INDEX OF TREATMENT PROCEDURE OUTLINES
DR. AZRIN

General Features of Behavior Therapy

1) Conduct a Behavioral Assessment (See separate page)

2) Establish goals of therapy

   a. observable behavior where relevant
   b. specific
   c. quantitative

3) Select only procedures validated for effectiveness in research, not "usual and customary."

4) Significant-other included in therapy; parent, spouse

5) Demonstrate (model) the procedure

6) Rehearsal of procedure by patient

7) Praise all approximations to desired behavior

8) Therapist provides a high frequency of descriptive praise

9) Obtain continuous progress measures...each session; standardized test/behavioral

10) Self-Recording Assignment

   a. Recording forms
   b. Daily or immediate recording
   c. Review previous records at start of each session
   d. Progress Chart

11) Therapy assignments, written

12. Social Support
13. Incentives
14. #

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early as is feasible. (See also Standard 4.03, Interruption of Services.)

(f) If the patient, client, or other recipient of services does not pay for services as agreed, and if the psychologist wishes to use collection agencies or legal measures to collect the fees, the psychologist first informs the person that such measures will be taken and provides that person an opportunity to make prompt payment. (See also Standard 5.11, Withholding Records for Nonpayment.)

1.26 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists accurately state the nature of the research or service provided, the fees or charges, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standard 5.05 [illegible])

1.06 Basis for Scientific and Professional Judgments

Psychologists rely on scientifically and professionally derived knowledge when making scientific or professional judgments or when engaging in scholarly or professional endeavors.

2. Evaluation, Assessment, or Intervention

2.01 Evaluation, Diagnosis, and Interventions in Professional Context

(a) Psychologists perform evaluations, diagnostic services, or interventions only within the context of a defined professional relationship. (See also Standard 1.03, Professional and Scientific Relationship.)

(b) Psychologists' assessments, recommendations, reports, and psychological diagnostic or evaluative statements are based on information and techniques (including personal interviews of the individual when appropriate) sufficient to provide appropriate substantiation for their findings. (See also Standard 7.02, Forensic Assessments.)

2.02 Competence and Appropriate Use of Assessments and Interventions

(a) Psychologists who develop, administer, score, interpret, or use psychological assessment techniques, interviews, tests, or instruments do so in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists refrain from misuse of assessment techniques, interventions, results, and interpretations and take reasonable steps to prevent others from misusing the information these techniques provide. This includes refraining from releasing raw test results or raw data to persons, other than to patients or clients as appropriate, who are not qualified to use such information. (See also Standards 1.02, Relationship of Ethics and Law, and 1.04, Boundaries of Competence.)

2.03 Test Construction

Psychologists who develop and conduct research with tests and other assessment techniques use scientific procedures and current professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

2.04 Use of Assessments in General and With Special Populations

(a) Psychologists who perform interventions or administer, score, interpret, or use assessment techniques are familiar with the reliability, validation, and related standardization or outcome studies of, and proper applications and uses of, the techniques they use.

(b) Psychologists recognize limits to the certainty with which diagnoses, judgments, or predictions can be made about individuals.

(c) Psychologists attempt to identify situations in which particular interventions or assessment techniques or norms may not be applicable or may require adjustment in administration or interpretation because of factors such as individuals' gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

2.05 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the various test factors and characteristics of the person being assessed that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant reservations they have about the accuracy or limitations of their interpretations.

2.06 Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons. (See also Standard 1.22, Delegation to and Supervision of Subordinates.)

2.07 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Similarly, psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

2.08 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring procedures to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the

Treatment of Depression

Cognitive Emphasis: Beck, Ellis
Behavioral Emphasis: Lewinsohn; Hersen; Azrin; McLean & Hakstian; Rehm

	Beh.	Cog.
Reinforcing Activities Priming:		
Assign Daily Planner, current and new activities	XX	
Behavioral Goal Setting		
overt activity, specific, "do" vs. "don't", record	XX	
Functional Behaviors relevant to cause of depression	XX	
Behavior marital therapy, vocational (job counseling)		
Educational (Study schedule), Social (Soc. Skills training)		
Problem-Solving Training		
Positive Statements re self, to others (compliments, appreciations),	XX	
about events, possible positive aspects of causal event.		
Self-monitoring Assignment: mood-cognition relation		XX
mood-behavior relation	XX	
Challenging Negative Cognitions: Socratic method, Underlying Assumptions		XX
Cognitions vs. statements, catastrophizing vs. reality testing		
all-or-none vs. probability, "should" vs. "preferable",		
alternative explanations to negative Cognitions.		

References:

McLean, P.D. & Hakstian, A.R. (1979). "Clinical depression: comparative efficacy of outpatient treatment." J. Cons. Clin. Psychol., 47, 818-836

Beck, A.T., et al (1979). Cognitive Therapy of depression, Guilford NY.

Lewinsohn, P.M. & Clarke, G.N. (1986). "The Coping with Depression Course." Eugene, OR: Costalia Press.

Azrin, N.H. & Besalel, V.A. (1981). "An operant reinforcement method of treating depression." Journal of Behavior Therapy & exptl. Psychiatry, 12, 145-151.

Behavioral Family Therapy for Schizophrenia

Patient characteristics: Psychosis, schizophrenia, living with the family

Setting: In clinic or at home; individual family or multiple (preferable); patient is present and participating

Assessment: 1). pre-treatment individual interviews 2). Structured problem-solving tasks provided by the therapist 3). observation during treatment session

Education re schizophrenia: causes, treatability symptomatology, pharmacotherapy, relapse indicators. Information provided verbally and with written materials

Communication Training: non-critical listening, positive statements, attending to positive vs. negative actions, avoiding criticism, making requests for change, compromising and negotiation, reacting calmly to disturbing behavior, compliments

Problem-Solving Training: Weekly planned family session; 1). Identify the goal - do not dwell on problem 2). "brainstorming" possible alternative solutions - several 3). evaluate the advantages and disadvantages of each alternative -only after the "brainstorming" 4). select the best of the alternatives, or designate which will be attempted first

Specific Procedure: Medication adherence guidelines, assignment of household responsibilities, anxiety reduction procedures, token economy or contingency contracting

References:

Falloon, I.R.H., Boyd, J.L. & McGill, C.W. (1984). Family carel of schizophrenia: A problem solving approach to the treatment of mental illness. New York: Guilford.

Social Skills Training for Schizophrenia
From Bellak and Mueser, pp. 115 & 116 in Craighead)

Table 7.3 Skill Topic areas

Interpersonal skills
Conversation skills
Dating and friendship
Assertiveness
Problem-solving
Self-care and maintenance skills
Vocational rehabilitation
Home finding and maintenance
Medication management
Leisure and recreation
Self-care and personal hygiene
Use of public transportation
Food preparation
Money management
Use of community agencies

Description of SST Procedures

The clinical procedures involved in SST, whether conducted in group or individual format, generally adhere to the following basic steps:

1. The patient's behavioral assets, deficits, and excesses in social situations are systematically assessed, through such methods as role-plays, naturalistic observation, and interviews.

2. Specific social behaviors are targeted for modification and a rationale for learning these behaviors is provided to the patient. (See below and "Skill Topic areas")

3. The therapist models the skill in a role-play.

4. Specific instructions are given to the patient to rehearse the skill.

5. The patient practices the skill in a role-play.

6. Positive feedback is given to the patient for specific components of the skill performed well, and corrective feedback is given to improve performance.

7. Repeated rehearsal and feedback take place.

8. A homework assignment is given to practice the skill in the natural environment, to facilitate generalization of the skill.

Conversation/Social skills: eye contact; voice clarity and loudness; facial and voice affect; expressing greetings and departure; initiating conversation; responding to requests; expressing interest; making requests; positive statements, no complaints.

Setting: Patient alone in office, family not present.

References:

Liberman, R.P., Dirisi, W.J. & Mueser, K.T. (1989). Social Skills Training for Psychiatric Patients. New York: Pergamon.

Treatment of Social Inadequacy

I. Identify whether depression or general anxiety exists. If so, treat for the depression or anxiety - relaxation training.

II. If situation-specific: dating, making friends, improving a relation, etc.

A. If no skill deficit exists, use systematic desensitization, active relaxation or anxiety management training

B. If skill deficit exists, or insufficient motivation

1. Assist patient to identify socially appropriate actions
2. Arrange the possible actions in a hierarchy of difficulty
3. Model the least difficult action
4. Role-play this least difficult action with therapist feedback
5. Conduct imaginal rehearsal of the action with an imagined favorable reaction
6. Assign in vivo practice of the action i.e. "exposure"
7. Repeat # 1- 6 in ascending hierarchy of difficulty thereby shaping successive approximations.

References:

Curran, J.P. (1977). "Skills training as an approach to the treatment of heterosexual social anxiety: A review." Psychological Bulletin, 84, 149-157.

Treatment of Eating Disorders: Obesity

I. Physical factors: Exercise program and nutritional counseling

III. Depression: identify as possible cause and treat if present

III. Stimulus Control and Psychological factors

1. Eat meals in same place (stimulus control)
2. Eat at same times each day - 3 to 4 meals (temporal control)
3. Do not skip meals (temporal control - hunger cycle)
4. Do not eat while engaged in other activities (response chaining)
5. Keep foods out of sight between meals (stimulus control)
6. Eat slowly savoring each mouthful (satisfy taste sensations)
7. Swallow food in mouth before reaching for next morsel (same as above)
8. Delay eating for 1 minute after being served (practice food refusal)
9. Leave slight amount of food (practice food refusal)
10. Avoid foods that require no preparation (avoids impulsive eating)
11. No snacks between meals (disturbs hunger cycle)
12. Use small plate (stimulus control)
13. Discard left-overs (same as #10)
14. Shop from a shopping list (stimulus control)
15. Shop when not hungry (decreased excessive food availability)
16. Eat bulky food items (simulates satiation)
17. When eating at a restaurant, decide on the meal type before looking at menu (stimulus control)
18. Weigh self frequently (reinforcement, corrective feedback)
19. Enlist family support (social prompts/reinforcement)
20. Establish weight loss goal of 1-2 lbs. per week (successive approximation)
21. Engage in another activity if hungry between meals (competing behavior)

References:

Stuart, R.B. "Behavioral Control of Overeating." Behavior Res. & Therapy, 5, 357-365.

Treatment of Bulimia

I. Cognitive - Behavioral Treatment

A. Follow the same steps as in treating obesity

In addition:

1). Provide correction of belief that non-purging results in weight gain
2). Stress not skipping meals; eat slowly, avoiding "taboo" foods
3). Weigh weekly (to avoid incidental slight day-by-day weight increase).
4). Identify problem situations and associated self-statements/cognitions
   a). rehearse corrective self-statements (cognitive rehearsal)
   b.) problem solve for possible competing activities
5). Self-recording of binge and purge episodes (progress chart-reinforcement)

II. Exposure/Interruption procedure (Extinction of anxiety rationale)

1. In-session eating of taboo foods
2. Eat until uncomfortable
3. Record SUDS level from start of eating at intervals of about 2 minutes
4. Delay purging (vomiting) for at least 2 hours
5. Focus thoughts on sensations of fullness
6. In vivo, the patient is instructed to delay vomiting for progressively longer periods
7. In vivo monitoring of binges, purges, food intake

References:

Fairburn, C.G., Marcus, MD., Wilson G.T. (1993). Cognitive Behavior Therapy for binge eating and bulimia nervosa: A treatment manual. In Fairburn, C.G. & Wilson, G.T. (Eds.) Binge Eating: Nature, assessment and treatment. New York: Guilford, pp. 361-404.

Leitenberg. H. et al (1988). "Exposure plus response-prevention treatment of bulimia nervosa." Journal Cons. & Clin. Psychol., 56, 535-541

Anorexia Treatment

Medical Precautions: tube feeding, vitamins, intravenous feeding, etc.

No coaxing to eat (SR+ attention for food refusal)

Fixed eating time: 3-4 regular meals (hunger cycle peak)

No special food (SR+ for food over selectivity)

Weigh each day at same time (immediate feedback)

Large meals: 4,000 calories: (% of food available eaten)

Large plate: (apparent small volume of food)

Response Goal: 1/4 lb. gain over previous peak (R+ for SR+)

Partial Response Feedback: number of calories eaten, number of mouthfuls.

Reinforcers: Exercise, jogging, walks, special social interactions, passes, visits, hospital discharge, recreational activities, no tube feeding, no intravenous feeding

Post-meal observation: 1+ hours (to prevent purging)

Cognitive restructuring: ? re body image, food-weight beliefs, interpersonal relations.

References:

Agras, W.S. et al (1`974). "Behavior Modification of anorexia nervosa." Arch. General Psychiatry, 30, 279-286

Alcoholism Treatment

I. Community Reinforcement Approach - Incompatible activities
Identify "risky" and "safe" situations/persons
Marital Functioning: Behavioral Marital Therapy
Vocational: Job-Club vocational counseling, full-time, permanent, supervised, not seasonal
Peer Associations: Non-alcoholic associations
Stimulus Control: Non-drinking situations
Daily Planner: Schedule associations and situations
Social clubs: non-alcoholic
Religious services (if applicable) regular attendance
Significant Other: Accompany to "risky" situations
Drink-refusal: In-session rehearsal
School/College: Enroll and attend
Enriched environment (for alternative reinforcers): TV, magazine, subscription, radio, recreational activities, visits to relatives and "safe" friends

II. Relapse Prevention
Identify "risky" and "safe" situations
Identify antecedent cognitions, rehearse alternatives
Teach drink refusal, leaving situations
Problem-solve for alternative activities (see all of the above in Community Reinforcement treatment)

III. Problem-Solving ("Self-directed," Motivational Interviewing) Miller, Sobells

a. Have patient reconstruct drinking occurrence during past 6 months on a calendar, designating which persons, places, situations were associated with each drinking episode, as well as quantity of liquor ingested. Summarize these aspects for the patient. Also, have patients list reasons for wishing to change.

b. Instruct the patients to devise their own plan for reducing drinking. Avoid any suggestions so as to maximize patient commitment and avoid unwelcome suggestions.

References:

Hunt, G.M. & Azrin, N.H. (1974). Á community-reinforcement approach to alcoholosm," Behavior Res. & Therapy, 11, 91-104.

Marlatt, G.A. (1985). Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors. New York: Guilford.

Miller, W.R. & Rollnick, S. (1991). Motivational Interviewing: Preparing people to change addictive behavior. New York: Guilford.

Covert Sensitization

1). Identify the details of the S- (negative stimulus sequence)

2). Identify the details of the SR- (natural negative consequences)

3). Demonstrate and rehearse gagging as an alternative SR-

4). Eyes closed, distraction - free setting

6). P imagine S- at full intensity

7). Therapist then instructs to imagine R- including cognitions and situation features

8). Therapist gives verbal prompts to heighten the aversiveness of the SR- Continued for approximately 1 minute of maintained distress

9). Alternate between incipient S- and full S- trials

10). Alternate between positive escape response and R- trials

11). Obtain 0-100 rating after each trial regarding strength of urge

12). Continue until ability to create urge is difficult - long latency

References:

Cautela, J.R. & Kearney, A.J. (1993). Covert Conditioning Casebook, Belmont, CA: Brooks/Cole.

Behavior Marital Therapy

I. Reciprocity Counseling

A. Communication Training

Positive Request Procedure: How to make requests

1. State problem: a). no blame/criticism b). brief c). no numerous examples d). impersonal terms
2. Make request: a). for action, not trait b). "do" not "don't" c). specific
3. Why reinforcing to self, specific, not "make me happy"
4. Why reinforcing to partner to do it
5. Offer to help in some way to carry out the requested action
6. State alternatives

Annoyance Prevention: reacting to perceived annoyance by partner

1. Self-relaxation
2. State problem: a). no blame/criticism b). brief c). no numerous examples d). impersonal terms
3. State partial self-responsibility or contribution
4. State possible "excuses" for partner's action/inaction, plausible.
5. Request a corrective action (See Positive Request above)

Reacting to an "unacceptable" request

1. Self-relaxation by Active Relaxation
2. Do not say "no" or interrupt
3. Rephrase/repeat request to assure correct understanding
4. State what part of request/reason is acceptable/reasonable
5. Suggest an alternative action (See Positive request above)

II. Behavioral Exchange (Contracting)

1. Request an action from partner - using Positive Request above
2. Partner requests an action in return for above - in same domain
3. Partner requests an action in a different (same if desired) domain
4. Continue alternating requests
5. Agreement written out, scheduled, signed by H, W, therapist

Problem-solving:

1. Same as Annoyance Prevention #1, (#2), self-relaxation
2. Generate several alternatives, evaluate after final list, select best

III. General Guidelines

Impartiality: Alternate between H & W
Counsel H & W together, not separately
H & W, not therapist, defines role standards

Increase Reinforcers (mutual); Assign, to
- Compliments
- Appreciations
- Offers to help
- Pleasant surprises

Emphasize satisfactions, not problems, past and current

Reciprocity Awareness
1). H & W separately list on a divided sheet what
a). I do for him/her b). He/she does for me
2). Each states to other a) & b) above
3). Therapist prompts appreciation by recipient
4). Therapist expresses praise for action by either
5). Assign additional listings of existing satisfactions

Criticism of Partner
1). Therapist interrupts 2). Requests rephrasing

Progress Measures
1). Locke-Wallace 2). Marital Happiness Inventory - weekly

References:

Azrin, N.H. (1980). "Comparison of Reciprocity and discussion-type counseling for marital problems." American Journal of Therapy, 8, 21-28.

Jacobson, N. (1984). "A component analysis of behavior marital therapy," JCCP, 61, 85-93.

Sexual Dysfunction Treatment

I. Low sexual desire - male, female
   a). Negative cognitions: identify, restructure
   b). Priming: Books, pictures, videos, kissing, touching
   c). Communication: Request, negotiation, manual
   d). Sexual technique

II. Premature Ejaculation: - male
   a). male - pause b). female - pause, squeeze before ejaculation

III. Impotence (erectile failure) - male
   a). Anxiety reduction - systematic desensitization, etc.
   b). Assure F orgasm - (manual, oral, mechanical)
   c). Sensate Focus: nude, stroking, mutual, stop before orgasm, F guides

IV. Orgasmic Reconditioning: situational orgasmic failure: Masturbation
   a). Fantasize adequate stimulus
   b). Substitute inadequate stimulus just prior to ejaculation
   c). Initiate inadequate stimulus progressively earlier
   d). New stimulus sufficient from initiation through ejaculation - Final goal

V. Orgasmic dysfunction - female - Shaping
   a). Identify genital parts, touching
   b). masturbation
   c). erotic material
   d). mechanical masturbation
   e). M views (participates) in masturbation
   f). F instructs M to stimulate g). F guides insertion

VI. Vaginismus
   a). Systematic desensitization, Relaxation
   b). Dilator cylinders: gradually increased diameter after desensitized on the earlier diameter

References:

Lo Picolo, J. (1994). Sexual Dysfunction in Craighead et al. Cognitive & Behavioral Interventions. Boston: Allyn & Bacon.

Behavioral Medicine Treatments

I. Pain Management

1. Progressive muscle relaxation training or Biofeedback

2. Cognitive restructuring
   a). Distraction
   b). alternative positive coping statements

3. "Well Behavior" enhancement
   a). Activity-rest cycling each hour. Gradually increase the activity portion within each hour
   b). Engage in all possible functional, recreational activities

4. Analgesic scheduling - not PRN
   a). Calculate average duration (N hours) between medication dosing on PRN
   b). Take medication every N hours - even if no pain present
   Delay medication for the N hours - even when pain is present
   c). Gradually increase the time between dosing

II. Stress Management

1. Identify cognitions/situations associated with stress
2. Identify earliest precursors (cognitions, affect, stimuli) of stress
3. Progressive muscle relaxation, Active Relaxation, breathing
4. Cognitive restructuring for negative cognitions
5. Problem-solving for alternative coping responses
6. Time Stress
   a). Daily Planner
   b). Problem-solving
7. Anger
   a). Annoyance Prevention Procedure
   b). Active Relaxation
8. Competitiveness
   a). Cognitive restructuring

References:

Keefe, F. J. & Beckham, J.C. (1994). Behavioral Medicine in Craighead et al. Cognitive & Behavioral Interventions. Boston: Allyn & Bacon.

~~Job Club~~ Azrin, N.H. + Besalel, V.A. "Job Club Counselor's Manual" PRO-ED Publishers, Austin, Texas 1981

JOB CLUB DISTINCTIVE FEATURES

1. *Job Seeking as a Full-time Job* The job seeker treats job finding as a full-time job. About one-half of each day should be devoted to obtaining job leads and arranging interviews, the rest of the day is then spent on actual interviews. This schedule is followed every day until a job is obtained.

2. *Friends, Relatives, and Acquaintances as Sources of Job Leads* The job seeker makes a systematic effort to contact friends, relatives, and acquaintances as a primary source of job leads.

3. *Standard Scripts and Forms* The job seeker is given standard scripts and forms that he follows when contacting friends or employers, writing letters, making telephone calls, and keeping records.

4. *Facilities and Supplies* To simplify the task of job seeking, the Job Club program provides all of the supplies and services necessary for a job search, such as a telephone, a typewriter, photocopies, stationery, postage, newspapers, and a work area.

5. *Group Support from Other Job Seekers* The program provides a group setting that is structured to enable job seekers to assist each other. Participants are directed to look for leads for other members of the group, and job leads from previous club members are made available to current members. The program is designed to foster mutual encouragement and support. Motivation is stimulated as fellow participants, who seemed to be unemployable, find jobs.

6. *Buddy System* Job Club members are paired off so that everyone has a "buddy" who gives advice and assistance in monitoring telephone calls, writing letters, scrutinizing want ads, and practicing for interviews.

7. *Obtaining Unpublicized Jobs* The Job Club teaches job seekers how to obtain interviews for jobs that have not been publicly advertised or that may not even yet exist. This procedure results in the discovery and creation of job openings.

8. *Use of the Telephone as the Primary Contact for Leads* The telephone, rather than letters or personal visits, is used extensively as the method of obtaining job leads and arranging interviews.

9. *Classified Directory (Yellow Pages) of Telephone Book* The yellow pages section of the telephone book is used daily to obtain new lists of potential employers.

10. *Emphasis on Personal and Social Skills* The Job Club program teaches job seekers how to emphasize distinctive personal and social skills in addition to work skills. These personal skills are stressed in the job seeker's résumé, in making contacts to obtain job leads, and in the interview.

11. *One Job Lead Uncovers Others* The program teaches job seekers how to turn unsuccessful job inquiries into job leads so as to generate a continuous fresh supply of leads and contacts.

12. *The Call-back* The job seeker is taught to arrange a second contact with an employer following an interview in order to facilitate the employer's decision. Similarly, a call-back is arranged with highly attractive employers in order to learn quickly about forthcoming openings.

13. *Transportation* The program teaches the job seeker how to arrange transportation to otherwise inaccessible job locations, thereby permitting consideration of a greater range of job possibilities. Also, the members of the group assist each other with transportation to the Job Club office and interviews.

14. *Former Employers* Job seekers are trained to approach former employers for job leads as well as job openings.

15. *Open Letters of Recommendation* The job seeker obtains open letters of recommendation to provide interviewers with the information necessary for reaching an immediate decision.

16. *Résumé* The program helps the job seeker construct a résumé that stresses personal skills, attributes, and functional work skills rather than a formal listing of job titles.

17. *Employment Application* The program teaches the job seeker how to emphasize positive personal attributes on standard application forms.

18. *Interview Training* The program teaches job seekers how to act during an interview and how to respond to common interview questions.

19. *Interview Checklist* The job seeker is given a list of actions to be covered during any interview. This list is reviewed immediately after each interview to highlight omissions or problems that might require subsequent correction.

Job Club cont'd)

20. *Job Wanted Ads* For job seekers who have great difficulty finding a job, the program provides for a job wanted ad to be placed in the newspaper. The wording of the ad emphasizes the job seeker's positive personal-social attributes.

21. *Nonemployment Derived Work Skills* The program teaches the job seeker to identify marketable work-related skills that may not have been acquired from or related to other previous paid employment.

22. *Structured Job Seeking Schedule* Job seekers use a form to plan each day's schedule of interviews, calls, and visits.

23. *Leads List* Job seekers maintain a running record of job leads to organize contacts and call-backs of potential employers.

24. *Progress Charts* The job seeker keeps a formal record of job seeking activities to permit quick evaluation of progress and to pinpoint possible reasons for job finding difficulty.

25. *Job Supervisor* Job seekers learn how to contact potential job supervisors in a company rather than personnel staff because the supervisor usually plays a critical role in hiring decisions and is also sometimes able to create a job geared to the skills or attributes of a particular applicant.

26. *Relocation* If no suitable jobs are available locally, the program teaches the job seeker how to obtain a job in another location.

27. *Handicaps* The program teaches job seekers how to deemphasize and discuss apparent handicaps, such as a physical disability or a prison record, and how to view the apparent handicaps in terms of their positive attributes.

28. *Letter Writing for Job Leads* The program provides sample letters and forms to be used as models by the job seeker in writing to people for job leads.

29. *Family Support* The job seekers enlist the support of their family and give them instructions as to the specific ways in which they can help.

30. *Photograph* (Optional) When feasible, the job seekers personalize their résumés by attaching a photograph.

31. *Employment Applications* The job seekers learn how to answer typical questions on employment application forms in such a manner that their positive attributes are emphasized.

32. *Capability for Many Positions* The job seekers learn to consider many types of positions, thereby not restricting themselves to one type of job.

Insomnia Treatment

I. Progressive Muscle Relaxation (See separate sheet)

II. Stimulus Control:
Sleep only in bed - not sofa, chair
Naps - None during day
No other activity in bed - no reading, TV, eating, problem-solving
Arise at same time in morning - even if tired
Retire at the same time at night
If unable to fall asleep in 15 minutes, arise, leave bed and bedroom
Return to bed only when tired
If wakefulness persists for several nights, retirement time is scheduled later

II. Sleep Hygiene:
Education re duration of sleep needed: individual differences, less with age
Distraction: Eliminate; masking noise considered
Diet: Reduce alcohol, caffeine
Exercise: During day, not immediately prior to bedtime

References:

Morin, C.M. & Azrin, N.H. (1988). "Behavioral & Cognitive Treatment of Geriatric Insomnia, JCCP, 56, 745-753.

Morin, C.M. (1993). Insomnia: Psychological Assessment and Management. New York: Guilford Press.

Post-Traumatic Stress Disorder

I. Flooding, Implosion Therapy
Identify details of several trauma-associated experiences
Relaxation at start and end of each session
Hierarchy: Initially use lessor distressing scene
Imaginal creation of trauma scene-eyes closed
Maintain scene for extended duration
Therapist prompts continuously re scene details and distress affect
Implosion: therapist emphasize distress affect/cognitions

Session Duration: 2+ hours
Situations: Actual trauma situation; also current trauma- related situations
Therapy Assignment: when stress is managed during session
a). Audiotape of successfully managed scene- daily listening
b). Self-exposure to successfully managed trauma- related situations in vivo
SUDS level: Pre and post each imaginal and in vivo- exposure

II. Anxiety Reduction Therapy (Veronen & Kilpatrick; Foa) for rape victims
Give rationale: Classical conditioning as cause; anxiety reduction as treatment
Progressive Muscle Relaxation: See separate page for details
Active Relaxation: See separate page for details
Controlled Breathing: deep, slow, diaphragmatic; exhale slowly
Thought-Stopping: Stop!! aloud, then silently
Functional skill rehearsal to trauma-related situation
Cognitive Restructuring: Functional, positive self-statements re anxiety-producing situations. Initially think aloud in office.
Gradualness: Non-rape related, then rape-related, then rape scene
Imaginal rehearsal: Induce anxiety scene; imaginally rehearse relaxation, breathing, functional behavior, thought-stopping, and cognitive restructuring noted above
In Vivo assignments of above behaviors after successful imaginal treatment
Self-recording of situation, behaviors, pre/post SUDS

III. Eye-Movement Desensitization and Reprocessing

References:

Veronen, L.J. & Kilpatarick, D.G. (1983). Stress Management for Rape Victims, in Meichenbaum, D. & Jremiko, M.E. (Eds.). Stress Reduction & Prevention. New York: Plenum.

Keane, T.M. et al (1989). "Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans." Behavior Therapy, 20, 245-260.

Foa, E.B. et al (1991). "Treatment of PTSD in Rape Victims: A comparison between procedures." JCCP, 59, 715-725.

Shapiro, F. Eye Movement Desensitization & Reprocessing (1995). New York: Guilford.

Obsessive - Compulsive Disorder (Contamination ritual)

Exposure - Interruption: Rationale - 2 factor theory
In- office creation of contamination situation
Hierarchy: Initial use of mildly feared situation
Session duration: 2+ hours
Session frequency: daily initially
Interruption: Washing not permitted except before meals; brief shower.
Focus: Keep patient focused cognitively on the feared object(s).
Imaginal: initially before in-office or in-vivo out-of-office exposure
SUDS: Frequent self-recording by patient of distress level
Exposure Continued each trial until distress level (SUDS) decreases each trial

Therapy Assignment: In-vivo deliberate exposure/interruption

References

Rachman, S. & Hodgson, R. (1980). Obsessions and Compulsions. Englewood Cliffs, NJ: Prentice Hall

Parent Child Abuse Treatment

I. Positive Parenting
- Punishment: Time-out, (over) correction, positive practice; not physical, reward program (Token Economy)
- Focus on child's positive behaviors: praise, appreciation, frequency increased
  - In-session role-play;
  - Therapy Assignments - keep record
- Identify problem situations
  - Rehearse solutions; T.O., overcorrection, warning
- Communication:
  - Praise for positive aspect of behavior
  - Instruction: Action (not trait), "do" not "don't", specific

II. Anger Control: See Annoyance Prevention procedure under "Behavioral Marital Therapy."

III. Stress Management: See Stress Management under "Behavioral Medicine."

IV. Marital Counseling: See Marital Counseling

Reference:

Wolfe, D.A., Sandler, J., & Kaufman, K. (1981). "A competency based parent training program for abusive parents." JCCP, 49, 633-640.

Active Relaxation Training

Progressive Muscle Relaxation: prior (2+ weeks)

Cue-Word: ("Relax", "Calm") at start of each relaxation, "Cue-Controlled Relaxation"
Regulated Breathing: at start of each relaxation, during.
Identify tense body muscles: use recording form in vivo

When to Use: At onset of anxiety - cognitive, affective, motor and physiological cue.

Immediately prior to entering anxiety-prone situation.
In-session listing of known anxiety-prone situation.

Procedure: Relax all muscles - except those used in the functional activity
Do not interrupt the functional activity
Use the cue-word (silently), initiate and maintain regulated breathing
Attend to and relax the previously identified tension-prone muscles.

Scan the various muscle groups - all
Attend to and relax the generally tense muscle groups: Teeth clenched, forehead, neck, stomach, hands
Attend to and relax hands if they are being used: writing, driving, etc.
Duration: continue until SUDS near zero
Record: On a form: pre and post SUDS, situation, which muscles tense, approximate duration

In-office rehearsal imaginal of simulated anxiety situations
Self-induce anxiety symptoms
Therapist feedback during patient's active relaxation

Reference:

Ost, L.G. (1988). "Applied relaxation vs. PMR in the treatment of panic disorder." Behavior Res. & Therapy, 26, 13-22.

Systematic Desensitization

Progressive Muscle Relaxation prior - for 1-2 weeks

Hierarchy Construction: 10-20 anxiety scenes
SUDS rating (0-100) each scene
Equidistant: SUDS between scenes
Anchor points: least (05 SUDS) or extreme (95-100 SUDS)
Prompting scene identification: actual fears ? N SUDS ?
Spatial-temporal variations, thematic variations

Relaxation Scene: Identify, details, used only between trials with muscle relaxation.

Settings: Lounge, distraction free, eyes closed
Procedures; Patient signal by raising finger briefly when image is clear
Patient holds image for 7 seconds, therapist terminates
If anxiety during scene excessive, patient signals, trial terminates
Number of trials: At least 2 per scene; repeat if SUDS greater than 10
SUDS rating: pre and post trial and verification of clarity
If SUDS remains high: repeat scene
return to previous scene
construct intermediate SUDS scene
Next session: Begin with previous mastered scene

Scene Presentation: Ascending sequence of SUD
Zero SUDS prior to scene presentation - relaxation scene if necessary
Therapist prompts: gives details of scene

Reference:

Rimm, D. & Masters (1974). Applicability of PMR and Systematic Desensitization in Behavior Therapy. New York: Academic Press, pp. 45-67.

Anxiety (Affect) Management Training (AMT)

Progressive Muscle Relaxation: prior 1- 2 weeks
- Cue - Word: ("Relax") at start of each muscle relaxation
- Regulated breathing: at start of each muscle relaxation
- Identify tense body muscles: use recording form

Relaxation Scene Identification: real, no motor activity, details, at end of PMR

Anxiety Scene Identification: at least 2: 60 and 90 SUDS; details: cognitive, affect, motor, physical details; no "escape" cognitions

Setting: Lounge, distraction free, loosen tight clothing, eyes closed

In Vivo Recording of stress situations: situation, SUDS level

Self-Induction imaginal (in office) of 60 SUDS stress scene
- Therapist instructs initiation of stress scene,
- Patient raises finger when 60 SUDS level and keeps raised during 60 SUDS
- Therapist gives detailed prompts until 60 SUDS achieved appropriate voice affect.
- Duration of Anxiety: 10-15 seconds, then induce relaxation

Self-Induction of Relaxation Scene after 10-15 seconds of anxiety
- Therapist prompts initiation of relaxation and prompts further relaxation until "near- zero"

Fading of prompts on succeeding trials
- Reduce detail prompts during the anxiety and relaxation scene
- Eliminate relaxation scene, focusing on muscles and breathing
  - Maintain anxiety scene imaginal while relaxing muscles and breathing
- Patient initiates anxiety scene (finger raised) with no therapist prompt
- Patient initiates relaxation efforts when SUDS = 60 with no therapist prompt

End Stage: Patient induces anxiety and relaxes self (to-near-zero-SUDS) with no therapist prompts

Alternate: 60 and 90 SUDS anxiety scene

Recording: Therapist records time (seconds) needed to reduce anxiety (finger raised)

In Vivo: Performance of above and self-recording of situation, SUDS, time to reduce anxiety

Reference:

Suinn, R.M. (1990). Anxiety Management Training. New York: Plenum Press.

Progressive Muscle Relaxation Training

Provide conceptual basis; relate to presenting problem/diagnosis, estimated benefit

Setting: Distraction-free, lounge chair/recliner, loosen clothing: tie, belt

Precautions: Sensitive/vulnerable body parts: back, teeth, contact lens, neck

Model: Hands (both), arms (both); performing concurrently with eyes open only initially.

Muscle Groups: head-to-toe: forehead, eyes, mouth, tongue, neck, shoulders, breathing, back, stomach, hips, legs, feet, toes; Emphasize (repeat) muscles specific to patient's locus of tension

Tense/Relax: Tense: 10 seconds; Relax 15-20 seconds: Only the designated muscle groups

Voice: Soft, mellifluous during "relax"; strident during "tense"

Associated Images: Tense: "hard", "stiff, "pressure", "hard as a rock", "tight", etc.
Relax: "limp", "loose", "water flowing from jar", "tenseness evaporating", etc.

Continuous Talk by therapist for above

Feedback comments, praise for appropriate response for each muscle, alert for movements/tensing of other muscles

Breathing: During each relaxation: slow smooth breathing, diaphragmatic breathing

Total Body Relaxation: After all individual muscles

SUDS: Pre and Post TX

Tape Recording: Given to patient for home use

TX Assignment: Twice daily with tape for approximately 15 minutes each time

Recording: Form indicating date, time, duration, pre and post SUDS

References:

Rimm, D. & Masters, J.C. (1974). Chapter: Applicability of PMR and Systematic Desensitization in Behavior Therapy. Academic Press, 45-67.

Wolpe, J. (1973). The Practice of Behavior Therapy (2nd ed). New York: Pergamon.

Panic Disorder

I. Provide conceptualization of cause:
sympathetic nervous system activation, symptoms normal: fainting, heart rate, fight-flight, Breathing: oxygen/CO2 ratio, cognitions, etc.

II. Self-Recording: Cognitions, affect, motor SUDS ratings for above precursors, duration, etc.

III. Progressive muscle relaxation (see separate sheet)

IV. Active relaxation (see separate sheet)

V. Breathing retraining:
Diaphramatic vs. thoracic
In office, then at home
Slow, smooth, deep breathes 6 seconds per cycle during relaxing phase of PMR

VI. Interoceptive symptom inducement
Ascertain what physical means induce symptoms ex: spinning exercise warmth, rapid breathing.
Induce in office with corrective practice.

VII. Cognitive Restructuring
Coping statement, relax, breathe, etc
Positive reinterpretation of symptoms: normal
Focus on speed of recovery

VIII. Planned in vivo exposure
Self-directed, hierarchy, controlled escape

IX. Beneficial significant other participant

Reference:

Barlow, D.H., et al (1989). "Behavioral Treatment of Panic Disorder." Behavior Therapy, 20, 261-282.

Generalized Anxiety Disorder

Functional Behavioral Assessment; self-recording with SUDS
Precursors, consequences, nature of symptoms, etc.
Co-Morbidity: with other mood disorders – very high

Provide conceptualization to patient of cause, nature, and treatment rationale, e.g. genetic, cognitive (anxious apprehension), early neg. experience, overgeneralization.

Progressive muscle relaxation
(See separate sheet)

Applied muscle relaxation
(See separate sheet)

Breathing retraining
(See separate sheet "Panic Disorder")

Cognitive behavior therapy
Included Applied Relaxation, breathing, and other coping statements/actions
"Relax," positive statements of reassurance, positive reinterpretation of symptoms
Problem solving: define problem, several alternatives, evaluate each only after listing several, select "best" to do first.
Decreasing negative self-statements and catastrophizing; cognitive restructuring
Anxiety Management Training (Suinn – See separate sheet)

Reference:

Barlow, D.H. (1988). Anxiety and its disorders: The nature and tratment of anxiety and panic. New York: Guilford.

Interpersonal Therapy for Depression

I. Resolve Interpersonal Conflicts with Significant Others
   a. problem solving training
   b. communication training
   c. work with individual patient (not with conflicted persons)

II. Adopt "Sick Role":
   Relieve self of day-to-day chores and responsibilities; lower standards

III. Procedures common to most treatments
   1. establish rapport and "working alliance"
   2. psychoeducation re depression
   3. state high probability of success of the treatment
   4. identify specific symptomatology
   5. identify significant others
   6. encourage patient to set primary treatment goal with the therapist
   7. sympathize with P re the seriousness of the symptoms
   8. emphasis on feeling state in depression vs. behavior or insight

Reference:

Weissman, M.M., Markowitz, J.C. & Kleman, G.L. (2000). Comprehensive Guide to Interpersonal Psychotherapy. New York: Basic Books.

MEDICATION ADHERENCE GUIDELINES

FROM: Azrin, N. H. & Teichner, G. "Evaluation of an Instructional Program for Improving Medication Compliance for Chronically Mentally Ill Outpatients, Behavior Research and Therapy, vol 36, 1998, pp 849-861.

The patient and family member assigned to the patient + family guidelines condition were given a pamphlet titled 'Guidelines to Taking Medications', and read aloud each of the guideline steps. The specific guidelines were: (1) to use a transparent 28-compartment pill box, which was given to them, consisting of 4 compartments designating 4 time periods for each of the 7 designated days in a week in which to store the pill medications. The subject and family member together were instructed in its use by (a) displaying a sample pill box filled with various pills, (b) then demonstrating the proper use of the pill box given to the subject with their own medications in the appropriate compartments for the first day and (c) having the subject place the medications in the appropriate compartments for the remaining 6 days. The other guidelines beside (1) use of the compartmentalized pill box were: (2) taking medications at the same time, place, or occasion each day. (3) Taking medications in the presence of the family member. (4) Having both the subject and the family member check the pill box, which was to be located in a visible location, throughout the day to ensure that medications were actually taken. (5) Having both the subject and the family member take their respective medications together when possible. (6) The family member giving compliments to the subject for taking medications. (7) Identifying and stating to oneself the positive consequences of pill taking (e.g. "I feel less tense when I take all my medications"). (8) Refilling the prescription 1 week before medications were used up. (9) Calling the clinic for an appointment, or for a prescription refill, well in advance, or for the psychiatrist to authorize the patient's pharmacy to refill the prescription. (10) Seeking financial assistance to help pay for medications if this was a burden (a list of clinic-affiliated agencies providing free or discounted prescribed medications was provided). (11) Speaking to the pharmacist to obtain information regarding possible precautions and a medication description sheet. (12) Jointly refilling the pill box at the start of each week with all medications. (13) Taking the pill box with them when away from home. (14) Discussing side effects, effectiveness, symptoms and expense of the drugs with the psychiatrist by means of (i) having the family member attend all of the subject's medical appointments and (ii) writing down symptoms, side effects, questions and so forth on a provided sheet of paper to be given immediately to the psychiatrist at the start of each visit. (15) Providing strategies to temporarily relieve side effects as they occur. (16) Having all prescriptions filled at the same pharmacy. (17) Having the family member ensure transportation to the clinic and pharmacy for the patient. (18) Avoiding the consumption of alcohol because of drug interactions. (19) Asking the subject and family member to review all of the above steps if they noticed a symptom change or side-effects. The separate patient and family pamphlets utilized a fill-in format whereby they wrote down their willingness (e.g. 'yes') and the specific actions they would take (e.g. name of the family member, pharmacy, time and place and occasion for taking medication, transportation assistance, etc.) to implement each guideline. The staff member assisted them in formulating the fill-in answers for each guideline, encouraged a commitment of adherence to each, and were given the pamphlet to keep as a reminder.