second, some people like to start meditation with a simple breathing exercise. It involves taking three deep breaths and gently closing your eyes or finding a place on the floor to rest them on following the third exhale. You may prepare to begin the same way at home. There is nothing particularly difficult about doing a mindfulness exercise, it simply requires your attention."

STEP 4: **LEAD THE PATIENT THROUGH INITIAL MINDFULNESS PRACTICE EXERCISE: THE RAISIN EXERCISE**

The provider should deliver this exercise in a way that is paced and appropriate to the process, speaking slowly and with a soothing, yet natural, tone. Allow time for the patient to fully engage and be aware of the experience during the presentation of the meditation. The provider should pause at appropriate times and allow sufficient time and space between instructions. The following online demonstrations on how to conduct the Raisin Exercise are also available:

- http://www.mbsrtraining.com/mindfully-eating-a-raisin-exercise/
- https://ggia.berkeley.edu/practice/raisin_meditation

- "This initial exercise is a simple exercise that shows what mindfulness, or paying attention in the moment, is like."
- "Let's start by having you sit up in a comfortable position, with your feet on the floor. I am going to pass you some raisins. Go ahead and take two or three and just hold them in your palm for now."
- "Now, I'd like you to choose one of these raisins to focus on, as best you can, bringing your full attention to this one small object for the next few minutes. First, you might notice which object you picked, what drew you to the one you chose. Was there something about this one in particular that drew your attention? "
- "Take time to look at this object carefully, as though you had never seen anything like it before. Bringing your attention to seeing the object, maybe picking it up with the other hand and observing all of its qualities. You might even imagine you've just arrived from another planet and that your task is to observe this object in as much detail as possible."
- "Feel its texture between your fingers, noticing its color and surfaces. All of the different shades and shadows, and its unique shape."

- "While you are doing this, you might be aware, too, of any thoughts you might be having about this little object, or about the exercise or how you are doing in the exercise. You might notice feelings, too, like pleasure or dislike of this object or this exercise. Just notice these thoughts or feelings as well, and, as best you can, bring your attention back to simply exploring the raisin."
- "Now bringing this object up under your nose and inhaling, noticing if the object has a smell. You might even bring it to your ear and squish it a little and see if it has a sound. And now take another look at it."
- "And now slowly bringing this object up to your lips, aware of the arm moving the hand to position it correctly. And then gently placing the object against your lips, sensing how it feels there. Holding it there for a moment, aware of the sensations and any reactions—maybe anticipation or the mouth beginning to salivate."
- "And now placing this raisin on the tongue, and pausing here to feel what this object feels like in the mouth. The surfaces, texture, even the temperature of this object. Now beginning with just one bite into this object and pausing again there. Noticing what tastes are released, if the texture has changed. Maybe the object has now become two objects."
- "Now chewing slowly, noting the actual taste and change in texture. Maybe noticing, too, how the tongue and jaw work together to position the object between the teeth, how the tongue knows exactly where to position it as you chew."
- "And when you feel ready to swallow, watching that impulse to swallow. Maybe pausing before swallowing to notice the urge. Then, as best you can, feeling the object as it travels down the throat and into the belly. You might even sense the body is one small object heavier."

STEP 5: **DEBRIEF**

- "What did you notice during that experience?"
- "Did you find that being aware of eating a raisin changed the experience of eating a raisin?"
- "Do you have a sense of how bringing this kind of awareness, using your senses, into other parts of your life might be helpful?"
- "How willing are you to do exercises like this at home, ones that sharpen your awareness?"

STEP 6: **LEAD THE PATIENT THROUGH BEGINNING MINDFULNESS MEDTIATION EXERCISE**

The provider should deliver this exercise in a way that is paced and appropriate to the process, speaking slowly and with a soothing, yet natural, tone. Allow time for the patient to fully engage and be aware of the experience during the presentation of the meditation. The provider should pause at appropriate times and allow sufficient time and space between instructions.

[As an alternative to this exercise, the provider may implement or play one of the Mindfulness Meditation exercises in the table below. If the provider is familiar with Mindfulness Meditation and has experience with one or more of the exercises in the table below, they may guide the patient through one or more of these exercises. It is recommended that any exercise implemented be similar to those presented here and be simple enough for the patient to complete and practice on their own.]

- "Let's begin this exercise by placing your feet solidly on the ground and sitting up in your chair so that your back is straight, but not rigid. Make sure that your head feels square to your shoulders, and place your arms in a comfortable position to your sides [*demonstrate for the patient by modeling the posture*]. This posture will help you to stay alert and focused. "
- "Begin by first noticing or paying attention to the fact that your body is actively sensing the environment. Notice that you can feel yourself sitting in the chair and you can feel your feet on the ground. Also notice that you can feel

the clothes on your skin and perhaps your jewelry. Notice, too, that you might feel the bend of your knees or elbows. Now, if you feel comfortable doing so, gently close your eyes, or locate a place in front of you where you can fix your gaze. Notice as you close your eyes that your ears tend to open. Take a few moments to pay attention to all of the sounds that you here. *[Take a short bit of time and list the different sounds that are present in the room—e.g., the blow of the air conditioning or heater, the sound of your voice]*. Just take this time to follow the sound *[pause for a few moments]*."

- "Now gently releasing your attention from sound, place your attention at the tip of your nose and begin to notice the sensation of air moving in and out of your nostrils *[pause]*, paying attention to your breathing. You may notice that the air coming in through your nostrils is slightly cooler than the air moving out of your nostrils *[pause]*. Allow yourself to just gently follow your breathing, paying attention to the gentle easy air as it passes in and out *[pause]*."
- "You may also notice your chest or stomach move as you inhale and exhale. Be aware of the expansion and contraction, be your breathing *[pause]*."
- "If you become distracted by your thoughts, just take a moment to notice where your thoughts took you, notice where your mind went, and then without judgment, let go and return your attention to your breathing. If you get distracted a hundred times, bring yourself back to your breath a hundred times."
- "Now let's just take the next few minutes to focus completely on breathing. If it helps, you can count with the breath, saying to yourself 'one' on the in-breath and 'two' on the out-breath, all the way up to 10 and then start over again, completing this cycle several times. If your mind pulls your attention away, gently bring your attention back to focusing on the breath." *[Another possibility instead of counting is to say, "breathing in" on the in-breath and "breathing out" on the out-breath, repeatedly, to assist with keeping attention on the breath. Allow several minutes for focused breathing.]*
- "Now releasing your attention from the breath, I invite you to turn your attention again to hearing. Notice whatever sounds arises. Also notice its intensity or quality. Simply be aware of hearing. If your mind pulls your attention away, gently bring your attention back to focusing on sound." *[Allow several minutes for focused attention on sound.]*
- "Now releasing your attention from sound, gently focus on your body and how it feels to sit in the chair *[pause]*, notice the placement of your feet *[pause*], and arms and head [*pause*]. Picture what the room will look like and when you are ready, rejoin the room by opening your eyes."

STEP 7: **DEBRIEF**

- "What did you notice during that experience?"
- "Do you have a sense of how bringing this kind of awareness, using your senses, into other parts of your life might be helpful?"
- "How willing are you to do exercises like these at home, ones that sharpen your awareness and bring you into the present moment?"

Work with the patient to identify the specific way in which they will practice specific Mindfulness Meditation exercises outside of session, including (1) frequency of practice, (2) time of day, and (3) location. Use the Practice Plan Summary Form (see Appendix A3) to record details of the Veteran's plan for practicing the skill outside of session.

The following is a list of web-based Mindfulness Meditation audio recordings that can be recommended to the patient. The provider should review each and be prepared to recommend one or more to the patient.

Source: Karlin, B. E., & Wenzel, A. (2018). *Evidence-based psychotherapy shared decision-making toolkit for mental health providers*. Waltham, MA: Education Development Center, Inc.

PRIMARY FOCUS	LENGTH (MINS.)	SOURCE
Body Scan (Female Guide)	3	Greater Good Science Center www.mindful.org/a-3-minute-body-scan-meditation-to-cultivate-mindfulness/
Body Scan (Female Guide)	10	Tara Brach www.tarabrach.com/ten-minute-basic-guided-meditation-practice/
Body Scan (Male Guide)	29	Jon Kabat-Zinn https://www.youtube.com/watch?v=15q-N-_kkrU
Breath, Sounds, and Body (Female Guide)	12	Excel at Life marc.ucla.edu/mpeg/02_Breath_Sound_Body_Meditation.mp3
Sounds and Thoughts (Male Guide, British Accent)	8	Mindfulness: Finding Peace in a Frantic World http://cdn.franticworld.com/wp-content/uploads/2012/02/Sounds-and-thoughts-meditation-from-book-Mindfulness-Finding-Peace-in-a-Frantic-World-128k.mp3
Breath (Male Guide)	10	John Kabat-Zinn www.youtube.com/watch?v=8HYLyuJZKno
Breath/General Mindfulness Meditation (Male Guide)	20	Jon Kabat-Zinn https://www.youtube.com/watch?v=524RMtfHKz8

The following table provides examples of Mindfulness Meditation mobile applications that may be considered for recommending to or using with patients, ranging from more basic or introductory applications to those that include more extensive content and features. All of the apps listed are free to download and include at least some free content, though they vary in the extent of free material available.

NAME	WHERE TO FIND IT	COMMENTS
Mindfulness Coach 	mobile.va.gov/app/mindfulness-coach	Developed by the VA and DoD, this app provides mindfulness education, exercises, and mindfulness tracking logs to monitor progress. The app also allows users to set reminders for engaging in mindfulness exercises. All content is free. A simple to use app for introduction to Mindfulness Meditation. Available for iPhone (Android coming soon).

NAME	WHERE TO FIND IT	COMMENTS
Stop, Breathe, Think 	www.stopbreathethink.com	This Mindfulness Meditation and compassion-building app is simple and easy to use. The app provides information on mindfulness, its benefits, and what to expect when engaging in exercises. It includes brief information on physiological processes underlying stress and the science of mindfulness. The app includes approximately 30 free guided exercises, led by different teachers, and covers different general themes. The app provides a tool for tracking meditation activity and mood. Users may also earn stickers for their progress. Additional content is available for purchase. A good option for those who wish to learn more about mindfulness and may not be fully motivated or who would benefit from greater structure and simplicity. Available for iPhone and Android devices.
Aura 	www.aurahealth.io	This mindfulness app provides daily 3-minute, non-repeating meditation recommendations. Personalized experience is provided based on information provided about the user's age, level of stress, optimism, and interest in mindfulness. Daily meditation recommendations are based on current mood. Daily 3-minute meditations are free. Access to longer meditations is available for purchase. A good option for those interested in a single, brief daily meditation experience and personalized recommendations. Available for iPhone and Android devices.
Headspace 	www.headspace.com	This app includes hundreds of themed sessions, allowing users to focus the application of mindfulness for specific aspects of their experience, such as stress, sleep, and performance. The app uses well-designed metaphors to help promote understanding of the practice of mindfulness and includes a playful interface. The app includes limited free content and additional content for purchase. A good choice for regular mindfulness practice applied to different aspects of life and for those who prefer a rich user experience, particularly if cost is not a concern. Available for iPhone and Android devices.
Insight Timer 	www.insighttimer.com	This app features over 4,500 free guided exercises from over 1,000 teachers. Users choose from among the different exercises and teachers, rather than receive step-by-step recommendations. Users may customize intervals and background sounds. The app also includes podcasts and presents a community feel, providing information on how many others are meditating at the current time. All content is free. A good choice for those who wish to have access to and explore deep content across many different themes and offered by many different teachers, as well as for those who may be interested in the social media elements of mindfulness and community feel offered by the app. Available for iPhone and Android devices.

- "Is there anything that may get in the way of your being able to do this? Do you have any questions?"
  - *Problem solve potential barriers, as appropriate.*

STEP 8: (OPTONAL): DISCUSS GENERAL APPLICATION OF MINDFULNESS STRATEGIES TO EVERYDAY LIFE

Provide and discuss the handout below to remind the patient that they can engage in mindfulness throughout their daily life, at virtually anytime.

Source: Karlin, B. E., & Wenzel, A. (2018). *Evidence-based psychotherapy shared decision-making toolkit for mental health providers*. Waltham, MA: Education Development Center, Inc.

MINDFULNESS IN DAILY LIFE

We can apply the principles of mindfulness to our daily life in many ways. Often when we are eating, dressing, bathing, and walking we don't pay attention to what is happening. We spend our time thinking about the future or the past, or worries, but not on what we are doing in the present. Although it's sometimes convenient to plan our day or remind ourselves of what we need to do while we're washing our face or eating, simply paying attention to the act of the water splashing against our face or the experience of eating a tasty meal or treat can help us be more centered and balanced. The reality is that we often get so caught up in our thoughts that we lose our experience of what is happening in our daily life.

One way to re-capture our experiences is to engage in mindfulness *throughout the day*. It takes practice to focus our mind on seemingly mundane activities. However, the remarkable thing is that many activities become much more interesting once we truly focus our attention on them and allow ourselves to notice every sensation! And, we can do it almost anytime and with little effort.

You can practice mindful awareness during virtually any activity, such as while:

- Taking a shower or bath
- Being with a loved one
- Playing with children
- Eating (especially flavorful foods)
- Spending time outdoors (e.g., observing the details of nature)
- Listening to music or peaceful sounds
- Sitting by a fire

HERE ARE SOME STEPS TO FOLLOW FOR PRACTICING MINDFULNESS DURING DAILY ACTIVITIES:

1. *Choose an activity (e.g., a meal, walk to the canteen, shower). Note when you will begin and end the activity so that you give it a clear beginning and a clear ending.*
2. *Decide that you will make an honest effort to focus your attention to the different senses associated with that activity (like in the Raisin Exercise).*
3. *During the activity, every time you notice your attention has drifted away, gently pull your attention back to the present moment, back to the activity. It's okay if you have to bring your attention back even 100 times.*
4. *Practice a non-judgmental attitude. If you notice something that you don't like or that worries you, practice acceptance and letting go. If you are having difficulty doing the activity or focusing your attention, accept yourself in the moment, let go of any self-criticism, and return your thoughts to the present moment.*

Try this at least 3 times this week.

THINGS TO REMEMBER:

- **You can practice mindfulness right now.** Simply turn your attention to one of your five senses—hearing, seeing, tasting, touching, or smelling. Notice what you experience in the moment with that sense. Anywhere and anytime is a good time for mindful awareness.
- **Daily practice.** Practicing mindfulness everyday will improve your skill. Even 5 minutes is helpful.
- **Minds are busy.** Our minds are always chattering. When you practice mindfulness, remember it is easy to be interrupted by that chatter. It happens to all who practice mindfulness. Simply notice when this happens and bring your attention back to the focus of your mindfulness. If you are distracted one hundred times, draw your attention back one hundred times!
- **It's a process.** Mindfulness isn't an end goal or about doing something right. We never reach a mindful state and remain there. Mindfulness is a practice!

Provider Tip Sheet

COGNITIVE DEFUSION

STEP 1: PROVIDE THE PATIENT WITH PSYCHOEDUCATION ABOUT COGNITIVE DEFUSION

- "I'd like to share an important idea that relates to why people sometimes feel stressed, down, or stuck. As humans, we have learned to think, and we think all the time. Our mind is chattering all day every day. Because our minds are so busy, we forget that we are thinking. We don't recognize the ongoing chatter of our minds as 'me having thoughts'. Instead, we seem to *become* the thoughts themselves, or believe them as fact. It's as if we *are* our thoughts. We lose our awareness of our thinking. When this happens, difficult thoughts can begin to affect our sense of ourselves and how we act in the world. They take over and we get lost in them. Does that make sense to you?"
- "There is an effective skill that I can teach you to help you recognize that you have thoughts but that you are not your thoughts. This can allow you to disentangle or 'de-fuse' from them. This skill is called 'Cognitive Defusion'. 'Cognitive' refers to thinking, and 'defusion' refers to separating or disentangling, so 'Cognitive Defusion' essentially means disentangling yourself from your thinking."
- "Let's explore this a bit more. When people are stressed, down, or stuck, they often automatically believe what they think, especially thoughts about themself. For example, a person might think, 'I am unlovable' and hold this thought to be true, forgetting to see it as a thought, as words that the mind produced. However, if they were able to distance themself from their mind or thoughts, they would see their thoughts simply for what they are—thoughts or thinking, but not reality or something that is literally true simply because your mind thought it."
- "Cognitive Defusion is a skill that helps you to see the difference between you, the thinker, and your thoughts. That is, you are a person who has thoughts and these thoughts are fluid, constantly on the move, coming and going, like leaves passing on a stream. Some of these thoughts are more difficult, and seem to stick a bit more (or we are more fused with them), almost like a leaf caught in a whirlpool. But it is important to remember that the leaf is not the stream and the thinker is not the thought. That is what Cognitive Defusion can help you do. It can allow you to get just a little distance from your thoughts, so that you can interact with them in a more flexible way and move forward in your life without being dragged down by your thoughts."
- "There are several exercises we can practice to help you learn Cognitive Defusion. After we complete the exercises, we'll talk about your experience with them and discuss ways you can do this in your life outside of session."

STEP 2: OBTAIN THE PATIENT'S BUY-IN

- "How does this sound to you?"
- "What questions might you have?"
- "Would you like to give this a try?"

Several Cognitive Defusion exercises are presented below. Begin with Exercise 1 (Recognizing Thinking) and proceed with additional exercises as time permits. Providers may select from Exercises 2-4 based on their familiarity with each exercise and sense of what may be most meaningful to particular patients. Patients should also be informed that they will have the opportunity to learn multiple exercises so that they can choose those that they find most helpful, as not everyone responds in exactly the same way or connects with all of the exercises.

- "There are several different exercises that we can do to help you learn the skill of Cognitive Defusion. Some people take especially well to certain exercises, while others prefer different ones. So, I'd like to go over a few options and then ask for your feedback. Are you willing to experiment with a few? We'll cover some of this today and can continue next time if we decide."

STEP 3: LEAD THE PATIENT THROUGH COGNITIVE DEFUSION EXERCISES

Exercise 1: Recognizing Thinking

Introduce to all patients the meta-cognitive skill of Recognizing Thinking, a foundational Cognitive Defusion skill, using the script below. The following web-based video developed by VA may also be used in session or recommended to patients to help them to recognize their thinking as part of Cognitive Defusion: https://www.youtube.com/watch?v=BXAzdXJGMeE

- "We all have a running dialogue that is constantly in our heads. At any given moment, it might say things like, 'I like this,' 'I don't like that,' or 'I'm no good.' It might be commenting on what you are doing or it might be evaluating or complaining. It always has something to say. Even right now, the dialogue is running. Your mind might be saying, 'I'm not sure about this' or 'What if this doesn't work?' We often don't pay attention to the running dialogue, but it's still happening in the background."

- "If you feel comfortable, I'd like to invite you to close your eyes for a few moments and simply notice. Notice the dialogue inside your head [*pause to allow time for the patient to notice*]. Now notice how your mind comments, questions, and evaluates [*pause*]. On and on it goes [*pause*]. If I ask you about your car, certain thoughts will come up [*pause, allowing time for the patient to notice*]. And if I ask you about what you last ate, certain thoughts will come up [*pause, allowing time for the patient to notice*]. Notice how you don't even need to do anything, your mind just continues the dialogue. It keeps on chattering."

- "Now I will invite you to open your eyes. What did you notice? Were you able to see how busy your mind is?"

- "The mind is so busy and automatic that we forget about it and take thoughts to be literally true. However, you are a person who has thoughts. You are not the thoughts. So, the first part of this skill, which we just did, is designed to help you to recognize that you have a mind that generates words that form a thought. Your mind is like a thought generating machine. Recognizing this can be powerful for helping you then get some distance from your thoughts. 'Seeing' thinking can help get you unstuck. What thoughts do you find yourself getting stuck on or wanting to get rid of, or that seem to be problematic?" [*Explore some of the more problematic/stuck thoughts the patient has*].

- "Now I'd like to invite you to try something that will help you detach a bit from your thoughts. Rather than saying, 'I am worthless,' or 'I can't do this,' I will invite you to say, '**I am having the thought right now that** I am worthless [*substitute the thought that the patient provided in response to the question above*],' or 'I am having the thought that I can't do this.' See the thought for what it is— a thought that you are having in this moment that will pass. Try it with a few of the thoughts you mentioned just for practice."

  You can use this strategy with multiple thoughts. You may also model the process and share a thought or two of your own, using the same strategy. Practice with the patient until they grasp the strategy and then continue to use the strategy in future sessions. This is a verbal convention to assist with recognizing the experience of thinking and can be used routinely, but does not need to be used for every thought. How much the strategy is used by the provider to teach the skill should be based on the patient's demonstrated understanding of the technique and on thoughtful consideration of the patient's disposition. It should not be overused or used in a way that makes the patient feel judged or belittled. Rather, recommend that the patient use it several times throughout a session, especially when stuck on a negative or problematic thought, to help the patient gain meta-cognitive awareness of their thinking.

- "What did you notice as you did this exercise?" [*Assess how successful the patient was in completing the exercise and defusing from their thoughts.*]

- "Practice recognizing thinking every day. See if you can notice thinking, rather than *being* your thinking. A helpful way to practice this for many people is by keeping a *Recognizing My Thinking Log* [*see Appendix A3*]. When you recognize an evaluative or problematic thought that is keeping you stuck, write it down, but start each thought with 'I am having the thought that…[*refer to Recognizing My Thinking Log*]'. Is this something you think you would like to practice?"

Exercise 2: Thought Repetition

- "Let's take a look now at thinking or thoughts from a little bit of a different perspective. Initially as we do this, it may not seem that it is related to your thinking, but we will link this to your thoughts when we finish. I'd like to invite you to close your eyes so we can engage your imagination. [*In the following, give enough time after each sentence to allow for the image to form or give enough time for the Veteran to imagine what you are asking them to imagine.*] In your mind's eye, I would like you to picture a lemon. Imagine its shape and color. Notice how you can see it's the color yellow and that it has little divots in its skin. Now imagine that you are holding this lemon. What might that lemon feel like as you squeeze it or pass it from hand to hand. Notice the sensation of touching the lemon, what does its skin feel like? Now imagine that you were sinking your fingertips into the lemon and breaking the skin, ripping the lemon open. Notice what you hear and sense as you do this. There is a sound that comes along with breaking a lemon open. Now notice what you see as you view the inside of the lemon. You might see sections and juice. Perhaps you see white around the edges, seeds, and pulp. Now bring the lemon up to your nose and smell the lemon. Notice its citrus-like scent. Now imagine taking a big bite out of the lemon and just slowly chewing on the pulp."

- "I now invite you to open your eyes. What did you notice as you did this exercise?" [*The patient should note the qualities of the lemon as perceived by different senses—e.g., seeing it, touching it, smelling it, tasting it, perhaps salivating or experiencing a 'pinch' around or at the mouth. Spend just a few moments on this before proceeding with the next step.*]

- "Now I am going to ask you to do something funny with me. I will join you. Let's repeat the word 'lemon' over and over and watch what happens. [*Say the word 'lemon', out loud with the patient for 30 seconds, repeating faster and louder.*] *After 30 seconds ask*: What happened to the image of the lemon? [*Most people will say it disappeared*] And what did you start to hear?' [*Most people will say they heard just sound*]. Right, the image goes away and the word 'lemon' becomes just a sound. We can bring it right back though—imagine a lemon." [*Pause and check to see if the image of a lemon has reappeared.*]

- "There is something really interesting about doing this little experiment. Notice how you touched, smelled, tasted, and interacted with the lemon, but there is no lemon here in the room. And it isn't as if you were literally and suddenly eating a real lemon, even though you interacted with it. Lemons aren't here in the room, and 'bad', 'no good', 'broken' [*or choose a thought you know the patient struggles with*] isn't in you. You can interact with the thoughts—'bad', 'no good,''broken'—just like you did with the thought of a lemon; yet, just like the lemon isn't here [*point around the room*], those thoughts don't exist in you [*point to the patient*]."

  Elicit general reactions to the exercise thus far. Then proceed to the next step.

- "Now let's condense a core distressing thought that you have into one or two words. [*Obtain negative thoughts from patient and condense into one or two words.*] Notice what experiences you are having as we say these thoughts out loud [*pause*]; now let's do the same thing with the word(s). Let's repeat them over and over. [*Repeat the word(s) for about 30 seconds getting louder and faster as you go, joining the patient in the exercise*]. Now what do you notice?" [*Process the experience with the patient. Typically, the patient takes the thought less seriously and the experience tends to change as the word(s) are repeated.*]

- *Complete the exercise:* "I wonder if 'I'm bad' [*or whatever thought the patient chose*] is like 'lemon'. Your mind is very good at convincing you that it is true because you can interact with it, and you have had a lot of time interacting with these words. It is helpful to notice how words work—they are effective for some things, but they are still just words, sounds that we make. Thinking them doesn't actually make them exist. Lemons aren't here and 'no good' isn't there [*point to the patient*]."

- "What did you notice as you did this exercise?" [*Assess how successful the patient was in completing the exercise and in defusing from their thoughts.]*

- "When you find yourself getting stuck on a thought or captured by your own words, try repeating them like we did here. I know it may seem unusual, but it can help. The goal is to get unstuck from negative thinking, to defuse from your thoughts, so you can move forward in your day and in your life. You can also do this silently if you are in a public place or around others. Practicing this regularly will make it more effective. Is this something you would like to practice?"

Exercise 3: Observing the Ongoing Flow of Thoughts: Leaves on a Stream

This exercise is an eyes-closed exercise. Complete the exercise as if you were guiding a meditation, speaking slowly and with a soothing, yet natural, tone and pausing, as appropriate, between instructions to provide the patient with time to form the images and practice observing thoughts. The visual of thoughts attached to clouds passing through the sky may be used instead of thoughts on top of leaves in the script below. A guided audio recording of this exercise may also be accessed at: http://drluoma.com/media/Leaves%20on%20the%20stream.mp3

- "OK, let's begin another Cognitive Defusion exercise."

- "I'd like to invite you to close your eyes and take a few deep breaths [*pause*]. Notice the air enter and exit as you breathe in and out. Let yourself settle into your chair."

- "Now I invite you to image a gently flowing stream. This can be a stream that you create in your imagination or one that you have visited. Picture this stream and its place in nature [*pause*]. Now imagine yourself sitting next to this stream simply watching as the water gently flows by [*pause*]. Notice the sound of the stream [*pause*] and all that you see."

- "Now imagine that a leaf, somewhere up stream, has fallen and landed on top of the water. The leaf is gently floating down the stream [*pause*]. Observe it riding on the water as it passes by [*pause*]. Now imagine that another leaf has fallen and it, too, is riding gently on top of the water [*pause*]. Watch as it passes, floating gently down the stream [*pause*]. Now imagine that leaves are falling, one after another, landing on the water and gently floating by. Simply observe the leaves as they pass."

- "Now imagine placing each thought that you have, one after another, on a leaf as it floats atop the stream [*pause*]. Notice that thoughts are weightless and can simply ride on the leaf as the leaf floats by. Imagine each thought, again one after the other, gently riding on top of a leaf as it passes by [*pause*]. One thought after another, gently riding on a leaf [*pause*]. Observe the ongoing flow of thinking. If you get distracted, if the stream stops flowing and you get caught by a thought, as soon as you notice, place that thought on a leaf and watch it float by, observing it pass [*pause*]. For the next few minutes, I invite you to simply observe the stream and the leaves, continuing to place your thoughts on each leaf and watching the thoughts as they gently float by and down the stream. [*Sit quietly for about 2 minutes allowing the patient time to practice the leaves on a stream exercise*]. Now gently turn your attention away from the stream and back to your breathing. Take a few deep breaths and open your eyes."

- "What did you notice as you did this exercise?" [*Assess how successful the patient was in completing the exercise and in defusing from their thoughts. Gently correct any misconceptions (e.g., 'Am I supposed to use this to get rid of thoughts, because the same thought kept floating by?') The idea is to gently observe thoughts come and go, not to eliminate them). Explore with the patient how they can use this skill to undermine attachment to thoughts and the mind. This type of exercise helps the patient to "unhook" from unproductive thoughts while also facilitating flexibility (thoughts no longer need to be eliminated, suppressed or struggled with, they can be observed, freeing the patient to take healthy, values-based actions).*

STEP 4: DEBRIEF AT CONCLUSION OF EXERCISES

- "What was this overall experience like for you? What did you notice?"
- "How helpful was this in helping you to defuse from your thoughts?"
- "Looking back at each of the exercises we covered, which ones did you find particularly useful or that resonated more with you?"
- "How willing are you to practice these exercises?"

Work with the patient to identify the specific way in which they will practice specific Cognitive Defusion exercises outside of session, including (1) frequency of practice, (2) time of day, and (3) location. Use the Practice Plan Summary Form (see Appendix A3) to record details of the Veteran's plan for practicing the skill outside of session.

- "Is there anything that may get in the way of your being able to do this? Do you have any questions?"
  - *Problem solve potential barriers, as appropriate.*

Sources for Cognitive Defusion Exercises:

Blackledge, J. T. (2015). *Cognitive defusion in practice: A clinician's guide to assessing, observing, and supporting change in your client*. Oakland, CA: Context Press.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). New York, NY: Guilford Press.

Source: Karlin, B. E., & Wenzel, A. (2018). *Evidence-based psychotherapy shared decision-making toolkit for mental health providers*. Waltham, MA: Education Development Center, Inc.

Provider Tip Sheet

COGNITIVE REAPPRAISAL

STEP 1: PROVIDE THE PATIENT WITH PSYCHOEDUCATION ABOUT COGNITIVE REAPPRAISAL

- "I'd like to talk with you about a very useful skill to help you manage how you feel and cope with difficult situations. It's something that will take some practice but is a very helpful skill."
- "The main idea behind what I'm going to talk with you about is this: How we feel in any situation we're faced with is directly related to how we interpret the situation—or the meaning we give to the situation. Situations themselves don't mean anything until our mind gives them meaning."
- "Here's a simple example to illustrate this point: Last week, I was walking down the street by my regular grocery store. As I was walking, I noticed a close colleague of mine coming toward me on the other side of the street. As she walked closer, she didn't wave or say anything to me. Right at that moment, the dialogue of thoughts in my head was, 'Wow, how rude. What did I do to her that she doesn't acknowledge me?' Based on these thoughts, how do you think I felt?" [*Patient likely responds with an emotion like 'upset', 'angry', 'sad', etc.*]
- "Exactly, that's how it felt in the moment. Then, I realized I was having these thoughts. So I asked myself, 'Might there be another way to look at the situation?' When I did that, I thought to myself, 'Maybe she didn't see me. Or, maybe she saw me but didn't think I would hear her.' When I looked at the situation this way, how do you think I felt?" [*Patient likely responds with something like 'less upset', 'okay', 'fine', etc.*]
- "Yes. I emotionally felt very different based on my different thinking about the situation."
- "While a simple example, it proves a very important point—not that you shouldn't go grocery shopping, but that how we feel is directly related to how we interpret, or look at, situations in our lives."

  At this point, the provider may draw a Situation, Thought, Emotion diagram to visually depict the relationship between thoughts and emotions and how changes in how we appraise situations can change how we feel:

  Situation → Thoughts → Emotions

  Next, you may ask the patient to see if they can identify the Situation, Thoughts, and Emotions from your example:

  Situation: Walked down street and friend did not say hello.
  Thoughts: "Maybe she didn't like me"
  Emotions: Angry, sad

  Situation: Walked down street and friend did not say hello.
  Thoughts: "Maybe she didn't see me." "Maybe she didn't think I would hear her."
  Emotions: Relief, no longer angry or sad

- "This process of stepping back and looking at situations is called, 'Cognitive Reappraisal'. 'Cognitive' refers to thinking. And 'Reappraisal' means coming up with a new appraisal, or meaning, of a situation—a new or modified way of explaining a situation."
- "Looking at and adjusting how we interpret situations is not a skill that we're born with that naturally develops. It's one that is learned. But when we learn how to step back and look at situations more fully and based on the facts, it can have really change how we feel."

STEP 2: OBTAIN THE PATIENT'S BUY-IN

- "How does this sound to you?"
- "What questions might you have?"
- "Would you like to give this a try?"

STEP 3: TEACH PATIENT HOW TO APPLY COGNITIVE REAPPRAISAL TO SITUATIONS IN THEIR LIFE

1. **Identify a scenario where the patient formulated an extreme or narrow appraisal resulting in a strong negative reaction.**
    - *Scenario may be one the patient has mentioned, or provider may elicit a situation from the patient. To help patient identify a situation, the provider may inquire,* "Can you think of a time recently when you were upset about something that happened? What specifically happened?"
        - *If the patient has difficulty distinguishing the situation, note that the situation refers to the "facts" of the occurrence. It is like the neutral play-by-play caller of a baseball game (not the color commentator).*
    - *Restate the situation for confirmation/clarification.*
2. **Elicit patient's appraisal of or thoughts about the situation.**
    - *The provider may ask:* "What did you make of the situation?" *or* "What thoughts did you have about the situation?"
    - *It is recommended that the provider elicit no more than 1-2 key thoughts about the situation.*
    - *Restate the thoughts for confirmation/clarification.*
3. **Identify emotional or other effect of the patient's appraisal of the situation.**
    - *If necessary, the provider may ask:* "When you have that thought about the situation, how do you feel?" *or* "What happens when you have that thought about the situation?"
    - *Respond with a reflection to demonstrate understanding and concern and to confirm and highlight the emotional consequence of the thought. The provider may say:* "It seems like having the thought that [X] made you feel…I can tell this is very upsetting for you."
4. **Summarize the Situation, Thought, and Emotion.**
    - *At this point, the provider may provide the patient with the Cognitive Reappraisal Worksheet* (see Appendix A3) *to help them with identifying and distinguishing the Situation, Thought, and Emotion. Providing the Worksheet, which helps provide structure to the process for many patients, is generally not provided earlier so as not to interrupt or alter the collaborative process and interchange between the provider and Veteran.*
    - *The provider reviews the left-hand side of the Worksheet with the patient and invites them to record the Situation, Thoughts, and Emotion in their respective boxes.*
5. **Help patient develop a new, modified, or broadened appraisal of the situation.**
    - *The provider may ask:* "I wonder if we could now take a step back and see if there might be another way to look at the situation, or perhaps a broader view of what happened? Would you be willing to explore this with me?"
    - *Using a non-directive, Guided Discovery approach, help the patient formulate a new or modified appraisal of the situation based on the facts of the situation.*

- *The provider may ask one or more of the following:*
  - "What is the most factual way to view the situation that [Situation]?"
  - "Considering all of the information about the situation, are there other ways someone else in the same situation, with the same facts, could view this situation?"
  - "How might you think about the situation so it has little effect on your emotions?"
  - "How might you view the situation a year from now?"
  - "How helpful is the thought that…?"
- *In some cases, restating patients' thoughts or conclusions about the situation back to them, as statements or in the form of a question (e.g.,* "So, the current situation with your wife means that you'll be alone and suffering for the rest of your life?"*), can help patients see the extreme or unhelpful nature of their thoughts and can facilitate reframing or shaping of their appraisals. In so doing, it is important to not come across as evaluative or invalidating of the patient's experience.*

- *Clarify/confirm patient's new or modified appraisal of the situation. Then ask the patient to restate the new thoughts and confirm patient's belief in the new appraisal. If patient does not believe new thoughts, continue with the Guided Discovery process.*
- *Once new thoughts about the situation are formulated and patient expresses some belief in the new reappraisal, ask the Veteran to record the thoughts in the "New Thoughts/Reappraisal" box in the right-hand column of the Cognitive Reappraisal Worksheet.*
- *Note: An alternative format—Catch It, Check It, Change It—may be used for helping patients develop new or modified appraisals. This approach is similar to that described above and presented in the Cognitive Reappraisal Worksheet, but includes a specific step for examining initial thoughts, making it a bit more complex and more appropriate for patients who are cognitively-minded or adept at monitoring and evaluating their thoughts (see Appendix A3).*

6. **Inquire about the emotional effect of the patient's new appraisal.**

- *The provider may ask:* "When you have the thought [Y] about the situation, how do you feel?" *or* "What happens when you have the thought [Y] about the situation?"
- *Respond with a paraphrasing statement to demonstrate understanding and highlight the consequence of the thought. The provider may say:* "When you have the thought [Y], you feel…"*Ask the patient to record the emotions in the "Emotions" box in the right-hand column of the Cognitive Reappraisal Worksheet.*
- *Ask the patient to compare this emotional response with the emotional immediately following initial appraisal.*
  - "How does that compare with what you felt when you had the initial thought '[X]'?"

STEP 4: **DEBRIEF**

- "What was the experience like for you? What did you notice?"
- "Do you buy this, that questioning how you look at situations before taking your initial thought as fact can help you to approach stressful or difficult situations in a more factual, helpful way?"
- "How willing would you be to practice this outside of session?"
- "How will you recognize when this tool, Cognitive Reappraisal, would be useful"?
  - *If the patient seems unsure of when to use this, remind them that a good indicator is if they feel a fairly strong negative emotion or reaction.*

- "How about using the worksheet we've been using to record at least two situations, 1-2 initial thoughts about each situation, and how you felt when you had each thought? Then, step back as we did, ask yourself the questions on the form, and write down 1-2 new or modified thoughts about the situation. Then, at the end, record the emotion you felt when having the new thought, just like we did today."

    - *Provide the patient with a few blank copies of the Cognitive Reappraisal Worksheet.*

- "Okay. Would you like to go ahead and summarize your plan to practice this skill and we can record it on the *Practice Plan Summary Form* [see Appendix A3]?"

  "Is there anything that may get in the way of your being able to do this? Do you have any questions?"

    - *Problem solve potential barriers, as appropriate.*

Source: Karlin, B. E., & Wenzel, A. (2018). *Evidence-based psychotherapy shared decision-making toolkit for mental health providers*. Waltham, MA: Education Development Center, Inc.

APPENDIX A3

Preparatory Skills Building

Patient Handouts

RELAXATION SKILLS PRACTICE LOG

Instructions: **Before** and **after** you practice each coping skill,
rate your level of stress or discomfort from 0-10, where:

0 = No stress or discomfort/totally relaxed 10 = Highest possible stress or discomfort

DATE	RATING BEFORE	COPING SKILL	RATING AFTER	COMMENTS OR REACTIONS

PRACTICE PLAN SUMMARY FORM

NAME OF COPING SKILL (INCLUDE AUDIO/ VISUAL RESOURCES, IF APPLICABLE)	**HOW WILL THIS HELP ME?**	**FREQUENCY OF PRACTICE**	**WHEN AND WHERE I WILL PRACTICE** TIME OF DAY | LOCATION	

COGNITIVE REAPPRAISAL WORKSHEET

REMEMBER:

Situation → Thoughts → Emotions

Situation

*What are the **facts** of what happened?*

Initial Thoughts/Appraisal

*What was your **initial** interpretation of the situation?*

New Thoughts/Reappraisal

After stepping back, what is a new or more complete way of looking at the situation? How might you think about the situation so it has little effect on your emotions? How might you view the situation a year from now?

Emotions

What emotion(s) did you feel when you had these thoughts?

Emotions

What emotion(s) do you feel when you have these thoughts?

RECOGNIZING THINKING LOG

FUSION:

Problematic thought or thought that keeps you stuck.

Example:

"I can't do this."

COGNITIVE DEFUSION:

Recognize the thought as an experience you are having.

Example:

*"I am having the thought that **I can't do this**."*

"I am having the thought that _____

_____."

"I am having the thought that _____

_____."

"I am having the thought that _____

_____."

"I am having the thought that _____

_____."

"I am having the thought that _____

_____."

"I am having the thought that _____

_____."

"I am having the thought that _____

_____."

"I am having the thought that _____

_____."

"I am having the thought that _____

_____."

"I am having the thought that _____

_____."

CATCH IT, CHECK IT, CHANGE IT WORKSHEET

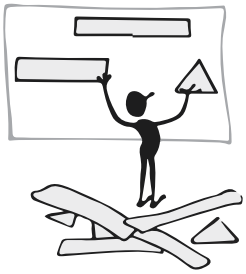
Step 1
Catch It

- When you notice a change in your mood or become upset, then ask yourself:
- **What am I thinking about right now?**

Step 2
Check it

- What is the evidence **for** the thought?
- What is the evidence **against** the thought?
- **Is it completely true?**

If no, then Step 3
Change it



- **What is a more truthful or more helpful thought?**

APPENDIX A4

Shared Decision-Making Session

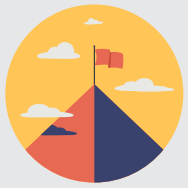
Provider Checklist

CONNECT

MOTIVATE

EDUCATE

EXPLORE



SET GOALS

CHOOSE

SHARED DECISION-MAKING SESSION

Provider Checklist

This checklist is intended to serve as an in-session guide for conducting the Shared Decision-Making (SDM) Session. Although each of the core components of the SDM Session should be addressed, it is encouraged that the checklist not be used in a rigid manner, and it is not intended for all questions to be asked in all cases. In conducting the session, it is important to remain mindful of the important focus of the session on interpersonal connection and engagement. Discussion should move naturally and fluidly, allowing for revisiting of earlier points of discussion, as needed, while following the guideposts of the session structure.

Remember to use the following foundational skills for establishing connection both initially and throughout the SDM Session:

- **PARAPHRASING**:
  Restate patient's remarks in own words.
- **REFLECTION**:
  Communicate *emotional content* (feeling) of patient's verbal and non-verbal communication.
- **SUMMARIZING**:
  Provide summary statement pulling together main points communicated by patient.
- **EXPRESSED EMPATHY**:
  Express appreciation of patient's internal experiences (verbal and nonverbal).
- **GENUINENESS**:
  Respond in authentic and transparent manner, truly meaning what is expressed.
- **WARMTH**:
  Convey sense of caring, support, and concern (verbal and nonverbal).
- **OPEN-ENDED QUESTIONING**:
  Ask questions that require more than a simple yes/no response.
- **CONFIDENCE**:
  Convey competence and optimism that treatment will help (verbal and nonverbal).

NOTES:

CONNECT: ESTABLISH INITIAL TRUST AND CONNECTION

- *Welcome Veteran.*
  - *Briefly describe your position within your treatment facility (in non-technical terms).*
  - *Ask whether there is anything you can do to make the patient more comfortable.*
  - *Ask the patient how they are doing, using elaboration to promote openness and disclosure, as appropriate.*
    - *Show genuine interest in the patient, give them interpersonal space, and provide an empathic response.*
- *Discuss purpose of visit.*
  - *Express appreciation for coming in and inquire about patient's understanding of the purpose of the visit.*
  - *Provide education about SDM Session.*
    - "Today, we'll be talking about different treatment options for you to choose from as part of a process called "shared decision-making." "Shared" means that I have valuable information for you about different treatment options, like what they involve and how effective they are. And, at the same time, you have valuable information about yourself, like what's important to you and what you hope to get out of treatment. We will pull this information together so that you can make a decision about the best treatment for you."
    - "As you can probably tell, you'll get the most out of this session by openly sharing your thoughts as we talk—including your reactions to different options, how things do or do not apply to you, and asking questions."
    - "I'm looking forward to working together to come up with a decision of what's best for you and your personal situation."
  - *Ask whether there is anything at the outset the Veteran believes is important for you to know about them as you work together to ID treatment match.*
    - "Before we get started, is there anything specific you'd like me to know as we work together to identify the treatment that would be the best fit for you?"
  - *Ask what role the patient would like to play in the decision-making process.*
    - "How involved would you like to be in the treatment selection process?"

TRANSITION TO ASSESS MOTIVATION:
"I'd like to ask you a few questions to learn a little bit more about your thoughts about treatment. Would that be okay?"

MOTIVATE: ASSESS AND ENHANCE MOTIVATION FOR TREATMENT

Assess Motivation

- *Inquire about past experiences with mental health treatment (positive and negative).*

NOTES:

- "Have you received mental health treatment before?"
  - *If yes:* "What did this consist of?" *[follow up to clarify, as appropriate]*

    "How helpful was treatment?"

    "Were there ways in which it was not helpful? How so?"

    "Did you have any problems with the treatment?"

- *Assess attitudes and expectations toward mental health treatment.*
  - "What are your thoughts about treatment for [depression]?"
  - "What do you think it will be like?"
  - "How much do you think treatment will be helpful on a 0–10 scale, with 0 = Not at All Helpful and 10 = Extremely Helpful?"
  - "Do you have any concerns about treatment? What are they?"

TRANSITION TO ENHANCE MOTIVATION:
"Thank you for telling me a bit about your thoughts about treatment. I'd like to talk more about this in a few moments. If it's okay with you, I'd like to now talk briefly about the changes or symptoms you've been experiencing and how these have impacted your day-to-day life. This will help us see how your life could look different. How does that sound?"

Enhance Motivation

- *Inquire about or summarize the prominent symptoms the patient has been experiencing.*
  - "Since you've been experiencing [depression], can you tell me a bit more about what changes or symptoms you've noticed? These may be changes in your mood, your thoughts, or certain changes in behaviors or things you do or don't do."
- *Identify ways in which the patient's symptoms are causing problems in their life (ask one or more of the following):*
  - "Looking at your day-to-day life, how have these changes [or symptoms] caused problems in your life?"
  - "How have these changes interfered with your personal life or life at home? Your job? School? Your relationships?"
  - "Has anyone noticed that your symptoms are causing problems in your life? What have they noticed?"
- *Identify ways in which the patient's life would be different if treatment were successful (ask one or more of the following):*
  - "Now, looking at your life again, how would your like look different if you were no longer experiencing the symptoms of [depression]?
  - "If your symptoms were to improve, what would you be doing differently?"
  - "What would it be like to feel different?"
  - "How would feeling different affect your work? School? Your romantic

NOTES:

relationship? Your relationship with your children?"

- "If your symptoms were to lessen significantly, what area of your life would change most? How?"
- "What hopes or aspirations have you been putting off because you are struggling right now?"

- *During instances of:*
  - *Change talk: Reinforce by requesting elaboration* ("How so?", "In what ways?")
  - *Sustain talk: Demonstrate empathy and understanding, then make amplified reflection and/or double-sided reflection*
  - *Ambivalence or uncertainty about treatment: Consider Pros and Cons Exercise*

TRANSITION TO EDUCATE:
"There are now some good treatments available for the problems you've been experiencing, and I think there are some options that could really help you. Would you like to take a closer look at these together?"

EDUCATE: EDUCATE VETERAN ABOUT EBPS AND OTHER TREATMENT OPTIONS

- *Introduce and discuss decision aids.*
  - *Use Treatment Options Grid to facilitate discussion of potential treatment options.*
  - *Provide Treatment Fact Sheet if Veteran would like additional information about specific treatments.*
  - *Consider introducing or referring Veteran to the Treatment Works for Vets website.*
  - *If working with a patient with PTSD, use decision resources developed by the National Center for PTSD:* www.ptsd.va.gov/apps/decisionaid.
- *Use active listening and related communication skills to maintain close interpersonal connection and demonstrate understanding of reactions, questions, and concerns.*
- *Relate, as appropriate, your firsthand experience of what happens in treatment and the experiences of other Veterans.*
- *Respond to questions and concerns based on your clinical experience and knowledge of the research literature in understandable language.*

TRANSITION TO EXPLORE:
"Perhaps we can shift our discussion toward what's most important to you, so that you can make a decision that is most consistent with who you are and what you value?"

EXPLORE: EXAMINE VALUES AND PREFERENCES

- *Elicit preferences that are important to patient (follow up and provide examples, as needed).*
  - "As we think about the different treatment options, what are the most important

NOTES:

factors for you to consider?"

- "Do you have any other preferences about treatment that we should consider as we move toward making a decision about treatment?"

- *Acknowledge and summarize what is important to the patient.*
  - "It sounds like [X] is important to you. That really makes sense. I'm glad you mentioned that."
  - "I have appreciated hearing more about what is important to you. From what you've said, it sounds like [X] and [Y] are really important. I think we should consider these factors as we make a decision about the best option for you."
  - *If patient identifies many factors, ask the patient to prioritize the most important ones:* "You mentioned several factors, including…Which ones are most important to you?"

- *Explore reactions to treatment options.*
  - "Considering what we've discussed so far, do you find that you connect with any of the treatments we reviewed? How so?"
  - "Were any of the treatments that we reviewed difficult for you to connect with? How so?"
  - "Was there anything about the treatments that I described that concerned you in any way? Which ones, and why?"
  - *Use Socratic questioning and/or provide information to help guide patients and make connections between treatments and preferences*
    - "You mentioned that you [spend a lot of time thinking negatively about yourself and staying home a lot, which makes you feel worse. You also noted that you have a hard time making decisions about things]. Of the treatments we discussed, are there any that seem like they might help with these things?"

- *Summarize and request feedback.*
  - "This has been a great discussion. It sounds like what is most important to you is…And based on what we've discussed so far, [X] may be a good treatment option for you. Do I have that right so far?"
  - "Before we proceed with the last parts of our discussion today, how do you feel about the discussion so far? Do you have any questions?"

TRANSITION TO SET GOALS:
"Is it OK if we take a moment to talk, specifically, about what you want to get out of treatment?"

SET GOALS: IDENTIFY POTENTIAL TREATMENT GOALS

- *Elicit at least 1 or 2 potential treatment goals, referring back to discussions of how life might be different (Motivate) and/or what matters to the Veteran (Explore) (ask one or more of the following):*
  - "If treatment is successful, how would your life look different than it does today?"

NOTES:

- "What, specifically, are the most important things you would like to get out of treatment?"
- "What would you like to focus on in treatment?"
- "What are the most important problems to address in treatment?"
- "Many people who seek treatment for [depression] focus on ways in which this problem impacts big areas of their lives, such as their relationship with their spouse or children or in their jobs. Is there an area of your life that your symptoms are affecting that could be addressed in treatment?"

- *If Veteran has difficulty identifying goals, consider one or more of the following:*
  - *Provide examples of common goals of other Veterans.*
    - "Would you like to hear common goals of other Vets who've had similar problems?"
  - *Introduce or refer to goal-setting exercises for certain conditions at the Treatment Works for Vets website.*
- *Link goals to treatments the patient is considering.*
  - "Do you think any of the treatments we discussed could help with [X]?"
- *Summarize and request feedback.*
  - "So, it sounds like we have identified a couple of possible goals that treatment could likely help you: [X] and [Y]. And, from our discussion, it seems like [treatment] could be a good match for these goals. How does that sound to you?What are your thoughts about this discussion?"

TRANSITION TO CHOOSE:
"Now that we've had a chance to talk about different treatment options, what's important to you, and possible goals for treatment, let's make a decision together about treatment for you."

CHOOSE: SELECT TREATMENT OR DETERMINE NEXT STEPS

- *Elicit patient summary.*
  - "From **my** point of view, we've covered a lot of ground here today. Can you tell me in your own words what we have accomplished, from **your** point of view?"
- *Assess where patient is in the decision-making process.*
  - "Based on the information I gave you, as well as your preferences and goals, do you have a sense of the direction in which you'd like to proceed?"
- *Confirm patient preference for treatment or next steps.*
  - "So, it sounds like you are interested in [X]?"
  - *If needed: Help point out and tie together key information and patient remarks from earlier in session.*

NOTES:

- "I'd like to share with you some things that stood out for me in our discussion so far."
- *If needed: Help patient decide between specific treatment options.*
  - "How about I list out the pros and cons of [treatments X and Y], based on what we've discussed, and you can tell me if you prefer one or the other?"

If Veteran selects a treatment:

- *Assess patient's reasoning for preference.*
  - "What is it that led you to that decision?" or "What are the specific reasons you have chosen [X]?"
- *Assess and problem solve potential barriers to treatment.*
  - "Is there anything that can get in the way of your being able to engage in [X]?"
- *Finalize plan.*
  - "Shall we go ahead and schedule an appointment?"
- *Provide a concluding summary.*
  - "It's been terrific to meet with you, [name of Veteran]. The purpose of our visit today was to make the best treatment decision for you, after looking at different options and considering what's important to you. I really appreciate what you've shared with me and how we've been able to make this decision. That's a big step. Based on our decision today, I'm confident that treatment will be very helpful to you."

Possible Outcomes of SDM Session:

1. *Select Treatment (Most Common): Veteran selects a treatment and schedules an initial treatment session.*
2. *Review and Follow-Up: Veteran chooses to further review information about treatment options and/or consult with family members or others, with a specific plan for follow-up on patient's decision.*
3. *Increase Treatment Readiness: Extend SDM Session: Veteran and provider determine that Veteran could benefit from one or more additional SDM Sessions to address motivational, attitudinal, knowledge, or logistical treatment barriers.*
4. *Increase Treatment Readiness: Preparatory Skills Building: Veteran and provider determine that Veteran could benefit from developing preparatory skills to promote psychological readiness prior to initiating treatment.*
5. *No Treatment Selected/Watchful Waiting: Veteran declines treatment at the current time or elects "watchful waiting," and provider follows up within a specified period of time.*

Source: Karlin, B. E., & Wenzel, A. (2018). *Evidence-based psychotherapy shared decision-making toolkit for mental health providers*. Waltham, MA: Education Development Center, Inc.

APPENDIX A5

Shared Decision-Making Session

Facility Implementation Checklist

SHARED DECISION-MAKING SESSION

Facility Implementation Checklist

This checklist summarizes the practical and logistical requirements and considerations for locally implementing the Shared Decision-Making (SDM) Session in facilities and clinics. This checklist is designed for clinical staff, program managers, and administrators involved in implementing administrative, workflow, and related requirements. Within the VA health care system, facility Local Evidence-Based Psychotherapy Coordinators will be central to coordinating the process for locally implementing the SDM Session.

Due to the variability of specific services, patient populations, clinical processes, size, and structure among the different settings and service systems (e.g., VA, other public systems, private settings) in which the SDM Session is implemented, the information included on this checklist is intended to serve as general guidelines and to be used flexibly to best fit local needs and circumstances. For additional information related to the requirements and considerations listed below, see Section 2.2 (Putting SDM into Practice: Practical and Logistical Guidelines and Considerations) in the *Evidence-Based Psychotherapy Shared Decision-Making Toolkit for Mental Health Providers.*

ISSUE	REQUIREMENTS	CONSIDERATIONS	PLAN	RESPONSIBLE PARTIES	STATUS
Patient Flow	◯ Establish procedures for identifying and connecting Veterans to SDM Session. ◯ Determine procedures that precede Veteran participation in SDM Session (e.g., psychodiagnostic evaluation).	Most Veterans will reach the SDM Session after being diagnosed with a mental health problem.			
Location	◯ Determine location where the SDM Session will be conducted (e.g., general mental health clinic, specialty mental health clinic [e.g., PTSD Clinic], primary care).	In most instances, Veterans will participate in the SDM Session after being referred to or presenting to a general or specialty mental health setting. The SDM Session may be implemented in primary care or another setting where mental health needs are identified.			
Staff Awareness	◯ Provide awareness training and documented policies and procedures on the general purpose, function, and process of the SDM Session among staff not directly involved in the delivery of the SDM Session. ◯ Identify staff to provide awareness training, outreach, and support related to policies and procedures. In the VA health care system, the facility Local EBP Coordinator may provide training, outreach, and related support.	Awareness training should help promote understanding of the overall SDM Session and how it is being implemented in the clinical setting. Training should be made available for both clinical and administrative staff (including appropriate leadership and front-line administrative personnel). Training should help promote understanding that the SDM process is an integral part of the treatment process that can help maximize engagement and outcomes, rather than be seen as an extra step in addition to or separate from treatment.			

ISSUE	REQUIREMENTS	CONSIDERATIONS	PLAN	RESPONSIBLE PARTIES	STATUS
Length	◯ Establish guidelines for the duration and number of SDM Sessions.	Most Veterans will participate in one SDM Session and be prepared to choose a treatment by the end of the session. In some cases, Veterans may require an additional one or few sessions to promote treatment readiness. This may consist of (1) one or more SDM Sessions to address, motivational, attitudinal, knowledge, or logistical barriers to treatment; or (2) preparatory skills building sessions to establish baseline skills or coping capacity. The duration and number of SDM visits vary depending on modality (individual vs. group) of SDM Session.			
Modality	◯ Establish policies and procedures for individual vs. group modality for conducting SDM Session.	Most often, the SDM Session is delivered in individual format, though the modality is flexible and may be tailored to best fit the local clinical setting and patient population. The length of individual SDM Sessions is 50–60 minutes and generally lasts one session. The length of group SDM Sessions is generally 90 minutes and typically lasts one session for groups with 1–3 members and two sessions for groups with 4–6 members. Providers of group SDM Sessions should have experience with managing group process to ensure individualized attention to and participation of all group members. Care should be exercised throughout the session to maintain the SDM focus and process and ensure that the "shared" component of SDM is not lost. Group size should be limited to allow for collaborative and individualized decision-making. Group SDM Sessions may require multiple sessions, depending on group size, needs and characteristics of group members, number of available and potentially appropriate treatment options, and experience of the provider.			

ISSUE	REQUIREMENTS	CONSIDERATIONS	PLAN	RESPONSIBLE PARTIES	STATUS
Provider	◯ Identify staff to deliver SDM Session. ◯	The provider of the SDM Session is generally a mental health professional or trainee with sufficient knowledge of relevant treatment options and of the SDM Session. In some settings, the SDM Session may be delivered by one or a few designated individuals who have this as a specific focus of their work. In other settings, this may be a broader shared activity. In many cases, the provider of the SDM Session will not be the same individual who delivers the chosen treatment. It is not necessary or practical for the provider of the SDM Session to be proficient in the actual delivery of different treatment options; however, it is important that the provider be sufficiently knowledgeable to describe and discuss treatment options.			
Scheduling and Documentation	◯ Develop procedures and guidelines for scheduling and documenting SDM Session and preparatory skills building sessions. ◯ Ensure availability of sessions of appropriate time length on scheduling grid for identified providers who deliver SDM Sessions or provide preparatory skills building sessions. Develop procedures for how and when Veterans are scheduled for chosen treatment option.	Scheduling should be flexible enough to allow providers to deliver additional SDM Sessions and preparatory skills building sessions, when indicated. Documentation of the SDM Session should include specific steps and strategies implemented, the patient's response and outcomes of the steps and strategies, and any obstacles encountered and ways in which these obstacles were addressed (see *SDM Session Documentation Template* [Appendix A6]). It is recommended that provider of selected treatment (if known) or treatment clinic be copied on or directly receive documentation of SDM Session to facilitate treatment initiation, engagement, and goal-setting. SDM Session documentation should have clearly identified label or code that is recognizable by treatment provider.			

ISSUE	REQUIREMENTS	CONSIDERATIONS	PLAN	RESPONSIBLE PARTIES	STATUS
Follow-up	◯ Establish guidelines for follow-up with Veterans who do not choose a treatment at the end of the SDM Session.	Guidelines for follow-up should include the modality of follow-up, the length of time between the SDM Session and follow-up, and the provider who will make the follow-up contact, if someone other than the provider of the SDM Session. Guidelines for follow-up will vary among clinics and facilities based on general clinic and facility policies for follow-up, patient population, staffing, and other factors. Guidelines should allow for patient preference and clinical judgment to inform the nature of follow-up.			
Transition to Treatment	◯ Establish procedures for smooth transition and continuity following SDM Session.	Veterans who choose a treatment should leave the SDM Session with an appointment or specific plan for initiating treatment. When possible, the provider of the SDM Session should communicate to new provider key information about the SDM Session to facilitate new therapeutic alliance and care continuity. Treatment provider should acknowledge, reinforce, and build on patient's participation in the SDM Session.			

Source: Karlin, B. E., & Wenzel, A. (2018). *Evidence-based psychotherapy shared decision-making toolkit for mental health providers*. Waltham, MA: Education Development Center, Inc.

APPENDIX A6

Shared Decision-Making Session

Documentation Template

MENTAL HEALTH TREATMENT SHARED DECISION-MAKING SESSION DOCUMENTATION TEMPLATE

TIME IN SESSION (in minutes): _____

SESSION FORMAT: _____

SESSION LOCATION: _____

DIAGNOSIS: _____

ASSESSMENT: _____

Patient is a _____ year-old [male/female] Veteran who was seen today for a Mental Health Treatment Shared Decision-Making (SDM) Session. The patient is presenting for problems related to_____
The purpose of the SDM Session is to promote patient informed choice, engagement, and active involvement in the treatment decision-making process.

SESSION CONTENT:
The SDM Session consisted of the following components:

1. Connect: Establish initial trust and interpersonal connection
   [Key issues/outcomes:]

   _____

   _____

   _____

   _____

2. Motivate: Assess and enhance motivation for treatment
   [Key issues/outcomes:]

   _____

   _____

   _____

   _____

3. Educate: Educate Veteran about EBPs and other treatment options
   [Key issues/outcomes:]

   _____

   _____

   _____

   _____

4. Explore: Explore values and preferences
   [Key issues/outcomes:]

5. Set Goals: Identify potential treatment goals
   [Key issues/outcomes:]

6. Choose: Select treatment or determine next steps
   [Key issues/outcomes:]

ADDITIONAL SESSION INFORMATION:

PLAN:

Source: Karlin, B. E., & Wenzel, A. (2018). *Evidence-based psychotherapy shared decision-making toolkit for mental health providers*. Waltham, MA: Education Development Center, Inc.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