Phase 1: Attend to Psychological Reactions

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Flow of Treatment

- **Phase 1: Attend to Physiological Reactions**
  - Develop rapport and assess
  - Conceptualize
- Phase 2: Build the Brain from the Bottom-Up
  - Wave1 interventions
  - Special considerations
- Phase 3: Connect the Bottom to the Top
  - Wave2 interventions
  - Case closure

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Phase 1: Attend to Physiological Reactions

- **Develop rapport and assess**
- Conceptualize

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Develop Rapport and Assess

- Overview
  - Counselor understanding and allegiance
  - Counselor-client trust
  - Conducting intake assessment
  - Listening, observing, and attending to in-session physiological reactions
  - Assessing predominant response process and style
  - Evaluating your belief in the model (allegiance)
  - Counselor suggestion, salesmanship, and delivery of psychoeducation about Wave1 and 2
  - Evaluating the client's belief in the model (expectancy)
  - Referral considerations for additional services

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Counselor understanding and allegiance

Counselor-client trust

Counselor delivery, suggestion, salesmanship

Influencers:

- Attendance
- Theory is logical or confusing
- Familiarity and similarity to current practice
- Reputation of CBT
- Respect for scientific basis
- Appreciation for non-blaming explanation of symptoms
- Readiness for change
- Setting

Client understanding, willingness, and expectancy

Client declines, nCBT not started

nCBT started

nCBT started

No results

Influencer:

- Outside-of-session practice

See results

Undermining and Drop out

History of "seeing results" sustains counselor allegiance when no results occur

Reinforcement and Sustainment

Counselor Understanding and Allegiance

- Client understanding, willingness, and expectancy (buy-in) is strongly influenced by counselor understanding and allegiance
- Counselor understanding and allegiance
  - Attendance at training
  - Theory as logical or confusing
  - Familiarity and similarity to current practice
  - Reputation of CBT
  - Respect for scientific basis of neuroscience
  - Appreciation for non-blaming explanation of symptoms
  - Readiness for change
  - Setting
- Self-evaluate your understanding of n-CBT first, before explaining it to a client (post-test of knowledge)

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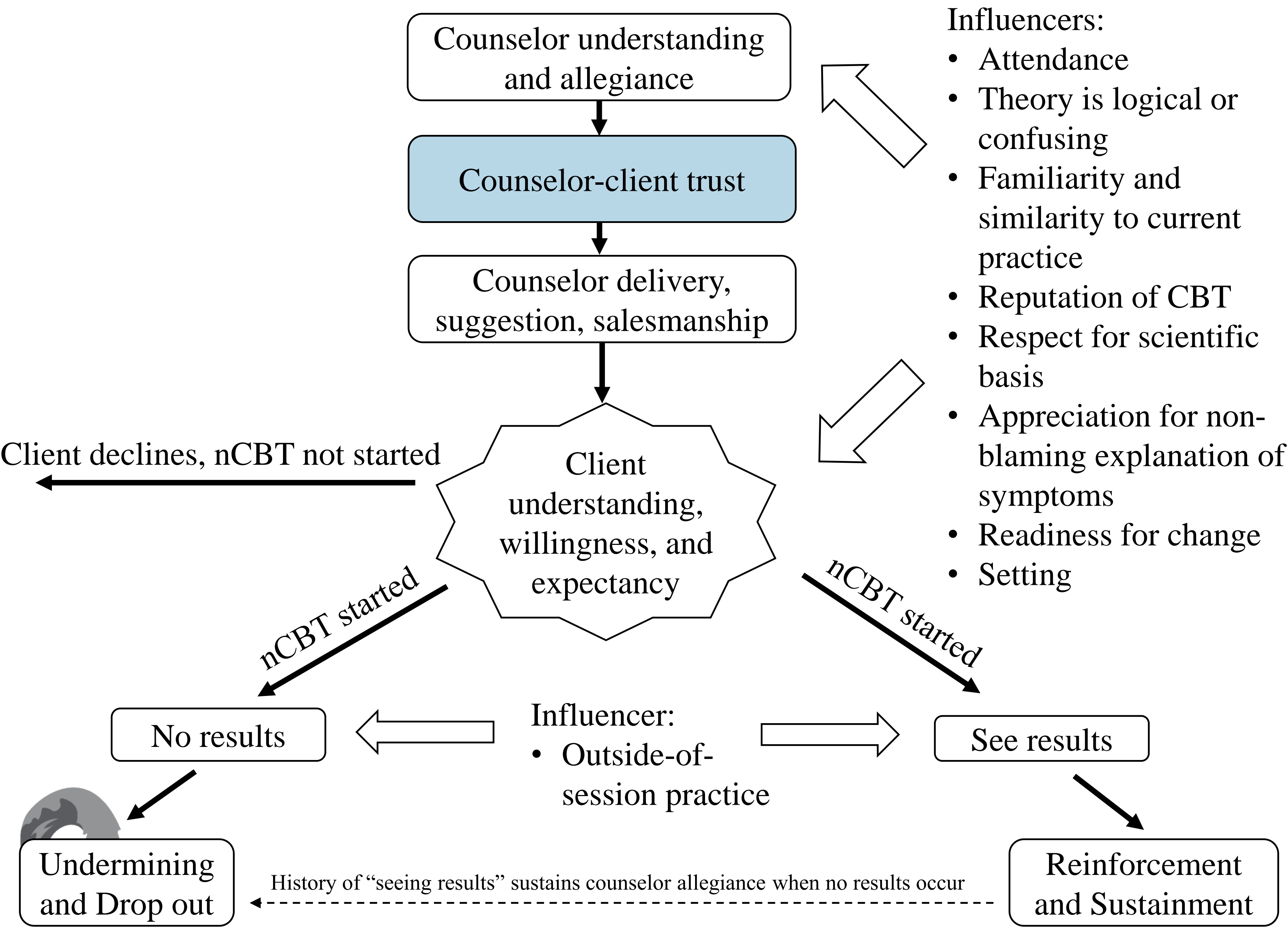
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Counselor-Client Trust

- Counselor-client trust is essential to client engagement in nCBT. Trust is built through
  - Validating client experience without trying to change it immediately
  - Describing assessments or interventions beforehand, with rationale
  - Facilitating client autonomy for deciding when they are ready for more challenging tasks (exposure, discussing past trauma, etc.) by using pre-conversations
  - Collaboratively determining treatment goals and outside-of-session practice
  - Providing structure in each session with collaborative agenda setting, and closing each session with a summary
  - Maintaining rapport: Feedback process to address alliance ruptures

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Counselor-Client Trust

- Examples of check-ins:
  - How are we doing today?
  - Are there topics that we haven't addressed today, that you'd like to get to next time?
  - What was it like to talk about _______ ?
  - Some clients have given me helpful feedback in the past about how I can adjust my approach to best meet them where they are at. Do you have any ideas about this?
- ORS/SRS can be helpful, though has limitations
- Outcomes assessments are important

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- 60 second roleplays:
  - Beginning a session with collaborative agenda setting
  - Pre-conversation for readiness to address trauma
  - Closing a session with a summary
  - Recruiting feedback about the session

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Conducting Intake Assessment

- Conducting Intake Assessment:
- Use either existing history form or interview,
- Or use the Neurobiopsychosocial History form
  - Client can complete this form before the session

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Areas Assessed at Intake

- Identifying information (e.g., age, racial/ethnic identity, gender identity)
- Reason for referral and referral source
- History of chief complaint (e.g., duration, frequency, intensity, context)
- Family history (e.g., early attachments, genetic predispositions, trauma)
- Relationship history (e.g., stability, trauma, social engagement)
- Developmental history (e.g., early signs of dysregulation)
- Educational history (e.g., highest level, strengths/weaknesses)
- Work history (e.g., current employment, gaps, interests, military)
- Medical history (e.g., past/present medical diagnoses and treatment history)
- Eating, sleeping, physical activity, substance use (e.g., even caffeine)
- Legal history (e.g., arrests, charges)
- Previous counseling (e.g., when and why, pros/cons, types of treatment)
- Mental Status Examination

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Attending to Physiology

- Be attentive to verbal and nonverbal content (especially cues of physiological activation), relative to…
    - The topics discussed
    - The counselor's verbal and nonverbal behavior
    - Any other potential antecedents

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Attending to Physiology

- Cues of physiological activation:
  - Changes in breath rate, depth, and location
  - Changes in vocal tone (stammering, shakiness, loud/soft pitch)
  - Blushing
  - Fidgeting and agitation
  - Muscle tension or tense posture
  - The counselor's own internal physiological response
  - Others?

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Attending to Physiology

- When you observe physiological reactions, bring them to the client's attention and ask:
  - Have you also noticed…
- Next, ask the client to "sit with" the physiological reaction, through the prompt:
  - Observe the feelings and sensations in different parts of your body

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Attending to Physiology

- Listening and observing → assessment
  - The client's physiological response,
  - And their response to their physiological response (e.g., difficulty "sitting with")
  - Information is crucial to assessing predominant response process/style and selecting interventions
  - Avoid immediately jumping to Wave1 or 2 interventions (this can create client perception that their responding is "wrong")

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- 60 second roleplays:
  - Attending to physiological activation

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Response Process and Styles

- Response processes:
  - Wave1
  - Wave2

- Wave1 response styles:
  - Approach (move toward)
  - Avoid (move away)
  - Freeze (motionless)

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Response Process and Styles

- Most of us experience all three types of response processes (Wave1 and 2) and Wave1 styles (approach, avoid, freeze) at varying times
- Response processes and styles are always naturally occurring, and are only sometimes problematic

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Response Style	More Helpful	Less Helpful
Approach (moving toward)	• Assertively confronting a problem • Reaching out to others for help ("tend-and-befriend")	• Combative or aggressive behavior (verbal, physical) • High risk sensation-seeking, such as substance use, gambling, unprotected sexual contact, self-injury
Avoid (moving away)	• Walking away from a heated situation when agitated and calming down before solving the problem later • Stopping ruminative thoughts	• Social withdrawal and isolation • Blocking or minimizing thoughts and feelings, rather than accepting and sitting-with • Emotional numbing • Substance use for the purpose of numbing or forgetting
Freeze (motionless)	• Final efforts at self-protection such as numbing or dissociation during traumatic experiences	• Stunned by a stimulus or trigger • Inability to make a decision because of feeling ambivalent, stuck, or conflicted about choices

Response Process and Style

- Assessing response process and style
  - Use self-report and in-session observation
  - Use Predominant Response Questionnaire (PRQ)
  - Use interview questions such as:
    - Think back to a recent time when you felt threatened in some way. How did you respond?

  - Assess response process (Wave1, 2)
  - Assess response style (approach, avoid, frozen)

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Response Process and Style

- Treatment planning for predominant response:
  - Depending on the predominant response process,
  - Wave 1: Select Wave1 interventions first
  - Wave 2: Select Wave 2 interventions first; consider using Wave1 interventions if useful
  - Remember that Wave1 and 2 processes are always occurring; the question is, which are *most/least helpful*

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Response Process and Style

- In addition to assisting clients to become more self-aware of physiological states,
- Clients can practice acting opposite to predominant response style
  - avoid rather than approach,
  - approach rather than avoid
- in real-life settings when they become physiologically and emotionally activated
  - state-dependent learning (in vivo)

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Counselor Allegiance

- At this point, you have gathered information about presenting problems, and predominant response process/style
- Do you think nCBT will be helpful with this particular client?
  - If so, why?
  - If not, why?
- This information can inform your rationale for why nCBT will be helpful in addressing the client's problems

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Individualize Treatment

- To the degree possible, individualize your approach to meet the client's needs
  - i.e., nCBT may need to be adapted (if so, the "principles" need to remain consistent, although the techniques might fluctuate)
  - Or, another treatment approach may be a better fit

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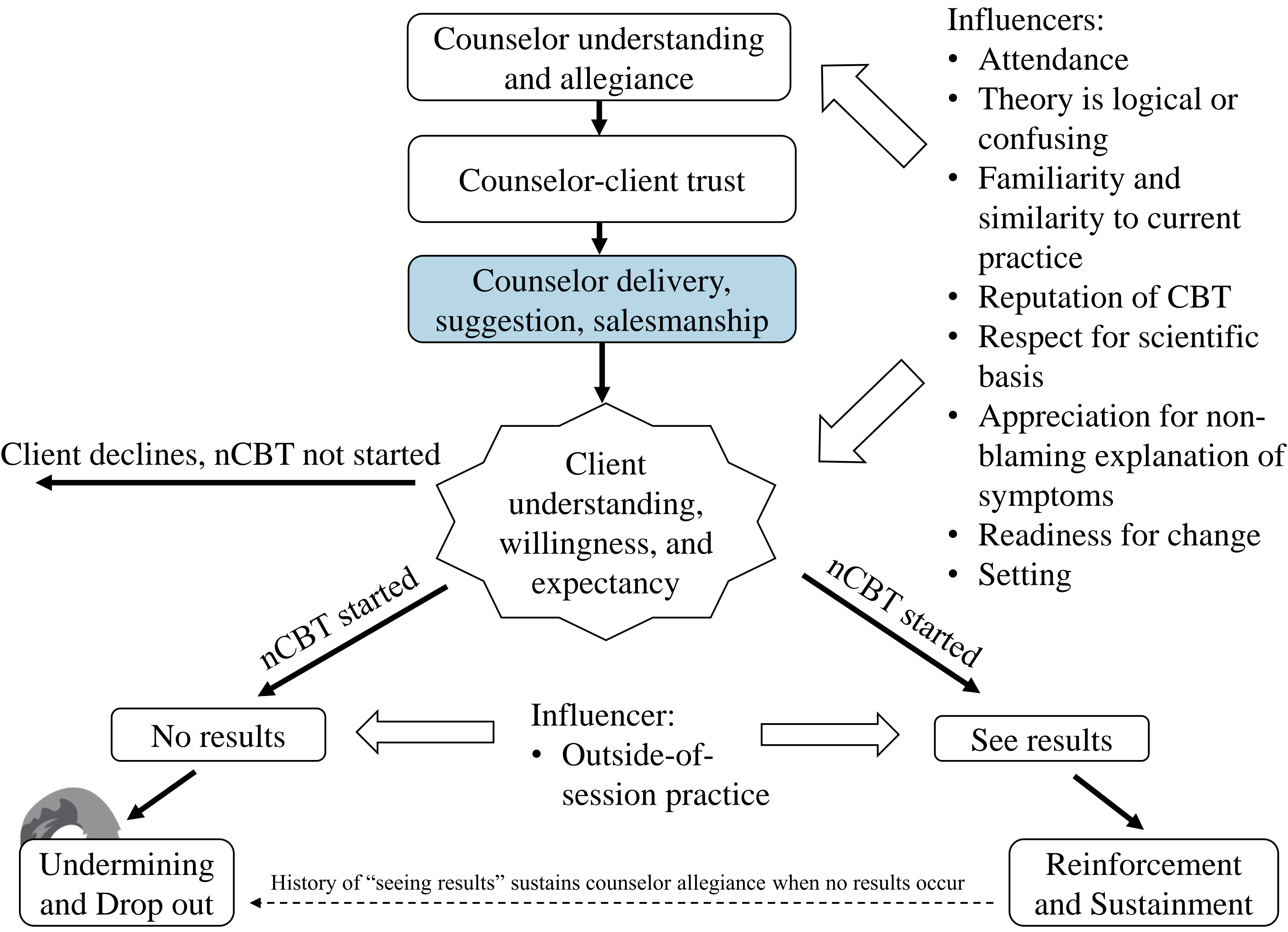
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Reinforcement and Sustainment

Suggestion, Salesmanship, Delivery

- Clearly verbalize that nCBT may be helpful in addressing the client's problems, with a rationale
  - You identified problems with…
  - And nCBT helps us understand these problems by…
  - Which we will address with…
- Provide psychoeducation on Wave1 and Wave2
  - Content
  - Delivery

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Psychoeducation: Why so early?

- Psychoeducation on Wave1 and 2 develops rapport
- by giving the client hope
- and reducing shame/self-blame
  - Over-attribution of responsibility in Western society for dysregulation (resulting in shame)
  - In many cases, the brain and body have learned adaptive mechanisms for responding automatically (i.e., we are not consciously in control of our behavior)

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Psychoeducation on Wave1 and 2

- Directions:

- 1. provide psychoeducation on **Wave1 process** and relevance to dysregulation such as trauma, panic attacks, intense anger and violent episodes
  - "Survival mode" (ANS, sympathetic vs. parasympathetic)
  - Siegel's "Yes and No" as an example
  - Description of automatic behavior, e.g., substance use, NSSI

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Psychoeducation on Wave1 and 2

- 2. provide psychoeducation on **Wave2 process** and relevance to depression, rumination, obsessions, worry, hopelessness, persistent anger and resentment

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Psychoeducation on Wave1 and 2

- Delivery
  - "Distilling without diluting", speaking in a manner the client can understand
  - Importance of visuals, activities, engagement
  - Metaphors can be useful to explain Wave1 vs. 2:
    - Surfing
    - Bear/Wooly Mammoth
    - Rabbit vs. turtle
    - Computer shortcuts

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Psychoeducation on Wave1 and 2

- Consider using the “New ABC Psychoeducation Sheet” and “How the Brain Responds to Threats” handout

- Check-in: Your thoughts/concerns about providing psychoeducation?

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- 60 second roleplays:
  - Providing psychoeducation on Wave1 and 2

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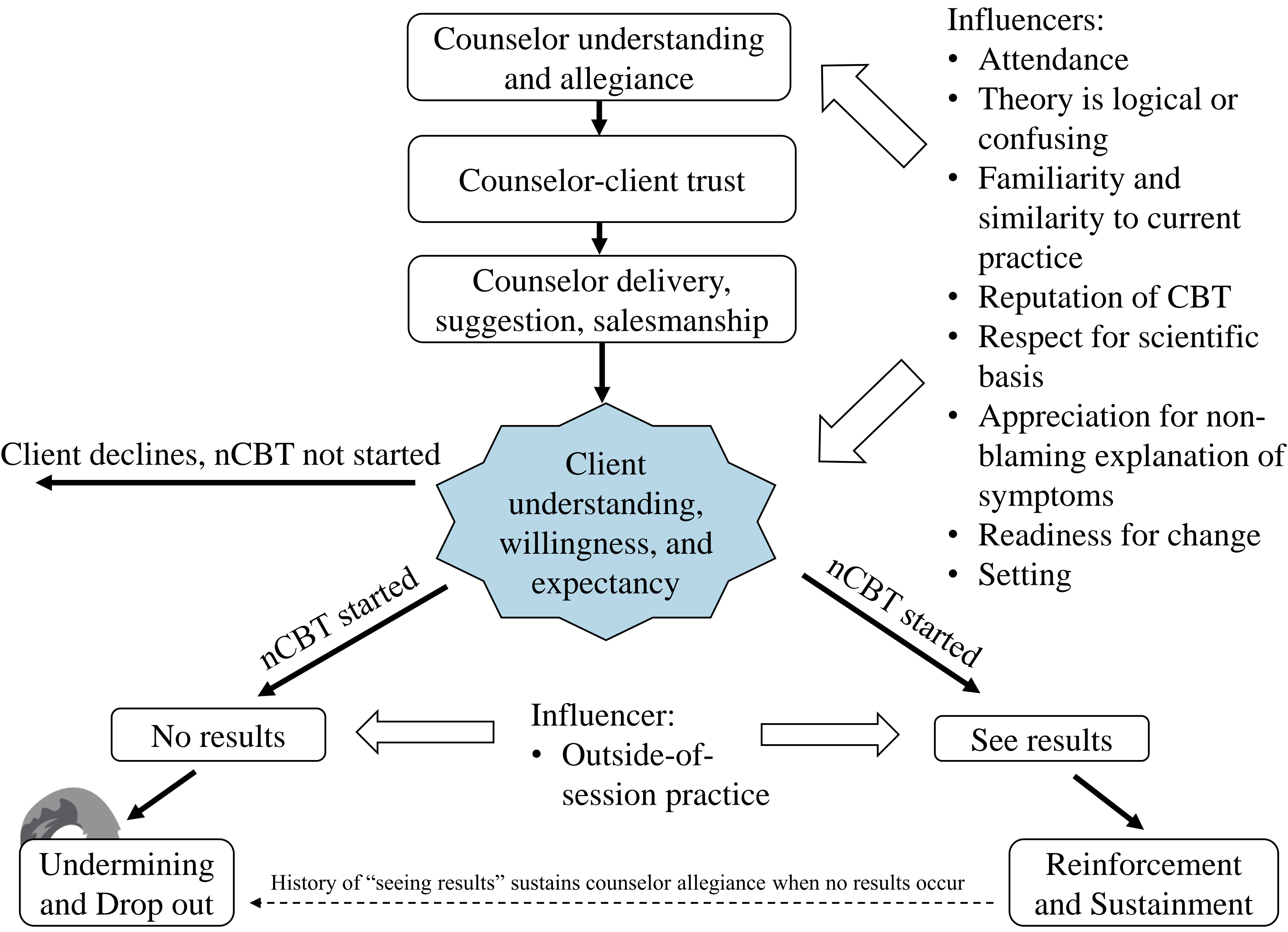
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Client Expectancy

- Inquire into client expectancy for change to occur. Use Credibility/Expectancy Questionnaire. Consider:
  - Attendance in counseling
  - Theory as logical or confusing
  - Familiarity and similarity to current practice
  - Reputation of CBT
  - Respect for scientific basis of neuroscience
  - Appreciation for non-blaming explanation of symptoms
  - Readiness for change
  - Setting

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Referral Considerations

- Does the client need:
  - Routine medical exam? (consider this if client has not had routine exam in the past few months)
  - Specific medical exam?
  - Evaluation of current/new psychiatric medication?
  - Substance use treatment/services?
  - Engagement in support groups?
  - Family or couples counseling?
  - Neurofeedback or biofeedback as part of treatment, and you don't provide this?
  - Other examples?

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Complete the PRQ

- Complete PRQ on yourself, to understand your predominant response process (Wave1, Wave2, combination) and response style (approach, avoid, freeze, combination)

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Phase 1: Attend to Physiological Reactions

- Develop rapport and Assess
- **Conceptualize**

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Conceptualize

- Conceptualizing Cases
- Planning Treatment
  - Discussing client's preferences, beliefs, and values
  - Collaborative goal setting
- Defining progress
  - Outcomes measurement
  - Identifying behavioral, physiological, emotional variables

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CCTP Template

- Use “Case Conceptualization and Treatment Planning” template
  - Presenting symptoms
  - Response process (Wave1, Wave2, combo)
  - Response style (approach, avoid, freeze, combo)
  - Context of response style
  - Treatment approach
  - Legal/ethical considerations

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Socio-Cultural Background

- Consider the influence of the client's socio-cultural background on presenting symptoms
- Client history → more reactive to certain stimuli/triggers in their environment
  - Oppression or marginalization → may respond reflexively when feeling their rights have been diminished or ignored.
  - Stereotypes/implicit bias → may respond reflexively to perceived threats

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Ongoing Activating Events

- Some activating events are perpetually present
  - E.g., ongoing oppression or marginalization

- Ongoing stimuli/triggers make any connected Wave1 responses difficult to modify.

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Ongoing Activating Events

- These considerations are important when planning treatment. We advise for cultural issues to be directly discussed with clients,
  - in an inquisitive fashion
  - that allows the client to come to their own understanding
  - of how their cultural background may be influencing their current responding
- Consider advocacy action steps, self-advocacy training

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Collaborative Goal Setting

- Provide assessment results of response process and style
- Present your rationale for the planned flow of treatment
- Recruit client's perspective
- Adjust treatment plan following collaboration
- POSERS goal setting template can be used

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True Goals vs. Means by which to achieve them…

- What is the true goal of:
  - Suicide
  - Substance use
  - Employment
  - Relationships

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POSERS Goal Setting

- Positive
- Own part
- Specific
- Evidence
- Resources
- Size
- Ecology

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Waves of the Counseling Relationship handout

- To foster rapport during goal setting,
- Consider using the Waves *of the Counseling Relationship* handout
  - Use during the initial informed consent process
  - and/or periodically during Phase 1 of treatment.
- Consider the following steps:

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Waves of the Counseling Relationship handout

- Start with an exploration of the client's wants for counseling.
  - If you had total control, what would you hope the outcome of our work to be?
  - What do you hope to be different?
  - What do you hope to think, feel, and do differently?

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Waves of the Counseling Relationship handout

- Explore the A1-C1 connection using the counseling relationship as the A1.
  - What did you feel physically and emotionally when…
    - …you prepared to come to counseling today?
    - …when you arrived at the office?
    - …when we first met?
  - How can this influence what we do during counseling sessions?

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Waves of the Counseling Relationship handout

- Explore the A2-B2 connection.
  - As we are talking about this, what's going through your mind?
  - What do you think about this process?
- Explore the B2-C2 connection.
  - As you have been thinking about the counseling process, what have you been feeling physically and emotionally?
  - How do you think this will influence what we do during the counseling process?

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Waves of the Counseling Relationship handout

- Explore B1.
  - Earlier we talked about those initial consequences related to counseling. What was familiar about those consequences (looking for potential implicit associations to previous attachments, object relations, others in their life, etc.)?
  - Where do you think those consequences came from?

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Waves of the Counseling Relationship handout

- Create new B2
  - Given what we have done so far, how does this compare to what you previously thought about counseling?
  - What do you think about counseling now?
- Plan new C2
  - How do you want this to influence our work together?

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Outcomes Measurement

- Defining variables and outcome measures
  - Clinical symptoms?
  - Emotions and behaviors?
  - Physiological activation?
  - Cognitive distortions?

- Research Domain Criteria can be a helpful framework to identify variables

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Outcomes Measurement

- Clinical symptoms
  - Brain-based assessment (EEG readings)
  - DSM-5 symptoms
    - Self-report checklists
    - DSM-5 Level 1 and 2 measures (disorder specific severity measures)

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Outcomes Measurement

- Emotions (sadness, anger, shame, anxiety, etc.)
- Behaviors (self-injury, suicide attempts, aggressive episodes, substance use, etc.)
- Are best assessed through tracking:
  - Frequency
  - Duration
  - Intensity
- Note PRQ and Experience Tracking tools

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Outcomes Measurement

- Physiological activation
  - Interoception? (Multidimensional Assessment of Interoceptive Awareness)
  - Heart rate? (Pulse oximeter)
  - Heart rate variability? (Heartmath Inc.)
  - Tension? (peripheral skin temperature)
- Cognitive distortions
  - Types of Thinking Scale

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Roleplay

- Roleplay (5 minutes)
  - Using PRQ and POSERS to collaboratively form treatment goals

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