1. ENRICHD PSYCHOSOCIAL INTERVENTION

1.1 OVERVIEW

The goal of the ENRICHD psychosocial intervention is to reduce mortality and morbidity following acute myocardial infarction by reducing depression and/or improving perceived social (emotional) support in participants who are at risk based upon these factors. The intervention combines a proven, state-of-the-art individual treatment for depression, a newly-developed individual treatment for low social (emotional) support that integrates elements from a number of established treatments, and a group treatment, applicable to participants who experience either depression and low perceived emotional support.

This Manual of Operations will outline separately, and in detail, the basic elements of the individual treatments for depression and social (emotional) support, and the group intervention. This Overview aims to integrate these treatments by highlighting the most critical common elements and focusing on their implementation across the three treatments.

1.2 THEORETICAL MODEL

The ENRICHD intervention is rooted in cognitive behavior therapy (CBT), as described by Beck and colleagues (1979) and refined by J. Beck (1995). This model hypothesizes that peoples' emotions and behaviors are influenced by their perception of events. It is not only the situation that determines how people feel, but the way in which they construe the situation. As such, a central task of the ENRICHD psychosocial treatment is to help the participant understand that automatic thoughts exist, influence feelings, can be altered, and, if altered, can have a beneficial impact on feelings. To accomplish this, CBT utilizes three basic strategies that are central to the ENRICHD intervention: behavioral activation, alteration of automatic thoughts, and active problem-solving.

The individual depression intervention follows a standard CBT approach in which depressed feelings are hypothesized to be a function of irrational automatic thoughts. CBT was chosen because it has demonstrated efficacy, across a rich database, at reducing both major and minor depression. In cases of severe or unremitting depression, however, it may not be possible to alleviate the depression with CBT alone. Thus, pharmacological therapy will be used as an adjunct to CBT to achieve treatment goals.

The individual social support intervention and the group intervention are also rooted in CBT but in addition draw on principles from social cognitive theory (Bandura, 1986). In this model, five interacting sources of influence--cognitive, behavioral, emotional, physiological, and environmental--are hypothesized to direct human behavior in dynamic, reciprocal interactions. Targeting any or all of these sources of influence is an appropriate route to behavior change since change in one will promote change in the others. This augments the CBT model by

suggesting that ultimate targets for behavior change include not only the CBT targets of cognitions, behaviors and emotions, but also the individual's physiological arousal and his/her social environment.

The theoretical underpinning of the individual social support intervention is that low perceived emotional support increases risk for cardiac recurrence. It may emerge in several ways. It may reflect cognitive deficits and thus be well suited to CBT approaches. It may reflect behavioral deficits, such as poor communication skills, and require behavioral skills training. It may have little to do with intrapersonal deficits but instead reflect a true environmental deficit characterized by social isolation, in which case work to mobilize one or more potential support-givers is required.

The theoretical underpinning of the group intervention is that a versatile repertoire of self-management skills is associated with continued improvement in depression and low perceived emotional support and maintenance of positive changes over time. This repertoire includes self-management skills across all five sources of influence. It reinforces and extends the principles of CBT, works in the environmental domain by using other group members to offer and receive emotional support for change, and works in the physiological domain by using relaxation skills to teach mind-body connections. In the group, it is possible to observe directly the dynamic, unfolding process of reciprocally interacting sources of influence: how thoughts influence feelings and behaviors, how feelings influence physiology, how behaviors influence environmental reactions, and how environmental reactions influence thoughts and feelings. It is also possible to observe directly the impact of change in any one source of influence on change in a number of others.

1.3 CRITERIA FOR SUCCESSFUL COUNSELING

The ENRICHD clinical trial is designed to evaluate results using all participants who have been randomized to receive the intervention, regardless of their individual success at behavior change. However, designation of individuals who have been successful at achieving therapeutic goals is important because they comprise the subgroup in whom greatest reduction in risk of recurrent events is hypothesized to occur.

Therapeutic success is judged by the counselor based upon several criteria that vary slightly depending upon the baseline diagnosis of depression, low social support, or both.

The first criterion for success is that there is an observed reduction in the relevant psychosocial risk factor. Reduction in risk in depression is defined as two consecutive scores of 7 or less on the Beck Depression Inventory. Reduction in risk in low perceived emotional support is defined as 2 consecutive scores of 2 or more items scored at 4 or greater on the Modified Duke Social Support Scale.

The second criterion is that the participant receives a minimum of 6 sessions of either individual or group therapy. This insures a minimum exposure to basic principles deemed important in ENRICHD.

The third criterion is that the participant demonstrates an ability to apply CBT skills by independently engaging in self therapy in which automatic thoughts leading to unwanted feelings are identified and altered. This criterion is met by attaining a perfect score of 12 on the CBT Performance Criteria Scale.

The fourth criterion, applying only to participants who screened in on low social support, is that the participant must be connected with at least one satisfying and supportive relationship. This is defined as a score of 3 or more on the Social Relationship Criterion Scale.

The counselor is expected to monitor each participant on each of these criteria after each treatment contact, on the Treatment Process Data Log (See Appendix). A copy of this Log, for each participant receiving active treatment, is sent to the Coordinating Center by the counselor every two weeks.

1.4 STRUCTURE

Since data on the relationship between these psychosocial factors and recurrence indicates that they exert an immediate adverse effect on prognosis, the individual intervention begins as soon as possible after randomization occurs. A hospital visit to the participant is strongly encouraged, if randomization occurs during the hospital stay. Individual counseling continues as long as it is needed but no longer than 6 months. Referral to group treatment occurs whenever a group becomes available if the participant has had at least 3 sessions of individual counseling and there are no contraindications to group counseling. There is an onus to refer participants who screened in on low social support to group as quickly as possible because the group provides a particularly powerful context for improving low perceived emotional support.

Participants should be terminated from active treatment when the criteria for successful counseling (Section 1.3) have been met. The duration of individual counseling is based upon the counselor's judgment, but the duration of group counseling is fixed at 12 sessions. Since referral to group counseling is, to a large extent, based upon the logistics of forming a group, participants may be seen in both individual and group counseling simultaneously. If a participant has had a group experience and has met criteria for successful counseling, individual counseling should be terminated. Individual counseling <u>can</u> be terminated if all criteria if all criteria for successful counseling have been met <u>except</u> a score of 12 on the CBT Performance Criterion Scale if the participant scores at least 5 and the counselor and supervisor agree that further progress on this criterion is unlikely.

Group treatment follows a partially open group format. A group begins as soon as there are at least 3 reliable participants available to join, and continues for 12 sessions. Enrollment is open to any other participants who may become available at any time during the 12-week group. A

participant can enter a group at any time up through his/her 6-month anniversary of randomization. If, for example, a participant begins a group at his/her anniversary date, his/her counseling will continue through 9 months post-randomization.

Psychosocial treatment concludes after a maximum of 6 months of counseling, and pharmacotherapy concludes after a maximum of one year of counseling. At the conclusion of active treatment, all participants are called each month on the phone to assess relapse, using the BDI and the Modified Duke. Calls end at month 7 from the time of randomization, with further calls being the exception and conducted only in unusual circumstances. If relapse has occurred within the 6-month window, the participant may be called back in for individual counseling. If relapse has occurred outside of the 6-month window, the participant may be referred to a community therapist.

1.5 RATIONALE FOR INDIVIDUAL AND GROUP MODALITIES

The ENRICHD intervention has to be powerful enough not only to promote change during treatment, but also maintenance of change after treatment has been discontinued for up to 3.5 years. The power of individual CBT for reduction of depression is supported by a consistent and extensive database. When combined with adjunctive pharmacotherapy for extreme cases, this represents the most powerful existing treatment approach for depression. When combined with maintenance sessions, only 10-20% can be expected to relapse.

The efficacy of the individual counseling designed for ENRICHD for improvement in social support is unknown, however its rationale is to accomplish two key treatment aims. First, the counselor quickly establishes a therapeutic alliance characterized by the provision of emotional support and unconditional positive regard. This is intended to provide an immediate alleviation of the feelings of low emotional support. Second, through interactions with the participant, the counselor can identify the reasons for feelings of low emotional support which could be due to deficits in communication skills, cognitions, and/or the social network. In the latter case, individual work makes it possible to examine the social network with the aim of identifying someone who could be involved in the counseling and ultimately replace the counselor as primary support-giver after counseling is discontinued.

Group counseling also lends to the power of the intervention. Of seven studies of behavioral interventions that have successfully reduced post-MI risk, six used a group intervention. Although the specific reasons for the success of groups with post-MI patients are not clear, some of the advantages are:

Groups make it possible for the therapist to step out of discussions and observe the dynamic process of reciprocally interacting sources of influence unfold. The therapist is provided with an objective view of interactional styles that is not filtered through any one participant's view of reality, and is afforded the opportunity to make "in vivo" observations on interpersonal dynamics.

Groups provide a context in which to practice new skills. New behavioral competencies are acquired when four criteria are satisfied: (1) knowledge--the individual knows what the skills are; (2) performance--the individual provides evidence that he/she can perform the skills; (3) generalization--the individual can apply the skills to a new situation; and (4) maintenance--the individual retains the skills after the treatment is discontinued. Whereas the individual treatment focuses on development of knowledge and an ability to perform the skill with the counselor, the group treatment provides the opportunity to generalize the learning to a new context.

Groups make it possible to learn vicariously. One of the most powerful opportunities afforded by the group is not the learning that occurs from counselor to participant, but the learning that occurs from participant to participant. An ability to see oneself in the experience of others fosters vicarious learning.

Groups provide the opportunity to receive and offer trust and support from peers. A well running group, characterized by an atmosphere of safety, acceptance, support, and positive feedback, makes it possible to experience the benefits of being more trustful and of helping others. Such an experience can challenge intrapersonal beliefs of helplessness and hopelessness, challenge interpersonal beliefs of cynicism and distrust, and build self-esteem, self-worth and self-efficacy.

1.6 CRITICAL COMMON ELEMENTS

The most important elements of treatment that are common across all parts of the intervention are the following.

1. The format of individual sessions should be consistent regardless of the particular part of the intervention one is in. The similarity in format makes sessions predictable for participants. This general format is:

    a) Setting the agenda;

    b) Introduction, including such things as engaging in a supportive interactions, checking mood, review of the events of the week, reactions to last session, and/or relaxation practice;

    c) Review of homework;

    d) Presentation of new material;

    e) Assignment of new homework;

    f) Summarization of the session;

    g) Feedback about the session.

2. The therapeutic alliance is critical across all parts of the intervention. In individual counseling, this alliance is between the counselor and the participant and it is the counselor's job to foster an atmosphere of intimacy and trust. For the individual social support intervention, this alliance is so critical that it has been elevated to one of the key treatment goals. The concomitant in group therapy is the creation of a cohesive group characterized by interpersonal trust. Group discussions will be difficult until the group coalesces. With the development of trust and a highly cohesive group, core cognitive structures can be identified and systematically changed.

3. The principles taught in individual and group counseling must be clearly connected. These principles include cognitive restructuring, communication skills training, problem-solving, network development, coping with negative affect, and relapse prevention. It is the counselor's responsibility to continually demonstrate the connection between learning in the group and that accomplished individually.

4. The counselor must always remain flexible and open to critical learning opportunities. Participants will bring to the session powerful experiences and their struggles to deal with them. The personal and powerful nature of these experiences can be associated with important insights, if given time and attention at the moment they arise. To do so may require that the counselor "switch gears" away from a planned topic. This is a particular problem in group therapy where there is a sequential set of topics to present. The counselor must exercise judgment to be able to respond to these moments while at the same time sticking to the protocol.

5. Common assessment tools between individual and group treatment will make the overall treatment more understandable to the participant. The key common tool is The Daily Log. This Log can be used to assess thoughts, feelings, situations, outcomes, and behaviors, or any combination of these, depending upon the work to be accomplished at any particular session. It is generalizable across the two individual interventions and across the individual and group interventions.

2. INDIVIDUAL COGNITIVE BEHAVIOR THERAPY FOR DEPRESSION

2.1 BACKGROUND AND RATIONALE

Of all the existing forms of psychotherapy for unipolar depression, cognitive behavior therapy (CBT: Beck et al., 1979) and interpersonal psychotherapy (Klerman et al., 1984) are best supported by outcomes research. Both were significantly more effective than placebo plus clinical management, and nearly as effective as imipramine in the NIMH Treatment of Depression Collaborative Research Program (TDCRP: Elkin et al., 1989). However, although other studies of interpersonal therapy have also shown promising results (e.g., Frank et al., 1990), a much more extensive database supports the efficacy of CBT for depression (AHCPR Clinical Practice Guidelines: Treatment for Major Depression, 1993; Dobson, 1989; Hollon et al., 1991; Robinson et al., 1990).

Patients who are both depressed and socially withdrawn or who have poor social skills tend to do better with CBT than with interpersonal psychotherapy (Rude et al., 1991; Sotsky et al., 1991). By design, such patients are likely to constitute a large proportion of the ENRICHD sample.

Cognitive-behavioral interventions are also well-matched to the typical psychosocial problems and the mild-to-moderate severity of depression commonly observed in cardiac populations (Carney et al., 1987). For example, behavioral activation and desensitization of health-related anxieties (e.g., overcoming unwarranted fears about and avoidance of returning to work, leisure activities, sexual intercourse, etc.) are typical themes in the early phases of psychotherapy with post-MI patients. Cognitive distortions (e.g., "catastrophizing" in response to mild exertional fatigue, "fortune telling" in response to fears of abandonment, "black and white thinking" in response to the need to discontinue medically risky leisure activities and to identify safer alternatives, etc.) are commonly identified during treatment. Finally, as a relatively brief, goal-oriented, collaborative, and emotionally supportive form of treatment, CBT is generally well accepted by cardiac and other medical patients.

For these reasons, CBT was chosen as the psychotherapeutic intervention for depression in this clinical trial. As in other clinical trials, ENRICHD counselors are expected to adhere to a manualized treatment protocol. However, the ENRICHD protocol is not a rigid cookbook. Instead, it is a reasonably flexible approach to CBT that provides considerable latitude within which to deliver the best, most effective clinical care possible. Our overriding goal is to ensure that our depressed patients get better.

The required treatment manuals for ENRICHD are (1) <u>Cognitive Therapy of Depression</u> (Beck, Rush, Shaw, and Emery, 1979), which is the core CBT protocol and which has been used in most previous outcome studies of CBT for depression, and (2) <u>Cognitive Therapy: Basics and Beyond</u> (J.S. Beck, 1995), which supplements the core CBT protocol. The J.S. Beck (1995) manual is designed to help CBT therapists to increase their clinical sensitivity and flexibility by expanding their repertoire of cognitive-behavioral techniques. It will help ENRICHD counselors to maximize effectiveness while working within the core framework of the Beck et al. (1979) CBT protocol.

Like most other research projects that have used Beck et al. (1979) as their treatment manual, we have also had to augment the manual in other ways to address the particular needs of the ENRICHD study. This section of the Manual of Operations thus focuses on issues that go beyond the material covered in Beck's (1979) core CBT protocol. Specifically, it (1) addresses critical non-technique aspects of treatment (such as when to refer for pharmacotherapy); (2) provides case examples involving cardiac patients to illustrate specific cognitive techniques; (3) discusses strategies for overcoming problems that commonly arise in treating cardiac patients; and (4) summarizes the use of process and clinical assessment tools for CBT, which are discussed in greater detail in the appendix entitled "Process Measures and Clinical Tools.

2.2 INITIAL (PRETREATMENT) CLINICAL EVALUATION

As the treating clinician, you will have access to the results of the screening and baseline assessments that were conducted by the case coordinator when the patient was recruited to participate in the trial. However, you are required to conduct an independent clinical evaluation of your own, prior to beginning counseling. In addition to evaluating the participant, use the initial evaluation session as an opportunity to start building rapport, to instill hope, and to induct the participant into counseling.

The principal purposes of the initial clinical evaluation are (1) to assess the participant's current problems and concerns; (2) briefly characterize the participant's social network; (3) diagnose the participant's depressive disorder according to the DSM-IV criteria for major depressive episode, minor depressive episode, and/or dysthymic disorder; and (4) determine the severity of the current depressive episode. The counselor also has the option to: (1) identify comorbid Axis I and Axis II psychiatric disorders which may affect the course of treatment; (2) characterize the participant's past psychiatric history; and (3) rate the participant's current functioning on the DSM-IV Axis V Global Assessment of Functioning Scale. The counselor also assess the participant's expectations about treatment and obtains other information that may be needed to formulate an individualized treatment plan. The initial clinical evaluation includes the DISH, which assesses current depressive symptoms and the 17-item Hamilton Depression score. You are also required to administer the Beck Depression Inventory unless the baseline BDI was obtained less than one week before the initial clinical evaluation.

If the participant has had any prior episodes of depression, determine what treatment, if any, was received, and how well the participant responded to it. If pharmacotherapy was used, the agent should be identified. The participant's response to that agent should be noted and this information should be provided to the study psychiatrist in the event that pharmacotherapy is considered.

The initial clinical evaluation is initiated at Session Zero and completed as soon as possible after that. Conduct the initial evaluation and initiate individual counseling as soon as is possible, preferably while the participant is still in the hospital. If there is not enough time to arrange Session Zero before discharge, or if the participant is not ready to tolerate a full session, it may still be possible to arrange a brief visit or telephone contact to start building rapport with the patient.

2.3 PROCESS MEASURES AND OTHER CLINICAL TOOLS

Starting with the initial clinical evaluation and continuing throughout treatment, you will be required to utilize several treatment process measures. These measures are mandatory and are used to assess the participant's problems, document the implementation of the treatment protocol, track the participant's progress in treatment, and determine whether the participant has successfully completed treatment. A variety of optional clinical tools are also available. The optional tools may be used when needed, at the discretion of the counselor and his/her supervisor. See Appendix for further details and instructions.

2.4 CONCURRENT PSYCHOPHARMACOLOGY

Participants who are severely depressed (defined as a Hamilton Depression score of 24 or higher) will be evaluated for antidepressant therapy in consultation with the study's psychiatrist and the participant's cardiologist and/or primary care physician. As the treating counselor, you are to reassess the severity of the participant's depression as part of your initial clinical evaluation. You may find that a participant who scored below 24 on the baseline Hamilton Depression scale now scores 24 or above on the basis of your interview. If so, you should refer the participant to be evaluated for antidepressant therapy.

During the course of counseling, you should also refer participants with major depression to the study psychiatrist for evaluation and consideration of additional treatment with an antidepressant if their BDI scores have not decreased by at least 50% by the fifth week of treatment or if they become more severely depressed. Moreover, if the participant scores >20 on the Hamilton Depression Scale at the time of the 6-month conclusion of treatment, referral to the study psychiatrist is also indicated. Not every participant will necessarily be prescribed an antidepressant following psychiatric evaluation. However, referral for psychopharmacology is

an option at any time during treatment if, the counselor's judgment, the participant is not responding to CBT. (see chapter 3)

2.5 TREATMENT SCHEDULE

During the initial phase of treatment, participants with major or minor depression will receive individual CBT. If possible, participants should be scheduled for twice-a-week sessions for the first two weeks of treatment, as this may help to promote more rapid improvement. Most participants will be seen once per week for the remainder of the initial phase of treatment. However, twice-weekly sessions may be scheduled for participants if, in the counselor's judgment, this would be advisable (e.g., due to severe depression or suicidal ideation).

Once-or twice-weekly 50-minute sessions of individual CBT and/or weekly sessions of group CBT will continue until the participant has met the *criteria for successful counseling*. The criteria are met when the participant has completed at least 6 sessions of individual or group counseling, has met the CBT performance criteria, and has scored 7 or below on the BDI for at least two consecutive weeks (see section 1.3). Ordinarily, participants will be seen for no more than 16 sessions of individual CBT. However, more sessions may be required in particularly difficult or unusual cases, or in cases in which the participant has remitted and then relapsed.

2.6 CBT PERFORMANCE CRITERIA

As noted above, one of the factors to consider when deciding whether to terminate CBT is whether the participant meets certain criteria that suggest a mastery of CBT skills. You may have additional criteria of your own for an individual participant. The following are performance criteria that are to be applied to all of your depressed participants and that are derived from the Beck (1979) and J.S. Beck (1995) treatment manuals. Refer to these sources for additional information. All participants should be rated on these criteria after every session using the CBT Performance Criteria Scale (See Appendix).

1. The participant initiates and utilizes behavioral activation techniques.

2. The participant identifies problematic situations and emotions.

3. The participant identifies dysfunctional thoughts in problematic and/or emotionally arousing situations.

4. The participant uses cognitive-behavioral techniques to evaluate and modify dysfunctional thoughts and beliefs.

5. The participant uses cognitive-behavioral techniques for active problem solving.

6. The participant demonstrates the willingness and ability to apply cognitive-behavioral skills to new and future problems and relapses.

2.7 SESSION-BY-SESSION GUIDELINES

The following is a model treatment outline based on the Beck et al. (1979) and J.S. Beck (1995) manuals. It is not intended to be a rigid schedule, but you are expected to use it as a guideline for treatment planning. Counselors should read the 2 manuals and the CBT training materials carefully and completely. They describe many techniques and procedures which will be helpful in treating depressed patients in the ENRICHD trial.

2.7.1 Pre-Treatment Visit or Call

If it is not possible to hold a full Session Zero immediately after randomization, call or visit the participant to start building rapport and interest in the treatment program.

2.7.2 Session Zero

1. Start building rapport and interest in the treatment program.

2. Conduct an initial clinical evaluation (see Appendix). Complete as much of the evaluation as possible in Session 0, and complete any remaining portions of the evaluation in subsequent sessions.

2.7.3 First Session

1. Continue building rapport.

2. Finish the initial clinical evaluation.

3. Discuss participant's expectations about counseling and recovery.

4. Check participant's present mood.

5. Review post-heart attack recovery since discharge from hospital, including adherence to medication and overall treatment regime.

6. Elicit negative attitudes regarding self, counseling, or counselor.

7. Pinpoint most urgent and accessible problem (e.g., hopelessness, suicidal wishes, loss of functioning, severe dysphoria).

8. Describe the cognitive model of depression.

9. Explain cognitive-behavioral strategies with emphasis on the rationale for behavioral assignments and homework.

10. Review Activity Chart for recording activities until next session.

11. Give the participant <u>Coping with Depression</u> or <u>Coping With Depression After a Heart Attack</u> (J.S. Beck, 1996) to read (optional).

12. Elicit verbal feedback about the session. Initiate use of the Client's Session Feedback Form, if the patient is ready (optional). *Note:* Most participants feel better by the end of the first session; if not, counselor should probe for reasons for lack of positive reaction (or adverse reaction).

2.7.4 Second Session

1. Mood check.

2. Inquire about effects of first session.

3. Review Activity Scheduling form.

4. Discuss reactions to <u>Coping with Depression</u> and/or cognitive model of depression.

5. Discuss problems and accomplishments since previous session.

6. Schedule activities until next session.

7. Discuss recording mastery and pleasure ratings on Activity Schedule (optional).

8. Prepare agenda and focus on the problem(s) to be discussed.

9. Inquire about reaction to this session.

2.7.5 Third Session

1. Prepare agenda.

2. Inquire about effects of second session

3. Review homework assignments

4. Provide instruction in identifying negative automatic thoughts (use "induced fantasy" or role playing if indicated).

5. Explain how these automatic thoughts represent distortions of reality and are related to other symptoms of depression.

6. Elicit automatic thoughts, specifically in relation to homework assignments.

7. Prepare homework assignments.

8. Elicit feedback regarding today's session.

2.7.6 Fourth Session

1. Follow some general format as in third session.

2. Continue instruction in identifying negative automatic thoughts.

3. Continue to clarify how these automatic thoughts represent distortions of reality and are related to other symptoms of depression.

4. Elicit automatic thoughts, specifically in relation to homework assignments.

5. Instruct patient in using the Dysfunctional Thoughts Records (optional).

2.7.7 Fifth Session

1. Follow some general format as in previous session.

2. Review schedule of activities with special reference to mastery and pleasure

3. Review and discuss automatic thoughts

4. Demonstrate to the participant ways of evaluating and correcting cognitive distortions (automatic thoughts).

2.7.8 Sessions 6, 7, and 8

1. Same format as above.

2. Continue to remove psychological blocks to return to premorbid level of functioning.

3. Continue to identify negative automatic thoughts.

4. Continue work on rational responses to automatic thoughts.

5. Give additional homework assignments.

6. Discuss the concept of basic assumptions (Chapter 12).

2.7.9 Sessions 8 - 12

1. Progressively delegate more responsibility for setting the agenda to the participant.

2. Progressively delegate more responsibility for homework to the participant.

3. Identify and discuss basic assumptions, testing the validity of the assumptions.

2.7.10 Closing Sessions

1. Prepare participant for termination of individual therapy.

2. Emphasize continuation of homework assignments and practicing other strategies after termination. Emphasize counseling as a learning process that continues throughout the individual's life.

3. Delineate anticipated problems and rehearse coping strategies.

2.8 ESSENTIAL ELEMENTS OF COGNITIVE THERAPY

The above outline is meant to be a *guideline* for each session of CBT, not an inflexible, invariant step-by-step procedure for treating depression in this trial. It is understood that it may be necessary to vary the content of sessions to some degree in order to address the particular needs of each patient. However, the treatment must stay within the generally accepted framework for CBT. The following is an overview of the essential elements of CBT that must be part of the depression intervention.

There are four essential elements to CBT as taught and practiced for the ENRICHD trial. For reasons of quality assurance, all four of these elements must be evident in the course of any given counseling case for it to be considered valid CBT.

The four elements are:

1. There must be a relatively <u>invariant structure</u> for the individual counseling sessions.

    2. The counselor must demonstrate clear understanding of the <u>cognitive model</u> and teach the model to the participant using the participant's own problems as examples.

3. Within the first 2 counseling sessions, the counselor must establish a <u>cognitive formulation</u> of the participant that consistently informs and guides the counselor's decisions over the course of the case. The cognitive formulation is continuously modified and elaborated upon over the course of counseling. The counselor shares the formulation with the participant and engages him/her in discussions about the adequacy of the formulation.

    4. The counselor must build a strong <u>therapeutic alliance</u> with the participant and carefully maintain it over time.

2.8.1 The Structure of Individual Counseling Sessions

"Cognitive therapy sessions are structured. No matter what the diagnosis or stage of treatment, the cognitive therapist tends to adhere to a set structure in every session...checks the patient's mood, asks for a brief review of the week, collaboratively sets an agenda for the session, elicits feedback about the previous session, reviews homework, discusses the agenda items, sets new homework, frequently summarizes, and seeks feedback at the end of each session. This structure remains constant throughout therapy....Following a set format makes the process of therapy more understandable for both the patient and his/her therapist and increases the likelihood that the

patient will be able to do self-therapy after termination. This format also focuses attention on what is more important to the patient and maximizes use of therapy time (J.S. Beck 1995, p. 8)".

2.8.2 The Cognitive Model

Cognitive therapy is a systematic approach to applying the <u>cognitive model</u> of human behavior to the participant's problems. It is not merely a collection of psychotherapeutic techniques. Although cognitive therapists must master a variety of techniques, they must be sensitive to the needs of the individual patient and flexible in the manner in which these techniques are applied.

"Cognitive therapy is based on the *cognitive model*, which hypothesizes that peoples' emotions and behaviors are influenced by their perception of events. It is not a situation in and of itself that determines what people feel, but rather the way in which they *construe* a situation...*The situation itself does not directly determine how they feel;* their emotional response is mediated by their perception of the situation. The cognitive therapist is particularly interested in the level of thinking (quick, evaluative thoughts dubbed *automatic thoughts*) that operates simultaneously with the more obvious, surface level of thinking (J.S. Beck 1995, p. 14)."

Automatic thoughts spring from beliefs people develop about themselves, other people, and their worlds, beginning in childhood. Their most central or *core beliefs* are understandings so fundamental and deep that they often do not articulate them, even to themselves. These ideas are regarded by the person as absolute truths, just the way things are. This belief may operate only when he/she is in a depressed state or it may be activated much of the time...*Core beliefs* are the most fundamental level of belief; they are global, rigid and over generalized. *Automatic thoughts*, the actual words or images that go through a person's mind, are situation specific and may be considered the most superficial level of cognition. There is a class of *intermediate beliefs* that exist between the two (Beck J, 1995, pp. 15-16).

2.8.3 Cognitive Formulations

"Treatment is based on both a cognitive formulation of a specific disorder and its application to the conceptualization or understanding of the individual patient. The therapist seeks in a variety of ways to produce cognitive change -- change in the patient's thinking and belief system -- in order to bring about enduring emotional and behavioral change (J.S. Beck 1995, p. 2)."

"Cognitive therapy is based on an ever-evolving formulation of the patient and his/her problems in cognitive terms" (J.S. Beck 1995, p. 5)." This formulation encompasses problematic behaviors, precipitating factors, key developmental events, and the patient's enduring patterns of interpreting these key developmental events.

2.8.4 Therapeutic Alliance

The therapist must demonstrate "warmth, empathy, caring, genuine regard, and competence. The therapist shows his/her regard....by making empathic statements, listening closely and carefully, accurately summarizing thoughts and feelings, and being realistically optimistic and upbeat. He/she also asks the patient for feedback at the end of each session to ensure that he/she feels understood and positive about the session" (Beck J, 1995, p. 5)."

2.9 REFERRAL TO GROUP COUNSELING

All patients are referred to ENRICHD group counseling as soon as a group becomes available and there are no contraindications to group counseling (e.g., presence of psychotic features, severe psychomotor retardation, Axis II disorders, severe social anxiety). Several weeks before the group is scheduled to begin, describe this part of the program to the participant and discuss his or her expectations about it.

The groups are designed to continue and extend the work that was begun in individual counseling by targeting depression and by focusing on maintenance of treatment gains and prevention of relapse. Depending upon the participant's particular needs, individual counseling may continue to run concurrently with group counseling, or it may be terminated before the group counseling begins.

If there is a gap of more than two weeks from the time that individual counseling ends and group counseling begins, the counselor should initiate telephone contacts each week with the participant to assess his/her functioning and depression status. The counselor should also ask the participant to complete a BDI once a week during this time. If the participant reports a return of depression symptoms or scores 7 or higher on the BDI, schedule an appointment to evaluate whether the participant needs to resume individual counseling.

Participants should be administered BDIs on a weekly basis during group counseling. If the participant shows signs of relapse as defined by reporting of symptoms or a BDI of 7 or higher, individual counseling may be resumed. The decision to resume individual counseling is based on the counselor's clinical judgment and the participant's preference.

2.10 MAINTENANCE COUNSELING AND RELAPSE PREVENTION

It is not uncommon for minor depression to progress to major depression, particularly in the context of a past history of major depression, and many participants with major depression who initially respond to treatment will subsequently relapse. Not even the most effective short-term treatments for depression, including CBT, are able to prevent relapses in every case.

Participants who are unmarried, who have recurrent or severe depression, who score high on measures of dysfunctional attitudes, who respond slowly to counseling, or who have residual symptoms (i.e., are only in partial remission) at the termination of counseling are among those who are most likely to relapse.

There is strong evidence that maintenance sessions can reduce relapse rates following short-term interventions. For example, Jarret et al. (1990) added 10 individual sessions of CBT over 8 months, and found that 51% of the controls compared to only 20% of patients receiving the maintenance sessions relapsed during the follow-up period. Similarly, in a group of patients with endogenous depression, Thase et al. (1991) found that 75% of patients receiving only short-term treatment relapsed, compared to only 10% of patients who also received maintenance CBT.

Group counseling may be sufficient to prevent relapse in patients treated for minor depression or for relatively mild and uncomplicated major depression. However, monthly individual maintenance counseling sessions may be needed to prevent relapse in some participants, even if they are concurrently participating in the group counseling. This is particularly important for participants with a history of recurrent depression and for those with moderate to severe major depression in *partial* remission at the end of the active (≥ weekly) phase of individual CBT.

Thus, at the termination of active (≥ weekly) individual counseling, determine whether your participant needs monthly individual maintenance CBT sessions to prevent his or her depressive disorder from relapsing, and if so, to treat him/her accordingly. It is important to note, however, that there is a time limit beyond which the participant will no longer receive treatment from ENRICHD project personnel. In most cases, the limit is *six months* from the time of enrollment in the project, although maintenance pharmacotherapy may continue for up to one year for participants who are treated with antidepressants.

Furthermore, all depressed participants will be asked to complete the BDI by telephone on a monthly basis for the remainder of the 6 months after termination of the active treatment phase. If it is determined during the telephone contacts that the patient's BDI score is 7 or higher, or if the counselor otherwise determines that the participant's psychiatric condition is deteriorating,

the participant should be encouraged to resume individual counseling to prevent relapse or further deterioration.

Both the Beck et al. (1979) and the J.S. Beck (1995) manuals include materials on relapse prevention and maintenance (booster) sessions. Refer to these sources for guidelines for maintenance counseling.

2.11 ADAPTATIONS OF THE STANDARD CBT PROTOCOL FOR ENRICHD

Because you are treating a special clinical population (i.e., patients who are recovering from an acute myocardial infarction), and because of the special circumstances within which you are delivering your treatment services (i.e., a large, multicenter clinical trial), you may encounter a variety of problems that are not discussed in the standard CBT manuals. The following section lists some of the kinds of problems you might encounter in working with ENRICHD participants, along with some potential solutions.

2.11.1 Problem

Take-home reading materials and written homework assignments may present adherence problems. For participants who are not yet sufficiently invested in the treatment, these problems are likely to occur early and decrease as counseling proceeds. For participants with lower literacy levels, these problems will persist throughout counseling.

2.11.2 Suggested Solutions

A. Adapt reading materials for low-literacy patients.

B. Adapt CBT terms used in-session for cultural and educational appropriateness.

C. Allow time, and develop a standard procedure, for completing homework assignments (behavioral as well as written) in-session, especially early in counseling.

D. Assign behavioral homework (i.e., specific behavioral tasks) whenever possible, especially early in counseling. However, mastery and pleasure ratings and other simple recording activities may accompany even the behavioral tasks.

E. Try to enlist the help of other family members whenever appropriate.

2.11.3 Problem

Many participants with CHD define their problems as physical rather than psychological in nature and thus are less amenable to psychological counseling. In order to maximize adherence and reduce drop-out early in treatment, participants must realize that treatment of their depression is important to their recovery.

2.11.4 Suggested Solutions

A. Educate the participant about the prevalence of depression following a myocardial infarction (i.e., normalize their experience), and about the role of depression in CHD morbidity and mortality.

B. Focus on CHD and issues related to the heart attack as a framework for early CBT sessions, while at the same time attending to, and encouraging discussion of, other issues. For example, the counselor may encourage the participant to focus on scheduling pleasurable activities and on overcoming limitations initially imposed by the heart attack, using graded activities, pacing, etc. to accommodate the participants with physical limitations. As participants become more invested in counseling, issues concerning their heart attack may become secondary. This will occur at different points in the early phases of counseling for different patients. The counselor may have to maintain some contact with the participant's physician, cardiac rehab therapist, etc. for reasons of medical safety and to minimize the possibility of failure experiences.

C. Obtain endorsement for the treatment from the participant's own physician. You may ask referring physicians to support the treatment program by speaking with them or writing a note to them about it.

2.12 COGNITIVE DISTORTIONS IN POST-MI PATIENTS

Although there have been many attempts to delineate the most common cognitive distortions or irrational beliefs of depressed patients, one of the clearest and certainly the most popular is the list provided by David Burns in <u>Feeling Good</u> (1980). The following are, according to Burns, the 10 most common cognitive distortions.

1. ALL-OR-NOTHING THINKING: You see things in black-and-white categories. If your performance falls short of perfect, you see yourself as a total failure.

2. OVERGENERALIZATION: You see a single negative event as a never-ending pattern of defeat.

3. MENTAL FILTER: You pick out a single negative detail and dwell on it exclusively so that your vision of all reality becomes darkened, like the drop of ink that discolors the entire beaker of water.

4. DISQUALIFYING THE POSITIVE: You reject positive experiences by insisting they don't count for some reason or other. In this way you can maintain a negative belief that is contradicted by your everyday experience.

5. JUMPING TO CONCLUSIONS: You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.

   a. Mind reading. You arbitrarily conclude that someone is reacting negatively to you, and you don't bother to check this out.

   b. The Fortune Teller Error. You anticipate that things will turn out badly, and you feel convinced that your prediction is an already-established fact.

6. MAGNIFICATION (CATASTROPHIZING) OR MINIMIZATION: You exaggerate the importance of things (such as your goof-up or someone else's achievement), or you inappropriately shrink things until they appear tiny (your own desirable qualities or the other fellow's imperfections). This is also called the "binocular trick".

7.   EMOTIONAL REASONING: You assume that your negative emotions necessarily reflect the way things really are: AI feel it, therefore it must be true.

8.   SHOULD STATEMENTS: You try to motivate yourself with shoulds and should nots, as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct "should" statements toward others, you feel anger, frustration and resentment.

9.   LABELING AND MISLABELING: This is an extreme form of overgeneralization. Instead of describing your error, you attach a negative label to yourself. "I'm a loser". When someone else's behavior rubs you the wrong way, you attach a negative label to him: "He's a goddamn louse". Mislabeling involves describing an event with language that is highly colored and emotionally loaded.

10. PERSONALIZATION: You see yourself as the cause of some negative external event for which in fact you were not primarily responsible.

Most depressed cardiac patients have problems similar in nature to those of other depressed patients, including marital conflicts, interpersonal loss, work-related stress, etc. Furthermore, most of the depressed post-MI patients you will treat during this study will be in the middle of a depressive episode that pre-dated the heart attack, and many will have a prior history of depressive episodes that may have begun decades before their heart disease became apparent. Some participants may actually be relatively unconcerned about their medical problems but extremely distraught about something else.

However, many of your participants will present with concerns specific to their cardiac illness and its sequelae. The following are examples of cognitive distortions that involve these kinds of issues.

a) "You're either healthy or you're good for nothing. I just had a heart attack, so obviously "I am good for nothing". (All or nothing thinking).

b) "If I can't work as hard and as long as I used to, there is no point in my even trying to return to work". (All or nothing thinking)

c) After being told by his doctor to take it easy for a few weeks: "I will never be able to take long walks again"! (Over generalization).

d) After being told to reduce foods high in saturated fats from his diet: "I will never be able to eat good food again". (Over generalization).

e) "I can't do anything I used to be able to do anymore". (Over generalization)

f) After an otherwise very positive physical examination, his doctor noted that his blood pressure was a little high: "I am still very sick, I am just not getting any better since my heart attack". (Disqualifying the positive).

g) After being told by his doctor that he is making good progress in lowering his cholesterol levels by watching his diet: "He is just trying to make me feel better. He really doesn't mean that. He thinks I am not trying". (Disqualifying the positive, fortune telling).

h) "No matter how hard I try to get better, nothing changes. It doesn't matter". (Disqualifying the positive)

i) "No matter how hard I try to exercise, my wife doesn't believe that I am really doing my best". (Mind reading).

j) "My family believes that I am not fulfilling my responsibilities since my heart attack. They are angry with me for not doing my share, even though they haven't actually said anything". (Mind reading).

k) "If I ask for help with the housework, my husband thinks I am using my illness as an excuse for being lazy". (Mind reading).

l) "My life is over now that I have had a heart attack. It will never be fun or exciting again". (Catastrophizing).

m) "I am convinced that I will have another heart attack! I know that there is nothing I can do to get better. I might just as well quit trying" (Fortune telling)

n) "Now that I have had my heart attack, none of my friends will want to be around me. They all think that I might have another one when we're out together." (Fortune telling).

o) "I should be able to continue to care for my family like I use to. (Should statement).

p) "I should be able to lower my cholesterol. I am hopeless." (Labeling and mislabeling, shoulding).

q) "I should have quit smoking a long time ago. I brought this heart attack on myself." (Personalization and should statements.)

In summary, the cognitive model can be adapted to the problems experienced by depressed post-MI patients. Some of their problems (e.g., interpersonal difficulties) may be the same as those seen in every depressed patient population, whereas others may be closely related to the participant's cardiac problems and/or hospitalization.

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3. SOCIAL SUPPORT INTERVENTION

3.1 RATIONALE FOR TREATMENT

More than 20 years of research have demonstrated the importance of social support in buffering the negative health effects of stressful life experiences. Associated research on health outcomes for people who lack such support, or who feel isolated or estranged from others, has focused on interventions, including network restructuring for individuals with untapped relationship resources, development or "grafting" of new ties for those with accessible supportive relationships, and the use of support groups for emotional and instrumental assistance to those suffering similar illnesses. Behaviorally-based interventions, such as supportive instructions during problem solving situations, teaching supportive communication techniques to spouses, and cognitive restructuring of attitudes about social interaction also have been utilized. In post-MI populations, individual and group interventions with the cardiac patient, his/her spouse, or both, have been shown to increase quality of life and physical health outcomes. Most of these interventions have involved support to the study participant(s) provided by a nurse or other healthcare professional. These efforts have met with various degrees of success, suggesting that conditions of low social support are amenable to intervention.

The social environment is an essential component in the social support equation: one must have access to people who can be mobilized in time of need. In addition, one's perceptions, attitudes and expectations about support are critical: whether one believes they need it, who they believe should provide it, what they see as the cost to accept it (emotional involvement, reciprocity), whether they believe they "deserve" it, and whether they feel it will be enough for them (satisfaction). Deficits in social and communication skills limit the quality of interpersonal interactions and ability to foster supportive relationships. Gender and ethnic variations in attitudes and expectations about social support are among the important individual differences that are evident in the use, desirability and utility of such support.

With these issues in mind, a social cognitive behavioral framework was selected to guide the design of the Social Support Intervention (SSI). Within this framework, behavioral, cognitive and affective factors, and environmental events, are seen as interacting determinants in one's perception of emotional support and connectedness, and ability to benefit from it. To improve perceived emotional support of ENRICHD participants, the SSI utilizes behavioral, cognitive behavioral, and network intervention methods. Treatment is matched to the deficits of the particular participant. Deficits are conceptualized to exist in attitudes and beliefs about the benefits of support, competence in social and communication skills, and/or the social context in which support potentially exists.

The individual counseling initiates a process of change, which is expanded upon and continued in group counseling. In the delivery of the counseling, the MI serves as the context for an examination and alteration of social interchange. Specific foci of the SSI are on behavioral repertoire, cognitive schema and, where indicated or feasible, marital, family, and network interactions. The point of intervention is modifiable attributes deemed to be most responsible for the participant's subjective sense of low perceived emotional support. Since counseling can have a network focus, members of the social network who are identified as likely potential sources of satisfying support can be involved. In the delivery of counseling, the counselor relies upon proven treatment techniques, including modeling, prompting and shaping, and cognitive behavioral methods.

3.1.1 Assessment

The SSI is informed by an ongoing multi-modal assessment, initiated at the first treatment contact and continued throughout counseling. It is aimed at determining: 1) the social/environmental, behavioral and cognitive factors that contribute to the subjective sense of low emotional support; and 2) the potential natural sources of support that exist in the larger community. Assessment conducted during the initial session(s) also serve(s) as an induction into the SSI, a basis for beginning the establishment of rapport between the counselor and participant, and a vehicle for instilling confidence about the likely benefits of participation in ENRICHD.

3.1.2 Goals of the Social Support Intervention (SSI)

The primary goal of the SSI is to alleviate the participant's subjective sense of having inadequate emotional support. There are two key elements to the accomplishment of this goal.

The first element is the immediate establishment of a supportive alliance between counselor and participant. This supportive alliance serves as an initial source of emotional support that immediately alleviates the participant's perception of having inadequate low emotional support. This alliance is fostered using a variety of empathic techniques, including provision of unconditional positive regard, reflection of feeling and content, and minimal encourages to talk.

With the formation of this alliance, and the perception of the participant that he/she is supported, the focus shifts to the second goal which is the development of emotionally supportive ties with others through:

1. the identification and mobilization of available social resources

2. the modification of cognitive impediments to feeling supported

3. the enhancement of communication skills repertoires necessary for the development and maintenance of satisfying and supportive relationships.

3.1.3 Participant Role

The establishment of new social ties and the development of new skills and ways of thinking them, require the active participation by ENRICHD participants and the assumption of responsibility for examination, inquiry, learning and practice. Participants are therefore expected to attend treatment sessions regularly, involve other members of the social network as agreed upon, and complete homework assigned during the course of treatment.

3.1.4 Counselor Role

One of the most important tasks of the counselor is the establishment of rapport and a therapeutic alliance. In this way, the participant begins to experience a strong sense of emotional support and social connection. The counselor must be able to utilize supportive and empathic counseling techniques, and be able to transition smoothly to an active teacher and role model in a directive approach that serves to support the development of new behavioral and cognitive skill repertoires.

The counselor must be well-versed in the treatment protocol, and deliver it in a conscientious manner. Review of session materials and notes taken during past sessions is essential to ensure that the main points of each session are covered in a manner that personalizes the treatment for each participant. The use of chalk boards and flip charts is highly recommended as a means of highlighting and paraphrasing main treatment points.

The counselor must administer the treatment protocol in a manner that is sensitive to the needs of the post-MI patient. This population is distinct from the traditional mental health population in that a profound physical insult is a large part of their clinical presentation. The problems that participants may encounter as part of their daily experience include chest pain, especially on exertion, loss of usual roles and level of functioning, threat and unpredictability of pain and death, fear of and longing for sexual intimacy, and reluctant adjustment to lifestyle changes. Problems of this kind should serve as an initial focus of each session, with the counselor taking on a supportive, yet problem-solving orientation. In this way, the treatment "makes sense" in the context of an acute MI and is seen by the participant as a way of alleviating the likelihood of subsequent cardiac problems.

3.1.5 Structure of Sessions

Each session begins with an initial supportive focus that reinforces a sense of alliance between the counselor and participant. The structured portion of the session follows the same outline as that presented in the depression intervention (See Sections 1.6; 2.8.1). The work of the past session is reviewed, along with the associated homework assignments, including a discussion of supportive and unsupportive experiences. The counselor reinforces positive efforts and successes, and probes to examine the actions, attitudes and beliefs associated with failed attempts, problematic interactions, or continued isolation. The counselor engages the participant

in a problem-solving process designed to identify other actions or attitudes that could have produced more desirable results. After this part of the work is completed, the counselor introduces the new material of the session, including a rationale, the relationship of this new material to past material, and the relevance of this material to successful living after an MI. The presentation of this material includes a solicitation of input and reactions from the participant. Modeling, role playing, and shaping of skills are utilized as appropriate.

The individual phase of treatment should typically be scheduled on a weekly basis, though more frequent meetings are encouraged where indicated. The exact number of sessions is determined by the participant's meeting the performance criteria and/or their involvement in group counseling. Sessions can take place in the participant's home and/or in the counselor's office and can include the presence of a potentially supportive other person during all or part of the sessions.

3.1.6 Involvement of Others (Network Members)

One of the criteria of successful treatment in the social support intervention is involvement in at least one supportive relationship. Toward that end, involvement of members of the participant's social network in the counseling may be a key component of treatment. This includes individuals who are identified as potential sources of social support but are currently unengaged and/or unconnected. In determining the appropriateness or advisability of involving another person in the treatment, the counselor should work closely with the participant to identify potentially supportive others and to engage these others in the treatment process.

The involvement of others should not alter the focus or process of treatment. Indeed, the counselor should be careful when involving an individual with whom the participant has a conflictual relationship that more complex marital or family issues of long standing nature don't distract from the task at hand. For example, a spouse estranged because of an extramarital affair may not constitute a relationship that can become supportive. Rather, the sessions should maintain a focus on post MI adjustment and the establishment of supportive social ties through the use of behavioral, cognitive behavioral and network interventions.

3.1.7 Homework

Homework is a key component of the SSI. Participants should be oriented to complete these treatment-related assignments during the first session. In making assignments, the counselor first provides a rationale, ensures that the participant understands and agrees with the assignment, starts the assignment in the session, and problem-solves any obstacles. Encouragement and negotiation to arrive at tasks that are perceived as "doable" is part of this process.

3.1.8 Criteria for Progressing to Group Counseling

The individually focused counseling initiates a process of change and group counseling then serves to reinforce and expand upon it. Transition from individual to group counseling can be accomplished in a gradual manner with the participant in both group and individual treatment concurrently. Transition to group is based upon: a) having a group to enter, b) the judgment of the counselor that the participant is ready and, c) the absence of any contraindications to group counseling. Contraindications include character pathology that will cause disruption in a group setting or significant levels of social phobia or severe shyness. Since the group can be a powerful instrument by which to improve perceived emotional support, the onus is to refer to group as quickly as possible.

3.1.9 Criteria for Successful Counseling

Successful treatment for low perceived social support is defined by the following criteria:

1. Completion of at least 6 sessions of either individual or group counseling

2. Involvement in at least one satisfying and supportive social relationship, operationalized as a score of at least 2 on the Social Relationship Criterion Scale;

3. Ability to do "self-therapy" regarding perceived low social support. This is operationalized as a score of 12 on the CBT Performance Criterion Scale and can include:

> a. ability to identify sources (situations, relationships, cognitions, emotions) of low social support and develop a plan to remedy this.

> b. ability to use new sources, either formal or informal, of emotional, informational, and instrumental support, when applicable.

> c. ability to apply communication and other social skills to modify or extricate themselves from conflictual or demanding relationships.

> d. the ability to identify and then modify cognitive distortions and unworkable attributions and rules that contribute to low perceived social support.

4. Improvement in perceived emotional support, operationalized as a score of ≥ 4 on at least 2 items of the Modified Duke.

3.2 THE SOCIAL SUPPORT INTERVENTION

3.2.1 Conceptualizing the Problem(s)

A conceptualization and formulation of the participant's unique reason(s) for feeling low emotional support determine the individualized course of treatment. The initial assessment using the Social Networks in Adult Life (SNAL) questionnaire helps to formulate the participant's problem (see Appendix A, Section 3.4.1). The counseling is matched to the specific problem creating the perception of low emotional support. Conceptualizing the participant's problem in social-cognitive-behavioral terms is crucial in determining the most effective course of treatment and in establishing empathic understanding with the participant.

The SSI is based upon the assumption that low perceived emotional support stems from any or all of three major deficits: structural, behavioral, or perceptual. Structural aspects include lack of family and friends and may be a "practical" problem rather than a psychological one. In this scenario the participant requires help identifying and mobilizing naturally existing relationships that can provide support: how, when, and where to meet new people or re-establish old ties. An alternative scenario may be the need to work in the behavioral realm to learn a broad range of "social skills" that facilitate the establishment of supportive social relations.

Perceptual aspects of low emotional support are the thoughts and feelings of unsupportedness and alienation. That is, the participant has people in the network but is unable or unwilling to access their support because of dysfunctional rules, attitudes or expectations, and/or conflict and dissatisfaction in the relationship. This psychological problem requires the counselor to assist the participant to discover the "why" about interactions with others rather than the "how, when and where" focus noted above. Intervention is aimed at cognitive restructuring following the standard CBT protocol as outlined in the Depression intervention in Chapter 2.

Examples of social support problems and accompanying intervention approaches follow:

> *Example 1*. The participant has a spouse/partner, family, and/or friends who are supportive and available but distorted cognitions or unworkable attitudes, rules, or beliefs prevent him/her from using the supportive network.
>
> Intervention. Cognitive restructuring and/or education about distorted or unworkable attitudes, expectations and perceptions about support.

Example 2. The participant has no perceptual or communication skill problems. While previously involved in a supportive social network, deaths and relocation now leave him/her socially isolated. The participant is willing to rebuild a network but needs help and encouragement in how to do this.

Intervention: Take a problem-solving approach. Support actions and activities revolving around social outreach or network building. Identify and mobilize naturally existing relationships that can provide support.

Example 3. The participant has a partner and/or family members with whom he/she has conflictual or unsupportive interactions.

Intervention: Determine with participant the wisdom of involving these individuals in counseling. If involvement is chosen, work to foster supportive interactions, using the MI as the focus of these efforts. Supportive communication skills training provides a natural focus. Should involvement of these others not be chosen, work with participant to gradually place limits on their involvement while also prompting and supporting actions and activities revolving around social outreach or network *building*.

Example 4. The participant exhibits a combination of 1, 2, or 3.

Intervention: Combine the appropriate treatments listed above.

3.2.2 Session 0

3.2.2.1 Goals

a   Establish rapport and supportive therapeutic alliance

b   Socialize the participant about the SSI

  1. Discuss participant's expectations about the SSI and recovery from MI

  2. Normalize the participant's difficulties and instill hope

c. Assess low perceived emotional support - the SNAL

d. Homework

  1. Initiate a contact with an indented person in the network.

  2. Activity Chart and Functions of Social Network.

  3. Continuation of assessment as needed.

3.2.2.2 Setting the Agenda

At every meeting with the participant, it is important to let him/her know what to expect. For session 0, the agenda revolves largely around getting to know the participant in their social context, and developing an appreciation of how the MI has had an impact on him/her. An example of this follows.

"I've had a chance to learn a little about you from the information that was collected in the hospital. What I'd like to do today is get to know more about you and understand how your heart attack has affected you. I'd also like to get to know a little about the people in your life and how they might be able to help you through this period in your life. By the end of our meeting today, I'd like to also begin to develop some ideas about what we might do in our work together. How does that sound?"

This is accomplished with a full appreciation of the steps for session 0 that unfold below.

3.2.2.3 Establishing Rapport and Supportive Therapeutic Alliance

The establishment of rapport and the fostering of feelings of being supported emotionally is a critical first task of the counselor. Through these efforts, the participant begins immediately to experience a sense of connection to someone else (in this case, the counselor) who he/she can count on to maintain the support throughout the program. Toward this end, the counselor gets to know the participant in a warm, empathic, and professional manner. Since a major concern for the participant is his/her recent MI, a natural focus for this support is the events surrounding the hospitalization and discharge. The skills that the counselor uses to establish this type of relationship are non-directive, empathic skills (See Section 3.3.4.8). The beneficial feelings associated with the experience of being supported may provide the motivation on the part of the participant to learn more about how to continue to have these feelings once the counseling, and the relationship with the counselor, is over.

It is important to note that many participants will not be fully committed to the goals of ENRICHD during the early phases of counseling. As such, the counselor must use judgment to extend the period of establishing the therapeutic alliance as long as is necessary. Beginning of active therapy with participants who are not fully committed to the goals of ENRICHD treatment runs the risk of early drop-out.

3.2.2.4 Socialization into the SSI

The counselor should begin by introducing him/herself and explaining who he/she is. Where possible, the initial meeting should occur in the hospital, shortly after randomization. Explain the purpose of this first meeting: to get to know the participant, to get an idea of the participant's social setting and his/her view of how he/she fits into this setting, and to discuss the rationale for the SSI and what to expect. The counselor should talk about ENRICHD as a program designed

to help the participant with his/her post MI adjustment and potentially to reduce the likelihood of further cardiac problems.

During this initial discussion, the counselor refers to information from the screening and baseline assessment that preceded the meeting, "checking in with them" about how things have been for his/her with regard to social issues (e.g., "Let me see if I understand"). The counselor should also use the SNAL to elicit network and support information needed for the formulation of treatment. It will be VERY useful to talk with the participant about the how things went in hospital (e.g., visitors, reaction to specific visitors, surprises about who did/did not visit), and how things have been since discharge (e.g., what the participant has done and thought about, what their social interactions have been like, the nature of the support received, surprises about who has/has not been supportive). The tone of this discussion should be very supportive, non-directive, acknowledging and affirming, using traditional therapeutic techniques to provide the participant with the sense that this is a safe setting.

Start to discuss the role that supportive social ties play in successful recovery after an MI and the impact that the lack of such ties may have on well-being and the future course of their disease. Use lay language and the same descriptors and words that the participant uses during the discussion. Frequently probe for understanding or resistance.

An example of a presentation to the participant is:

> "Help from family and friends in the form of caring and listening is important to everyone, especially when they are getting well. This helps people to cope better with the stress of being sick. Not having this help can lead some people to feel unloved, isolated, or discouraged. Getting more help from people, and feeling that they care, can be important in getting better after a heart attack. What do you think about that?"

> "What we will be doing during the time we work together is finding out what kinds of situations are leading to thoughts and feelings about not getting the love, help, or attention you may need. Once we know about the situations that make you feel unsupported, we can figure out different ways to change or fix these situations so you don't feel nervous, mad, lonely, or uncared about. This may involve learning new things to do and how to do them. How does that sound?"

The natural progression of this discussion leads to a description of the logistical aspects of the SSI. This includes describing the assessment and the potential involvement of significant others and/or network members in the assessment and subsequent treatment. IT IS IMPORTANT to let the participant know that s/he will make the decision to include these other people. In addition, it will be important for the counselor to use his/her own judgment about the inclusion of these others at different points in the initial and subsequent sessions. Issues to consider include the

participant's feelings and sensibilities, the presence of a significant other at the initial sessions (e.g., provides ride), and the need to conduct the assessment and treatment with minimal interference from other people. This may require the inclusion of a "troublesome significant other" in a peripheral way and for only a portion of the session so that the significant other feels included and doesn't sabotage the intervention.

Including (a) significant other(s) in part or all of a session can be very useful, especially during the assessment phase. Involvement of a significant other makes it possible for the counselor to observe interactional patterns directly and identify any communication skills deficits that the participant may have. Moreover, the significant other can provide information about current relationships, usual and special activities, failed attempts at reconciliation, distortions about social support that the participant may be reluctant to mention, and possible social sources of dissatisfaction, burden and emotional distress. Enlisting a significant other as an ally can undercut sabotage and reinforce participant's efforts at problem-solving and successful outcomes. Involvement of others at this point also establishes a precedent for their involvement during later sessions.

The time frame, structure, and progression of treatment, including the progression to group-based treatment is elaborated, and an assessment is made of any barriers to involvement in the group that the participant perceives. This discussion also serves as the basis for a description of the "ground rules" of participation (e.g., length of sessions, issues of attendance, promptness, notification of anticipated absence/need for rescheduling, scheduling of sessions, and homework) and the development of an explicit counseling contract.

Formation of a counseling contract with the participant (and network members, as indicated) occurs at this point, regarding the nature of the counseling, the foci of the counseling, and the responsibilities of all parties over the course of counseling.

3.2.2.5 Assessment

Assessment features both qualitative and quantitative strategies, using a semi-structured interview format and the associated Social Networks in Adult Life concentric circle (Appendix A, Section 3.4.1). This helps the counselor and participant become aware of the social network (i.e., size, structure, and composition). In addition, each participant is asked to identify the kinds of support available, whether or not this is satisfactory, and what kinds of support he/she would like to have but is not getting. From this assessment, the counselor and participant can identify areas that need improvement and places where needs are not being met.

The counselor begins by interviewing the participant, using the structure provided by the SNAL. A "Network Map" is developed using the concentric circle diagram. The participant is prompted to indicate where in the concentric circles the people in his/her network "belong". If the participant is unable to identify people to place on the network map (e.g., he/she lives in a

"structurally isolated" manner, having little or no substantive contact with people), he/she are prompted to think about people with whom he/she has regular face-to-face contact in daily activities (e.g., service people, neighbors, co-workers, etc.), and place them on the map.

3.2.2.6 Homework - Initiating Social Contact

It is important that the counselor begin the work of having the participant make an initial contact. Remember, the participant has screened into ENRICHD because of low perceived emotional support; beginning to alleviate this perception becomes a paramount focus. For example, a particular friend hasn't been notified that the participant has had a heart attack, yet the participant would really like to talk to this person about the experience. Identifying problems during the initial session can motivate the participant's involvement in treatment by presenting it as something that will address his/her particular needs.

3.2.2.7 Homework - Activity Chart, Functions of Network, Continuing Assessment

The session ends with the assignment of an initial homework task. The counselor sends the participant home with the Activity Chart (see Appendix E, Section 3.4.5) and the Some Functions of a Social Network list (see Appendix B, Section 3.4.2), gives instructions for their use, and requests that the participant take time each day before the next session to complete the former and read/think about the latter. The counselor may also give the participant the Network Map and People In My Life List (see Appendix A, Section 3.4.1) to complete at home.

3.2.2.8 Feedback

The counselor can try to boost motivation by expressing confidence in the participant's ability to do well in treatment. Ask for feedback about the first session: "How much do you believe now that it's important to connect with someone this week? If the reply is "Very much", ask "What could you do this week to make that happen?".

If the reply is "Not very much", ask "Why"?.   Ask about feeling hopeless about the heart attack and about relationships in his/her life or lack of them. Inquire about the participant's natural fear of changing anything about his/her life. These are cognitions such as: "I could make it even worse than it is" or "I'm more of a burden now so I should just not rock the boat or ask for anything more".

3.2.2.9 Reticence About ENRICHD and the SSI

IT IS IMPORTANT TO NOTE that at this initial session the participant may express reticence regarding his/her agreement to participate in ENRICHD. Whether this happens at the first session or in subsequent sessions, there are two approaches that may help. One approach is to affirm the participant's reluctance. Then, review the events that lead to his/her enrollment in ENRICHD, encourage the participant to express any doubts about the treatment and/or his/her

ability to perform the homework (self-efficacy), and reaffirm the possibilities that can be gained through involvement with ENRICHD. An alternative approach is to assume that the reluctance is associated with an inadequate establishment of trust in the therapeutic relationship. In this case, the counselor should back off from his/her own agenda, and instead engage in supportive, non-directive interactions with the participant. With time, cultivation of trust in the counselor, and a realization of the benefits of being in a supportive encounter, the participant may convert and become more fully committed to the ENRICHD counseling goals. (see chapter 7 for a full discussion of ways to approach reluctant participants).

3.2.3 Sessions 1 and 2

3.2.3.1 Goals For The Sessions

a. Checking In

    1. Inquire about the response to, and effects of, the first session

    2. Discuss cardiac and support problems since last session

    3. Review Homework

      i) Social contact

      ii) Activity Chart and Functions of Social Network

      iii) Continued assessment

b. Continue the assessment using the SNAL and associated forms.

c. Prepare agenda and decide on problem to be discussed from continuing assessment.

d. Homework.

3.2.3.2 Checking In - Review of Response to Session 0 and to the Week

As with all subsequent sessions, sessions 1 and 2 are initiated with a review of the participant's reaction to the last session, a brief discussion of events since the last session, and an examination and brief discussion of the homework. Encouragement is provided as indicated, maintaining the sense of support, connection, and alliance. As needed, problems that have arisen during the past week are described and approached using problem-solving techniques. Focus on answering the question, "How do problems encountered during the week relate to low social support?" For instance, a common complaint from the participant will be, "I don't understand what the

cardiologist said." In the session, then, the counselor asks, "Who could go with you to the doctor's office or who could help you write out questions to ask the doctor?" This introduces topics for discussion and continued assessment: the nature of the participant's social relationships and communication skills.

3.2.3.3 Checking In - Review of Homework

Efforts made by the participant to complete the various homework assignments are an important focus. They represent the commitment of the participant to the trial and the major part of the work that comprises the SSI. It is of the utmost importance that the counselor review this work and reinforce the participant's efforts.

Discuss the "Some Functions of a Social Network" list with the participant. Help him/her to identify specific functions that are important. Also, reinforce any additional work performed on the SNAL. Review the Activity Scheduling form. Identify specific activities that were satisfying and summarize the overall "feeling" of the week.

3.2.3.4 Continued Assessment

The counselor returns to the SNAL and Network Map and works to complete it. Engage the participant in a discussion about moving people around on the map, with a particular focus on moving people closer to, or further from the participant. A useful method to employ may be acting out the concept with the participant. In this technique, the interventionist represents specific "other people" and starts to move closer from across the room, asking the participant to tell his/her when to stop coming closer.

During this part of the exercise, look for automatic thoughts about other people, about involving others, about reciprocity and propriety concerns, and about expectations of others and self. Ask for feedback about understanding. Role play interactions with selected members of the network.

Some examples of questions aimed at engaging the participant and aspects of assessment addressed by these questions include:

> "What would happen if you moved this person in? Do you think that this is a good idea? If not, why not? What if they moved in this far? This far? How would you feel about it? What would you think about it? What would happen if you didn't move them closer? Would they move in anyway? How would you feel about that?".

These questions serve a number of useful purposes. They help to identify some of the participant's wishes, desires, and concerns regarding closeness in general and closeness with specific people in particular. These questions provide the counselor with information about the participant's cognitive framework and beliefs, and cognitive distortions as regards social support,

while also revealing the presence of social anxiety or chronic shyness. In addition, by asking what would happen by moving specific people closer in or further away, potential systems issues can be identified (e.g., if Aunt May moves in, what does Uncle Harry do?).

Questions aimed at identifying cognitive distortions, social anxiety, or chronic shyness include:

"Have you tried to get specific people to move closer? Who are they? If not, why not? What happened? How have you tried to get people to move closer/further away? How have you/would you try to do that? What happened? What did you do then?"

Questions aimed at providing information regarding the participant's social, communication, assertiveness, and social outreach skills, as well as cognitive distortions, social anxiety, and chronic shyness include:

"Why haven't you tried to move these people in/out?"

As the counselor prompts and reinforces the efforts of the participant during the concentric circle exercise, he/she also must be listening for the social situations that serve as "hooks and triggers" of negative emotions in general and the perception or experience of having little or no social support. Specific attributes to look for include feelings of sadness, isolation, being uncared for, excluded from, or not a part of the larger social milieu; conditions that provoke the participant to stop engaging in social outreach efforts; intentions and efforts to outreach that typically "fall flat" (e.g., call to child, friend, etc.); the circumstances associated with these efforts "going flat"; and, interactions with network members such as spouse that lead to 'negative interactions' and hence, feelings of being unsupported.

Where potentially fruitful, the counselor should discuss with the participant the idea of bringing a significant other or network member to the next session and how the presence of this person could serve to further the assessment and subsequent treatment efforts. This discussion can be introduced at any time during the assessment, with the counselor letting the nature of the ongoing discussion govern the introduction of this new aspect. Concerns about involving others should be discussed so that the participant guides the introduction of others, but uses the counselor as a (social) resource for helping with this decision. As needed, the counselor should engage the participant in a role play around inviting an identified other person to the session. This interaction can then be practiced, so that the participant reaches a sufficient level of comfort with the task. Another way to handle participant anxiety about asking someone to accompany him/her is to have the participant call the person while they're still in the office or at home if you're visiting there.

Should the joint decision be made to bring in other people during the assessment phase (and potentially, the treatment phase), the interventionist should use his/her clinical judgment as to the

degree to which these others should be involved. Hence, the counselor could choose to have them be present through the whole session, to have them be present during only part of the session, or to meet with the participant and these other people individually during the course of a session. IT IS IMPORTANT TO REMEMBER that the intention is not to engage these members of the social system (e.g., family, marital or couples setting) in more complex marital, family, or systems therapy. Rather, the involvement of network members facilitates the establishment and development of supportive social ties that will ENHANCE MAXIMAL POST-MI RECOVERY for the participant. Hence, the focus of all discussions should be the MI, the usual course of MI recovery, the needs of the post MI patient, and in particular, the importance of supportive social relationships for good recovery, for reducing the risk of poor outcomes, and for enhancing overall well being.

When a significant other or other network member is brought to session, the counselor should spend a part of the session making the(se) individual(s) feel comfortable. The counselor should introduce his/herself and briefly describe the ENRICHD study. Inquire into the member(s') understanding of why he/she has been invited. Answer questions as they arise. Briefly describe the rationale for having others attend, and then begin the task of assessing the nature of interactions that occur between the participant and network member(s). If the network member(s) have been invited because of the potential role he/she might play in becoming a new source of supportive social ties, the discussion should focus to a greater degree on the role the(se) individual(s) might play and his/her willingness to do so. The participant should take part in these discussions. If the network member(s) have been invited because he/she is the source of conflictual, unsatisfying, burdensome or unsupportive social interactions, the discussion should focus on the needs of the post MI patient, how these needs might be met more successfully, and again, the willingness of the(se) individual(s) to play a part in meeting them. Probing efforts at prompting, modeling and shaping supportive communication should be utilized as indicated. The goal during this assessment is a determination of whether the relationship between the participant and the network member(s) is amenable to the scope of the SSI. If this is the case, the(se) individual(s) becomes a participant in the SSI and may be invited back to subsequent sessions.

3.2.3.5 Preparation of Treatment Agenda

As the exercise(s) draw(s) toward completion, or as the time allowed for the session draws to an end, the counselor should leave a few minutes to review the exercise(s) with the participant(s) and summarize the important findings that are associated with a sense of having low support. The counselor should praise the participant(s) for his/her hard work and perseverance with the task(s). If further assessment work is needed, the interventionist should indicate that in the next session s/he will pick up where s/he left off.

When the assessment work is largely completed, the counselor should draw attention to the findings and elaborate what attributes of the social environment (e.g., the structure, the specific social interchanges between specific individuals, the participant's identified skill deficits and/or cognitive framework regarding social interactions) appear to contribute to the participant's sense of low support. The counselor should speak about these "causes" in a manner that articulates potential targets for subsequent work with the participant (and network members as indicated), and the course that this work could take (e.g., the particular targets and treatment approaches, as described below). Particular emphasis should be drawn to the notion of "upsetting situations" that serve as "triggers and hooks" for feelings of low support, and the importance of support for good post MI recovery. The counselor should then begin to articulate strategies that can be useful in altering these outcomes. The participant (and network members) should be left with a concrete idea about the sessions to follow. The counselor goes through the decision process in a manner that is understandable and makes sense to the participant, eliciting expectations and concerns about both the intervention and the participant's belief about being able to accomplish these goals. It will also be desirable to involve the participant (and network members) to a significant degree, so that they have a sense of choosing what the focus of the work will be.

ATTENTION ALSO MUST BE GIVEN to differences in the foci of treatment due to gender and cultural differences in the perception, use, and maintenance of social relationships. For instance, in relationship building, men may need more help with beliefs about the need for and expectations about friendship, nonverbal communication skills, and friendship maintenance skills. In contrast, women may need more help with assertiveness, and beliefs about reciprocity in relationships. African-Americans may rely more on family members, especially children, for decisions about treatment, outside activities, etc.

3.2.3.6 Homework

a. Continue working on the network map, thinking about the movements of people that could enhance   feelings of support, reduce feelings of isolation or social burden or lead to satisfying social relationships.

    b. Have participant continue with social outreach as initiated earlier (have these efforts monitored on the Activity Chart)

    c. Introduce the Network Improvement Form. In assigning this form, the interventionist should explain its use and ascertain the participant's understanding of how to complete it, problems s/he foresees in filling it out, how useful s/he thinks it will be, etc. (see Appendix D).

d. Invite other network members to the next session, as agreed upon.

If a network member has participated in an assessment session, s/he too is given a homework assignment, consistent with the role s/he is likely to play in the intervention. For example, if it is a partner who needs to be supportive, the homework assignment would be a prompt to provide that support, providing feedback to the counselor at the next session about "how it went". Similarly, if the partner is likely to be involved in the intervention as a way of establishing supportive communication, then the homework should be to engage in some initial attempt at such communication, with the Homework Reporting Form again providing feedback to the interventionist at the next session.

3.2.3.7 Remaining Sessions

At this point, the formal assessment has been completed, although it will continue less formally throughout counseling. The problems to be addressed have been identified, the supportive alliance between participant and counselor is functioning, the participant and counselor have set specific goals, and the participant has begun to experience some relief of feelings of low support.

Based upon the initial assessment, the counselor chooses one or more modules for further counseling.

Module 1 - Social Outreach and Network Development, used when the participant experiences true social isolation.

Module 2 - Cognitive Therapy, used when the participant has automatic thoughts that preclude formation of supportive relationships.

Module 3 - Social, Communication and Assertiveness Skills, used when the participant has real behavioral deficits in skills at effective communication.

3.3 SOCIAL SUPPORT INTERVENTION MODULES

3.3.1 Introduction

A modular approach has been taken for the subsequent sections of the SSI Manual of Operations. Three Modules are included which focus on three different deficits that could be the cause of low perceived emotional support--environmental, cognitive, and behavioral.

One deficit could be environmental. This is the case when there is true social isolation. Such environmental deficits could involve:

> -- real physical isolation from others, due to environmental circumstances (e.g., living alone, living in a rural setting);

-- under utilization of networks that have been there all along (e.g., emotional disconnection from spouse);

-- recent loss of significant other.

Another deficit could be cognitive. This is the case when automatic thoughts limit one's interest and/or willingness to engage in supportive relationships. Cognitive deficits could include such thoughts as:

-- "I don't want to risk getting hurt by others"

-- "Others don't understand me, are too naive, etc."

-- "I take pride in my self-reliance. I like to keep problems to myself"

-- "I don't want to burden my family/friends"

A third deficit could be behavioral. This is the case where poor or inadequate communication skills limit one's ability to carry on conversation or engage in supportive interactions. Such behavioral underpinnings could include skill deficits like:

-- Conditioned obsolescence: the spouse made all the social contacts and, now that the spouse is gone, the participant doesn't know how to do this;

-- Never having learned how to express feelings, listen, pass the time of day;

-- Communication, assertion, problem solving and overall social skills deficits that "interfere" with the use of an already existing network of people (e.g., spouse, family, neighbors).

For treatment of environmental deficits, refer to Module 1: Social Outreach and Network Development. For treatment of cognitive deficits, refer to Module 2: Cognitive Management. For treatment of behavioral deficits, refer to Module 3: Communication and Assertiveness Skills Training.

Although the modules are presented as separate entities, in most cases, low perceived emotional support will not stem for only one deficit. It will not be due to JUST a behavioral skills deficit, OR some cognitive distortions, OR physical isolation/network problems. It is more likely to become apparent that the perceived sense of low emotional support will be found to be a combination of the three and a number of potential targets for successful intervention will be revealed. The modules are provided as individual components to promote simplicity in presentation of treatment recommendations. Counselors are encouraged to combine them, as needed, based upon the participant's unique presentation. An examination of the three modules will quickly reveal that they have a great deal in common: the use of standard behavioral, cognitive behavioral, and social mobilization techniques to accomplish their various goals.

A final note concerns the absence of a session-by-session script for the modules. This was done intentionally. The purpose of the modules is to provide a guide for the counselor about the key points, issues, and treatment elements. The session-by-session delivery of these elements will be guided by the eventual "make up" of each participant's treatment. Each session will follow the general flow of sessions, as outlined in Section 2.8.1.

3.3.2 Module 1: Social Outreach And Network Development

3.3.2.1 Goal

The goal of Module 1 is to describe procedures aimed at facilitating the development of at least one satisfying and supportive social relationship for the participant with low perceived emotional support. A relationship that is emotionally satisfying and supportive is defined as having someone to speak to or confide in about problems. Meeting this criterion can involve the establishment/re-establishment of more than one relationship. It is important to think about this effort within the context of the participant's larger social network. Hence, the outreach efforts of Module 1 should leave the participant with a set of skills that facilitate the continued development of a satisfying and supportive network, long after their participation in the SSI has been completed. In this way, the participant will also learn "self therapy", thereby "inoculating" him/herself against further social isolation.

3.3.2.2 Rationale

Module 1 focuses on outreach efforts by the participant aimed at re-establishing previously supportive relationships, or establishing new ones. Social interchange forms the basis for emotional support. It includes having someone to talk to about problems and difficulties, having someone with whom to express emotional experiences, and/or having someone who understands you. A network of supportive relationships provides outlets for activities that bring joy and deep satisfaction. For a variety of reasons, social interchange can become constrained and "drop away" as a person progresses through their life course. Moreover, while people going about their daily routine come face-to-face with an extraordinary number of people, they do not necessarily experience any inherent connection to these people or think of them as potential sources of satisfying support.

In accomplishing this effort, remember to stay within the participant's frame of reference and not force or pressure her/him into trying to get close to people that s/he wouldn't normally consider relating to in this way. Respect the participant's preferences and idiosyncrasies.

3.3.2.3 Treatment

A. Why reach out?

While enrollment in ENRICHD for the participant with LPSS requires a subjective sense of having insufficient or unsatisfactory support, it may nonetheless be important to spend some

time talking about the importance of social support. The need for this will be apparent from the initial contact(s) with the participant and his/her response to your efforts at getting to know him/her and the people in their his/her life (through the use of the SNAL). Appendix B (Some Functions of a Social Network) can be helpful with the reticent participant. Appendix C (Network Improvement Form) can be useful in helping the participant to identify specific support deficits and targets.

B. Who to reach out to?

   1. Networks That Are Already There.

The SNAL and the associated "People In My Life" form provide a focus for a discussion of people with whom to begin the outreach effort. These forms will already have been used as a way of getting to know the participant and the network of people in his/her life. They will be useful in learning about the history of specific relationships and changes that might have occurred over some time span. As such, they will help the counselor and participant to identify previously supportive relationships, the things that happened to reduce their supportiveness, and potential targets for outreach efforts that might be fruitful. These can include:

   -- people moving away;

   -- decreased frequency of contact associated with care of a sick spouse;

   -- decreased frequency of contact associated with perceived slights;

   -- changes in daily routines.

A typical homework assignment after completion of the SNAL might be to have the participant "choose" 1 or 2 people from their SNAL to communicate with during the upcoming week. The session could be used to work on specific plans to accomplish this, such as scheduling a joint activity. During the subsequent sessions, the participant can report back regarding the outcomes, and regarding the pros and cons of reaching out to people in general. If these individuals don't work out, 2 new people can be selected, and so on.

Homework assignments can also be useful in re-establishing contacts with groups and organizations with whom the participant formerly associated. These can include churches, synagogues, civic organizations, volunteer groups, reading groups, hobby-based groups, senior centers, etc.

   2. The Community.

The SNAL can be used to expand the participant's ideas about his/her network and it's members. Most people, when queried about the people in their lives, will mention those who fall within "standard" relationships, such as spouse, children, extended family, friends, and neighbors.

They will not include the wide range of other people with whom they have some kind of regular contact: people at stores and markets, service people, and/or people who they regularly pass by and "nod" to as they go about their daily routine. This larger group of people with whom the participant has some degree of regular (once every 1-2 weeks) contact is the participant's community. The SNAL can be used to expand the idea of "network" by having the participant include these previously unthought of others. (See Appendix F: Community.)

Once community members begin to be listed on the SNAL, the participant can be engaged in discussions and role plays about how they might get to know something about these people. The counselor may wish to shift the focus of the discussion from the idea of outreach for support to the idea of finding out something they didn't know about these other people in the community. Two such people could be chosen each week with subsequent sessions being used to discuss what was learned about these 2 people, identify what did/did not work, and chart a course of action for getting to know other community people.

For some participants, the SNAL may be truly sparse, with few or no people listed. This may be the case for elderly participants who have experienced many losses and life changes. The success of outreach efforts for these participants will rely heavily on:

1. The counselor's ability to get to know and understand the participant (e.g., their desires, interests, areas of needed support, interactional style, preferred activities);

2. The counselor's working knowledge of the availability of specific organizations and activities that could be of potential interest to the participant. Local newspapers highlight activities that may be of interest to the participant. Communication with local social workers and/or service organizations could help to identify programs and services, such as a van service to a Senior Center, lunch programs, opportunities to teach children at local churches, etc.

When discussing and role playing outreach efforts involving attendance at meetings or social centers, the counselor may find the participant to be particularly reluctant. In such circumstances it could be important for the counselor to consider accompanying the participant and doing some in-vivo modeling. For example, the counselor could accompany the participant to a Senior Center for the first few times to help "break the ice". This can not only be a powerful experience for the participant but also a unique opportunity to observe the participant "in action".

3. Family and Significant Others.

Among those who might be identified for outreach efforts are family members (e.g., children, siblings, spouse) or significant others. The counselor should make an effort to involve these individuals in the counseling sessions. This involvement permits the counselor to:

-- determine if problems are solvable within the ENRICHD framework or may require outside marital/family counseling;

--determine if the spouse or significant other may be relied upon as a potential support-giver;

--observe dysfunctional interactional patterns and work with them (see Module 3).

It is important to involve the participant in all decisions regarding who to bring in and when. These efforts can have a significant and lasting effect on the alliance established between the participant and counselor and no actions should be taken that would adversely affect it.

> 4. Other Counseling Group Members.

The counseling group provides an ideal opportunity for participants to develop new social ties. The group provides, in a sense, an artificially generated community in which social outreach can be practiced. This outreach could ultimately be transformed into the establishment of new, enduring relationships. Among the advantages of the group for cultivating social connections are the following:

--it provides a good medium with which to test beliefs about people;

--it provides the opportunity to form new friendship(s) that could be maintained outside of the group;

--it provides the opportunity to practice social/communication skills;

--when a participant is seen both in individual and group counseling, it provides the opportunity for him/her to participate in group interactions and then discuss experiences and feelings with the counselor during individual sessions. (When so doing, it will be important to "bring the individual discussions" back to the group, making sure to do this in a way that supports the participant, maintains confidentiality, and "moves" the agenda forward.)

3.3.2.4 In-Session Exercises

A. Social Support: Uses and Preferences

Discuss some common functions of social ties, using Appendix B (Functions of a Social Network) as an aid. Work with the participant to select those functions that:

--they already have in their social ties;

--they once had but no longer have;

--who they might have this with and how they might establish it.

The baseline assessment can be used to prompt the participant about what has lead to this subjective sense of low support (e.g., What is missing? What could they gain? What would

support them?), and the potential people who could provide this (Who might make up a satisfying network?). Referring to the Network Map/List completed during the SNAL and Appendix C (The Network Improvement Form) will be particularly helpful. Pay particular attention to family members and those in close geographical proximity to the participant.

Some additional questions to use as prompts for discussion include:

--What would support be for you?

--What kinds of things do people do for you? What things would you like people to do for you that they don't currently do?

--What would you like your network to "look like" realistically, not ideally? What kinds of people would you like to have in your network? What are the qualities you would like the people in your network to have? What qualities do you bring to your network?

--What kinds of activities bring enjoyment to your life? How often do you get to do these things? Who does them with you? What activities that you once did brought you enjoyment or pleasure? Do you think they would bring you enjoyment again if you were to do them? Who did you do them with? Why did it stop? Who else might you do them with? How might you find out?

--What kinds of activities do you think would bring enjoyment to your life (Things you never did but often think about doing)? Where might you find other people already engaging in these activities, or who might be interested in doing   them with you? How might you find out?

--How could you approach "strangers" in a way that creates opportunities for being related? How could you approach people in the outer edges of your network map (completed as part of the SNAL) to create the same opportunities?

--Looking over the Network Improvement Form: Where could your network be improved? How might you begin to do this? (Use a problem-solving methodology). What qualities of people, and what types of activities, would improve your network in the way that you desire?

B. Problem Solving

For participants who have a hard time engaging in outreach assignments and connecting to others, it will be important for the counselor to help the participant to identify and understand barriers to social outreach. In addition, it will be important to help the participant understand how these barriers contribute to staying "isolated". Barriers are diverse and may include cognitions (see Appendix D: Belief Barriers to Social Support and Module 2: Cognitive Management) and/or behaviors such as nonverbal communication style, verbal communication style, lack of interest in the attempts of others to reach out to the participant, and personal

benefits of staying unconnected (See Module 3: Communication and Assertiveness Skills Training).

3.3.3 Module 2: Cognitive Management

3.3.3.1 Goal

The goal of this module is to identify and modify underlying cognitive distortions, unworkable rules and attributions, and or social anxiety/chronic shyness that interfere with the development and maintenance of a satisfying and supportive social network.

3.3.3.2 Rationale

The participant's distorted perceptions of such things as their place in the larger social framework, the likelihood that others would be interested in playing a supportive role for them, or the possible cost of asking for, or accepting, such support may play a paramount role in their feeling unsupported. In cases of social anxiety or chronic shyness, perception serves as the key isolating element. Cognitive factors in each of these cases serve as a stimulus for the subsequent behaviors leading to real or perceived isolation, or that precludes development and maintenance of social ties. Hence, the cognitive domain is an essential focus of the SSI, and cognitive behavior therapy serves as the modality of treatment.

3.3.3.3 Skill Guidelines, In-Session Exercises and Homework

A detailed description of the guidelines for the conduct of cognitive behavior therapy is presented in Chapter 2 within the context of the treatment of depression. The principles, methods, skills guidelines, in-session exercises, and homework are the same as those relevant for this Module. The themes of the cognitive distortions (e.g., all or nothing thinking, overgeneralization, mental filter, magnification, emotional reasoning) will be similar. What is distinct, is the nature of the cognitive distortions that serve as the focus of intervention.

Provided below is a sampling of cognitive distortions that participants who have low perceived emotional support are likely to have and that serve to focus the associated cognitive intervention(s). In addition, the counselor is encouraged to use the "Belief Barriers To Social Support" exercise (see Appendix E) as a way of getting the participant to further articulate cognitive distortions, unworkable rules, and unworkable attributions that interfere with the formation and maintenance of supportive and satisfying social relations.

3.3.3.4 Cognitive Distortions Associated with Low Perceived Emotional Support in Post MI Patients

"My family (daughter, son, etc.) has done enough. I don't want to bother them. I don't want to burden them."

"My children are too busy for an old woman / man."

"I don't want them (neighbor, mail carrier, etc.) to know my business. All they want is to know your business so they can gossip about you."

"Ladies don't do those sorts of things (initiate conversations, invitations)."

"Men don't do those sorts of things (ask for support)"

"She doesn't talk about anything but herself - I can't get a word in edgewise."

"They all sit around talking about their illnesses and disabilities - it's boring."

"No one listens to me. They interrupt me, don't stop what they're doing, and walk away while I'm still talking."

"He can't do those kinds of things (washing, cleaning, cooking). He's never done them before/all our marriage."

"That's my job, not hers/his."

"I like being alone."

"What would I talk about with them/him/her?"

"I'm too old to learn new ways."

"I'm too old to make new friends. They'll just die anyway."

"No one cares about me / wants me."

"I'm too old / too ugly / no one would care about another old lady."

"They're (family member) supposed to call me. I'm the parent, they're the children."

"I've always relied on my wife to arrange friends and activities."

"If I told someone how I feel or what I want, they'd be scared away."

"I don't want to connect with anyone because I risk getting hurt again, like I have in the past."

"Other people can't help me. They don't understand; are too naive; too stupid; too _____"

"I don't want to feel obligated to other people."

"I take pride in my self-reliance. I like to keep problems to myself"

3.3.4 Module 3: Social, Communication and Assertiveness Skills Training

3.3.4.1 Skill Set 1 - Nonverbal Communication

Rationale

Nonverbal communication, sometimes called "body language" plays a big part in the messages we convey to other people. When we talk to others, we not only use actual words but we use a certain way of talking as well. This way of talking is nonverbal communication. For example, (for men) in a job interview, one person might look down at the floor or off in the distance, while a different person might look directly at the person doing the interviewing. What very different messages might the nonverbal communication of these two job applicants convey to the interviewer? For example (for women), during a visit with a friend, one person might look out the window or watch TV while the other person is talking, whereas a different person might look directly at the person talking. What very different messages might the nonverbal communication of these two people convey to the other friend?

Nonverbal behavior can help or hinder communication. The same words can be interpreted very differently, depending on how those words are delivered. For example, if you fidget, rock back and forth, and/or speak in a whisper when you ask someone for the money he/she owes you, how likely is it that your words will be taken seriously? Sometimes people say one thing with their words and something very different with their actions; that is, their nonverbal actions contradict their words. For example, you are in your doctor's office waiting to be seen. A nurse comes into the room to take you blood pressure and asks "How are you doing?". She looks past you or down at the floor while she's pumping up the cuff, never acknowledging that she's heard your answer. A different nurse might ask the same question while looking directly into your eyes and waiting for you to answer before pumping up the blood pressure cuff. Which nurse's response feels the best to you?

Developing effective nonverbal behavior can make a world of difference in your interactions with others. It will increase the chances that others will react positively to you. It also will increase the likelihood of more satisfying communication with them and will help you to feel better about yourself.

People are often unaware of the nonverbal message they send. They act in automatic or habitual ways and may not be aware of the impact they are having on the other person. In this session, we will discuss several different components of nonverbal behavior and help you pinpoint those that can help you become a more effective communicator.

Skill Guidelines

Posture
A relaxed posture makes you look natural to others and feels natural to you. Try to find a comfortable position in which your back is resting against the chair and your arms are either on the arm rests or folded across your body. Think about being relaxed and how good your body feels when you are relaxed. Other people will also recognize when you are relaxed and not feel that you are afraid to talk with them. Some other messages which you may communicate to your listener through your posture are shyness or insecurity. To avoid that, stand or sit directly facing the person you are speaking with or at no more than a slight angle.

Personal Space
When talking with someone, it's important to maintain a comfortable distance between you and them - not too close and not too far. Each person has what's called personal space. This is the amount of space they like to keep between themselves and others. If this space becomes too small, the other person may begin to feel uncomfortable and stop listening to what you are saying. In the future, they may also try to avoid you. To keep this from happening, remember to keep about a two foot distance from others when you are talking to or listening to them.

Eye Contact
Initiating and keeping eye contact with others when you are talking with them is a way of showing interest and keeping their attention. Not looking at others when they speak tells them that you are afraid or you are not really interested. Eye contact shows the person that you are following what they are saying and that you are interested in hearing more. It's also important to understand that you can "overuse" eye contact such that the other person thinks you are staring; this will make them feel uncomfortable. Try to strike a happy medium with frequent eye contact (a little more than half the time).

Head Nods
A head nod that conveys interest and understanding is an easy way of letting the other person know that you are listening to, and interested in, what they are saying and who they are. It also lets them know that you are following the conversation.

Facial Expression
As with all other aspects of body language, facial expression is very important. It is one of the most effective ways that we communicate with others. A pleasant facial expression can put others at ease and let them know that you are enjoying speaking with them. It can also leave them feeling like they'd like to know you better. A scowl or frown can push people away by making them feel that you don't like them or what they are saying. Being able to laugh and smile when you converse sends the message that you are a pleasant person to be around.

Nervous Movements and Hand Gestures
These kinds of body movements can be distracting to others and tell them that you are nervous or uncomfortable. It leaves them feeling the same way. It can be useful to begin to notice if you do these kinds of things when you're talking to others. When you notice something, try and see what happens when you purposefully relax yourself. Notice how your nervous movements start to disappear. Also, notice if there are any other ways to relax yourself--like placing your arms on a chair's arm rests, or sitting with your feet on the floor. If you send the message that you are comfortable (even if you are not), then others will be too.

Tone of Voice
Imagine a situation where one person is trying to make a helpful suggestion to another person. By using a calm and caring voice, the speaker demonstrates concern, interest, and respect. Imagine if those same words are delivered in a cold, sarcastic tone of voice. The message would be totally different and likely result in an argument or resentment. Your tone of voice can aid in communication, particularly when it is firm, warm, and relaxed.

In-Session Exercises

The counselor can use modeling and role-playing to demonstrate the congruent and noncongruent nonverbal message and the power of nonverbal communication such as tone of voice, facial expression, and posture. For instance, the counselor could demonstrate his/her use of eye contact with the participant and what that communicates to the him/her. Then the counselor could ask the participant to use eye contact appropriately and inappropriately to check the learning that has occurred.

3.3.4.2 Skill Set 2 - Starting Conversations

Rationale
Conversation is an important first step in establishing relationships with others. Initial conversation can be the most important, for it is a beginning step and can provoke interest or avoidance in others. Beginning a conversation is a skill that everyone can learn.

Skill Guidelines

Consider places that you could meet people. What are some of those places (generate a list). How might you start conversations with people there?

How do you feel about starting a conversation with someone you don't know? What are some of the reactions you have had in the past when you've tried to do so? (Probe responses and do some initial problem solving)? There are a number of common misconceptions that people have about starting conversations. Some of them are:

   1. You should only talk about important things or weighty matters.

2. You are responsible for keeping the conversation going. If it 'peters out' it's your fault.

3. You should never talk about yourself.

Actually, in starting new conversations, it is important that they be fun, a way of sharing ideas with others, and a way of getting to know each other in a casual and comfortable way. Small talk is OK. A conversation is a two-way street, with each person contributing something to the mix. That's why it's OK and useful to share something about yourself when you are talking with others, while also asking them questions about themselves. This way, real sharing takes place.

Other suggestions for beginning conversations include:

1. Listen for clues about what might be good topics for discussion. Use their body language or pieces of their conversations with others. Choose the right moment to initiate. Pick a moment when there is a pause in another conversation, or when the person is not otherwise engaged.

2. Speak up and let the other person know you're interested in talking. Use eye contact and say something first. Remember the value of small talk.

3. Use open ended questions, a technique that is easy to use and effective in keeping a conversation going. This approach naturally encourages discussion.

4. Check the reception to your approach by checking body language and the responses to your questions. Is there interest? Is it increasing or decreasing? Conversations can be brief or long. They can lead to lasting relationships or just be brief episodes throughout the day. It's OK to change the topic of conversation if the interest is not there. It is also OK to end a conversation gracefully when the interest is waning.

5. Gracefully ending a conversation leaves the listener with the feeling that you enjoyed sharing conversation and that your feeling is sincere. People enjoy the sharing that comes from pleasant conversation and an assertive comment communicates this. It also increases the likelihood that the other person will want to talk with you again.

In-Session Exercises

Practice starting and ending conversations. Have particular people in mind that you might do this with. Examples include an interaction with a "stranger on a bus" who you often see on rides to/from work.

Homework

Practice listening skills and asking open-ended questions at least once a day. Keep a self-monitoring log of how you did. What were your thoughts before and after practicing the skill? What was the other person's response to you? What did you do well? What do you need more practice at?

Be aware of times when other people aren't listening to you. How does that feel? Notice when you don't listen to another. What is distracting you?

Start a conversation with someone you don't know. What did you talk about? How did they respond? What did you think and feel? What worked? What didn't?

3.3.4.3 Skill Set 3 - Giving and Receiving Compliments

Rationale

The satisfaction people get from relationships with others depends, in part, on sharing positive things with them. It is therefore important to be able to tell them positive things. It is equally important to be able to hear them when they make positive comments to us. This is something that most people find at least a little uncomfortable. In addition, it is often something that "drops out" of longer lasting relationships. We stop giving compliments and start to take others for granted. We assume they know how we feel. Compliments and expressions of positive feelings about others is what keeps relationships alive. It is therefore important to be able to give and receive compliments.

Skill Guidelines

1. Whenever possible, state your compliments in terms of your own feelings, rather than as absolute. This tells the other person that the subject of your compliment is something you personally feel good about (e.g., "I really like that outfit" vs. "That's a nice outfit").

2. In giving compliments, be specific. Pick out specific things, attributes or actions for the compliment.

3. Accept compliments that are given to you. Don't negate them, turn them down, or turn them around. A good idea is to take a stance with hands slightly away from your side and palms facing forward while you say, "Thank you".

4. Even if you disagree with the content of the compliment (e.g., you don't like the outfit you just got complimented on), indicate that you appreciate the positive feedback.

In Session Exercises

Practice sincere and insincere compliments. Role-play compliments to particular people.

Homework

Practice giving and receiving compliments with particular people from your network map.

3.3.4.4 Skill Set 4 - Giving Criticism

Rationale

At times we all come into contact with things people do that we find objectionable or disagreeable. It is important to be able to let people know how we feel while also making requests for change, and to do this in a way that does not hurt their feelings or push them away. This is often difficult. Some people don't give criticism because they feel it is not nice and they don't want to hurt anybody. Some don't give criticism because they don't want to start a fight. It's possible to learn to give criticism in a way that allows a relationship to continue without doing damage or being hurtful.

Skill Guidelines

1. Calm down first before speaking.

2. State the criticism in terms of your own feelings, wants, or desires not in terms of absolutes (give examples).

3. Give the criticism in a clear and firm voice. Avoid anger in your tone. If angry, calm down first.

4. Direct your criticism at the behavior that bothers you--the person's behavior, not the person. Listen for feedback to make sure the other person understands the source of your criticism. Try again until you are certain they understand.

5. Request a specific behavior change from the other person. Negotiate counter offers, and be willing to work out a compromise.

6. Start and finish the conversation on a positive note.

In-Session Exercises

Demonstrate examples of destructive/aggressive criticism and constructive/assertive criticism. Ask the participant for examples of undesirable actions on the part of others. Prompt, model, and role play effective giving of criticism. This is most effective when it is done within the context of a problem that the participant is having at that particular time.

Homework

Follow through *in vivo* with the role-played situation. Monitor thoughts, feelings and emotions.

3.3.4.5 Skill Set 5 - Receiving Criticism

Rationale

Making mistakes is a part of the human condition. Thus, criticism of our mistakes will be encountered in our daily routine. One of the most difficult things is being able to receive criticism gracefully. Criticism, when given and received well, provides an opportunity to learn about ourselves and how we affect others. It allows us to grow as individuals. Being able to receive criticism gracefully is also an important way of avoiding arguments and fights, while letting others know we are receptive to and respect their feelings and point of view.

There are two types of criticism that we are exposed to regularly, neither of which requires an emotional or hostile response. They are constructive criticism (described and illustrated in the previous skill set), and destructive or aggressive criticism. This latter criticism is often based on an emotional reaction, and is directed at the person, rather than their behavior or actions. Neither constructive nor aggressive criticism is worth fighting over.

Skill Guidelines

The main goal in receiving criticism is to learn from it and avoid defensiveness. Remember, even destructive criticism may contain useful information.

1. Don't get defensive, get into a debate, or counterattack. Nothing productive will come of this.

2. Sincerely clarify the criticism so that you are clear about its content and purpose.

3. Find something in the criticism that you can agree with and restate it in a more direct fashion (e.g., you're right, I have been leaving you alone on weekends).

4. Propose a workable compromise. Negotiate a mutually acceptable response.

5. Reject unwarranted criticism assertively.

In Session Exercises

Discuss with the participant examples of constructive and destructive criticism they have often faced. Have them practice turning destructive criticism into constructive criticism. Prompt, model and role play. Have them identify particular people from whom they have difficulty receiving criticism.

Homework

Practice receiving criticism effectively. Monitor thoughts, feelings and emotions.

3.3.4.6 Skill Set 6 - Assertiveness Skills and Refusing Requests

Rationale

Assertiveness means recognizing your rights in your interactions with others, rather than acceding to what someone else expects or demands, solely because they want you to. Among the rights you have are the right to:

1. Express your opinion;

2. Express your feeling in a thoughtful way;

3. Request others to make changes in their behaviors that affect you;

4. Accept or reject anything others say or ask of you.

There are four basic interpersonal styles: passive, aggressive, passive-aggressive, and assertive. Passive people tend to give up their rights if there appears to be a conflict between what they want and what others want. They don't communicate their wants, needs, thoughts, or feelings. Sometimes this leads them to feel depressed or isolated from others. People have no way of knowing what the passive person wants, so they cannot possibly respond to their needs. Others can come to resent the passive person for not communicating.

Aggressive people act to protect their own rights, but do this by violating the rights of others. This may help them achieve their goals, wants, and desires, but it generates ill will from others later on.

Passive-aggressive people are indirect, often hinting at what they think, feel, need, or want. They may make sarcastic comments or speak softly and indirectly, without stating what's on their mind. They may also "act out" or give people the "silent treatment" as a way of letting their wishes be known. As often as not, those around them don't get the message of what is needed, wanted, or felt. The result is the resentment and ill will of others, while the passive aggressive person feels frustrated and victimized.

Assertive people decide what they want, plan an appropriate way to involve others, and act on the plan.   This most often includes making clear statements of wants, needs, thoughts, and feelings. In addition, it includes making direct requests of others, without threats, demands or other negative statements. Assertive people may decide that a passive or aggressive mode is appropriate under a given situation. What is unique, however, is that this comes from a thoughtful approach to the situation and is situation specific, rather than a general mode of action. Assertive responses lead to a sense of self satisfaction and high regard from others. Assertiveness is the best way people have of letting others know how they feel and what they want or need. It can lead to a greater sense of control in life.

As noted above, one particular situation that provides an opportunity for assertiveness is when others make requests or demands of us. When people do this, an assertive response is one in which the request is considered thoughtfully and a choice is made to accept or decline the request. Some of the issues to consider have to do with whether honoring the request will interfere with previous plans, with other desires, or with previous commitments. It is also important to consider whether you really WANT to fulfill the request. You have the right to refuse requests without having to feel guilty or selfish. All it takes is the word, "NO". You also have the right to negotiate requests made of you, by making a "counter offer".

People often feel very uncomfortable in saying no. Even with practice, this discomfort can remain. This is natural. It is, however, important to put this word in your vocabulary and use it in an assertive way. This will provide a greater sense of well being and more satisfying and mutually respectful social relationships.

Skill Guidelines

Think before you speak. Be aware of your reactions. What are you reacting to? Don't make assumptions. Ask for clarification. Plan your response. Be direct and specific. Stay focused on the issue at hand. Don't bring in history. Pay attention to body language. Make sure your voice and your body communicate the same message. If you don't believe you've been heard, don't be afraid to restate your request, feelings, or thoughts. Be willing to compromise and negotiate. It's possible for everyone to get what they want and need.

In-Session Exercises

Have the participant generate examples of interactions with others (or desired interactions). Role play these in the various interpersonal styles. Have the participant project likely outcomes of the various approaches. Pay particular attention to requests, and the declining and/or renegotiation of requests.

Homework

Have the participant practice assertiveness, declining requests, and negotiation with specific people on their network map. Use role plays to select the particular people.

3.3.4.7 Skill Set 7 - Problem Solving

Rationale

A great deal of communication between people is devoted to the mutual and satisfying management of problems that arise during social interchange. Problem situations are routinely encountered by individuals who are engaged in a deliberate process of change, such as that associated with participation in ENRICHD. The ability to methodically and thoughtfully address problems that arise can lead to greater success, whether in the domain of social interchange or in the larger domain of network engagement and shaping.

Skill Guidelines

The thoughtful and deliberate act of problem-solving has been broken into four logical steps:

1. Clearly and specifically state what the problem is. This includes phrasing the problem in terms of behaviors that are currently occurring or not occurring, and breaking large or complex problems down into several smaller problems that can be dealt with one at a time. If others are involved in the problem-solving process, it is essential to make certain that all parties agree on the nature of the problem and are willing to discuss and solve it.

2. Brainstorm possible solutions. In doing this it is important to think broadly, while also staying solution-oriented. The goal is not to defend oneself, decide on who is right or wrong, or to establish any "truth" regarding what happened in the past. Rather, the goal is to generate a whole host of possible alternate solutions, each of which will be examined in the next step

3. Review each of the "brainstormed" solutions for the likelihood of success and its desirability. Select one solution that has a high likelihood of success (and, where others are involved, is agreeable to all parties). State the selected solution clearly, and specifically, so that no questions remains as to what is involved. Do not select a solution that you are not inclined to implement. Also, do not select a solution that is likely to provoke emotional upset, feelings of resentment or anger, or feelings of discouragement. In working with others, if you cannot find a solution that pleases all parties, suggest a compromise solution.

4. Select a fair trial period for implementing the solution. Give it a chance to work. Review the solution at the end of the trial period. If it doesn't work after this period of time brainstorm other alternatives, or select one of the other alternatives that were originally brainstormed.

In-Session Exercises
Review with the participant some current problems. Select several straightforward problems for closer examination. Walk the participant through the problem-solving framework described above with 1 or 2 selected problems. Prompt, model, and shape appropriate responses within the problem-solving framework.

Homework
Have participant complete the Problem Solving Homework Form (See Appendix).

3.3.4.8 Skill Set 8: SUPPORTIVE COMMUNICATION

Rationale

Communicating in a supportive way will promote similar kinds of communication from others to you. Moreover, it will reduce the likelihood that bad feelings and resentment build up and affect other areas of your life together. Getting better after a heart attack is more likely to happen when you both have a better way of reacting to and dealing with difficulties in a relationship.

Skill Guidelines

1. Use active listening. Empathic communication is a way to let someone else know that you are interested in what the he/she is saying and feeling and that you understand and are supportive. Good communication also helps you to get a better understanding of what someone else means and is feeling. Paraphrasing and reflecting feeling are ways to be an active listener

    a. Reflecting Feeling. There are many situations in life in which one individual simply wants to talk and be listened to. Reflecting fleeing means that you listen for how a person feels about something and reflect that feeling back to him or her, rather than advice-giving and listening in silence. It feels very good to have another person's undivided attention and get the feedback that your feelings are understood.

    Example: Reflection of Feeling

    Wife: I feel fine. I don't understand why the doctor says I should take it easy. How will anything get done?

    Husband: You feel like your old self and you're worried that we won't need you anymore.

    b. Paraphrasing or Reflecting Content. This is the other type of active listening that simply requires that you summarize what the other has said. This insures that you have understood what the other person is trying to say. It also lets them know that they have been heard and understood. This can also be helpful to the other person, by helping them get a better understanding of what they want and need. Generally, paraphrasing or reflecting content will begin with a statement like, "what you're saying is..... or "you think that......"

2. Don't let things build up. Frequent contact with someone almost insures that some of his/her behaviors will bother you. When a spouse is recovering from a major illness, we sometimes believe that we shouldn't upset his/her by complaining or giving negative feedback. Letting many "little things" that bother you build up or accumulate over time by not saying anything about them often leads to the "BIG BLOW-UP".   What are the usual consequences of such a

blow-up? If you don't start a big blow-up then you may begin to withdraw from the other person for fear of blowing up at him/her. This leaves your spouse wondering what's the matter and feeling sad, mad, and lonely. How might speaking up earlier have prevented these scenes and bad feelings?

3. Use your skills in receiving criticism. Being able to hear your spouse or significant other when he/she is upset about something you've done or not done can stop fights before they happen and lead to acceptable solutions to problems.

4. Express your positive feelings. We sometimes forget when dealing with people who are very close to us that we can have, at different times, different reactions to a loved ones' behavior. Sometimes we have a positive, loving reaction and at other times a negative, angry reaction to the other's actions. However, it is not inconsistent to express both of these reactions to our loved one. It is a problem if we think that it's only necessary to express bad feelings. When criticism occurs without any expression of positive feelings, good feelings get overlooked and the couple may begin to focus only on the bad. Another reason that couples forget to express positive feelings is that they believe that to do so would contradict the criticism they made. For example, a wife may refrain from saying that the dinner her spouse cooked was good because it was ready an hour late.

5. Sex role typecasting. As a result of the way we've been raised, many of us believe that being caring, supportive or nurturing to another person is a woman's role/job. This puts a big burden on women and leaves many men feeling helpless in the face of crisis, illness, or upset. Some men believe that "it's not in me" to be caring and supportive. Other men believe that the only type of support that they can give is financial or material help. Yet even then, the type of material help is limited to "manly" help like taking out the trash or moving things or providing transportation. This type of help is fine if that's what the spouse wants or finds this helpful. It isn't fine if your spouse needs help with house cleaning or dish washing or needs a hug or an expression of caring or listening. Providing support to your loved one isn't about being male or female. Providing support is listening to the other person and giving his/her what she needs in the best way you know how. A person doesn't lose masculinity or femininity by giving support that is desired.

6. Support is support is support. The belief that there's only one or two kinds of support that work in all situations is very prevalent. Often people believe that being supportive means being loving, caring, listening or doing for the other person. This is only half right. There are about three kinds of support and each kind is important and has its time and place in the recovery period of an illness or crisis. Emotional support is loving, caring and respecting another and acknowledging, validating and affirming their thoughts and feelings. Tangible or material aid is a second type of support that can be just as important for some stages of recovery from illness as emotional support. For instance, sometimes it's more important to make a meal, grocery shop, or baby-sit a child for someone than to say that you love him/her and walk away. The third type of support is information support. This is providing a loved

one with new information how to handle a problem or a different type of health care. Some kinds of support can be overdone. Sometimes what people believe is supportive sounds hollow or superficial because we're thinking about ourselves instead of the person needing support. Sometimes we offer a kind of support that is different than the kind of support that is needed.

In-Session Exercises

Role play various scenarios that the participant (and their partner) as examples of conflict situations. Problem solve these, using the skill repertoire that has been learned during the previous skill based sessions. Prompt, model and shape effective and supportive communication that is consistent with close and intimate relationships.

Homework

Read: Gottman, 1976, A Couple's Guide to Communication. pp. 1-5

3.4 APPENDICES

3.4.1 SOCIAL NETWORKS IN ADULT LIFE (SNAL) (Modified)

Part I: Use of the Network Map

EXAMPLE: "As a way of getting to know you and how your MI has affected you, I want to ask you about the people in your life right now." Proceed to inquire about family members, spouse/significant other, children, siblings, friends, neighbors, etc. Then say, "To help me keep this straight, I'm going to use this map that I have found to be very useful. It also helps me understand how everyone is related and how close you feel to them". Take out the Network Map and say, "If we put you in the middle (show blank Map to participant), where would we put in the other people that you've mentioned? This first circle would be for those people that you feel the closest to. Who would those people be?" Work with the participant to fill this out. Then ask, "Do you feel so close to any of these people that it's hard to imagine life without them?" Make note of who these people are. Then say, "Now, in the next circle, let's place the people that you don't feel quite that close to, but who are still important to you. Who would they be?" Again, work with the participant to fill this out. Then say, "Okay, the people who you feel less close to, but who are still important to you would go in the third circle. Who would those people be?" Again, work with the participant to fill this circle out.

REMEMBER - Throughout this process, circles can be empty, full, or anywhere in between. The Network Map can also be started in one session and completed in another, or even given as a take home assignment.

REMEMBER - The placement of people on the Network Map can also be done in a way that represents their relationship/closeness to each other, by where there names are written in within the same circle (e.g., close together, 180^0 apart).

In addition to asking the participant about people who are close to them, you will also need to ask them about conflictual relations. You can do this by saying, "Now that I'm getting a good picture of the people who are close to you, what about the people who you see on a regular basis who you DON'T feel close to; maybe even people who you have unpleasant disagreements with, or who upset you, or make you feel angry or hurt? For instance, an in-law, a boss, co-worker, neighbor, or someone like that. Who would that be in your life?" Put the names of these people somewhere on the outside of the circles, such as the corner of the paper. If they are people whom the participant also feels close to, you might keep their name in the circle, but write it in RED.

As you work on the Network Map with the participant, you will also want to call attention to any inconsistencies you notice. For example, if you know the participant is married but you notice that the spouse is not in any of the circles, you will want to say something like, "I notice your

husband (wife, son, daughter, etc.) isn't in any of the circles. How come?" The purpose of this query is to find out if any of these people represent conflictual relations. You will then want to follow up this occurrence by asking about any other relations that are similar - relations that are sources of conflict.

The identification of conflictual relations leads the counselor and the participant to work on how to: a) increase the level of support in the relationship, such as through communication work (see Module 3, Section 3.3.4), or b) reduce the level of involvement or contact with the conflictual person, such as through assertion and similar skills (see Module 3, Section 3.3.4), and/or through the development of alternative sources of support (see Module 1, Section 3.3.1).

In the subsequent session(s), you would work with the participant to transfer the names of the people on the Network Map to the People In My Life list. Using this form, you would then inquire of the participant their sense of satisfaction with each of these people and the frequency of contact with them. A further exercise is then to inquire about what they want of each of these people. This then serves as a point of treatment - having the participant begin to make the kind of contacts and requests of these people that will lead to increased levels of satisfying social support. Using The People In My Life list as homework will be useful in this exercise. These exercises also serve to reveal conflictual relations and underlying skill deficits, cognitive distortions and unworkable attributions and rules.

In the subsequent sessions during which you are working with the participant to develop a satisfying and supportive social network (Module 1, Section 3.31), you will use the Network Map to place the people whom the participant has regular contact but doesn't really know - THEIR COMMUNITY. These people would be placed in the outermost circle - circle 4. Part of the work associated with Module 1 is then to have the participant engage in actions to bring those people closer in to the middle. For instance, this would include discussion of who that person is and how they could go about: a) finding out if they want them closer, and b) if so, bringing them closer. This then would serve as the basis for any supportive work, such as problem solving, behavioral activation, and challenging of cognitive distortions and unworkable attributions and rules.

NETWORK MAP

Part II: PEOPLE IN MY LIFE

After completion of the circle diagram / Network Map, transfer names to this list and answer associated questions. Use a second list, if necessary.

Most Important (Inner Circles)	Name	Satisfied with Support	How often do you see/hear from this person?
Least Important (Outer Circle)			
More People	First Name	What do you want from this person?	Have you contacted him/her this week?

Using "The People In My Life" List

After transferring names from the Network Map to "The People In My Life" list, work with the participant around the following questions. As with the Network Map, this may be given to the participant as a homework assignment. Also, the answering of these questions can be accomplished as an "evolutionary" task, accomplished over a period of the first few sessions, and thereby serving as a focus for beginning to develop a more satisfying and supportive social network.

Example: "Over the coming week, think about the following questions. As you think about these questions, keep in mind the people that we have listed on your People In My Life list".

1. Have you been getting the help you want and the support you need from each person you named? If not, why not? Have you contacted them this week?

2. If you were going to change your network, how would you want it to change?

   a. Would you want to have more people in it?

   b. Who would these people be?

   c. Have you contacted them this week? If you didn't, what got in the way of contacting them more?

3. Which of the following clubs and organizations do you belong to?

   ___ Church, synagogue or religious connected group

   ___ Labor union

   ___ Fraternal lodge or veterans' organization

   ___ Business, civic or professional group

   ___ Community or neighborhood organization

   ___ Social or card playing group

   ___ Sports team

   ___ Political organization or action oriented group

   ___ Charity, welfare or volunteer organization

   ___ Senior citizens group

4. What could you do this week to get more involved with one or more of these groups?

3.4.2 APPENDIX B.   SOME FUNCTIONS OF A SOCIAL NETWORK

People in a social network can meet a variety of needs and provide different kinds of assistance. This can include:

1. Help when I am sick or tired.

2. Provide encouragement.

3. Listen to me and understand my feelings.

4. Do things with me (such as going out to eat, seeing a movie, going shopping).

5. Comfort me when I am sad.

6. Give me advice when I ask for it.

7. Talk to me about my work or daily activities.

8. Provide physical assistance (such as a ride to an appointment).

9. Introduce me to new people and activities.

10. Participate in an activity we both enjoy.

11. Offer encouragement and let me know I'm doing things well.

12. Let me know that I'm OK just the way I am.

13. Show comfort and caring through affection, touch and physical attention.

14. Provide information.

15. Express interest and concern about my well being.

16. Teach me new things.

17. Help me solve a problem.

18. Provide me with a safe place to talk about my thoughts and feelings.

19. Let me know that I make a difference.

It is helpful for people with an illness to have a lot of support. People who have a satisfying and supportive network are able to deal with stress more effectively. What kind of help are you getting, want or need? How can you get what you want or need?

3.4.3 APPENDIX C.   NETWORK IMPROVEMENT FORM

	Satisfactory	Needs Improvement	High Priority for Change
How much help are you getting with transportation?	_____	_____	_____
How much help are you getting taking care of home?	_____	_____	_____
How much help are you getting in making decisions or problem solving?	_____	_____	_____
Are you socializing enough?	_____	_____	_____
Are you getting enough companionship?	_____	_____	_____
Do you have someone to share personal thoughts and feelings with?	_____	_____	_____
Do you work with others on mutually satisfying tasks? (e.g., community group)?	_____	_____	_____
Do you learn from and/or teach others?	_____	_____	_____
Do you have someone who provides emotional support and encouragement?	_____	_____	_____
Do you reach out to people who have expressed an interest in getting to know you better?	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Having identified one or two priority areas, I will try the following during the next week:

_____

_____

_____

3.4.4 APPENDIX D.   BELIEF BARRIERS TO SOCIAL SUPPORT

If I ask for support.

1. They might think that I cannot solve my own problems.

2. They might think that I want them to take care of me.

3. They might think that I want them to do my job for me.

4. They might make me feel like a helpless child.

5. They might use me for their own purposes.

6. They might try to control me.

7. I might become dependent on their help.

8. I might lose my self respect.

9._____

10._____

11._____

12._____

13._____

14._____

3.4.5 APPENDIX E   ACTIVITY CHART

Instructions for Use

The Activity Chart is simply a clinical tool for the participant and the interventionist to monitor the daily activities of the participant. In addition, the Activity Chart provides for the determination of ratio of socially based activities to more solitary activities. The Activity Chart can also be used to plan weekly activities, thereby serving to facilitate an increase in the level of satisfying and supportive socially based activities.

The inclusion of a rating scale for Satisfaction and Social Support provides an additional useful clinical tool by providing the interventionist and the participant with a "grounded" index of these more emotionally-based factors of social support. It can serve to provide the participant with new insight into conflictual relationships, uncover previously unrecognized satisfaction and support in already existing relationships, and help to check predictions, cognitive distortions and unworkable rules and attributions.

The counselor may first ask the participant to monitor activities, as a means of collecting important information about social interactions. Examples of how to do this should be provided in session, with problem solving serving to overcome any identified obstacles. The inclusion of the Satisfaction/Support component can then be initiated in the following session when the interventionist reviews the homework. This can be done by asking the participant about each of the reported activities and the feelings associated with them. The participant would then be asked to monitor the affective components as well as the Activity Schedule for each subsequent homework assignment.

The counselor is referred to pages 200-211 of "Cognitive Therapy: Basics and Beyond" for a further discussion and examples regarding the use of the Activity Chart.

ACTIVITY CHART

Time	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
6-7 AM							
7-8							
8-9							
9-10							
10-11							
11-12							
12-1 PM							
1-2							
2-3							
3-4							
4-5							
5-6							
6-7							
7-8							
8-9							
9-10							
10-11							
11-12							
12-1 AM							
1-2							
2-3							
3-4							
4-5							
5-6							

Activity Chart

Satisfaction Scale	**Social Support Scale**
0	**0**
1	**1**
2	**2**
3	**3**
4	**4**
5	**5**
6	**6**
7	**7**
8	**8**
9	**9**
10	**10**

3.4.6 Appendix F: Community

Community is defined as a diverse "network" of people who have at least bi-weekly contact. The contact can be face-to-face, by phone, mail, etc. The key element is this frequency of contact. A community is distinct from a group in this way. While groups are defined by a common goal, mission or activity, a community is defined strictly by frequency of contact.

These contacts are, of course, initiated for specific purposes. These specific purposes, however, often hide the potential <u>commonalties of interests</u> and <u>opportunities for support</u> that exist among people in COMMUNITY. While membership in a group requires that "everyone be of the same purpose" (and, implicitly, constrain their own individuality), membership in a COMMUNITY is automatic. In groups, the completion of the purposes to a dissolution of the group. In addition, a shifting or waning of interest results in a "falling away" from the group. This is often the root cause of the LPSS that results in ENRICHD participation! With the automatic membership of COMMUNITY, each member is and remains a part by being exactly who they are, with their shifting interests, ideas and points of view. This kind of network brings with it a degree of <u>diversity</u> - diversity of interest, points of view, and action. Indeed, COMMUNITY needs that kind of diversity to thrive. What everyone is being who they are and expressing their true interests, then <u>natural connections and affinities can form</u>. COMMUNITY is, therefore, very stable (as distinct from groups), because in COMMUNITY, people are always related. COMMUNITY, in its stability, also provides for a dynamic relatedness among its members. In COMMUNITY, as one's interests and outlets for self-expression shift and evolve, there are always people "available" who one can "find", with whom one can share those interests, and with whom it is possible to establish a natural affinity based on shared interests and outlets for self-expression. Hence COMMUNITY provides for the changes that occur throughout the life-span. In COMMUNITY there is always someone with whom to share, and from whom to gather support. They are out there and need only be found through simple human interchange.

COMMUNITY, therefore encompasses the natural, diverse, and dynamic ties that exist, and interactions that can occur, among people. It provides a view of human existence that offers the possibility that we are ALL, ALREADY RELATED, and that the nature of this relatedness can encompass an extraordinary diversity of interchange and "personality". In this view, there is nothing to build, overcome, develop, break-down, form, or construct in order to be related. You are already related. Hence, there is no natural obstacle in social interchange, only the obstacles that are artificially put in place. In the view, RELATEDNESS, one is free to be related. The only questions revolve around the nature by which this natural tie, this relatedness is expressed.

4. GROUP INTERVENTION

4.1 RATIONALE

The ENRICHD psychosocial treatment begins with individual counseling and evolves into group counseling. There are several reasons for including group counseling. Group psychosocial interventions have been associated with post-MI risk reduction. Also, the group intervention makes it possible to intervene on the dynamic process that results in the conditions that made patients eligible for this trial. Social cognitive theory (Bandura, 1992) assumes that any risk factor (in this case, depression and low perceived social support) has cognitive, behavioral, affective, social, and physiological manifestations that reciprocally influence one another to sustain risk. The use of group counseling makes it possible to observe this process unfold during the course of group discussions and to target some or all parts of it. The group context provides a powerful laboratory for learning in which a variety of opportunities for new insights can take place (Thoresen & Bracke, 1996). Among these learning opportunities are the following:

4.1.1   *In Vivo* Observation of Skill Deficits.

The social interactions that characterize group process provide the leader with a window into members' social skills and, by virtue of their behavior, and their reported feelings and cognitions. During the course of social interactions, the leader is provided with a more objective view of the interactional style of the member, a view not filtered through the member's particular view of reality. Observation of maladaptive interactions among members makes it possible to reflect on the process, provide feedback, and restructure and/or replace maladaptive behaviors, affect, and/or cognitions.

4.1.2   A Context in Which to Practice New Skills.

New behavioral competencies are acquired when four criteria are satisfied: (1) knowledge--the individual knows what the skills are; (2) performance--the individual provides evidence that he/she can perform the skills; (3) generalization--the individual can apply the skills to a similar or new situation; and (4) maintenance--the individual retains the skills after the treatment is discontinued (Bandura, 1992). Whereas the individual treatment focuses on development of knowledge and an ability to perform the skill with the leader, the group treatment provides the opportunity to practice and generalize learning to other persons. The introduction of specific content areas stimulates discussions that require application of new skills. The extent to which new skills are applied to new problems helps the leader to determine the extent to which learning has occurred.

4.1.3   The Experience of Interpersonal Trust.

Mistrust and negative expectations of oneself and of others are characteristic of individuals who are depressed or have low perceived social support. The individual phase of treatment fosters the development of an intimate relationship (therapeutic alliance) between the member and the counselor. The group phase of treatment makes it possible to expand these feelings of trust beyond the leader to include others who are similar to the member in many ways (i.e., to peers). A well running group is characterized by an atmosphere of safety, acceptance, mutual trust, support, and positive as well as constructive feedback. These interpersonal experiences can make it possible for individuals to reconsider their negative expectations of others and explore the benefits of being more trustful, accepting, and committed to change.

4.1.4   The Opportunity to Experience the Benefits of Helping Others.

One of the most powerful opportunities offered by the group context is not the learning that occurs from leader to members, but the learning that occurs between members. An ability to see oneself in the experience of others fosters vicarious learning. More importantly, by offering help and support to others, members build self-confidence, self-esteem and self-worth. These positive feelings are personally reinforcing and motivate continued interest in learning how to maintain these feelings and actions as well as the beliefs consistent with them.

Recurrent myocardial events in patients who are depressed or have low social support occur early in the post-MI period. Thus, an early and powerful intervention is critical to success. Logistical concerns preclude the initiation of group counseling immediately after randomization. Thus, group counseling will commence as soon as possible after preliminary skill development has taken place in individual counseling and sufficient numbers of members have accumulated to form a group.

4.1.5   Overview

The group intervention consists of 12 two-hour sessions. It is recommended that the content outlined in the Session 1 dealing with how a group functions should be dealt with in the individual session preceding the first group session. Then the group Session 1 will deal primarily with the content on thoughts, emotions, and CHD.

To maximize the opportunity for all ENRICHD participants to have a group experience, a modified open group format is used. Once a solid base of 3 reliable participants has been identified who commit to attending on a regular basis, other members may rotate in and out, depending upon their willingness and availability. These rotating participants can, but do not have to, make a commitment to attending future sessions. With this format, the group leader will present the "topic of the day", per protocol, but also makes an effort to devote time to an important issue brought up by one or more of the participants at the beginning of the session (e.g., a specific problem they are having, troubling symptoms, etc.). To tailor sessions in a way that makes them relevant and appealing to both the committed, and the drop-in, participants

requires skill on the part of the counselor in timing, presentation, ways to involve all participants, etc.

Content will be presented using structured exercises which stimulate interest and discussion. These content areas include the connection between behavior and CHD, self-confidence, relapse prevention, cognitions, the importance of social ties, communication skills, emotions, and life plans and goals. Within any one of the 12 sessions, a similar format will be followed (see Section 1.6; Section 4.4). The leader needs to consider the diverse backgrounds and prior experience of the members when presenting the material outlined in the manual.

4.2 CRITICAL PRINCIPLES OF GROUP COUNSELING FOR THE GROUP LEADER

It is important for the leader to appreciate three principles that are essential to the success of the group intervention.

1. A central and critical task for the leader is to establish a cohesive group characterized by interpersonal trust and respect. Members who are depressed or have low social support have difficulties engaging in interpersonal interactions since mistrust and negative expectations are predominant. In individual counseling, members have the opportunity to develop an intimate and trusting relationship with the counselor. This relationship can be used as leverage to instill the value of the group to each of the members. However, candid group discussions will be difficult until group cohesiveness develops. The use of group exercises with an emphasis on skill-building provides a non-threatening bridge that can keep motivation, interest, and involvement high while trust and cohesion develops. With the development of trust and a more cohesive group, core cognitive structures and related emotions can be identified and systematically changed. It is key that members do most of the talking. The leader serves as a facilitator who keeps members on track with respect to the goals of each session.

2. It is the leader's responsibility to make a clear connection between principles learned in individual counseling and those learned in group counseling. The basic principles taught in the group parallel those learned in individual counseling and include understanding cognitions, social skills training, problem-solving, coping with affect, and relapse prevention. The presentation and examples may vary from the individual to the group setting and could create confusion for members. Thus, the leader must continually demonstrate the connection between learning in the group and that accomplished individually. The leader also serves as a model who shares his/her own experiences as they are relevant to the skill training to be accomplished within each session.

3. The leader must always remain flexible to the occurrence of critical learning opportunities in group counseling. The most powerful learning in group counseling comes at unexpected moments. Members will increasingly bring to the group experiences they have had and their struggles to deal with them. The personal nature of these experiences can be associated with

powerful insights if given time and attention at the moment they arise. Thus, they should be capitalized upon when they occur, despite the sequential presentation of topics in the Manual of Operations. To do so, the leader must have a thorough understanding of all therapeutic goals and content before beginning the first session and be able to quickly "switch gears" in the event that an unexpected learning opportunity emerges. The leader also must be well-versed in cardiovascular pathophysiology and prepared to deal with issues related to heart disease that will arise during the group.

4.3 PROCESS RELATED ISSUES

The ENRICHD Group Intervention seeks to help post-myocardial infarction (MI) patients decrease their risk of CHD mortality and morbidity by learning skills to alter what they think and believe and how they behave in everyday life situations. The focus is on reducing depression and increasing social support, especially perceived emotional support. The group phase of the intervention offers a context in which members can further learn about and practice a variety of skills in a mutually supportive and caring setting.

All groups can be said to involve a variety of "process" and "task" factors. How members feel about each other and how well they can observe and recall their automatic thoughts are examples of process and task, respectively. Developing and maintaining an optimal balance between group process and group task is the artistry of group work. We only have 12 group sessions, and some members may only participate in only one or two due to the modified open enrollment format. To cover the tasks (the curriculum or substance of the program), group leaders need to stay "on task" much of the time. Thus, the flavor of the group intervention is much more that of psycho-education than of a long-term group psychotherapy sessions. However, in any group, process-related issues are involved and emerge. If consistently ignored, these process issues can diminish or destroy the effectiveness of the group. We need, therefore, to be mindful and indeed flexible in how we conduct group sessions.

One of the best ways to address process-related issues is to be concerned about what "meaning" the MI experience has for each member. This perceived meaning can powerfully influence what the person thinks and how the person will respond to the group treatment. Having a sense of this "personal construction" or interpretation of the MI can help you relate to each member and, importantly, can shed light on how each member explains the disease to himself/herself. Furthermore, the choices and decisions members will make will be influenced by their view of why they had the MI.

A common perception of the MI is that of a wake-up call, i.e., a powerful message that the person needs to make some big changes in how he/she lives. The person may have a sense of relief that things can now change for the better. Another meaning is one of guilt and punishment. "I've done wrong, this is my or God's punishment . . . .   I'm not a good person. . . ." These somewhat extreme examples illustrate the range of perceived interpretation of the MI

and clearly can influence thoughts, feelings and social actions. As with most basic beliefs, the person may not be readily aware or conscious of the meaning given to the MI experience.

Gender may influence the meaning members attribute to their MI. Post-MI women often report thinking of their MI as evidence that they have done something wrong. They blame themselves, sometimes seeing their MI as a punishment for not being a good enough person. Commonly they feel depressed, sad and at times guilty. By contrast, post-MI men feel and may express anger and resentment about the MI. "Why me?!" "I've worked so hard and this is my reward?" Clearly, however, the above does not fit all men and women. Still, it helps to be mindful of how each member construes the meaning and the message of their MI. It will be important to help members evaluate these beliefs.

Given that any single group may be composed of men and women from different racial, ethnic, religious and socioeconomic backgrounds, we need to remember that "One size does not fit all!" For example, often female members act passively and typically defer more to male group members when the group leader is a man (e.g., males tend to dominate discussion). This is less the case with woman leaders. Some male members also "compete" more with a male leader around issues of control and competence and may feel less "threatened" by a female leader.

We cannot assume that everyone will respond comparably to what we do as group leaders. Instead we need to use a variety of modes to convey our message. We need to be flexible and adaptive in helping members learn how to do things differently. Some can listen, readily understand, and learn. Others need to see it and write it down, while still others need to hear it, see it, speak it and do it. Always try, therefore, to use more than one modality. Using a handout, an overhead (see Appendix C, Section 4.6.3.), a chalkboard, or flip chart, and having all members become active in discussing an issue greatly improves the chances of successful learning.

Another way to create an effective group process is to use metaphors and similes. Using sports metaphors, such as "everyone on this team needs to go both ways, offensively carrying the ball and breaking through some tough offensive lines" or a cooking simile, such as "practicing relaxation is like washing every leaf of lettuce carefully in making a salad," can effectively convey information and foster understanding. By asking members about their favorite activities and listening to the examples they use, you can gain insight into possible metaphors/similes to use.

Here are some common process-related issues to be aware of in your group work with post-MIs.

4.3.1   Engaging Group Members

Some members may be too "engaging" (too talkative, dominate discussions) while others "speak only when asked." Learn names of each member as soon as possible. It helps to speak to members using their name ("Fred, what's your biggest concern about getting better?"). Use

large size name tags so that you and the members can learn each others' names.   Each session, make a point of involving every member (or addressing each in some way) so that you demonstrate clearly their need to be active participants. No one should leave a group session without verbally participating in some way. Ask one or two members to "sum up" the main points discussed so far--during the session, not just at the end of two hours. Highlight active participation--that includes active LISTENING--during the first session when discussing members' responsibilities and leaders' responsibilities.

4.3.2   Identifying and Recognizing Member Issues

Some members are easy to "read" in terms of something bothering or of concern to them. Their "non-verbals" speak loudly and you can comment, "Louise, you seem bothered by something" or "What's up Jack?" Others seem to cover-up well. Themes of common concern--going back to work, sexual activity, sense of loss and/or life change, fear of dying, anger and resentment about suffering a heart attack--will be brought up by you or someone in the group. Other issues may not be as common or obvious. For example, if your group has 4 men and 2 women you'll need to anticipate that the two women may feel very uncomfortable speaking openly about their own personal concerns ("How am I going to keep up with the housework and return to my outside job?"). Or the group may be a mix of members with different ethnic/racial backgrounds. Generally, your alertness and sensitivity to possible issues makes the difference. Remember, if you have a "gut feeling" that something is "up," share that with the group (e.g., "Help me out with this; I sense that some of you are not really up to the task or . . ."). Avoid trying to mind-read. Instead, err, if needed, in the direction of being open and honest.

Sometimes you may sense an issue (e.g., they seem resistant to working on communication skills) but decide to hold off on commenting on it until later in that session or in the next session. That is part of the artistry of group work. Timing is everything. For example, a member may express a major concern about his distrust of others, especially in delegating authority to someone else. However, you may be scheduled to discuss the topic of communicating more effectively. You may acknowledge briefly that concern, but wait until you begin the listening dyads. At that point, you could mention how negative emotional states, such as anger, can powerfully interfere with our ability to listen carefully with full attention to someone else. You could also note that not being listened to by someone you care about--a very common experience--can be the source of an angry reaction. Weaving a prior issue back into the discussion effectively connects a process issue with the task at hand.

4.3.3   Members Modeling/Assisting Others

One of the greatest strengths/benefits of small group work lies in the power of vicarious learning. Much is learned by members observing what other members are doing, saying, feeling, and/or thinking, as well as by observing the leader. Be alert to any example or illustration of a member making progress in one of the goals and point it out. It is seldom obvious to group members in

the early sessions that a member is modeling a skill or conceptualizing a problem in an effective way. Let the group know that Jackie, for example, has just demonstrated an assertive, not an aggressive, reaction, to a demand she felt was out of line. Let the group know that Frank mentioned his automatic thoughts about problems he is having with his oldest son. This is referred to as "catch 'em doing good."

4.3.4 Knowing How Best to Use Time in the Sessions

Undoubtedly you'll be faced with decisions about deviating from the planned agenda for a session. While this manual specifies in some detail the flow for each session, you may decide that a member(s) is(are) having problems not on the agenda that need(s) to be dealt with during this session. Generally, you should stay on task, but you have the final say in what's most important.

Sometimes our "best laid plans" do not seem to fit the particular situation. For example, Session 5 is planned to cover communication. As you start to present information on how to be a more effective listener, a group member may express considerable anger about a particular situation (e.g., how he was treated by his cardiologist, or his son's indifference to this recent life threatening situation). Even though anger is officially scheduled for Session 7, you can briefly deal with his anger as a type of communication and relate how anger often closes down active listening. Alternatively, you could quickly switch from the Session 5 communication agenda to the Session 7 anger agenda. In the long run, the answer about what's the best use of group session time depends upon how well the group members are progressing.

4.3.5 Closing Down Discussions On A Particular Topic (Often One Not On The Session Agenda).

It is inevitable that your success as a group leader will be associated with your ability to foster active participation by members. Sometimes, a member or 2 will go beyond what is needed in discussing a particular problem or issue (e.g., they will reiterate points already discussed, drift off into another topic, etc.). One way of managing this kind of situation is to step in, saying, for example, "We need to move on to. . . ." or "Can anyone briefly sum up what's been said, and then we'll move on to. . . ." If the issue is too complicated or is premature (e.g., it'll be covered in 3 weeks), you can say, "Let's keep this important issue in mind and come back to it at a later session." or "That's an interesting issue but it may be more than we can resolve for now. . . ."

Remember, one of your major tasks is to keep the group focused on the session agenda, especially since time is limited. You can decide to deal with an unplanned issue, but that decision needs to be clinically defensible.

4.3.6 Dealing with "Noisy" (Over Active) and "Silent" Group Members

Dealing with "noisy" and "silent" group members is common, if not inevitable. Ongoing clarification of the responsibilities and "rules" of the group helps prevent members who talk too much or not at all. Some feel anxious or threatened in a group if they actively participate, and others feel the same way if they are not participating. Several ways exist to deal with the extremes of participation. The leader can comment to the group about members' level of participation; often it is about not speaking up, inattentiveness and/or seeming preoccupation. Typically you may deal with an overactive member by a comment, such as, "Jack, you've heard what Bill has been saying. How do you see it?" or "Is there anything else that needs to be said?" Sometimes a comment to a particular member at the end of the session as group members are leaving is appropriate. "Bill, I'm hoping you'll get more involved. I know you have a lot to share. . . ." or "I sense Thelma that you're pretty nervous." She may acknowledge that she is. On occasion, a separate phone call or contact in individual counseling may be in order if you believe that a moral, personal, or confidential contact is in order.

4.3.7 Recognizing Relapse

One of your tasks is to keep track of how each member is functioning relative to depression and/or low perceived social support. A simple, "How are you doing?" to a member before or after the group session, for example, or during the group, may yield an answer indicative of some relapse. Sometimes another group member may comment to you, "You know, Jack's looking pretty glum these days." or "Wonder what's up with Linda? Seems out of it." After a few sessions the leader can often spot signs of depression/feeling isolated in terms of voice and non-verbal manifestations. It's wise to remind group members that you have a shared responsibility of "staying in touch" with each member. Backsliding and lapses are common and can be nipped in the bud if noted early on.

If a relapse occurs, the leader should work with the participant in individual counseling, and/or consult with the site supervisor about contacting the attending psychiatrist.

4.3.8 Use of Humor

Humor goes a long way in helping members lighten up and let go. When leaders use "laughable examples" of their own personal inconsistencies and contradictions, members can begin to see themselves as, at times, fallible and flawed--the true nature of all humans. Cartoons, humorous newspaper columns, and other sources are effective when shared with the group. (Bring a copy for everyone).

4.3.9 Participation By Telephone Conferencing

Since our participants are post-MI patients who may, in many cases, also experience significant comorbidity, it is likely that sickness will preclude travel to particular group meeting. Moreover, some participants may be unable to attend sessions because of work-related travel or vacations.

In cases such as these, <u>any</u> kind of participation is better than none at all. Thus, you are encouraged to offer them the opportunity to participate in the group by speaker phone. One or two non-attenders can easily participate via speaker phone. More than two non-attenders can be set up on a conference call which can then be conferenced into the group session via speaker phone. This strategy puts additional burden on the counselor to continually involve the non-attender(s) in the process of the discussion and to verbalize any written teaching aids that are being used.

4.3.10   Other General Issues

Other issues (often social-emotional concerns) that are commonly experienced in post MI groups are noted below and require the leader's consideration. Many are common to all types of groups seeking to help persons change their lifestyle. These issues should be dealt with directly.

Confusion about what the member is supposed to do. "What's my role?" "What's the leader's role?"

> Fear about being in a group (person has never been in a psychosocial type of group), especially about confidentiality, self-disclosure, trusting others.

> Difficulty expressing feelings, especially negative or "bad" feelings about others, and about oneself.

> Problems in listening to other group members, often not understanding what value or benefit they might gain from others, sometimes resenting that another group member "talks too much."

> Problems with the energy level or mood of the group. This often presents in non-verbal behavior (looking bored, disengaged, tired/dozing off, etc.).

4.3.11   Closing the Session

Closing each group session with an affirmation has proved very helpful with many post-MI groups. It is a way of saying we care for each other and hope we can support and nurture each other in the recovery process.

4.4 TEMPLATE: STANDARD SESSION COMPONENTS AND SEQUENCE

Sessions 2-12 will include the standard components listed below. Session 1 will follow the same general format, though there will be no review of homework or cognitive script review. In addition, all sessions that include new members will include introductions and will introduce the group as a "journey to coping well". Although not scripted into the manual, it is recommended that the leader weave this metaphor throughout the remaining sessions. Likewise, it is

recommended that the leader state that part of the journey to coping well involves identifying what is meaningful and important in their lives.

Members will also complete the Beck Depression Inventory and the Modified Perceived Social Support (MDuke), prior to the beginning of the session. A good time is while they are waiting for the group to begin.

The standard components of each group session are (see also Section 1.6):

1. Setting an agenda

2. Relaxation/cognitive focusing practice

3. Review of homework (e.g., monitoring of selected exercises, Log, activity scheduling)

4. Cognitive script review/pleasurable activities/sharing with group members

5. Planned topic

6. Summing up (initially by leaders and then by members)

7. Homework assignments

8. Behavioral contract

9. Preview of next session

10. Member feedback (verbal and written)

4.4.1   Setting An Agenda

At the outset of each session, the leader will set the planned agenda by providing members with a session overview of what is to occur. In addition to the planned didactic topic of Session 1, the emphasis of the agenda will be on socializing members to the group program. (Members who join the group after Session 1 will be socialized by the original group members and/or by the leader, as needed.

Members input to setting the agenda will be largely in terms of the cognitive script review/sharing period. Additional input will be in the context of progress with respect to skill acquisition.

In addition to setting the agenda for the current session, the leader will briefly sum up what occurred in the previous session (i.e., session bridging).

4.4.2   Relaxation/Cognitive Focusing Practice Period

Learning and practicing relaxation or cognitive focusing skills is to occur at the onset of each session after the agenda has been set. The practice period will be limited to 15 minutes. Besides the expected effects on decreasing sympathetic tone, the practice period will relax the members, place them at ease, and focus their attention. Consequently, it is expected that this practice period will increase receptivity to the information to be presented.

4.4.3   Review Of Homework

Homework is an essential component of this intervention. As such, it is essential that it be reviewed each session to underscore its importance to the group members. Review of the homework will also provide an opportunity to assess members' progress. Members are to be verbally reinforced for completing homework. Difficulties with homework completion are not to be judged as failure but as an occasion for learning. Success and problems with completing homework provide important opportunities to use problem solving and reinforce relapse prevention principles.

4.4.4   Cognitive Script Review/Pleasurable Activities/Sharing With Group Members

A review will be done during each session to evaluate participants' maintenance, continued progress, or difficulties with respect to ability to use cognitive skills and social functioning. The activity enables members: (1) to understand the connection between automatic thoughts and feelings and behavior; and (2) to identify key automatic thoughts. During Sessions 2-12, 2 participants will be asked for their cognitive review. This provides an opportunity for modeling, sharing, and group problem solving. This is consistent with the emphasis on participants learning from other members. For the "low perceived social support" participants, this skill may be rudimentary relative to the "depressed" members. In situations where there are differences in competencies, the leader should enlist the support of the more skilled participant to help the less skilled participant review his/her script. This will foster a helping relationship among participants.

The following questions need to be addressed during the cognitive review (Beck, 1995). We recommend that questions a-d be asked in the early session 1-5; questions a-g can be completed in the later sessions 6-12.

       a.   What has gone well for you?

       b.   What problems arose?

       c.   How did you handle the problems?

       d.   Was there a better way of handling the problems?

  e. What problems could arise between this session and the next time we do your cognitive review? Imagine the problem in detail.

  f. What automatic thoughts might you have?

  g. How will you deal with those thoughts? How will you problem solve?

4.4.5 Planned Topic

A planned topic will be presented during each session. The main topics covered in Sessions 1-6 are presented as review of material that is likely to be learned during individual sessions. During Sessions 1-6 the tone will be set for member participation by encouraging participants to review past topics with new participants. Across all sessions, the planned topic consists of didactic information presented with skill guidelines and in-session exercises.

4.4.5.1 Skill practice with corrective feedback

The in-session exercises function to reinforce the didactic information, provide in session practice, and facilitate discussion among the members. An optional confidence rating scale (i.e., group meeting rating scale) will be completed following skill practice.

4.4.5.2 Vignettes

One or two vignettes were developed for most sessions by the Miami Center. They can be found in Appendix B (Section 4.6.2). They were designed to illustrate particular points relevant to the planned session topic. For example, the vignettes for session 1 illustrate the situations depicted in the cognitive model diagrams. Group members often tend to be less inhibited about identifying the "weaknesses" and "strengths" of the hypothetical characters than themselves. Consequently, the vignettes serve to facilitate discussion among the group members. Members often report that they see similarities between themselves and the points illustrated in the vignettes. As such, the vignettes serve to "prime" the members to evaluate their own situations, thoughts, and coping styles. The vignettes are particularly useful with low literacy, minority, and non-psychologically minded members. The use of vignettes is optional and they can be modified to suit the particular group.

4.4.5.3 Handouts/Overheads

A series of handouts and overheads have been developed by the Miami Center. They are located in Appendix C (Section 4.6.3). In general, members benefit from receiving information in multiple modalities. An example of a certificate of group completion, which can be presented to members at session 12, is also included. The handouts and overheads are useful tools, especially for low literacy individuals. The use of these materials is optional. Materials can be supplemented and modified as needed.

4.4.5.4 Summing Up

As each major component of the session is completed, a summary is to be provided to review and underscore important points. An end of session summary will also to be presented. Initially the leader will provide the summaries. However, over time, this activity becomes the responsibility of members.

4.4.5.5 Homework Assignments

Homework will be assigned to all participants. Participants have input into homework assignments by determining their frequency (e.g., number of times relaxation is practiced/week) and tailoring assignments to their particular skill level and needs. Within each session, the homework assignments have been specified. The specified assignments are to be used as guidelines and can be modified. For example, centers have reported that completing an Activity Chart each week is burdensome for many members. In that case, the assignment might be substituted or altered, e.g., do a pleasurable activity.

The homework assignments and recording forms are located in Appendix D (Section 4.6.4). They provide an easy format for members to keep track of and to record homework assignments. The forms may be modified. Their use is optional.

4.4.5.6 Behavioral Contract

It is optional to develop a personal behavioral contract for each homework assignment, for attending the next session, for reviewing materials and completing cognitive reviews. Contracts will be determined by the member. The procedure involves pairing off with another member. The dyad members will give each other feedback about their contracts. Members will be instructed to develop a contract that is highly likely to be followed.

4.4.5.7 Preview of Next Session

The leader provides a 1-2 minute preview of the next session's planned topic.

4.4.5.8 Member Feedback

Verbal and written feedback is solicited from the members. Verbal feedback will be sought from members seeking impressions about the material presented. It provides an opportunity for members to express opinions and gives the leader an opportunity to clarify any misunderstandings.

Written feedback may be obtained in the form of client feedback evaluations forms (optional). Members will be asked to respond to questions about the leader, the topic and homework.

Since developing confidence and mastery will be emphasized throughout the group program, simple confidence assessments tailored to each session can be completed at this point (optional).

Assessments are not concerned with the skills one has but with judgments of what one can do with whatever skills one possesses.

For each session, the time allocations listed below are suggested:

a. 35 min. - setting agenda, review of script/sharing, review of homework

b. 15 min. - relaxation

c. 55 min. - planned topic, skill guidelines, exercise

d. 15 min. - summing up, homework assignments, behavioral contract, preview of next session, member feedback

Following the session, the CBT Performance Criteria Rating Form should be completed by the leader for each group member.

Appendix E (Section 4.6.5) includes the session outlines developed by the Miami center. These outlines present only one example of how the session material can be sequenced. Use of the outline is optional. The outlines help the group leader to conduct each session in an effective and nonpressured manner.

4.5 SESSIONS

4.5.1 Session 1: Introduction to Group Program and Role of Behavior, Emotions And Thoughts To Coronary Heart Disease (CHD)

Rationale

Participants have begun work in the individual program that they will continue in group program. The group provides members with the opportunity to offer help and support to each other while pursuing ways to deal with common problems. It also offers the opportunity to learn vicariously through observations of other members coping with problems. The group is psycho-educational.

The group will be open, as long as there are three (3) reliable participants who can be counted on to come regularly. New members may join at anytime. The first sessions will focus on a review of skills learned in the individual phase of the program.

The goal of Session 1 is to provide a rationale for, and an overview of, the group program as well as to continue the work started in individual counseling. The group members will be oriented to how groups function and will be given guidelines regarding expectations for group members and the leader. In addition, Session 1 will provide a sample of the format which will be used in the rest of the program. Besides providing didactic information, the leader will promote an environment which is conducive to open discussion. As in individual counseling, the leader will continue to function as a collaborator and group members will be encouraged to assume an active role. This is key given the brief, time-limited format of the group. Skills learned in individual counseling will continued to be reinforced by the leader. The leader will also teach specific skills. For example, the leader will teach relaxation skills which will help members to relax and to focus their thoughts and attention on the task at hand. Also, social interaction skills that were learned during individual counseling can be practiced and further developed during the group counseling. With each skill practiced, confidence in one's ability to practice and become proficient in the skill will be developed so that the skill will be maintained following the group program. Exercises will be conducted to provide members with an opportunity to develop and test their skills in the group. Homework will also be assigned.

4.5.1.1 Role of Behavior, Emotions And Thoughts To CHD

A major aim of the group program is to help members cope with, and recover from, their heart attacks, a shared major life stressor. Since thoughts about events can influence feelings, behavior, and physiological functioning, it will be important for members to understand these relationships.

4.5.1.2 Introductory Information

Note: The detailed information below is provided as a resource for the leader. The information is to be presented simply, in the leader's own words and with consideration of the education level and background of the members. This also applies to all subsequent sessions.

Welcome

1. Given the sequencing of the protocol, most of the group members are likely to have been individual participants of the group leader. As such, the leader begins by welcoming the members to the group and indicating that they all have something in common, i.e., a recent heart attack.

2. Members will be asked to introduce themselves and indicate when they had their heart attack. Also, members will be asked to briefly share their experiences recovering from their heart attack. The learning objective of the sharing is to help members discover that they are not alone and that others have feelings and experiences that are similar to their own.

   a. The leader should note (recorded mentally or written) how individuals relate their experiences. Do they blame others? Do they feel helpless or hopeless? Do they have a difficult time talking in front of a group? Do they avoid describing feelings? This information (as well as other observational information) can be used to help develop individual treatment goals.

4.5.1.3 Goals Of The Group Program

The goals of the program will be presented by the leader. This is a key component of the rationale for treatment. It provides a framework for underscoring the importance/value of the intervention to members' health. The following goals are to be articulated by the leader. It is preferred that this material is to be presented in an individual orientation session rather than during this initial group meeting.

1. The group program is designed to help members maintain their improved sense of well-being as well as continue to make improvements in well-being.

2. The group program is intended to help members recover from a heart attack.

3. Learn and use a menu of coping skills (e.g., communication skills, assertion, problem solving, relaxation, and engaging in pleasant activities) effectively to cope more adequately with feelings, physical condition, and recovery from the heart attack.

4. Groups are powerful modalities. Active participation has been associated with long-term survival for CHD and other major medical conditions. The program is designed to utilize the power of the group to help members improve quality of life.

5. Develop trust and mutual respect for each other and foster a sense of group cohesiveness.

The following goal statement should be made in the leader's own words during the individual orientation to group meeting.

As you know, the ENRICHD trial is made up of individuals who have had a recent heart attack. The aim of ENRICHD is to improve physical health and recovery by helping individuals learn to think about and deal with their medical status in a different way. This is accomplished by making efforts to improve quality of life and sense of well-being. Since a heart attack is by definition a major stressor in anyone's life, it can lead to a wide range of unpleasant feelings -- fear, sadness, anger are a few that come to mind. Such feelings can lead to distress on a number of fronts.

First, negative feelings cause changes in bodily functions -- increased blood pressure, heart rate, and levels of stress hormones such as adrenalin and cortisol -- that can slow recovery from the heart attack or even, in some cases, increase the risk of a second heart attack. Therefore, learning how to identify, evaluate and manage these feelings can be an important step in the process of recovery from a heart attack. By learning to handle feelings better, you will not only feel better, you may also be able to reduce your risk of having more health problems later on.

Second, these negative feelings, the distress they cause and our worry about our heart condition can produce may also cause us to withdraw from contacts with friends and relatives. The support we get from those close to us -- both emotional support in dealing with the stress we are under and tangible support in coping with material needs (e.g., a ride to doctor appointments) -- can be an important aid in recovering from a heart attack. It is also important, therefore, to learn skills that will help us to build and maintain strong positive relationships with friends and relatives.

During your individual counseling, all of you have learned many important skills. You learned about the relationship between beliefs, thoughts, perceptions, and emotions. You learned how to identify problems, break them into manageable components, and to solve them. You also learned how to set realistic goals.

Recall, that during your individual counseling, you also did "homework", kept logs, and learned to evaluate your own progress.

In many respects, the things that you learned in your individual counseling have prepared you for the group counseling. The group counseling is designed to give you the opportunity to practice, learn how to use skills in your own world, and maintain these skills to improve quality of life and sense of well-being. Since your individual sessions were personally designed for each of you, the group program will start out by reviewing some important information so that all members can start at the same place. Then, new and more advanced material will be presented to help you learn and use a menu of coping skills and to cope more effectively with feelings, physical condition, and recovery. By having a menu of skills available, you can make choices, exercise options, and feel free to mix and match relevant skills.

Improvements are likely to be maximized when the material is learned in a supportive and caring environment like a group. Groups have been used extensively with medical patients and are considered by most to be the "modality" of choice. Groups are powerful.   The group provides a "laboratory" to rehearse skills and to obtain feedback from other group members who are dealing with similar problems following a heart attack. The other group members will be able to make suggestions that help you with certain problems and you will be able to make suggestions that help them. The group then will be able to provide you with more points of view than could be available individually. Active participation in groups has been associated with long-term survival and fewer medical setbacks for CHD patients and patients with other major medical conditions. The group program is designed to utilize the power of the group to help members improve life quality. This is accomplished, in part, through the relationships that develop among the group members. Developing trust and mutual respect for each other and a sense of group cohesiveness are likely to promote better health outcomes.

While groups are powerful ways to help people change, each person is unique and is special in many ways. We expect some of you to show more progress than others in the beginning. That's okay. It also is helpful as some can learn from the experiences of others. No one is perfect, including me. We are looking for progress, not perfection. For example, if we look at baseball players, a baseball player is considered a success if he hits the ball one out of every three times at bat. He doesn't have to hit it every time to make progress. Together, we all can help each other make as much progress as possible."

The following goal statement should be made in the leader's own words during the first group session. It is recommended that the leader incorporate the "Journey to Coping Well" metaphor throughout the remaining sessions.

"Learning to cope well with recovery from MI is like a journey. (Draw on board) The destination you are all trying to reach is where you can be coping well. The road to that destination is one you will need to negotiate (draw a winding road). The road is long, takes a number of unexpected twists, and turns. There will occasionally be hazards in the road (rough areas, areas where the road narrows to one lane) that you will need to be prepared for. There are also roads that turn off from the main road (indicate on the map), that if you are not paying attention may lead you away from your destination of coping well.

When you take a trip it is always helpful to have a Road Map like the one we have drawn and also helps to have some tools to deal with problems that might come up. A major purpose of this group is to help you develop a personal Road Map for the journey that you are taking. We will spend time highlighting issues and problems that can be thought of as hazards and rough areas in the road. Some of these you might already be aware of; others will be new. Being aware of these hazards is very important in preparing yourself to cope successfully.

Each of you has already developed some skills that can help you along this journey (mention some training that members have already had). In this group we will build upon those skills and add some new skills that you can use to deal with problems that might come up in your journey. These skills include (provide a list of the skills that will be covered in the group here). Again, all of your skills can be thought of as tools. Some of these tools you might use very frequently to prevent problems from coming up. For example, there are certain things we do regularly to our cars to make sure they stay in good shape for a trip (a rag to check the oil, an air pressure gauge to check the air in your tires). Other skills are tools that are only used when you are having trouble. For example, you may have things in a tool kit in your car just in case it breaks down (a tire changing kit, a set of wrenches, etc.). By familiarizing yourself with these skills you can both prepare yourself for the journey and cope with problems as they come up."

4.5.1.4 Overview of Group Program

The following major areas of the group program are to be presented with examples. Make clear that some of this material is review while the rest is more advanced training.

1. The relationship among thoughts, behaviors, emotions, and the cardiovascular system.

2. Relapse prevention

3. Pleasant activities

4. Relaxation training

5. How to identify and manage feelings

6. Social ties, feeling connected, helping others

7. Communication

8. Assertion

9. Problem solving

10. Life goals

4.5.1.5 What Makes For An Effective Group?

1. What's expected from each member?

    The critical message for members to hear is that their active and full participation in the group is important for them to benefit from participation and for the group program to succeed. As members learned in individual counseling, the member rather than the counselor, per se, is instrumental to bringing about personal change. An effective group is one in which members cooperate and are actively involved in their own care. As with individual sessions, the setting promotes behavior changes, but the occurrence of these changes is under the member's control.

2. What's expected from the leader?

    The leader will serve as a consultant to the group members. As in individual sessions, the leader will actively collaborate with the members by providing didactic information, guidance, and assistance with problem solving. In addition, the leader will encourage self-management and understanding of how skills learned can be applied to various situations during and following treatment. The leader will share own relevant experiences only if appropriate.

3. Confidentiality

Remind members that their individual sessions were confidential. No one other than the participant, the counselor, and the counselor's supervisor (who monitors the counselor's behavior, not the participant's) is privy to the content of the individual sessions. As in the individual sessions, the group sessions will be "recorded" so that the supervisor can monitor the activities of the group and provide the leader with feedback. This enables the needs of the ENRICHD trial to be met. It also allows for the member to be better served. Tapes will be treated with the strictest confidence.

Strict confidentiality is an important condition of group process. Members will be informed that it is permissible to discuss their own experiences and what they are learning in the group, but that it is inappropriate to discuss the experiences of others. Members will be asked to verbally assent to maintaining group confidentiality.

4. Attendance

Members are important contributors to the group program. Without the regular attendance of the members, the group process is likely to be negatively affected and members will not fully benefit from participation. Attendance is important since it promotes a sense of cohesion among the members. If the member anticipates missing an appointment, it is her responsibility to inform the leader in advance. If the member misses an appointment, the leader will immediately contact the member by phone.

5. Between session activities

Homework/practicing of skills must be accomplished between sessions. As in individual counseling, homework provides members with opportunities to practice skills that are taught within the sessions. Research shows that those who practice skills make the most progress and derive the most benefit. Although some homework assignments will be common among all members, other assignments may be individually tailored for each member. The importance of reporting back to the group regarding progress (e.g., success and failure) with assignments will be underscored.

6. Making and maintaining commitment

Leader needs to acknowledge that the members' participation in the ENRICHD trial to date reflects their commitment to participation. The leader also must acknowledge that maintaining commitment is essential. Member behavior, as reflected by attendance, promptness, homework completion, and active participation will provide evidence of commitment level. Indicate that it may be difficult to maintain level of commitment at all times. Potential barriers to making the commitment (and solutions) need to be explored and problem solving should be conducted around this issue.

Brief recap and review of basic skills taught in the individual program. During this period, the leader will ask each member to give opinions about a few of the major themes/topics of the individual counseling. The topics are not to be of a personally self-disclosive nature but general topics, e.g., understanding the relationship between beliefs and feelings. Key points not cited will be offered by the leader. The leader will then use this as an opportunity to bridge the individual program to the group program.

4.5.1.6 Introduction/Review Of How Thoughts, Behaviors, And Emotions Influence CHD

It is important to keep in mind that the common experience of all members is that they have recently had a heart attack. Presentation of this information should be accomplished in an interesting manner and multiple modalities are encouraged (e.g., lecture, discussion, overheads, audio and/or video tapes, e.g., NBC Connie Chung special - 30 minutes). The following information should be presented.

   a. Review the cognitive model

Introduce stress as a very general term that means various things to various people.   When stressed, people may have a variety of responses including irritability, anxiety, sadness, feeling lonely etc. A heart attack is by definition a major stressor in anyone's life. As such, it can lead to a wide range of unpleasant feelings -- fear, sadness, anger are a few that come to mind. Such feelings can lead to distress on a number of fronts.

Stressors can be situations that trigger automatic thoughts associated with one's belief system. These thoughts then lead to certain emotional, behavioral, and physiological reactions. (Use diagrams of the cognitive model to illustrate). This provides a transition to physiological responses.

   b. Conduct the In-Session Exercise

   c. Physiological responses

These exercises that you just completed illustrate that thoughts elicit emotions. When emotions (e.g., sadness, anger, joy) are experienced, physical changes also occur. It is important to become aware of the physical sensations that are associated with various emotions.

A variety of physiological responses take place in response to a situation that triggers automatic thoughts. If you interpret the situation as "pleasant" or as "stressful", then your body will respond in a certain way. The first set of responses is the "fight-flight" response, because its effects enable the person to take quick physical action in response to the stressor/situation. The following cardiovascular responses can occur a) heart rate increases, b) blood pressure increases, c) blood flows to muscles away from organs so that you can either "fight" or take "flight" (ask members for other suggestions). People have responded this way when faced with a stressor

since the time of the cave man. These responses are so fast that they occur quickly in almost the same instant that a situation is interpreted as stressful.

However, an important difference needs to be made between you and the cave man. With the fight-flight response your body is prepared to take some sort of physical action against the stressor/situation. But in today's society, physical action is not usually the best way to deal with the situations. For example, if a pharmacist overcharges you for your heart medication, the more adaptive response is not to hit him or to run away. In this circumstance, one might respond actively (e.g., assertively) or passively (e.g., not speak up about the overcharge). In both cases, the body still responds as if were ready to fight. The physiological changes still take place and they still affect the body. Most of what is known about these changes concerns the cardiovascular system.

For example, the fatty acids that are released into the blood in response to a stressor are not used because a physically active response is not made. These fats may contribute to the development of atherosclerosis or hardening of the arteries via conversion into "bad" cholesterol. "Also, the adrenaline and noradrenaline that are released may lead to damage of the blood vessel walls, which can make them vulnerable to hardening of the arteries, and dangerous clotting as well.

In people who are vulnerable to high blood pressure, the increase in blood pressure during stress may add up over the years, leading to hypertension, which in turn can lead to many other cardiovascular complications. In people whose heart muscles are already weakened (e.g., from atherosclerosis), the increase in heart rate during the stress response can exacerbate their cardiovascular condition.

Therefore, it is important to learn to decrease these cardiovascular responses. During the group program we will be talking about thinking about situations in different ways so that they are not stressful to you. We will also be teaching you various skills, including relaxation techniques that will help you cope more effectively with stressful situations. Relaxation has the added benefit of calming the body.

4.5.1.7 Group Member Workbook

Distribute the member workbook binder and review the contents for Session 1. Explain that the members are asked to bring the binder to each session. Materials will be distributed for each session. This information will include written reminders about the information, principles, and skills that are discussed.

4.5.1.8 Confidence Scale

Self-confidence has been shown to be a necessary component of successful behavior change programs. If a person increases his or her confidence that specific actions needed to complete a task can be done successfully, then the person will make greater efforts to practice, will persist for a longer time under more difficult conditions, and will be more likely to master the task. Typically, the level of confidence that one can successfully perform the necessary actions to accomplish a goal is the single best predictor of trying to do so and of actually accomplishing the goal (Bandura, 1992).

Members should be told that we aim to help them build their confidence in a variety of skill areas. We are asking group members to try to do several different things successfully. Therefore, developing confidence and mastery will be emphasized throughout the group program. As such, in this and all future sessions it will be important for the leader and the members to foster member confidence.

We may be checking their confidence each session. Assessments are not concerned with the skills one has but with judgments of what one can do with whatever skills on possesses. Following the introduction of a new skill, the leader may assess confidence with the session self-confidence scale.

4.5.1.9 In-Session Exercises

1.   Thoughts and Feelings Exercise

a. Think of someone you are having difficulty with. (pause). Close your eyes and get a good picture of this person in your mind. See their hair, the color of their eyes, what their face looks like, how they usually walk, what kind of clothes they wear, what kind of expression they usually have on their face, where you usually see them. And then think about how their voice sounds, how they smell. Then think about how you usually feel when you're with them (how they make you feel). See where in your body you are aware of physical sensations- paying particular attention to your chest and your abdomen, where we feel a lot of the sensations that are connected with our emotions. (probes if needed, Do you feel tight, loose in there, full of butterflies, warm, open, closed, like something is sinking, or rising, or clutching-- how does all that feel inside?)

b. Now think of someone you love (or care about a lot). Close your eyes and get a good picture of them in your mind. You might want to imagine them sitting right next to you. See their hair, the color of their eyes, what their face looks like, how they usually walk, what kind of clothes they wear, what kind of expression they usually have on their face, where you usually see them. And then think about how their voice sounds, how they smell. Then think about how you usually feel when you're with them. (i.e. how they make you feel). See where in your body you are aware of physical sensations- paying particular attention to your chest and your abdomen,

where we feel a lot of the sensations that are connected with our emotions. (probes if needed, Do you feel tight, loose in there, full of butterflies, warm, open, closed, like something is sinking, or rising, or clutching-- how does all that feel inside?)

At this point, the leader goes around the group and has the members describe the physical sensations they felt during the exercise. Encourage comparison of responses to the two types of persons imagined.

2. Relaxation

   a. Relaxation is to be presented as a skill to be learned that can quiet the body and the mind. Members are told that they will be taught a variety of exercises over the course of the group program. Relaxation is useful to be included as part of the members' behavioral coping skills repertoire. Relaxation will be presented at the beginning of subsequent sessions. The procedures for the breathing exercise are presented in the workbook.

4.5.1.10 Homework

(Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they had with the assignments.)

Monitor thoughts and feelings about medical condition. Have members adaptively respond if they think their thoughts are exaggerated. If members have difficulty adaptively responding, they should bring this up during the next session.

Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social as well as nonsocial activities. Circle social activities where you felt supported. Discuss that it is expected that mood and sense of well-being is likely to be improved when members engage in pleasurable pursuits. Participation in pleasurable activities can help members cope with various negative moods. Engaging in pleasant activities can also be used as a reward for coping with recovery from the heart attack.

Practice breathing exercise every day for at least 5 minutes and rate tension before and after practice on the Activity Chart. Also, practice breathing whenever you begin to feel stressed.

Conduct a cognitive review. Inform members that only two of them will actually be asked to discuss their review during the next session. Other members will be checked on. Describe how this activity helps members maintain gains made during the individual sessions. Questions for the review are presented in the workbook.

4.5.2 Session 2: Emotions: Identifying And Evaluating Them

The order of Session 2 and 3 may be switched, depending upon the effectiveness for the particular group.

Rationale

Within the context of the cognitive model, we have discussed how thoughts, feelings, and behaviors are linked (briefly review cognitive model diagram). It is known that negative emotions may play a role in heart disease. Negative emotions can also influence the way that one looks at one's self and others. Negative emotions and the thoughts that are associated with them can be associated with behaviors that result in withdrawal from social relationships and can cause others to withdraw from you. Learning how to distinguish, identify, and evaluate negative emotions is an important step in promoting personal well-being.

In addition to your understanding the relationship between thoughts, behaviors, and emotions, it is critical to become more aware of such feelings whenever they occur. Some people have difficulty distinguishing among emotions while others have difficulty distinguishing thoughts from feelings (Beck, 1995). The Log that you have been using to monitor your thoughts also provides important information about positive and negative emotions and the intensity of emotions. By keeping a record of those situations in which you experience feelings, you increase your awareness of these feelings, as well as the circumstances in which they occur and the accompanying thoughts. After you increased your awareness of feelings and the situations that arouse them and thoughts that accompany them, you will be ready to evaluate them and then decide which steps to take to manage them.

You can evaluate your negative feelings by asking yourself four questions about the feelings, thoughts, and the situation. The answers to these questions will help you decide whether a given negative emotion is a signal that you need to act to change the situation or your thoughts about it, or whether it is not a signal for action but rather a feeling that you need to quell. In either case, you will learn additional skills, such as assertion skills, in subsequent group sessions.

4.5.2.1 Skill Guidelines

The Log that you first used in your individual sessions and that you are currently using in the group program is an important tool to increase you ability to identify thoughts and feelings.

1. As you know by now, record keeping is a very effective means of becoming more aware of one's thoughts and feelings. All the skills you will be learning build upon the base of being aware of your own thoughts and feelings. By now, most of you have learned this skill well.

   a. You know that thoughts are whatever you are thinking at any moment -- the words that are "playing" in your mind at any point in time.

      You will need to be aware of a whole range of feelings. The following are thought to be universal emotions

      anger

      fear

      joy

      disgust

      sadness

   b. Possibly universal emotions are:

      contempt

      surprise

      interest

   c. Very widespread emotions are:

      shame

      love

   d. Chronic negative emotional states powerfully relate to CHD-related processes.

A growing body of research has documented associations between psychological/psychosocial variables and cardiac recurrences and mortality post heart attack. Research indicates that depression, lack of social support, and distress are important predictors of negative CHD-related processes.

   g. Can you remember having had any of these feelings recently? You are the world's expert in what you are feeling. No one has the right to tell you aren't feeling that. Feelings just are. Feelings may be based on faulty thinking about a given situation. We will be learning how to decide when that is the case.

2. Evaluating thoughts, feelings and options.

So far, we have concentrated on identifying thoughts and feelings and the situations in which they arise. Now we are going to use that awareness as a base for evaluating thoughts and feelings, to decide whether to act or to try to overcome the feeling.

First, the leader reviews the use of "What's the Evidence" procedure. (The questions are found on the bottom of the Log and in the workbook). Members are asked about their experiences with the procedure to date. "The What's the Evidence?" questions are listed below.

--What is the evidence?

--What is the evidence that supports this idea?

--What is the evidence against this idea?

--Is there an alternative explanation?

--What is the worst thing that could happen? Could I live through it?

--What is best thing that could happen?

--What is the most realistic outcome?

--What is the effect of my believing the automatic thought?

--What could be the effect of changing my thinking?

--What should I do about it?

--What would I tell _____ (a friend) if he or she were in the same situation?

Next, the leader explains additional evaluative questions for negative thoughts and feelings, as well as explorations of options for handling them (Cognitive Flowchart). Leader should first illustrate with an example. Next ask for a volunteer to subject his/her own Log entry to the four questions, and repeat for each member in the group.

--Important: Is the situation and my thoughts/feelings worth my continuing attention? How you rated intensity of the feeling on the Log serves as a marker for importance.

-- Appropriate: Are my thoughts/feelings appropriate, given the objective facts (what most people would agree happened) of the situation? (versus--Do my thoughts represent cognitive distortions that lead to negative emotional states?)

-- Modifiable: Are there actions I can take that will fix the situation so that I don't continue to have the negative thoughts/feelings? (or, Can I modify my thoughts/interpretation of the events?)

-- Worth It: Will taking action (changing my thoughts or changing my behavior) lead to a net gain, weighing both my and the other person's needs?

If you note the first letter of the first three questions above and the two words of the fourth question, you will note that they spell out a statement that will help you to remember these four important questions for evaluating your negative thoughts and feelings: "I AM WORTH IT!"

If you simply remember, "I AM WORTH IT!" every time you become aware of a negative thought or feeling, it will help you to remember the four questions you need to answer about any situation in which you are experiencing negative thoughts or feelings.

4.5.2.2 In-Session Exercises

Ask the members, going around the group, to describe situations from the last few weeks when they experienced emotions. Write on a flip chart or board the following format that members have been using in keeping the Log. The goal of this exercise is to illustrate the evaluation process using "What's the Evidence?" and "I AM WORTH IT!"

1. Situation: Be sure to record only the objective facts of the situation that you can actually observe -- not your interpretation or judgment about the facts. Also indicate where and with whom.

2. Thoughts: Write down what your thoughts are in the situation.

3. Feelings: Write down words that describe any feelings you were experiencing. Then rate the intensity of these feelings. The more intense a negative emotion is, the more attention the situation (associated with the negative emotion) needs.

4. What you did: Note any actions you took.

5. Outcome: What happened?

Next, the leader and members working together will take each member's situation in turn and translate what was said about the chosen situation into a Log entry, which the leader writes out on the flip chart or board and the members' then evaluate.

Continuing to keep a log of your thoughts and feelings will have several benefits:

a. Making a formal record encourages careful observations of actual behaviors, feelings and thoughts while or soon after they occur. Engaging in these kinds of observations will make you more self-aware and objective.

b. Having this written record allows you to review what triggered your negative/positive thoughts and feelings in a systematic and rational way and to examine how you actually behaved. This will enable you to evaluate how well you handled the given situation and to consider other ways you could have handled the situation. In later sessions you will learn about other behavioral options that might be more effective.

c. Once a Log entry is made, you have a permanent record. You can use this record to re-examine old situations on as many different occasions and from as many different perspectives -- some of which we will be covering in later sessions -- as you deem useful. Indeed, we shall be using your log entries to apply new skills we shall be covering later, most immediately the evaluation of thoughts and feelings.

4.5.2.3 Homework

(Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they had with the assignments.)

1. Monitor thoughts associated with negative feelings. Remember, not all thoughts associated with negative feelings are inaccurate. Use the "What's the evidence?" card and the "I AM WORTH IT!" questions to help you evaluate your thoughts. Thoughts you have difficulty responding to, bring up in next session.

2. Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social as well as nonsocial activities. Circle social activities where you felt supported.

3. Practice breathing exercise every day for at least 15 minutes and rate tension before and after practice on the Activity Chart. Also, practice breathing whenever you begin to feel stressed.

4.   Conduct a cognitive review. Inform members that only two of them will actually be asked to discuss their review during the next session. Other members will be checked on. Questions for the review are presented in the workbook.

4.5.3   Session 3: Cognitions

The order of Sessions 2 and 3 may be switched, whichever way is more effective for the particular group.

Rationale

As has been discussed, there is a relationship among thoughts, feelings, behavior, and physiological responses. Negative thinking can, therefore, lead to negative feeling states, negative actions, and potentially to negative physiological consequences (and other negative consequences). You need to be aware of the relationship between what you think about a situation and how you feel.

If your interpretations about situations are accurate, then your feelings/emotions are likely to be appropriate/valid and will probably match the situation. However, automatic thinking associated with a situation may involve inaccurate perceptions. If your perceptions/thinking is inaccurate, then your feelings/emotions as well as your behavior are likely to be inappropriate. This is how negative feelings may occur unnecessarily. However, this does not mean that these are the only circumstances under which negative feelings may occur.

Your interpretations may fit the situations, and thus be pretty accurate. If you are upset and your thinking is accurate, problem solving may help. If not, you need to make changes that will reduce such thoughts. It is essential to break the cycle and to substitute more adaptive or useful thoughts for maladaptive thoughts, and move away from a downward spiral.

Behind automatic thoughts are beliefs that each of us has developed over our lives. Our personal sets of beliefs influences how we interpret particular situations. These beliefs reflect personal ideas that we have but they may not be based on truth (Beck 1995). Our underlying beliefs may be longstanding (i.e., core beliefs developed since childhood) or they may be related to a significant more recent event (i.e., intermediate belief precipitated by heart attack).

Personal thoughts associated with a particular situation lead us to specific reactions. We experience certain emotions, display specific behaviors, and have specific physiological reactions. (Use members' own examples to illustrate these points.)

4.5.3.1 Skill Guidelines

Each emotion is hypothesized to have its own core pattern of thinking. Different emotions have different patterns of thinking associated with them. To illustrate how thoughts, emotions, and behavior are closely linked together, consider a person waiting for the phone call.

Example. The person waiting for the phone call (situation) thinks no one is interested in her (thought/interpretation), consequently he feels sad. She thinks "NOW THAT I AM SICK NOBODY IS INTERESTED IN ME ANYMORE" (thought/interpretation). This leads to even

more sadness (emotional reaction). In feeling sad, she doesn't do anything (behavioral reaction). She doesn't call anyone and fails to do anything to help herself. Soon she may even prefer to avoid people to prevent herself from more pain and rejection.

A good place to intervene is at the level of thoughts/cognitions. How a person interprets situations determines how the person feels about them. It is important to evaluate a thought when one becomes aware of it. So our person home alone could break the cycle by changing her negative thoughts to something more like "I haven't heard from Joe yet. He probably got delayed. I'll give him a call." A thought like this will lead to less feelings of sadness and loneliness and a change in behavior.

While this technique is simple enough, it does take lots of practice to use it effectively. Several steps are involved:

Step 1. IDENTIFY thinking patterns

Step 2. EVALUATE thoughts/interpretations

Step 3. RESPOND by considering alternative interpretations

These steps can lead to positive changes in mood and behavior.

There are several examples of negative distorted thinking that people use. Negative thinking often involves inaccurate perceptions which are commonly used by most people at one time or another. For some people who use them most of the time, they have become "thinking habits" We will introduce some of the most common types of negative thoughts (see handout on Types of Negative Distorted Thinking which defines terms). These concepts will be applied in future sessions to use in conjunction with the Log and Cognitive Flowchart. The Log and Cognitive Flowchart are tools to help you evaluate thoughts and feelings so that you can learn to recognize different kinds of negative distorted thinking and control it. (*This information should be discussed by eliciting examples of different kinds of negative thinking from the group.*)

a. All - or - nothing thinking (aka Black and White Thinking)

b. Over-generalization

c. Mental filter

d. Disqualifying the positive

e. Jumping to conclusions

1. Mind reading

2. Fortune teller error

 f. Magnification (aka catastrophizing) or minimization

 g. Emotional reasoning

 h. Should statements

 i. Labeling and mislabeling

 j. Personalization

4.5.3.2 In-Session Exercises

Have the group identify the negative thinking in the following example.

Recently, an additional volunteer has been recruited at the church/temple to perform similar duties to yours. You say to yourself, "I am being replaced. If I was any good as a volunteer, they wouldn't need anyone else."

Then, using a flipchart, have group members discuss personal examples of automatic thinking as related to the following contexts: heart attack, medical insurance, family relationships, and social network. Ask members what they say to themselves once they have identified negative thoughts, evaluated them, and replace them with more rational thoughts.

4.5.3.3 Homework

(Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they had with the assignments.)

"My negative thought of the week". Briefly note in your Log what strikes you as the most interesting negative kind of thinking (as discussed in this group session) you had this week. Give some of the details of what happened. What beliefs may have been at work? Use the "What's the evidence?" card to help you evaluate your thoughts. Thoughts you have difficulty responding to, bring up next session.

Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social as well as nonsocial activities. Circle social activities where you felt supported.

Practice breathing exercise every day for at least 10 minutes and rate tension before and after practice on the Activity Chart. Also, practice breathing whenever you begin to feel stressed.

Conduct a cognitive review. Inform members that only two of them will actually be asked to discuss their review during the next session. Other members will be checked on. Questions for the review are presented in the workbook.

4.5.4   Session 4: Feeling Connected With Others

Rationale

Feeling connected with others has been associated with increased sense of well-being, quality of life, and improved health outcomes.

The group program continues the work begun in the individual program by providing a socially supportive environment which fosters the development of socially supportive ties and provides additional opportunity for the members to develop their social repertoire in a social setting.

4.5.4.1 Skill Guidelines

The session focus is to identify beneficial, plentiful, detrimental, and deficient sources of social support for each group member, and to learn new strategies for improving and increasing supportive ties in their life.

1.   Important resources

   a. What are your most valuable personal and material resources? e.g., sense of humor, intelligence, money, home, car, physical health, etc..

   b. Discuss how our social resources (i.e. relationships with other people) tend to enhance or detract from the importance we place on these previously discussed resources.

2. In what ways is social support relevant to health (both mental and physical)?

3. Ask group members to identify ways in which supportive relationships might enhance their lives and may possibly promote their health. Include in the discussion the benefits of social support listed below.

   Information Support (e.g. doctors and nurses)

   1) Promotes healthier behaviors

   2) Facilitates one's ability to obtain necessary medical care

   3) Provides advice leading to solutions

   Tangible Support (e.g. friends and family)

   1) Helps accomplish chores

   2) Provides money to pay bills

   3) Provides assistance to meet various obligations

Social/Emotional Support (e.g., spouses, family, friends, church, community)

    1) Someone who really listens to you

    2) Helps you feel better about yourself

    3) Feel more secure knowing someone is ready to be with you

    4) Increases positive self-evaluations

4. Who are supportive people in our lives?

In what ways are these people able to provide us with support (e.g. emotional, tangible, affiliation)? Are these people available whenever we need them, or only at intermittent times? Are our interactions with others (even ones we love) always positive?

5. In what ways do we provide other people with support?

Why does our willingness and ability to provide such support generally make us feel good (e.g. increased self-esteem, self-efficacy, and sense of purpose, reduces feelings of helplessness and victim mentality - always getting support but never giving any in return).

6. Obstacles to Obtaining and Maintaining Support Network

a. Let's discuss some of the obstacles that stand in the way of obtaining or maintaining a solid social network:

b. Generate a list of obstacles that might prevent people from maintaining a strong support network.

- - - *Potential Obstacles:*

    a. Multiple bereavements

    b. Sickness of friends limits social activities

    c. Fractured family ties

    d. Self-imposed social withdrawal due to fears

    e. Sense of disconnection from life and people prior to your heart attack

7. Rate of controllability of each on a scale of 1 (low control) to 4 (greater control).

Modifying Coping Strategies to Obtain Support

Seek out information (as relates to their medical condition).

Seek out tangible aid (money, advice, instructions).

Communicate needs and feelings (good and bad) more effectively to friends, family, and supportive others (e.g., medical personnel).

Allow yourself to rely on trusted friends.

Enjoying being nurtured, expressing feelings assertively.

Finding a central confidant and increasing connection (e.g., spouse, close friend, religious leader, etc.).

Increase involvement in the community (lending support).

Get a pet.

4.5.4.2 In-Session Exercises

Support provider assessment exercise to help group members identify where their networks show strengths and weaknesses. *Note: If a person says "no one" be prepared to do problem solving in the group*

a. Who are the supportive people in you life? Provide an example of the informational, tangible, and social/emotional support they give you.

b. In what way do these people provide support?

c. Are they available when you need them?

d. Are your interactions with them always positive?

e. How do you provide support to other people? How does it make you feel?
    (i.e., increases self-esteem, self-efficacy, sense of purpose, reduces feelings of helplessness).

4.5.4.3 Homework

(*Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they had with the assignments.*)

"So who is being supportive?" Log the situations that you felt supported by someone (information, tangible, or social /emotional). Note what happened and how you felt. Also, note any negative thoughts about each support event.

Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social as well as nonsocial activities. Circle social activities where you felt supported.

Practice breathing exercise every day for at least 15 minutes and rate tension before and after practice on the Activity Chart. Also, practice breathing whenever you begin to feel stressed.

Conduct a cognitive review. Inform members that only two of them will actually be asked to discuss their review during the next session. Other members will be checked on. Questions for the review are presented in the workbook.

4.5.5   Communicating Effectively

Rationale

Good communication skills can help improve your quality of life. By communicating effectively using both speaking up and listening skills, you can ensure that both you and others (e.g., your spouse, physician, son or daughter, coworker) become more aware of each other's feelings and needs.

As you become a more effective communicator, you will become more aware of your thoughts, feelings and needs. As your ability to speak up grows, your confidence will improve, thereby lifting your mood.

The other part of becoming a more effective communicator involves becoming more effective in listening to others and letting them know you've really heard what they are saying. Others will appreciate you for being supportive by listening. As a result they will become more supportive of you, thereby increasing your sense of belonging. Since you will have achieved a sense of belonging by using your listening skills, it will add to your increasing self-confidence, thereby lifting your mood and sense of well-being.

4.5.5.1 Skill Guidelines

Communicating effectively. *Note*: *Additional information including guidelines for effective speaking are in the workbook. Presentation of this information should be 'discussion oriented" with questions elicited from the members regarding effective communication. Use difficulties that members report as a springboard to problem solve and teach skills. The leader may have to help members modify dysfunctional beliefs about speaking and listening.*

1. Most communication is nonverbal. What clues do you use to determine what the other person is feeling, aside from the content of what is said? There is a connection between nonverbal behaviors and basic emotions that people experience. For example, a frown, a scowl, tears,

and a smile convey important information about what a person is feeling. To be an effective communicator, you need to appear calm, in control, interested in the other person, and as nonagitated as possible (Body language handout). This body posture will convey your interest, as well as gain others' interest, in engaging in communication.

2. Speaking and listening are both necessary and best in equal doses, so that talk becomes conversation, not a monologue on either side. (Exception: With children and some troubled adults, you will need to listen most of the time.) Some of you may have trouble speaking up and some may not be good at listening. Today we will discuss speaking up first.

Sometimes when people don't speak up in a situation it is accompanied by a realization that he or she doesn't have a very high opinion of himself/herself, seeing their personal needs as unnecessary and their personal opinions as unimportant. He or she sees themselves as being there to care for others, but not vice versa. The underlying (i.e., intermediate) belief seems to be: "Only by being attentive to others will I gain worth. Clearly, such thinking involves only half the equation--higher self-esteem is called for. This is a lifelong task for many of us.

3. Effective speaking helps you communicate thoughts and feelings. By doing this effectively, others may better understand your needs and you may feel better about yourself. Some of the key points in speaking up effectively are as follows:

  a. Just do it. Introduce yourself, listen to what he has to say and if you get a chance, tell him a little about yourself too.

  b. Try to use I statements when appropriate, but be careful not to overuse them.

  c. The best way to let another person truly know you is to tell them what you are feeling. Share yourself often.

  d. Speak from personal experience. This will help you to be focused and not sound vague.

  e. Be specific.

  f. Make sure your 'body language" conveys your interest.

4. Listening effectively is just as important as speaking, when it comes to building good relationships. So as not to be perceived as uninterested, or passive, it is important to develop effective listening skills.

a. Speaking and Listening go together. Now that you have learned effective ways of speaking, let's focus on the other half of the conversation.

b. Effective listening is an essential skill you can use to learn what others are thinking and feeling, as well as demonstrating to them that you care about them. By doing this effectively, you accomplish two important goals: you understand them better and they are drawn closer

to you (because you are showing them the courtesy of trying to hear and listen to their message). While truly effective listening can be very hard for some of us, the basics (Guideline for listening handout) are really quite simple:

1. Keep **quiet** until the other person finishes speaking (don't feel that you have to jump in after a few seconds' silence!).

2. Make sure your "**body language**" conveys your interest

3. When the other person is finished speaking, **reflect back** what you understood them to be trying to say--"What I hear you saying is. . . ." or "So you are feeling upset that. . . ."

5. Giving Compliments. (This material is optional, depending upon time constraints. The section is adapted from the presentation in the Social Support Individual Counseling Section.)

Part of the satisfaction we get from others is related to our ability to share positive things. It is, therefore, important to make positive comments and to accept positive things. It is, therefore, important to make positive comments and to accept positive comments in a gracious manner, e.g., giving and receiving compliments. In long-term relationships, we often take the other person for granted and assume that they already know how we feel about them.

a. Giving compliments

1. When giving compliments, use "I" statements.

   For example, "I like that outfit" vs. "That's a nice outfit".

2. Be specific. Pick out attributes or actions for the compliment.

   For example, "Mr. X, I appreciated when you gave me the opportunity to go first. That was kind of you."

b. Accepting compliments

1. Accept compliments that are given to you. Do not negate them, turn them down, or turn them around. Say thank you.

2. Even if you disagree with the content of the compliment, indicate your appreciation.

For example, when someone tells you that they like what you are wearing, do not respond "This old thing?" or "It was the only thing I had clean." Even if you do not like the outfit, thank the person for the compliment. This makes the other person feel as though you are really listening and validating them.

4.5.5.2 In-Session Exercises

Speaking/Listening exercise (20 minutes)

Ask participants to pair up with someone in the group they don't know well. The two of them are to find a quiet place. For about the first 3 minutes, the first person talks--trying to follow the Speaking Up Guidelines--about whatever he or she wishes (a topic they care about, but not their most gut-wrenching current life crisis issue!), with the second person remaining completely quiet, with eyes focused on the first person. After the first person finishes what he or she has to say, the second person for about 3 minutes relates what he or she understood the first person to be saying, focusing on the information given, its emotional significance, or both (not added information, advice, judgments, psychological interpretations, or questions).

Emphasize that participants are not to analyze each other's behaviors, nor the overall situation - they are simply to reflect back to the speaker what content they heard and any emotions the speaker might have conveyed. The first person then makes any appropriate clarifying or augmenting statements. They then switch roles and repeat the process.

Reconvene the group (at 15 minutes) and ask the speaking/listening couples to report back on the experience. This sharing inevitably brings home the power of effective listening as a means of drawing two people closer together.

Giving and receiving compliments exercise.

Divide group into pairs. Ask a member of each pair to give a compliment to his/her partner and have the partner accept it based on the above information. Then the leader provides feedback.

Have the members switch roles. Now, the member who gave compliments receives one and the member who received the compliment gives one.

4.5.5.3 Homework

(Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they had with the assignments.)

1. Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social as well as nonsocial activities. Circle social activities where you felt supported.

2. Communication homework. With respect to speaking up and listening, ask members what kind of rehearsal they would benefit from this week.

a. For those who indicate listening, assign the following:

Sometime before the next session, when you are engaged in a conversation with another person (one on one), without announcing what you are doing, go into the listening mode. Keep quiet (an occasional "uh huh" is okay, but nothing more should pass your lips!) and use body language that at least gives the impression you are interested. If the other person asks a question of you--e.g., "what do you think?"--say, "I'd rather hear all you have to say about this first." Then, when the other person has wound down, reflect back, "What I hear you saying is. . . .", and give it your best shot to tell him/her what you heard. Conclude by asking "Is that it?"

b. For those who indicate speaking up, assign the following:

"Contract" with someone to do the listening while you speak following the Speaking Up Guidelines---just as was done in the in-session exercise.

c. Have members mark their practice on the Activity Chart and rate pleasure and accomplishment/satisfaction).

3. Monitor negative thoughts about speaking up and listening. Evaluate these thoughts and respond adaptively. Bring up any difficulties next week.

4. Practice breathing exercise every day for at least 20 minutes and rate tension before and after practice on the Activity Chart. Also, practice breathing whenever you begin to feel stressed.

5. Conduct a cognitive review. Inform members that only 2 of them will actually be asked to discuss their review during the next session. Other members will be checked on. Questions for the review are presented in the workbook.

4.5.6   Session 6: Relapse Prevention Training

Rationale

Every member in the group has had an MI and has had to cope with both the short- and long-term consequences of this event. In both the individual and group sessions you have learned a number of different coping skills.

At times, you may be able to cope quite well both in terms of your mood and your ability to maintain an active lifestyle. At other times, you may have a lot of difficulty coping and experience a major setback. When you have a setback in coping your life can be changed in important ways. You may also be tempted to stop practicing and stop applying coping skills that you have learned. As a result you may slide back into your old ways of dealing with problems and concerns.

Relapse prevention training is designed to help you prevent relapsing by developing more confidence in your coping abilities, learning how to approach problem situations, and how to overcome obstacles and road blocks.

4.5.6.1 Skill Guidelines

Relapse prevention training has several basic principles (Marlatt & Gordon, 1985):

Plan ahead to prevent relapse. It is important to start early with relapse prevention training. That is why we are introducing this training at this point the group and will spend time in later sessions focused on issues of coping skills practice and setbacks in coping.

Identify high risk situations. We will help you identify high risk situations that represent major obstacles to your coping skills. We will also help you develop a plan for dealing with these situations.

Role playing. To develop confidence in your ability to apply coping skills to deal with challenging high risk situations, it is important to rehearse them. We will role play actual problem situations in the group sessions and help you practice applying your coping skills.

Self-monitoring. Your Logs are an excellent way to keep track of your practice with coping skills and prompting you to reward yourself for progress in coping.

4.5.6.2 In-Session Exercises

1. Recognizing High Risk Situations: The Relapse Road Map Exercise

    Think about the process of coping with an MI as a journey on which you are the driver. When taking a journey it is helpful to have a road map. The map not only indicates your destination but also important choice points along the road.

    One way to prepare yourself to deal with problem, high risk situations is to develop a personal road map. (Leader draws a diagram on the board with setback in coping relapse as the destination and winding road leading up to it.)

    The final point on this road is a setback in coping or a relapse. The road leading up to that point refers to the time period leading up to that event.

    If you pay attention you can learn to become aware of early warning signs that you are having trouble coping. Some of these signs occur early on the road others occur much late (Leader draws traffic signs along the road leaving space on the signs to enter information to be provided by the members.)

    What are some of the warning signs that let you know that you are headed for difficulties in coping? (Leader fills in the signs with examples provided by the members.)

    These signs might include irritability, difficulty sleeping, or trouble concentrating.

    Each of you needs to develop a list that includes the particular warning signs that are crucial for you. (Have participants complete a list of their own warning signs.)

    Early warning signs can serve as red flags alerting you to potential problems. They can increase your awareness of the events that might lead up to your stopping coping efforts.

    Early warning signs can also help you take corrective action. When these signs occur it is often important to slow down, pay attention to them, and enlist others to help guide you through this difficult time.

2. Recognizing High Risk Situations: Cognitive Rehearsal of a Prior Relapse

    Another goal of increasing your awareness of how you tend to cope with high risk situations is to review in your mind how you have dealt with particularly difficult situations. (Leader guides members through a 5 minute rehearsal.)

    Imagine yourself encountering a difficult, high risk situation and having difficulty coping with it effectively.

Imagine the situation vividly. Try to experience the negative thoughts and feelings that might occur (e.g., loss of confidence in coping abilities, self-blame, guilt, depression).

Rather than giving in to these thoughts and feelings and abandoning your coping skills, imagine yourself using different strategies to overcome and cope effectively. (Leader asks members to stop imagining situation.)

<u>Review and feedback</u>. Have group members discuss the specific situations they imagined themselves confronting. What are some of the thoughts and feelings that you had in this situation? How did your thoughts and feelings change when you imagined yourself coping more effectively? Note positive aspects and problems.

3. Role Playing: Behavioral Rehearsal Exercise

We will now practice, using a role play format, how you might respond to a high risk situation or setback.

Set up a role play situation using one of the situations identified by the members. The group leader is to model the member role in this situation and other members are to model other individuals in the situation.

<u>Role play situation</u>. The group leader should verbalize his thoughts and feelings using a "think aloud" technique. Role play should illustrate some of the problems in coping as well as methods for overcoming these problems.

<u>Have group discuss role play</u>. Note positive aspects and problems. Suggest alternative coping methods.

Repeat role play demonstration with a member if there is time. Provide feedback to the member.

4.5.6.3 Homework

(Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they had with the assignments.)

Use your Log to help you become aware of your successes and where you may need to practice more. Keep track of early warning signs, obstacles, and high risk situations. Record this information in the "other" column of your Log.

Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social as well as nonsocial activities. Circle social activities where you felt supported.

Practice four muscle group relaxation exercise daily. Rate tension before and after practice on the Activity Chart. Also, practice breathing whenever you begin to feel stressed.

Conduct a cognitive review. Inform members that only two of them will actually be asked to discuss their review during the next session. Other members will be checked on. Questions for the review are presented in the workbook.

4.5.7   Session 7: Anger Management

Rationale

Patients who have had an MI are likely to be particularly vulnerable to the effects of anger/hostility on their physical health. Research indicates that anger/hostility may contribute to the development of coronary heart disease and may also affect a heart patients current condition because of its effects on the cardiovascular system. In this context, anger is dysfunctional, even when it is not excessive.

Feeling angry, like feeling stressed in general, affects the cardiovascular system as well as other parts of the body. When someone is angry that person's body reacts in predictable ways: blood pressure increases, heart rate increases, blood flow to your muscles increase, muscle tension increases, and adrenaline flows.

It is important to identify, evaluate, and respond appropriately to anger-provoking situations. Coping with anger-provoking situations can help you avoid the negative health consequences of anger.

4.5.7.1 Skill Guidelines

Anger management

Note: Interpersonal situations often require assertive responses. Assertion will be addressed in detail next session.

It is important to understand the role that anger plays in our lives. Often feelings of anger are preceded by feeling anxious or hurt in response to a particular situation.

   a. There are three important steps in managing anger (or any other stressor).

> <u>Identify the anger provoking situation</u>. It is important to identify the situations that make you angry. By learning to recognize the warning signs for situations that place you at high risk for anger, you can learn to cope with and manage them more effectively.

Evaluate the anger provoking situation. When a situation occurs that makes you angry, it is important for you to evaluate the meaning of the situation by examining your automatic thoughts. Subject your thoughts to "What's the evidence?" and "I am worth it" as you consider alternative interpretations. Often, you will find that many of the situations that make you angry are common everyday occurrences to which you attribute certain significance.

Learning from the anger provoking situation. After you have considered alternatives, decide how you could cope this and with similar situations in the future.

The 3 "A's": Avoid, Adapt, Alter

a. Anger provoking situations in general and stressful situations in particular can be managed using the 3 "A's".

　　1). Avoid. Avoiding is a useful approach for some situations. You can not necessarily avoid all anger provoking situations since that might serve to isolate you from others. However, you may be able to adjust your life to avoid some anger provoking moments, e.g., you can avoid interacting with someone who makes you angry.

　　2). Alter. In situations where you have some control, it may be useful to alter the anger provoking situations. You need to consider the situation and decide what aspect you can realistically change, e.g., if someone does something that makes you angry, you can tell them how their behavior makes you feel and ask them to change their behavior

　　3). Adapt. Adapting is often the best option though it is not necessarily easy. Remember your interpretation (thoughts) of a situation is what causes anger (or stress). You can reduce feelings of anger (or stress) by adapting. For example:

　　　　a. After evaluating your thoughts, change your thoughts and beliefs about a situation.

　　　　b. Adapt by making yourself less vulnerable to anger by practicing relaxation.

　　　　c. Adapt when you learn to anticipate anger provoking situations and prepare for them by rehearsing what you will do.

Your relapse prevention skills can be applied to a variety of situations including anger-provoking situations.

　　a. Plan ahead to prevent problems in coping with anger.

　　b. Identify high risk situations for anger by marking them on your Log.

　　c. Practice your coping skills so that you are prepared for a high risk anger situations.

4.5.7.2 In-Session Exercises

What makes you angry?

a. Go around the group and have members identify situations that make people angry. The leader should list the situations on a flip chart or a board.

b. Have the group address the following questions:

    1. How do you usually respond when you are angry?

    2. Do you think that you should change this?

    3. How do other people respond to you when you are angry?

    4. Does anger affect your interpersonal relationships?

    5. How do you feel about the way that others respond to you when you are angry?

    6.   Do you ever hold your anger-in? How does that make you feel?

Role Playing: Behavioral Rehearsal Exercise

We will now practice, using a role play format, how you might respond to an anger-provoking situation. Set up a role play situation using one of the situations identified by the members. The group leader is to model the member role in this situation and other members are to model other individuals in the situation.

Role play situation. The group leader should verbalize his thoughts and feelings using a "think aloud" technique. Role play should illustrate some of the problems in coping as well as methods for overcoming these problems.

Have group discuss role play. Note positive aspects and problems. Suggest alternative coping methods.

Repeat role play demonstration with a member if there is time. Provide feedback to the member.

4.5.7.3 Homework

(Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they had with the assignments.)

Use your Log to help you become aware of situations that are high risk for anger. Monitor and evaluate your thoughts in these situations (and situations where you actually experience anger) as well as your feelings, what you did and the outcome. Be prepared to discuss this next session.

Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social as well as nonsocial activities. Circle social activities where you felt supported.

Practice 4 muscle group relaxation exercise daily. Rate tension before and after practice on the Activity Chart.   Also, practice breathing whenever you begin to feel stressed.

Conduct a cognitive review. Inform members that only 2 of them will actually be asked to discuss their review during the next session. Other members will be checked on. Questions for the review are presented in the workbook.

4.5.8   Session 8: Communicating Effectively: Assertion

Rationale

There will be times when negative thoughts and the associated emotions are a useful and valid signal that tell you to do something to change that situation.

Assertion can take either of two forms: a) asking for a change that you want in order to decrease your negative feelings; and b) saying "No" to avoid being in a situation that will cause your negative feelings to continue, or new ones to arise. It always involves eliciting the help or cooperation of another person; it never involves attacking and demanding.

By communicating effectively with others in ways that meet your wants and needs, assertion will help to reduce those negative thoughts and feelings that arose in a situation that you have now caused to change and enable you to get others to change how they treat you without driving them away. In addition to these direct benefits, the increased confidence and sense of mastery that grows out of being successfully assertive will serve to increase your well-being.

4.5.8.1 Skill Guidelines

1. The four communication styles (passive, aggressive, passive-aggressive, and assertive) are introduced to members. Discuss both the positives and negatives of each of these styles. This helps members to distinguish assertive responses from other responses.

Passive. Indirectly violating own rights by failing to express honest feelings and beliefs.

> Positive: Person avoids confrontation and rarely experiences direct rejection.

> Negative: Leads other people to make choices; hard to achieve personal goals; leads to built up resentment and guilt for not taking care of self.

Aggressive. Standing up for your rights by denying feelings of other people.

> Positive: People usually don't bully an aggressive person.

Negative: People avoid an aggressive person.

Passive-Aggressive: Indirectly and passively resistant.

Positive: Avoids direct conflict.

Negative: Can often cause more interpersonal conflict than if directly approached situation or person.

Assertive: Standing up for rights and expressing individual feelings, beliefs, in a direct way that does not violate rights of others.

Positive: Person chooses own goals; doesn't turn people off; promotes self-efficacy and self-esteem; decreases interpersonal conflict.

2. Assertion is the most effective tool one can use to change a situation arising in a relationship that elicits negative thoughts and associated feelings. When the evaluation process using the Log and Cognitive Flowchart results in "Yes" answers to the 4 "I AM WORTH IT!" questions, conclude that action is called for.

a. In its simplest form, assertion means simply asking for what you want. Make a straight forward request. Often, you must make the same request more than once.

-- "It would mean a lot to me if you would _____."

-- "It would mean a lot to me, if next time we're in this situation, you would_____."-

-- 'May I finish my sentence, please."

b. When this doesn't suffice, the "deluxe" version of assertion consists of four steps:

Step 1. Describe the objective, observable, verifiable facts of the situation (here's where all that log keeping experience pays off).

-- Discussing ideas about what to do next Sunday afternoon with a friend over the telephone. You suggested going to the park to take a walk and your friend said that it was a stupid idea.

Step 2. Share the feelings this situation engendered in you.

-- "I felt hurt when you called my idea stupid (or put down, angry, enraged, whatever -- you're the world's expert on what you're feeling!)

Step 3. Request a specific change.

-- "Fine to say why you don't want to go to the park, but please don't use words like "stupid" to describe my suggestion."

Step 4. (Optional) You might want to specify consequences -- only those you are prepared to deliver -- if the change does not occur.

-- "Our friendship is important to me. However, I can't spend time with you if you continue to speak with me in negative terms.

c. Just Say "No": Equally important to asking for what you want, is another assertion tool that will help you deflect the unwanted demands of others. Just say "No" to requests that you don't want to accede to.

1. Participants can practice saying "No' with respect to various situations in which they have been asked to do things they'd really rather not do. A key principle is to "just say No," without offering excuses that invite further cajoling.

2. The type of assertions described above are of relatively low level in terms of demand. Members may want to work on more difficult situations. The leader should be responsive to the needs of the members and adjust material and exercise accordingly.

d. Barriers to Assertiveness: Discuss barriers to assertiveness that keep the members from acting in an assertive manner. Some of the points to touch on include: fear of rejection, mistaken sense of responsibility, and mistaken view of one's own rights. Note how many of these barriers may involve distorted thinking (i.e., black and white thinking, shoulds, mind-reading, etc.) And discuss ways to challenge these thoughts. If possible, go through some examples of barriers to assertiveness using the members examples.

4.5.8.2 In-Session Exercises

1. Use the examples below to illustrate the four communication styles. Read the scenario and have group members identify each of the styles. Also allow group members to come up with other response which might fit into each of the four categories.

Linda is waiting in the line at the pharmacy to get her prescription filled. A lady cuts in front of her in the line. Linda has four options:

1) Not saying anything but fuming silently about inconsiderate people.

2) Not saying anything to the lady but turning to the person behind her and saying in an angry voice so that the lady can hear, "Some people are so rude."

3) Shouting, "Hey, what do you think you're doing? Get back to the end of the line where you belong!"

4) Saying, "Excuse me but perhaps you didn't notice that the line ends over there. I am already in line."

2. During the group session, each participant chooses a log entry involving another person that he/she believes will get "Yes" answers to all four questions and, after confirming that evaluation ("I am worth it") does yield four "Yes" answers (feedback from the group can be very helpful here), goes on to role-play the assertion steps.

Practice is essential, for it is very easy to get one or more of the steps wrong -- "Please stop putting me down," instead of "Please don't use words like stupid to describe my suggestion for the weekend."

The leader will often need to coach participants closely during assertion practice: for example, "No, that's not right. You just said "You never give me any attention." Try again, and this time say exactly how he wasn't giving you attention in that particular situation."

4.5.8.3 Homework

(Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they had with the assignments.)

At least once before the next session, practice assertion, try to find an occasion in which you can use each form of assertion we have covered in today's session: Simple, complex and "just say no" Come to the next session prepared to report how it went. If you don't practice assertion, observe a situation where you wish you had and prepare to practice in the next session.

Monitor thoughts associated with negative feelings. Remember, not all thoughts associated with negative feelings are inaccurate. Use the "What's the evidence?" card and the "I AM WORTH IT!" questions to help you evaluate your thoughts. Thoughts you have difficulty responding to, bring up next session.

Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social as well as nonsocial activities. Circle social activities where you felt supported.

Practice warming exercise daily. Rate tension before and after practice on the Activity Chart. Also, practice breathing whenever you begin to feel stressed.

Conduct a cognitive review. Inform members that only 2 of them will actually be asked to discuss their review during the next session. Other members will be checked on. Questions for the review are presented in the workbook.

4.5.9   Session 9: Problem Solving, Relapse Prevention Training, Life Project

Relapse Training

An important part of preventing a relapse is being prepared. In this session we will focus on two topics that will help better prepare you to cope with setbacks and relapses.

      a. First, we will teach you problem solving skills that may be useful in dealing with really difficult situations.

      b. Second, we will help each of you develop a personal plan for coping with relapses when they occur.

Problem Solving

The major objective of problem solving is to review a variety of alternatives and to identify the most effective way to cope with a situation.

By working on problem solving one can identify a much broader range of coping options and enhance the likelihood that the most effective response will be selected from several alternatives.

Life Project

A concrete way to help participants do something that they personally have wanted to achieve but have not been able to do so is called a Life Project. Doing such a task is likely to bring about a greater sense of meaning and joy.

a. Think of the Life Project as a personal problem to be solved, i.e., something each person has wanted to do but has been unsuccessful.

b. Think of the Life Project as a relatively short term task that is within the realm of accomplishing in a matter of days or weeks, or maybe months.

c. Provide the following as examples of Life Projects (also solicit member examples): learning to play a musical instrument; passing your family history to your children and grandchildren; planting a garden; volunteering; resolving family differences; traveling etc.

4.5.9.1 Skill Guidelines

Problem solving involves five steps (list on board and briefly describe each): 1) problem definition, 2) generating alternatives, 3) decision making, 4) implementing the decision, and 5) evaluating the outcome (Goldfried & Davison, 1976).

1. Problem definition. Participants often tend to describe problems in a very global, vague fashion. The goal of problem definition is to pinpoint specific problems the individual is confronted with in a given situation. (Leader asks a group member to volunteer a problem situation.)

    a. What behavioral problems are likely to occur in this situation? What kinds of behaviors must be increased or decreased in order to cope with this situation?

    b. What thoughts and feelings are likely to occur in this situation? How would these thoughts and feelings affect your abilities to cope?

    c. What physiological problems are likely to occur in this situation? Will the individual feel anxious and have heart rate speeding, difficulty breathing, excessive sweating, etc.?

2. Generating alternatives. Participants should be encouraged to brainstorm a broad range alternative coping options. Encourage them to start with general approaches then to move to specifics later.

    a. <u>Review rules of brainstorming</u>. Hold nothing back, share whatever first comes to mind.

    b. <u>Number of alternatives</u>. Try to develop at least 3 different alternative approaches.

    c. <u>Mix and match coping skills</u>. Some problem situations might require adding together learned coping skills in different combinations. Other situations might require individual to draw on other resources and skills.

3 & 4. Selecting and implementing an alternative. Reviews pros and cons of each of the 3 alternatives. What is the best option. Member should be assigned task of implementing this option in the future.

4.5.9.2 In-Session Exercises

Relapse prevention

1. Developing a Plan for Coping With Setbacks

    a. Some times setbacks and relapses cannot be avoided and it is necessary to find a way to cope with them. Developing a personal plan for coping with relapses beforehand can be particularly helpful when you find yourself in these situations. What are the basic elements of such a plan? (Leader hands out a sheet on which is listed the titles of each of the following sections.)

    b. <u>Stop, look, and listen</u>. Your reaction at this time can be viewed as a warning sign that you are in danger. What can you do to stop, look, and listen? (Leader asks members to fill in this section of the sheet and then reviews the responses.).   You might, for example, go to a quiet place, rest, and review the situation and how you are reacting to it.

    c. <u>Keep calm by using rational self-talk</u>. You have learned in this group how to use cognitive methods to monitor and change negative self-talk. How could you apply this

during a setback or relapse? (Leader asks members to fill in this section of the sheet and then reviews the responses.)

Remind yourself that almost everyone experiences setbacks. The fact that you are having one is not a sign of loss of control, defective willpower, or a personality flaw. Calm yourself by telling yourself that setbacks provide opportunities for new learning to occur. Remember that during a setback there is a strong tendency for your thinking to become more irrational and your beliefs about your own coping abilities to become much more negative.

    d. <u>Review the situation leading up to the setback/relapse</u>. What can you do to review the events leading up to the setback? (Leader asks members to fill in this section of the sheet and then reviews the responses.)

       Were there any warning signs or other factors that might be important (e.g., time of day, activities you were doing, mood). Are there different ways that you might have coped with the events that might have helped?

    e. <u>Make an immediate plan for coping</u>. What are some methods that can be used at these very difficult times? (Leader asks members to fill in this section of the sheet and then reviews the responses.)

If you can remove yourself from the high risk situation, do so. If this is not possible, use imagery or other methods to try to distance yourself from the problems you are confronting. Try to do something pleasant for yourself. Use your skills to deal with overly negative thoughts. Ask your friends/family to help by providing suggestions for ways of coping or alternative activities. Call a friend and seek out support.

4.5.9.3 Homework

(Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they had with the assignments.)

Monitor high risk situations and your coping responses on your Logs.

Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social as well as nonsocial activities. Circle social activities where you felt supported.

Practice warming relaxation exercise daily. Rate tension before and after practice on the Activity Chart. Also, practice relaxation whenever you begin to feel stressed.

Conduct a cognitive review. Inform members that only 2 of them will actually be asked to discuss their review during the next session. Other members will be checked on. Questions for the review are presented in the workbook.

Think, dream, brainstorm about what you might do for your Life Project. Remember, it is something you have wanted to do but have not. Also, it is something that would be interesting, meaningful, and joyful to do.

4.5.10 Session 10: Personal Values and Goals

Values and Life Goals

Personal values and life goals are introduced. Focusing on the personal values and goals can help members gain a better sense of direction and purpose in life as well help them make more informed choices and decisions. Especially after an MI, many people may feel hopeless and helpless. Such feelings can be lessened if people identify what is important and meaningful in their lives.

The goal is to help members examine and explore their personal values and goals. Having a greater sense of "where one is going in one's life and why" offers guidance and direction in evaluating what priorities to set and what goals to seek. Members will learn how to distinguish between goals that are consistent with their personal values and those that are not. Goals should be ones that are not harmful to coping or recovery from the MI (i.e., negative goals).

Personal Project

Doing a personal project (i.e., a goal that the person wants to accomplish) serves several purposes: (1) It helps increase perceived quality of life; (2) It relates directly to personal values and goals; (3) It provides a concrete, specific activity that can help participants make changes that provide more satisfaction, meaning, and self-efficacy in their lives.

4.5.10.1 Skill Guidelines

Values, Goals, and Personal Project

1. Learn what personal values are and how they differ from goals, intentions, and priorities.

   a. One's values are related to one's happiness, meaningfulness, hopefulness, quality of life and a greater sense of purpose and direction. These values have been called integrity, honesty, kindness, compassion, cooperation, service to others, and forgiveness. Love is probably the most central personal value.

   b. Each participant needs to evaluate what personal values are important and set goals that are consistent with these values.

      1) Members will also understand how reducing self-defeating core beliefs and negative goals leads to better attention, higher energy, more enthusiasm, and improved quality of life. They can see how negative attributions about oneself and others and a pessimistic/cynical outlook about the future adversely impact one's attention, mood,

and energy level. These negative thoughts can also contribute to social isolation, depression, and CHD.

    2) Members will practice reflecting on what's of prime importance in their lives and what values seem to be involved.

    3) Starting to plan and carry out a personal project helps participants increase life satisfaction, personal enjoyment, sense of accomplishment, and self-efficacy. Members may also benefit because the experience of planning and completing a personal project can help reduce depression, sense of loneliness and isolation, angry feelings, and other negative affect states. Some members may experience a sense of "ongoing joy" from finally doing what they want to do.

2. Members will examine how values and goals relate to their everyday choices and decisions.

    a. Most members have not reflected on this connection. They often make choices based upon the immediate situation, pressing deadlines/urgencies, habit, social norms or expectations. The aim is moving toward a more balanced, and calmer lifestyle in which our physical, mental, social and spiritual needs are considered. The question each member needs to ask is "What has to be balanced for me to create greater quality of life?".

3. Learn to make decisions and choices: Urgency vs. Importance as the criterion.

    a. Use the 2 by 2 chart of topics that are urgency and important. Group focuses on how much of their time is spent on urgent, but not important, tasks and how they can reduce this category and increase time spent on important, but not urgent, tasks. (See Table on the Urgent and Important Connection.)

4.5.10.2 In-Session Exercises

Life Goals

1. Group Exercise on "What's Really Important?"

    a. Handout Urgent and Important Tasks Chart

    b. Ask each member for one example of one or more urgent and/or important tasks or activities.

    c. Focus on what's important but not urgent (see chart)

2. Have group members give examples of what is of prime importance in their lives.

    a. Make a list of what's really important in life.

3. Look back at the last 6 months and think of the important things that have occurred

    (For example, your heart attack) and how they have influenced your life.

The Urgent/Important Connections

	Urgent Tasks	Not Urgent Tasks
Important Tasks	Deadline-driven activities Crises "Last minute" stuff	Planning, reflecting Prevention work "Considering principles/ values/decisions Time with friends/family Solitude in nature Spiritual growth
Not Important Tasks	Some phone calls Some activities Some phone calls Some meetings Many pressing/time urgent matters Many popular activities	Busywork Too much TV, newspapers Junk mail "Escape" stuff Trivia, junk activities

Adapted from Covey, Merrill and Merrill (1995)

Personal Project

Note that the personal project is an excellent example of something that is "Important/Not Urgent". Focus on the personal project as part of this exercise.

Look at your heart attack as a second chance at life. What would you like to accomplish in the next 10-15 years? Help group members operationalize their goals (i.e., personal projects).

Ending of Group
In order to begin preparing members for the group ending after Session 12, concerns will be explored.

4.5.10.3 Homework

(Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they had with the assignments.)

Setting a Value-Based Goal

Develop a specific goal for this coming week that is based upon at least one personal value that you believe is crucial. (Caution: Members who believe that a personal value is to devote themselves to others may not devote enough time and energy to taking care of themselves.)

Here are the steps to follow:

1. Identify one positive value that you believe is crucial.

2. Ask, "What could I do over the next 4 days that would help me to spend more time with my family (i.e., give and receive social support). My goal is to spend at least 20 minutes a day with my family in a mutually enjoyable activity.

3. Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social, as well as nonsocial, activities. Circle social activities where you felt supported.

4. Practice meditation relaxation daily. Rate tension before and after practice on the Activity Chart. Also, practice relaxation whenever you begin to feel stressed.

5. Conduct a cognitive review. Inform members that only 2 of them will actually be asked to discuss their review during the next session. Other members will be checked on. Questions for the review are presented in the workbook.

6. Think about what you might do for your personal project. Talk with someone about it and begin to think about how to go about doing your personal project.

4.5.11 Future Plans

Rationale

Values, Life Goals, and Personal Project

This session continues the topic of values and life goals started in Session 10. We continue to focus on the concept of balance in life regarding taking care of our basic human needs (physical, economic, social, mental, and spiritual). Values and life goals may become clearer after a significant life event such as a heart attack. There are several connections between balancing these needs and well-being. One major connection is making time for being with others (i.e., those who provide you with acceptance and emotional support; meet your social needs). Another connection is identifying where you want to go with life and what kind of person you want to become.

Members will be encouraged to consider what offers a greater sense of meaning and purpose in life, and how they can feel more connected.

Members will also be asked to identify at least one goal that can be accomplished in a "short" period of time (weeks, not years) by the personal project that members are considering planning.

Mental needs (cognitive/psychological) focus on promoting more adaptive patterns of thinking. Thinking about oneself and how we judge ourselves powerfully influences well-being. Gaining a greater sense of control over one's thoughts, particularly in reducing distractions and increasing focus and attention, also helps manage emotions. One of the most valuable mental needs is to feel more confident that you can do those things well. This confidence leads to a sense of accomplishment and mastery.

Note also that daily practice of relaxation and/or cognitive focusing at home and in each group session also serves to promote greater perceived balance in basic needs and helps create more energy and positive emotional states (e.g., feel calmer, have fewer distracting thoughts, more positively focused attention).

4.5.11.1 Skill Guidelines

Discussion of Group Ending

Discuss the upcoming end of the group. Ask member about some of their thoughts regarding the end of the group. Also elicit what group members plan to do after the group has ended (i.e., remaining in contact with other group members, continuing to practice relaxation, self-therapy sessions, maintaining pleasurable activities, working toward life goals, etc.).

Life Goals

"Urgent" or >not urgent" and >important" or "not important" activities

Continue discussion of the 2 by 2 chart of Urgent and Important activities. The discussion should address how having a heart attack has influenced activities. In addition, the relationship between urgent and important dichotomies and pleasure and accomplishment should be addresses. Each group member will identify at least one activity to stop doing from the urgent/not important category.

Personal projects may take a short period of time (several days to a few weeks) or extend to several months. The key issue is to gain pleasure, satisfaction, and/or a sense of joy from doing the project. (Focus on the process, noting that how it is done is almost as important as completing it.) Assist group members in defining their personal projects and in deciding how they will meet their goals. Much of this discussion will be related to some of the questions discussed in Session 10. The personal project may provide an excellent way to practice problem-solving, relapse prevention, communication skills, and emotional understanding. Emphasize the point that one can have many personal projects that are accomplished over time.

4.5.11.2 In-Session Exercises

<u>Life Goals</u>

Complete "Questions About Better Living" exercise. Go around the room focusing on one question at a time. This exercise allows group members to focus on their strengths and allows them to focus on areas of their lives which provide the greatest sense of worth and meaning. Note that question #4 on the list (What qualities about others do I admire the most?) is also listed on the homework for this week. Group leaders may want to save this question for the following week.

<u>Ending of Group</u>

Continue preparing members for the group ending after Session 12 by exploring concerns and problem solving how to manage high-risk situations.

4.5.11.3 Homework

(Inform members that all assignments will be discussed during the following session. They should feel free to discuss any success and problems that they have had with the assignments.)

Think about each group member and write down one thing that you liked about each person.

Complete an Activity Chart (with pleasure and accomplishment/satisfaction ratings for the next week). Be sure that members indicate social as well as nonsocial activities. Circle social activities where you felt supported.

Practice relaxation (exercise of your choice) daily. Rate tension before and after practice in the Activity Chart. Also, practice relaxation whenever you begin to feel stressed.

Conduct a cognitive review. Inform members that only 2 of them will actually be asked to discuss their review during the next session. Other members will be checked on. Questions for the review are presented in the workbook.

Continue (or start) work on your personal project. Develop a plan for how to do it, gather information, and consult with others. It is important to begin before the last session.

4.5.12 Session 12: Holding On To Progress And Staying Well

Maintenance

Relapse prevention will be addressed with respect to maintaining progress post treatment and preparing for possible setbacks.

Life Project

Discussion of Life Project and ways to keep it going (maintenance) as well as how to keep it focused.

Ending of Group

Completion of the group program is presented as a natural progression of the overall intervention.

4.5.12.1 Skill Guidelines

Review of Material

Go through each of the 11 sessions reviewing the important topics for each session. This should be an interactive presentation allowing group members to recall and expand upon the material learned within the different sessions.

Maintenance

1. The value of continuing to use the skills that they have learned will be discussed.
2. The importance of regularly scheduled post group phone contacts will be underscored.   They will be used as a tool to assess and promote maintenance. The phone contact procedures and the schedule of calls will also be described.

Life Project

Each member will make a brief "progress report" on his/her Life Project.

Ending of Group

The advantages of the group finishing will be discussed as well as measures to overcome the disadvantages. Personal responses to and concerns about termination will be processed. Termination often elicits automatic thoughts; automatic thoughts will be evaluated.

4.5.12.2 In-Session Exercises

Maintenance

1. Discuss plans for maintaining progress--To help maintain gains members need to continue practicing what they have learned.

2. Have each participant develop a maintenance plan. Basic elements of plan include: 1) daily record of practice with learned skills, 2) daily record of early warning signs, 3) list of reinforcers to use in rewarding practice or goal attainment, 4) list of recent obstacles, high risk situations, or setbacks and record of how member has coped with them, and 5) list of basic steps in coping with a setback.

Ending of Group

1. Sense of loss

   Discuss how to handle the "loss" that may be felt about the group coming to an end. Great opportunity to do some creative problem solving and come to group with some concrete ideas on how to maintain the benefits of the group.

2. Qualities admired in other group members

3. Have group members go around the room and describe the qualities they admire most abut each of the other group members (see homework assignment #1).

4.5.12.3 Homework

1. A general assignment is given to all members to continue to practice and use the skills that they learned. Members will be encouraged to set personal schedules to practice relaxation, conduct cognitive reviews, etc.

2. All members are asked to plan time for and to continue working on their Life Project. Members may (voluntary, not required) to contact each other about their projects.

4.6 APPENDICES

4.6.1   Appendix A: Relaxation Exercises

4.6.2   Appendix B: Vignettes

4.6.3   Appendix C: Handouts/Overheads

4.6.4   Appendix D: Homework Assignments and Recording Forms

4.6.5   Appendix E: Session Outlines

4.6.6   Appendix F: Mortality and Morbidity

Death or Re-infarction of a group member: Effect on other members and therapeutic response

Background and Rationale
All of us have thoughts of death and dying at times but most of the time we effectively ward them off because they make us anxious, producing a sense of vulnerability and helplessness. When faced with a life threatening illness, it becomes much harder to avoid these thoughts and they are brought into focus. In this study, once the group intervention starts, patients will talk with each other about their coronary events, the relative seriousness of them, and they will learn that some are sicker than they, some may be on a heart transplant list, some will re-infarct, and some will die during the group treatment. We need to be prepared to deal with these events.

For some of our patients, many of these themes, e.g., vulnerability, death, isolation, loss of control, things left undone in life, shifting values, and associated practical matters, will have come up in the individual treatment. For some, these issues may not have been addressed yet because the intervention is done so early that the patient has not had time to process and incorporate the event. They may have been encouraged to return quickly to a full, "normal" life and have received physician support for avoiding such issues. (The thought of death makes doctors feel anxious and helpless too, thwarted in their efforts to prevent death). For others, these themes may have been avoided. This is consistent with a lifestyle of avoiding emotion and introspection. Secondarily, these patients may fear that negative emotion will produce chest pain and a second event.

In the group treatment, when some member has a second coronary event or dies, previously warded off anxiety about death and its meanings will be much harder to avoid for remaining group members. Whether discussed or not, this will impact the group. If patients do not address their reactions to the recurrent illness or death of a member, the therapist should take time to facilitate this as it will reduce anxiety and strengthen the group. If this doesn't occur, patients may attempt to ward off the anxiety by blaming the person who died (they didn't stop smoking, were angry, missed meetings, etc.), or distancing from them. They may even experience more depression and isolation and some might decide to terminate from treatment. (Since the same issues evoke anxiety in all of us, there may be a parallel wish on the part of therapists and other care providers to avoid dealing with it. That issue needs to be addressed in similar fashion in supervision.)

David Spiegel (1993, Spiegel & Spira, 1991) has written about and studied the process of "detoxifying death and dying" in women with metastatic breast cancer and more recently extended his work to primary breast cancer and other diagnoses (Classen et. al, 1993, personal communication, Spiegel, 1996). This model is adapted here for use with this population. The ENRICHD population differs in some obvious ways from the women with metastatic breast

cancer but much less so than from women with primary cancer. In primary breast cancer as in cardiac patients in ENRICHD, the severity of the threat and knowledge of probable cause of patients' deaths is not as clear nor as proximal in time. The ENRICHD groups are short term, so patients don't know each other as well, are not as attached, nor as committed to helping each other. Nonetheless, the issues are very real and they are similar.

In some ways, thoughts and feelings about death may be more embarrassing with heart disease, especially if an individual's cardiologist is very reassuring and minimizes the threat. Despite reassurance and statistics, every patient knows of someone who had a negative ECG one day and dropped dead the next. It may feel weak or shameful to admit to terror of another cardiac event or death. (Who wants to risk insulting the doctor who saved you last time and who wants to think that his or her reassurance might be inaccurate?) Compared to breast cancer where death is a long process over which patients may be able to control a number of variables, death from a cardiac event may be more terrifying since it may be sudden, giving the patient even less control. Everyone in group has made it through the first event, been encouraged to see friends, go back to work, exercise, have sex, and keep life normal. Then a group member dies. Spiegel's model has effectively helped patients to cope with and develop some sense of mastery, acceptance, and peace with these issues. Using it to elucidate important content, we will re-frame it here to work within the cognitive therapy model of this study.

In discussing the identification of automatic thoughts, Judith Beck (Beck, J., 1995) notes that "certain events are almost universally upsetting" (Beck, J., 1995, p. 75) but that people with psychological disorders may evaluate neutral or even positive events negatively. In working with dying women, it becomes clear that even this universally frightening event is construed quite differently depending on the psychological history of the patient. Thus, in addition to all the normally difficult thoughts and feelings, negative or inaccurate automatic thoughts can worsen the experience of these events, and we should be able to assist patients in coping with these events in our groups.

4.6.6.1 General principles concerning therapeutic interventions regarding recurrent illness or death of a group member include:

1. As an overall strategy, use David Spiegel's advice to medical student's, "Don't just do something. Stand there."

2. Encourage and support expression of anxiety and other emotions; avoidance will not relieve it. Patients may be more comfortable and willing to express associated thoughts, especially if a majority are men.

Therapeutic strategies: Support patients in staying with the issues associated with the group member's event, whether illness or death. Gently inquire about their thoughts, images, and feelings. If anyone expresses feelings about this, stay with them. Be careful not to minimize or

reassure. You may model appropriate responses in your announcement of the event and your sadness and concem. Come back to the issue if patients change the topic quickly.

Encourage patients to notice their automatic thoughts. Help them to distinguish between the natural thoughts and upset feelings associated with a real threat and those automatic, maladaptive thoughts that occur as a pattern for them .

3. Anxiety and fear of chest pain: It is true that anxiety increases heart rate and that psychological factors may be associated with chest pain. This needs to be explained and detoxified as well. Our discussions may raise patients' anxiety levels for a brief time, but we are demonstrating that emotion can be expressed in a time limited way and contained and the cardiac risk is extremely small (Personal communication, Robert DeBusk, M.D.).

Therapeutic strategies: Remind patients that they have been told to exercise and to have a normal sex life, most are returning to work and to family life where they may be exposed to pressures, anger, and unpleasant surprises. Many human interactions produce some emotional reaction and the effort to suppress those feelings may be worse than expressing them in a safe and reassuring environment.

4. Discuss the sense of loss. Then grieve and memorialize the person who died. In order to decrease their distress, patients may sometimes scapegoat or blame the person who died.

Therapeutic strategies: As noted above, allowing patients to blame or distance themselves from the person who died or had another cardiac event will increase their sense of isolation. If someone says things that blame the victim, inquire about what other thoughts or feelings they may be having, e.g., a sense of helplessness or fear. The most important way to reassure someone that they will not be forgotten is to remember others who die. The only way we really live on is in the thoughts of others.

Discussing the sense of loss may require some time. Each person will reflect, either aloud or to themselves, on similarities and differences between him/herself and the deceased. Some thoughts will help them note real differences, age, sex, family history, type of MI, etc. Differences will be reassuring. Stay with their thoughts and feelings. Do not allow your discomfort to close off their thoughts and feelings. Again have patients look for automatic thoughts that are making this experience more noxious for them and help them make corrective interventions.

Grieving for and memorializing the person who died may be brief or extensive depending on how attached the group was to this person and on how long the group has been together. You can help by modeling regret at the death and saying some positive things you will remember. If the person was negative or distant from the group, people may need to express some of their negative feelings and associations as well. Just be sure it's balanced.

5. "Detoxifying death" involves first providing the opportunity to talk about the fear. Then the thoughts and images should be broken down into pieces, thus making them more manageable. Decreasing the sense of isolation with these thoughts is often helpful in itself. It provides a sense of relief, comfort and connectedness that energizes and extends life. (Initially in the breast cancer project, there were fears that dwelling on these issue and anxieties would be physically harmful, but the opposite has proven true. Patients in the study survive on average twice as long as those who don't receive the intervention.)

Therapeutic strategies: Encourage open expression of thoughts and feelings surrounding the death of someone else and one's own death. Inquire whether the group member's death has brought up thoughts about their own. Ask whether people have thought about this in the past or since their heart attack.

Ask whether the person is willing to share some of these thoughts with the group. As you know in a group, once one person starts to express sensitive material, others will join in. Listen and allow time for them to express their thoughts and feelings. Normalize their fears by saying that most people have some thoughts or images and feelings about dying when they have a serious illness. Ask specifically what part of the process they fear. Probe gently by asking what is the *most difficult* thought or image they have about death, (e.g., is it the fear of being dead or the thought of dying?) Usually, it is the fear of the dying process, not of being dead. What about that is most frightening? For some it is apt to be the last moments, sudden death in a car, being alone at their desk, or in bed. Some may fear heart failure and shortness of breath or pain. Some people are frightened of going through defibrillation or general CPR. Once the fear is expressed, help them examine whether there are parts of this they can control. Some will want to write a living will or declare themselves a DNR (Do Not Resuscitate). Some will want to talk with their doctor about limits of treatment. Discussions with doctors, family and each other can be very reassuring. Making the fear explicit and isolating to one or few aspects of this process diminishes the power of the event. It demonstrates that they can tolerate these thoughts without any immediate harm though they are never pleasant. Tears and regrets may be expressed and many patients express a sense of great relief.

6. Patients often have unfinished business that they will feel better by completing. This may mean making an effort to heal or give up a relationship. It may mean taking practical steps, such as making a will, that have been put off. Or it may mean making a decision about addressing core values, looking for a different job, working fewer hours, and taking more time with family.

Therapeutic strategies: See 7 below.

7. People may talk about a life project, something they have always wanted to do and have put off. Now they can make the changes necessary to accomplish this goal.

Therapeutic strategies: Encourage patients to tackle a life project that is possible to complete. Check-in with them at later sessions about their efforts to begin and their progress.

8. <u>Resistance and anger:</u> Some patients will initially feel upset by these discussions. Allow them to express their negative feelings toward the use of groups, the project and the therapist for putting them in a position to experience these feelings.

Therapeutic strategies: Respect different patients' need to deal with these issues in their own ways. Tell patients that you hope the group can be a place where different needs can all be met. Inquire about how they can be together and become more comfonable with accepting the differing needs of people in the group. Give permission for those who need to withdraw from certain discussions to sit quietly during them. Some will want to talk, while others may maintain their stance of denial or silence. Don't allow these discussions to go on for too long a time. (See below.)

9. Time: Assume that it will take a few minutes in each of several session to deal with these issues. Initially, when someone has an event or dies, it may require a large part of the session to discuss the reactions. At each succeeding session, the time requirement will be reduced.

Therapeutic strategies: In some groups, the patients may bring the issue up spontaneously. In others, the therapist will have to do so. In some groups, patients will move too quickly away from these issues and the therapist should gently encourage discussion. However, in each session, after spending a few minutes to deal with these matters, move on to complete the agenda for that session. This provides safety and relief for everyone.

10. Providing our patients an opponunity to express feelings and thoughts about their illness and death frees up energy that can allow them to embrace life more fully. This can be a positive side effect of having had a heart attack.

11. Therapists have the same feelings and fears that patients have. We are also upset by a patient's death and it is appropriate to acknowledge to patients that you are saddened also. Therapists need to deal with their own reactions to death and poor prognosis. These reactions should be discussed in supervision.

4.6.7   REFERENCES

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5. GROUP MEMBER WORKBOOK

5.1 SESSION 1

5.1.1 Goals of the Group Program

The group program is designed to help members maintain their improved sense of well-being as well as continue to make improvements in well-being.

1. The group program is intended to help members recover from a heart attack.

2. Learn and use a menu of coping skills (e.g., communication skills, assertion, problem solving, relaxation, and engaging in pleasant activities) effectively to cope more adequately with feelings, physical condition, and recovery from the heart attack.

3. Groups are powerful modalities. Active participation has been associated with long-term survival for CHD and other major medical conditions. The program is designed to utilize the power of the group to help members improve quality of life.

4. Develop trust and mutual respect for each other and foster a sense of group cohesiveness.

5.1.2 What Makes For An Effective Group?

1. What's expected from each member?

    a. Active and full participation in the group is important .

        i). An effective group is one in which members cooperate and are actively involved in their own care.

        ii). The group is a setting that promotes making behavior changes that are under the members' control.

2. What's expected from the leader?

    a. The leader will serve as a consultant to the group members.

        i). As in individual sessions, the leader will actively collaborate with the members by providing didactic information, guidance, and assistance with problem solving.

ii). The leader will encourage understanding of how skills learned in the group (as well as individually) can be applied to various situations during and following treatment.

3.   Confidentiality

a.   Remember that individual sessions were confidential.

i). No one other than the individual, the counselor, and the counselor's supervisor (who monitors the counselor's behavior not the individual's) is privy to the content of the individual sessions.

b. As in the individual sessions, the group sessions will be "recorded" so that the supervisor can monitor the activities of the group and provide the leader with feedback. This allows for the member to be better served. Tapes will be treated with the strictest confidence.

c. Strict confidentiality is an important condition of group process.

i). It is permissible to discuss your own experiences and what you are learning in the group, but that it is inappropriate to discuss the experiences of others.

4.   Attendance

a. Attendance is important for the group to function effectively.

i). If the member misses an appointment, the leader will immediately contact the member by phone.

5.   Between session activities

a. Homework/practicing of skills needs to be done between sessions.

i). Research shows that those who practice skills make the most progress and derive the most benefit.

ii). It will be important to report back to the group regarding progress (e.g., success and failure) with assignments.

6. Making and maintaining commitment

a. Maintaining commitment is essential.

        i). Member behavior as reflected by attendance, promptness, homework completion, and active participation will provide evidence of commitment level.

        ii). It may be difficult to maintain level of commitment at all times.

5.1.3 Cognitive Review Questions

The following questions need to be addressed during the cognitive review:

a.   What has gone well for you?

b.   What problems arose? How did you handle them? Was there a better way of handling them?

c.   What problems could arise between this session and the next time we do your review ? Imagine the problem in detail?

d.   What automatic thoughts might you have? What beliefs might be activated? How will you deal with the automatic thoughts and beliefs? How will you problem solve?

e.   What cognitive work did you do? What cognitive work would you like to do between now and your next review? What automatic thoughts might get in the way of doing the cognitive work? How will you answer these thoughts?

f.   What further goals do you have for yourself? How will you achieve them? How can the things you learned in the individual program help?

5.2 SESSION 2

5.2.1 Types Of Negative Thinking

a. <u>All- or-nothing thinking (aka Black and White Thinking)</u>. You appraise things in black-and-white categories. There are no in between or gray areas. All-or-nothing thinking forms the basis of perfectionism. It causes you to fear any mistake or imperfection because if your performance falls short of perfect, you see yourself as a total failure. Then you may feel inadequate and worthless. This type of thinking is unrealistic because life is rarely completely one way or the other

b. <u>Over-generalization</u>. You see a single negative event as a never-ending pattern of defeat. You conclude that one thing that happened to you once will occur over and over again. Since what happened is usually unpleasant, you feel upset.

c. <u>Mental filter</u>: You pick out a single negative detail and dwell on it exclusively so that your vision of all reality becomes darkened, like the drop of ink that discolors the entire beaker of water. When you are depressed you see the world through special glasses that filter out anything positive. All that you allow to enter your conscious mind is negative and because you are unaware of this filtering process, you conclude that everything is negative.

d. <u>Disqualifying the positive</u>. You reject positive experiences by insisting they "don't count" for some reason or other. This way you can maintain a negative belief that is contradicted by your everyday experiences. An everyday example of this is the way that some people tend to respond to compliments. We are conditioned to respond to compliments and when someone praises your work, clothes or appearance you might automatically tell yourself, "They are just being nice." Disqualifying the positive is one of the most destructive examples of negative thinking since what you are telling yourself that you are second-rate and not worth it.

e. <u>Jumping to conclusions</u>. You make a negative interpretation even though there are no definite facts that convincingly support your conclusion. There are two types of this jumping to conclusion errors: "mind reading" and the "fortune teller error."

  1) <u>Mind reading</u>. You arbitrarily conclude that someone is reacting negatively to you, and you don't bother to check this out. For example, you make the assumption that other people are looking down on you and you are so convinced about this that you don't even bother to check it out.

  2) <u>Fortune teller error</u>.   You anticipate that things will turn out badly and you feel convinced that your prediction is an already-established fact. It is like having a crystal

ball that foretells only misery for you. You imagine that something bad is going to happen and you take this prediction as a fact even though this is unrealistic.

Magnification (aka Catastrophizing) or minimization. You exaggerate the importance of things (such as your goof-up or someone else's achievement) or you inappropriately shrink things until they appear tiny (your own desirable qualities or the other fellow's imperfections). This is also called the "binocular trick." Magnification commonly occurs when you look at your own mistakes and exaggerate their importance: "I made a mistake, now everyone will know and my reputation will be ruined!" You are catastrophizing your mistakes as if you were looking through binoculars to that make them look larger than they really are. Minimizing occurs when you look at your strengths and good points and minimize their significance as if you were looking through the wrong end of the binoculars.

Emotional reasoning. You assume that your negative emotions necessarily reflect the way things really are: "I feel it, therefore it must be true." For example: "I feel guilty, therefore I deserve this." "I feel depressed, therefore I'm a loser." This kind of thinking is misleading because your feelings reflect your thoughts and beliefs. If they are distorted, as is often the case, your emotions will have little validity. Emotional reasoning plays a role in keeping some people depressed. Because things feel so negative to you, you assume they truly are.

Should statements: You try to motivate yourself with shoulds and shouldn'ts, as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct should statements toward others, you feel anger, frustration, and resentment. When you tell yourself that you should do this or that you are putting pressure on yourself and start to get resentful. Common examples are "I should be able to do this all by myself. " "I should not ask for help." or "I shouldn't have to ask for help (people should be able to read my mind and, if they don't, they don't care about me.)"

Labeling and mislabeling. This is an extreme form of over-generalization. Personal labeling means creating a completely negative self-image based on your error. Instead of describing your error ("I made a mistake") you attach a negative label to yourself: "I'm a loser." When someone else's behavior rubs you the wrong way, you attach a negative label to him: "He's a louse." Mislabeling involves describing an event with language that is highly colored and emotionally loaded. Alternative "I did something stupid," not "I am stupid."

Personalization.   You see yourself as the cause of some negative external event which in fact you were not primarily responsible for. You arbitrarily decide that what happened is your fault or reflects your inadequacy. Personalization causes you to feel guilt.

5.2.2 Understanding Thinking

How a person interprets situations determines how the person feels about situations. Use this technique to understand thoughts that are associated with various situations. While this technique is simple enough, it does take lots of practice to use it effectively. Several steps are involved:

    Step 1. IDENTIFY thinking patterns

    Step 2. EVALUATE thoughts/interpretations

    Step 3. RESPOND by considering alternative interpretations

These steps can lead to positive changes in mood and behavior.

5.3 SESSION 3

5.3.1 Identifying Feelings

The Log that you first used in your individual sessions and that you are currently using in the group program is an important tool to increase you ability to identify negative and positive thoughts and feelings.

As you know by now, record keeping is a very effective means of becoming more aware of one's thoughts and feelings. All the skills you will be learning build upon the base of being aware of your own thoughts and feelings. By now, most of you have learned this skill well. You know that thoughts are whatever you are thinking at any moment -- the words that are "playing" in your mind at any point in time.You will need to be aware of a whole range of feelings.

The following are thought to be universal emotions:

1. anger

2. fear

3. joy

4. disgust

5. sadness

Possibly universal emotions are:

1. contempt

2. surprise

3. interest

Very widespread emotions are:

1. shame

2. love

Chronic negative emotional states powerfully relate to CHD-related processes. A growing body of research has documented associations between psychological/psychosocial variables and cardiac recurrences and mortality post heart attack. Research indicates that depression, lack of social support, and distress are important predictors of negative CHD-related processes.

Feelings may be based on faulty thinking about a given situation.   It is important to develop an awareness of this as a base for evaluating negative thoughts and negative feelings, to decide whether to act or to try to overcome the feeling. Using the Cognitive Flowchart may be useful in this regard.

5.3.2 "What's The Evidence?"

--What is the evidence?

--What is the evidence that supports this idea?

--What is the evidence against this idea?

--Is there an alternative explanation?

--What is the worst thing that could happen? Could I live through it?

--What is best thing that could happen?

--What is the most realistic outcome?

--What is the effect of my believing the automatic thought?

--What could be the effect of changing my thinking?

--What should I do about it?

--What would I tell _____ (a friend) if he or she were in the same situation?

5.3.3 Procedures For Using The Cognitive Flowchart

Use the following questions to evaluate a situation after you have completed "What's the evidence?"

– Important: Is the situation and my thoughts/feelings worth my continuing attention? How you rated intensity of the feeling on the Log serves as a marker for importance.

– Appropriate: Are my thoughts/feelings appropriate, given the objective facts (not my interpretation of them) of the situation? (versus--Do my thoughts represent cognitive distortions that lead to negative emotional states?)

– Modifiable: Are there actions I can take that will fix the situation so that I don't continue to have the negative thoughts/feelings? (or, Can I modify my thoughts/interpretation of the events?)

– Worth It: Will taking action (changing my thoughts or changing my behavior) lead to a net gain, weighing both my and the other person's needs?

If you note the first letter of the first three questions above and the two words of the fourth question, you will note that they spell out a statement that will help you to remember these four important questions for evaluating your negative thoughts and feelings: "I AM WORTH IT!"

If you simply remember, "I AM WORTH IT!" every time you become aware of a negative thought or feeling, it will help you to remember the four questions you need to answer about any situation in which you are experiencing negative thoughts or feelings.

5.4 SESSION 4

5.4.1 Benefits of Social Connectedness

Feeling connected with others has been associated with increased sense of well-being, quality of life, and improved healt outcomes.

Types of Social Connectedness and Benefits

Informational (e.g. doctors and nurses)

1. Promotes healthier behaviors

2. Facilitates one's ability to obtain necessary medical care

3. Provides advice leading to solutions

Tangible (e.g. friends and family)

1. Helps accomplish chores

2. Provides money to pay bills

3. Provides assistance to meet various obligations

Social/Emotional (e.g., spouses, family, friends, church, community)

1. Someone who really listens to you

2. Helps you feel better about yourself

3. Feel more secure knowing someone is ready to be with you

4. Increases positive self-evaluations

5.4.2 Modifying Coping Strategies to Obtain Support

1. Seek out information (as relates to their medical condition).

2. Seek out tangible aid (money, advice, instructions).

3. Communicate needs and feelings (good and bad) more effectively to friends, family, and supportive others (e.g., medical personnel).

4. Allow yourself to rely on trusted friends.

5. Enjoying nurturance, expressing feelings assertively.

6. Finding a central confidant and increasing connection (e.g., spouse, close friend, religious leader, etc.).

7. Increase involvement in the community (lending support).

8. Get a pet!

5.5 SESSION 5

5.5.1 Communicating Effectively

1. Most communication is nonverbal. What clues do you use to determine what the other person is feeling, aside from the content of what is said? To be an effective communicator, you need to appear as calm, in control, interested in the other person, and nonagitated as possible (Body language handout).

2. Speaking and listening are both necessary and best in equal doses, so that talk becomes conversation, not a monologue on either side. (Exception: With children, and with some troubled adults you will need to listen most of the time.) Some of you may have trouble speaking up while others will find it difficult to listen. We will discuss speaking up first, as not speaking in itself is a problem. How can you have a good relationship with someone if you send out so few signals about what you are like and what you need and want?

Among "nonspeakers, usually the recognition of a hesitancy to speak eventually is accompanied by a realization that he or she doesn't have a very high opinion of himself/herself, seeing personal needs as unnecessary, personal opinions unimportant. He or she is there to care for others, but not vice versa. Only by being so attentive to others will he or she gain worth. Clearly, such thinking involves only half the equation--higher self-esteem is called for.   This is a lifelong task for many of us.

3. Here are guidelines for being a more effective speaker:

    a)   <u>Just do it</u>. If you are shy and often silent, an important early step to better relationships is to begin speaking out. Initiate and maintain conversations with interest and even enthusiasm. Introduce yourself to the other person at your table in the cafeteria at lunchtime or at the bus stop. Listen to what he has to say and if you get a chance, tell him a little about yourself too. Go up to someone you don't know during coffee hour after the church service. After she starts a conversation, listen intently, then tell her something on a related topic of special interest to you. If children come to the coffee hour, ask one of them if she has a favorite sport. At a family dinner, ask a relative what he's been up to lately, then tell him what you've been doing recently. If you are shy, assume the other person will be interested. (If you aren't shy, but usually are rather talkative, focus on the listening strategy instead of this one!)

    b)   <u>Try as frequently as appropriate to use "I" statements</u>. You both share yourself and allow others to disagree. Notice how the second, less preferred choice in each pair of statements listed below puts the other person on the spot, where they are forced to either agree or disagree with your statement about the situation. On the other hand, when you use the first, "I" statement, you don't put this pressure on the other person.

– "I was upset to have to wait for an hour in the waiting room for my appointment (Instead of "It's terrible to have to wait an hour in the waiting room.")

– "I dislike fried chicken, " (Instead of "Fried chicken tastes lousy!")

– "I am disappointed supper isn't ready," (Instead of "It's terrible that supper isn't ready.")

– "I like red roses best," (Instead of "Red roses are the most beautiful flowers in the world.")

– "I am cold," (Instead of "This room is too cold.")

– "I don't like buttered popcorn," (Instead of "You ruined the popcorn.")

– "I feel so stressed when the living room is messy," (Instead of "You never do your fair share keeping this place picked up.")

c) <u>Share yourself often</u>.   The best way to let another person truly know you is to tell them what you are feeling: friendly; sad; angry, happy; scared; courageous; whatever. Also share doubts and dreams. How can you possibly feel connected to others if they don't know you?

Of course, once you have mastered the earlier-mentioned skill of identifying your feelings, speaking up becomes easier.

— "I feel lonely," (Instead of "You aren't giving me enough attention.")

— "I feel disappointed that the peanut butter is gone, when I was looking so forward to a good sandwich." (Instead of "You finished the peanut butter, without any reminder added to the grocery list!!")

— "I am depressed about the effect of my heart condition on my quality of life." (Instead of "I can't do the things I used to do.")

4. <u>Speak out of your personal experience</u>s. This will keep you from sounding vague or authoritative. This is easier, once you become accustomed to it.

— "I opened the door to our study. Papers covered the desktop and half of the floor besides. I felt so frustrated, tired, and annoyed."(Instead of "You are incredibly messy. Can't you ever do your share of the work.")

— "I had trouble getting to the pharmacy today." (Instead of "Why can't you ever help me out with errands.")

5.   Be specific.

  –   "As you sit there, with the moonlight hitting your face, I think you are very beautiful. (Instead of "You are wonderful.")

  –   "You promised to take me to the doctor today; but you had to cancel." (Instead of "You have no time for me.")

6.   When you speak, synchronize the spoken words and your body language, so that both reflect what you deliberately decide you want to communicate. If inconsistencies exist between spoken words and body language, the nonverbal message usually dominates.

Speaking so you communicate effectively is just as important as listening, when it comes to building good relationships. If you only listen, no matter how well, you are at risk of being passive.

5.5.2 Body Language

Duke psychologist John Barefoot has conducted numerous interviews over a number of years. He has concluded that style -- tone of voice and "body language" -- is an important index of communication.

Dr. Barefoot looks for evasions which keep the other person at a distance and show contempt for the situation. "Maybe." "You can't really say." or "That may be." sometimes can be spoken in ways that invalidate what was said before, without explicitly challenging the other person. Some people often cross their arms, avoid eye contact, or curl the upper lip to the side while slightly wrinkling the nose. John also watches out for indirect challenges which can be as subtle as answering in a tone of voice which implies the question is stupid. "Of course!" roughly can translate, "That was a stupid question, if ever I heard one!" In the midst of considering these relatively subtle cues, don't forget that direct challenges are also a great way to not listen effectively!

Instead of allowing your body language to alienate others when in conversation, convey your caring through your body. Begin by keeping still. Focus your eyes on his or her eyes, glancing away occasionally so that your gaze does not feel invasive to the other party. (The more direct looking, the more intimacy.) You can still appear bored, if your expression is glazed, so make looking an active process. Unknit your brow. Relax your jaw and your large muscles as well. Uncross your arms. Lean slightly forward. Even though you are being silent, it's OK to nod your head occasionally or murmur "uh huh" to let the speaker know you are interested and involved in what's being said. Small movements of the head at the neck also can indicate your attentiveness. Being aware of so many details may feel awkward at first but becomes less so with practice, especially as you find yourself becoming interested in what is being said. To get a better idea of how good listeners behave, pay close attention to interviewers on television--like

Barbara Walters, Charlie Gibson, Jane Pauley, Katie Couric, Mike Wallace and others. They really appear interested in what the interviewee is saying.

As you become more practiced, you'll want to make all of this other than simply a posture you assume, by really being interested in what you or the other person is saying.

5.5.3 SPEAKING UP

1. Just do it.

2. Make "I" statements.

3. Share yourself, especially your feelings.

4. Speak out of personal experience.

5. Be specific.

6. Use positive body language.

5.5.4 Guidelines for Listening

1. Keep quiet until the other person finishes speaking

    a. Don't feel that you have to jump in after a few seconds' silence!

2. Make sure your "body language" conveys your interest

3. When the other person is finished speaking, reflect back what you understood them to be trying to say -- "What I hear you saying is...."

    a. Then give it your best shot to tell him/her what you thought you were trying to say -- not why the person was right or wrong or the first thing that comes into your mind in association with what was said.

5.6 SESSION 6

5.6.1 Relapse Prevention

Relapse prevention training has several basic principles:

<u>Plan ahead to prevent relapse</u>. It is important to start early with relapse prevention training.

<u>Identify high risk situations</u>. Identify high risk situations that represent major obstacles to your coping skills. Develop a plan for dealing with these situations.

<u>Role playing</u>. To develop confidence in your ability to apply coping skills to deal with challenging high risk situations, it is important to rehearse them.

<u>Self-monitoring</u>. Your Logs are an excellent way to keep track of your practice with coping skills and prompting you to reward yourself for progress in coping.

5.6.2 Muscle Relaxation

Note: When tensing your muscles, tense them only slightly, just so that you feel the tension. You do not want to tense maximally.

<u>Four muscle groups</u>

1. Right and Left Arms (make a fist tensing hands and forearms while tensing upper arms by pushing upper arms down against chair).

2. Face, Neck, and Throat (simultaneously raise eyebrows or frown, squint, wrinkle up nose, bite down, and pull the corners of your mouth back, while pulling your chin toward chest but don't let it touch chest).

3. Chest, shoulders, Upper Back, and Abdomen (take a deep breath, pull shoulder blades back and together, while at the same time making the stomach hard by either pulling in or pushing out).

4. Right and Left Thighs, Calves, and Feet (lift your legs slightly while pulling toes toward head, curling them and turning your feet inward).

5.7 SESSION 7

5.7.1 The 3 "A's": Avoid, Adapt, Alter

Anger provoking situations in general and stressful situations in particular can be managed using the 3 "A's".

1. <u>Avoid</u>. Avoiding is a useful approach for some situations. You can not necessarily avoid all anger provoking situations since that might serve to isolate you from others. However, you may be able to adjust your life to avoid some anger provoking moments.

    a. e.g., you can avoid interacting with someone who makes you angry.

2. <u>Alter</u>. In situations where you have some control, it may be useful to alter the anger provoking situations. You need to consider the situation and decide what aspect you can realistically change.

    a. e.g., if someone does something that makes you angry, you can tell them how their behavior makes you feel and ask them to change their behavior.

3. <u>Adapt</u>. Adapting is often the best option though it is not necessarily easy. Remember your interpretation (thoughts) of a situation is what causes anger (or stress). You can reduce feelings of anger (or stress) by adapting. For example:

    a. After evaluating your thoughts, change your thoughts and beliefs about a situation.

    b. Adapt by making yourself less vulnerable to anger by practicing relaxation.

    c. Adapt when you learn to anticipate anger provoking situations and prepare for them by rehearsing what you will do.

5.7.2 Facing Anger

Slow down the process

1. Recognize that you are angry before you react.

2. Notice physical symptoms.

3. Acknowledge your anger (don't invalidate your emotion).

4. Are you too upset or angry to appropriately deal with the situation now? Do you need a buffer or a cooling down period?

Anger appraisal of the situation

1. Evaluate your thoughts about the situation.

2. If the situation is interpersonal, consider the other person's perspective.

Expressing anger: Consider the following:

1. Recognize your own needs.

2. If the situation is interpersonal, recognize the needs of the other person.

3. Assess timing (i.e., Do I need to be in a better mood to say something about this. Does the other person need to be in a better mood).

4. What is the desired outcome? (If the situation is interpersonal, do you want to save the relationship or do you want a certain goal no matter what it does to the relationship.

5.8 SESSION 8

5.8.1 Assertiveness training

1. Assertion

    a. Whenever your evaluation of your negative thoughts and feelings in a given situation (involving another person) using the "I AM WORTH IT!" questions on the Cognitive Flowchart leads you to answer "Yes" to all four questions, it is a clear signal that in this particular situation, you need to act. However, it does not mean that you have been unleashed to attack, put down the other person, and righteously demand that he/she change. The kind of action that is called for is assertion, which is always far more likely to bring about the change you want.

    b. Assertion to get others to change can take either of two forms. First is asking -- using either a simple or a more complex approach -- for the change you want in the situation or the behavior of another person. Second is simply refusing yourself to start or continue doing something that will cause you to have negative feelings by "just saying no".

    c. Simple Assertion: You just directly ask for what you want.

        Example of simple assertion: "Please let me finish washing dishes before we leave for the store.

    d. Complex assertion:

        1. A fully developed complex assertion involves three mandatory steps and one optional step:

            – Describe the objective facts of the situation that you want to change.

            – Describe the feelings you experience in the situation just described.

            – Request the change in behavior you want from the other person.

            – (optional) Describe the consequences you are prepared to deliver if the change is not forthcoming.

    e. Just say No.

        1. How to say no: The other part of assertion is refusing the requests of others. This is good advice if you routinely overextend yourself on behalf of others, then end

up feeling exhausted and resentful. You will need to decide if you are one of those people who are either afraid of rejection or simply more sensitive to the needs of others than to your own needs. Such people consequently end up on every committee. Or always entertain the rest of the family. In short, usually do what the other person wants, while neglecting personal needs. If you qualify, you need to learn to say no.

2. How you say no is important. Sometimes its best to begin with restatement:

   – You want me to babysit the grandchildren next week.

   – You may want to emphasize:

   – I know how important getting babysitter is to you.

f. Sometimes you next want to share a statement of how you are feeling. Omit this step if these feelings are hostile, ranging from mild pique to raging anger (Give me a break! I've already done more than my fair share babysitting.) Do consider sharing feelings you are experiencing as too much (I feel tired already!). Do not share feelings with persistent people likely to argue that your feelings are the problem.

h. Always include an explicit no. Avoid long-winded explanations, excuses, or apologetic behavior -- they only encourage the other person to persist in trying to talk you into doing what you want to avoid.

1. "Sorry, but no". I do not want to babysit the grandchildren next week.

2. Assertion is hardly ever easy to pull off. The process of asking the I AM WORTH IT! questions will help you to calm down so that you can do it right, but very often you will need to practice a quick relaxation on the spot, to make sure your negative thoughts and feelings do not interfere to the extent that you blow it when trying to be effectively assertive. So, calm yourself down, rehearse in your mind the assertion statements you are going to make, following the guidelines just outlined and also on your Assertion guidelines handout . Here are some further examples of embellishments you can add, as you become more practiced at assertion, to the basic steps in the handout.

Example of adding description of the behavior that is bothering you: "John, when you come to visit with me, I would prefer to have a conversation with you rather than to watch television."

Example of adding empathy: "I know it's hard to find a babysitter for the grandchildren, but watching them next week is a burden on me."

Example of reminding the person of earlier promises: "Doctor, you had promised me that I would be seen immediately if I arrived on time for an 8:30 am appointment.

Example of adding information about your own feelings: "When you came over late, I felt worried that something terrible had happened to you. In the future, if you are running late, please call me."

Example of consequences: "If you miss one more appointment to help me with my housekeeping, I will need to hire someone else."

5.8.2 Assertion Guidelines

ASSERTION TO GET WHAT YOU WANT

1. Describe the behavior that is causing your negative feelings.

2. Describe your feelings.

3. Request the specific change of behavior you need.

4. (Optional, if the first three do not work) State the consequences.

_____

ASSERTION TO PROTECT YOURSELF

1. Just say No. (Simple, isn't it!)

5.9 SESSION 9

5.9.1 Problem Solving

Problem solving involves five steps: 1) problem definition, 2) generating alternatives, 3) decision making, 4) implementing the decision, and 5) evaluating the outcome.

Problem definition. The goal of problem definition is to pinpoint specific problems the individual is confronted with in a given situation.

a. What behavioral problems are likely to occur in this situation? What kinds of behaviors must be increased or decreased in order to cope with this situation?

b. What thoughts and feelings are likely to occur in this situation? How would these thoughts and feelings affect your abilities to cope?

c. What physiological problems are likely to occur in this situation? Will the individual feel anxious and have heart rate speeding, difficulty breathing, excessive sweating, etc.?

Generating alternatives.

a. <u>Review rules of brainstorming</u>. Hold nothing back, share whatever first comes to mind.

b. <u>Number of alternatives</u>. Try to develop at least 3 different alternative approaches.

c. <u>Mix and match coping skills</u>. Some problem situations might require adding together learned coping skills in different combinations. Other situations might require individual to draw on other resources and skills.

Selecting and implementing an alternative. Reviews pros and cons of each of the 3 alternatives. What is the best option. Implement this option in the future.

5.9.2 Developing A Plan for Coping With Setbacks

<u>Stop, look, and listen</u>

<u>Keep calm by using rational self-talk</u>

<u>Review the situation leading up to the setback/relapse</u>.

<u>Make an immediate plan for coping</u>

5.9.3 Warming Exercise

You can do the warming exercises sitting or lying down:

1. Sit in an armchair in which your head, back and extremities are comfortably supported and you are as relaxed as possible, or

2. Lie down with your head supported, your legs about eight inches apart, your toes pointed slightly outward and your arms resting comfortably at your sides without touching them.

Repeat each of the following phrases four (4) times.

> I am calm.
>
> I am at peace with myself.
>
> My right arm is warm.
>
> My left arm is warm.
>
> Both of my arms are warm.
>
> My right leg is warm.
>
> My left leg is warm.
>
> Both of my legs are warm.
>
> My arms and legs are warm.

Take a few minutes for enjoyment.

Then say to yourself, "When I open my eyes, I will feel refreshed and alert". (say this four times). Then open your eyes, breathe a few deep breaths as you stretch and flex your arms.

5.10 SESSION 10

5.10.1 Principles Of Living

Principles of Living come from what have been called 'truths' developed over many centuries from many cultures, what today we call the 'wisdom traditions'. These are universal laws of living that have withstood the test of time over thousands of years. Such principles related to happiness, meaningfulness, hopefulness, quality of life and a greater sense of purpose and direction. These principles have been called integrity, honesty, kindness, compassion, cooperation, service to others and forgiveness. Love is probably the most central principle of living.

To live a more principled life involves priorities and goals that are congruent with identified life principles. A principle can be regarded of as a core belief that one accepts as true. However, not all core beliefs are universal principles of living. For example, a person's core belief may be that all people are evil or dangerous, not to be trusted. Such a belief while powerful in its impact on automatic thoughts, behavior and emotions--not to mention social relations--would not be considered a life-affirming principle of living that has been validated in the experience of many people over time. Instead some negative core beliefs have been found to foster chronic disease.

It is important to examine how principles and goals relate to everyday choices and decisions. Most people have not reflected on this connection, often making choices based on the immediate situation, pressing deadline/urgency, habit, or social norms or expectations. We live in an increasingly impatient, 'hurry up' culture. The heart of principles of living or 'putting first things first' is moving toward a more balanced and calmer lifestyle in which our physical, mental, social and spiritual needs are considered in what we do. 'What has to be balanced for me to create greater quality of life?'

Physical needs, Economic needs, Mental needs, Social needs, Spiritual needs--all humans have these five related needs and try to satisfy them in a variety of ways. Certain principles of living lie at the base of these needs, such as the principles of trust and integrity which underlie social needs. Principles of moderation, honesty and thrift can be said to underlie economic needs and principles of love, compassion and forgiveness create the basis for satisfying spiritual needs.

5.10.2 Tuning In Task

Make a daily entry into your Log about how you decide or choose what to do and how that choice or decision is connected to a principle or core belief. Do you feel any discrepancy between what you are doing at any moment and what you believe to be a principle or core belief? Do you notice a difference between your social roles (or biological/gender/career roles) and your own deep inner thoughts? Come to the next session ready to talk about what you observed.

5.10.3 Setting A Principled-Based Goal

To start setting goals that are based on certain principles (and conscience) takes a lot of courage and commitment. Yet that's what it takes to make the kind of changes that will give you more quality of life and help you feel better.

a. Develop a specific goal for this coming week that is based on at least one Principle of Living that you believe is a core/bedrock/"nothing more important belief".

b. Here are the steps to follow:

    1. Identify one Principle of Living that you believe is crucial.

    2. Ask, what could I do over the next four days that would put this Principle into action

        a) Example: Principle is compassion. Goal is spend at least one hour with 'Jack or Jackie' listening very actively and sensitively to them about their problems or concerns, keeping in mind what it takes to listen with empathy and understanding.)

5.10.4 Breath Counting Meditation

This is perhaps the most relaxing form of meditation. Following the gentle ins and outs of the breath creates a sense of peace and restfulness.

1. Find your posture and center yourself. Take several deep breaths. Either close your eyes or fix them on a spot on the floor about four feet in front of you. Your eyes may or may not be focused.

2. Take deep but not forced belly breaths. As you do, focus your attention on each part of the breath: the inhale, the turn (the point at which you stop inhaling and start exhaling), the exhale, the pause between the exhale and inhale), the turn (the point at which you start to inhale), the inhale, and so on. Pay careful attention to the pause. What are the sensations in your body as you pause between breaths?

3. As you exhale, say "one." Continue counting each exhale by saying "two...three...four." Then begin again with "one." If you lose count, simply start over with "one."

4. When you discover that your mind has slipped into thought, note this, then gently return to the counting of your breath.

5. If a particular sensation in your body catches your attention, focus on the sensation until it recedes. Then return your attention to the inhale and the exhale and the counting of your breath.

6. If you wish, try the following variation. Begin by counting your breath for several minutes. Then stop the actual counting and put your attention on the sensations of breathing. Focus on your abdomen as it expands and contracts. Can you sense how the size of the empty space in your abdomen grows and shrinks as your breath goes in and out of your belly? At first, you may have more thoughts when you practice this way than you had when you were counting breaths. The counting kept your mind returning in a small circle of numbers which left less room for rising thoughts. Do not be disturbed by this. Simply note each thought and then return your awareness to the sensations of your breath. Every now and then, you may come across a thought that you find enticing and want to contemplate. Tell yourself you will consider this thought when the meditation period is over and let it go. Sensations other than breathing may call your attention from time to time: a strain in your shoulder, or the pins and needles of your legs falling asleep. When this happens, let your attention focus on these new sensations until they fade into the background. Then go back to your breath. The sounds of the outside world will cross and recross the boundaries of your awareness. Note their passing and return to your breath.

7. Things to Keep in Mind

    a) It is not necessary to feel as though you are relaxing while you meditate in order for you to actually become relaxed. You may feel as though you are thinking thousands of thoughts and are very restless. However, when you open your eyes at the end of your meditation, you will realize you feel much more relaxed than you did before meditating.

    b) As your mind quiets with meditation, old or hidden pain can arise from your subconscious. If you find that when you meditate you suddenly feel angry, depressed, or frightened, try to gently allow yourself to experience the feeling while resisting the temptation to make sense out of your feelings. If you feel the need, talk to a friend, counselor, or meditation teacher.

    c) You may hear or read about ideal conditions for meditation: that you should meditate only in a quiet place. Or meditate only two hours after you've eaten. Or meditate only in a position that you can hold comfortably for twenty minutes, and so on. Yes, these are ideal conditions, but life is seldom ideal. If the place isn't absolutely quiet or the only

time you have to meditate is right after lunch, don't let these small obstacles keep you from meditating. If you find yourself being particularly bothered by noises or the rumblings of a full stomach, simply incorporate the annoying sensation in with the object of your meditation.

d) If you adopt a daily sitting practice, you may find that there are stretches of time during which you will not want to meditate. Do not expect that your desire to meditate will grow constantly with your practice. If you feel discouraged, be gentle with yourself and try to work creatively on ways to make your practice more comfortable. Know that these periods of discouragement will go away by themselves in time. For helping to maintain a schedule, the value of finding a group with which you can meditate at least once a week cannot be overstated.

5.11 SESSION 11:

5.11.1 'Dreams and Values Exercise'

Use your watch to go through the following timed exercise.

1. Take one minute and answer the following question. Write down everything that comes to your mind.

    a. If I had unlimited time and resources, what would I do? Don't be afraid to dream. Unlock possibilities.

2. Take one minute and write down your values. Below is a partial list that might help stimulate your thinking.

peace of mind	spiritual fulfillment
security	friendships
wealth	family
good health	respect of others
close relationship with...	sense of accomplishment
recognition or fame	travel
free time to...	contributing time, knowledge, or money
happiness	longevity

3. Take one minute and go through your list of values, identifying the top five.

4. Take a few minutes and compare your list of five values to your dreams.

    a. You may find you have dreams that are not in harmony with your values. You may dream of living the life of Indiana Jones, but you don't really value the idea of the life of crawling through cobwebs and sleeping with scorpions. If you don't get your dreams out in the open and look at them in the cool light of day, you may spend years living with illusions and the subconscious feeling that you're somehow settling for second best. Work on the two lists until you feel your dreams reflect your values.

5. Now take one minute to look at your values as they relate to the four fundamental areas of human fulfillment.

   a. Do they reflect your physical, social, mental, and spiritual needs and capacities? Work on your list until you feel they do.

6. Finally, take one last minute to answer this question:

   a. What principles will produce the values on my final list?

5.11.2 What is a Vision Statement?

Vision Statements foster imagination and create motivation by allowing persons to see beyond their current life situation. These future-focused statements also encourage a greater sense of hope and a more optimistic outlook on life. Such statements help transcend the past and present, and in effect, also helps us invent our future. At a more pragmatic level, the experience of developing one's Vision Statement can powerfully influence the choices and decision one makes in the present. By influencing choices and decisions, a Vision Statement creates influential consequences, ones that can alter our future.

Vision however needs to offer a balanced outlook in terms of our basic needs (i.e., physical, economic, social, mental, and spiritual). For example, if our vision statement, and thus our mission in life, is limited to strictly economic needs (such as becoming a millionaire) we will make choices that can quickly create tremendous imbalance that can bring on negative consequences. By contrast, our everyday choices are guided by our stated vision, which has been grounded in principles of living, then we can alter the nature of the various 'dysfunctional' scripts we've learned from others in growing up (parents, siblings, close relative and friends, teachers, ministers, employers, etc.).   Also, we can alter our automatic thoughts and images.

5.11.3 Examples of Vision Statements

I will live each day with courage and a belief in myself and others. I will live by the values of integrity, freedom of choice, and a love of all people. I will strive to keep commitments not only to others but to myself as well. I will remember that to truly live, I must climb the mountain today, for tomorrow may be too late. I know that my mountain may seem no more than a hill to others and I will accept that. I will be renewed by my own personal victories and triumphs no matter how small. I will continue to make my own choices and to live with them as I have always done. I will not make excuses or blame others. I will, for as long as possible, keep my mind and body healthy and strong as that I am able to make the choice to comb the mountain. I will help others as best I can and I will thank those who help me along the way.

For myself, I want to develop self-knowledge, self love, and self-allowing. I want to use my healing talents to keep hope alive and express my vision courageously in word and action. In my family, I want to build healthy, loving relationships in which we let each other become our best selves. At work, I want to establish a fault-free, self-perpetuating, learning environment. In the world, I want to nurture the development of all life forms, in harmony with the laws of nature.

To be humble.

To say thanks to God in some way, every day.

To never react to abuse by passing it on.

To find the self within that does and can look at all sides without loss.

I believe in treating all people with kindness and respect.

I believe by knowing what I value, I truly know what I want.

To be driven by my values and beliefs

I want to experience life's passions with the newness of a child's love, the sweetness and joy of young love, and the respect and reverence of mature love.

My goals are to achieve a position of respect and knowledge, to utilize that position to help others, to play an active role in a public organization.

Finally, to go through life with a smile on my face and a twinkle in my eye.

To be the person my children look to with pride when they say, 'This is my dad/mom.'

To be the one my children come to for love, comfort, and understanding.

To be the friend known as caring and always willing to listen emphatically to their concerns.

To be a person not willing to win at the cost of another's spirit.

To be a person who can feel pain and not want to hurt another.

To be the person who speaks for the one that cannot, to listen for the one that cannot hear, see for the one without sight, an have the ability to say, 'You did that, not I.'

To have my deeds always match my words through the grace of God.

I will maintain a positive attitude and a sense of humor in everything I do. I want to be known by my family as a caring and loving spouse and parent; by my associates as a fair and honest person; and my friends as someone they can count on. To the people who work for me and with me, I pledge my respect and will strive every day to earn their respect. Controlling all my actions is a strong sense of integrity which I believe the most important character trait.

5.11.4 Some Helpful Hints Creating A Personal Vision Statement

1. Dig deep within yourself, try to connect inside yourself with what you 'know' is really important in your life.

2. Keep in mind your 4 basic needs: physical/economic, social, mental and spiritual and how they all require your attention if you are to live a more balanced and connected life.

3. Think about what you really value and the Principles you want to live by.

4. Consider all the different and significant roles in your life -- personal, family, work, community -- and seek balance between these various roles.

5. Write your vision statement to inspire and encourage yourself, NOT to impress anyone else.

6. Above all, be honest with yourself and be patient. It's challenging yet very valuable and rewarding work!

7. Some people find the following exercise helpful.

   a. Imagine it's 10 years since your heart attack and loved ones, friends, work colleagues, neighbors and others have come to celebrate your 10th anniversary in surviving being treated for heart disease. Try to imagine this festive, wonderful celebration with these people there. Imagine that each of these people know you from different roles you have played -- as a parent, spouse, child, work colleague, neighbor, old childhood or teenage friend, someone from your church/temple or community organization, etc. Each speaks about you at the party. Wait would you want them to say? What personal qualities or characteristics of you would you hope they'd mention about you over these past ten years since your heart attack? Make a list of these qualities and characteristics. Try to connect these things you write about you to the Principles of Living that you have identified as central to your life.

5.11.5 Questions about Living Better

(Adapted from Covey, Merrill & Merrill, 1995)

Instructions: Take some time, say at least 1 or 2 hours or more than 1 day to start to think about answers to the following basic questions. Write out your answers on the forms provided.

1. What do I feel are my greatest strengths?

2. What strengths in me have others who know me were mentioned?

3. What do I deeply and truly enjoy doing?

4. What qualities about others do I admire the most?

5. Which one person has made the greatest positive impact on my life?

6. Why has this person had such a significant impact on me?

7. What have been my happiest moments?

8. Why were they happy?

9. If I had unlimited time and resources, what would I decide to do?

10. What are the 3 or 4 most important things to me?

11. When I look at my work life, what activities do I think (and feel) are of the greatest worth?

12. When I look at my personal life, what activities are of the greatest worth?

13. What can I do that will be of real worth to others?

14. What are my most important physical needs? Social needs? Mental needs? Spiritual needs?

15. What principles of living will help me satisfy those needs?

16. What are the important roles in my life?

17. What are the most important LIFETIME GOALS I want to fulfill in each of these roles?

5.11.6 The Urgent/Important Connections

	Urgent Tasks	Not Urgent Tasks
Important Tasks	Deadline-driven activities Crises "Last minute" stuff	Planning, reflecting Prevention work "Considering principles/ values/decisions Time with friends/family Solitude in nature Spiritual growth
Not Important Tasks	Some phone calls Some activities Some phone calls Some meetings Many pressing/time urgent matters Many popular activities	Busywork Too much TV, newspapers Junk mail "Escape" stuff Trivia, junk activities

Adapted from Covey, Merrill and Merrill (1995)

11.   Psychopharmacological Intervention

11.1   Goals of Psychopharmacology

The goal of psychopharmacology is to ensure that patients with more severe forms of depression and those who fail to benefit adequately from the ENRICHD CBT/Group intervention are provided the full range of therapeutic options for depression. Although it is important to optimize patients' opportunity to achieve full resolution of depression, it is essential to safeguard the intent of ENRICHD to examine the effectiveness of psychosocial interventions in post-MI depression and social isolation. Thus, there is an incentive to impose a relatively high threshold for instituting psychopharmacology at the time of intake and randomization. Simultaneously, the need to ensure rapid remission of depression, to mitigate the presumed post-MI risks, argues for a low threshold for considering psychopharmacology if the response to CBT/Group is inadequate.

For these reasons, the criterion adopted for considering psychopharmacology at intake represents severe depression (Hamilton Depression Scale score $\geq$ 24), which the clinical literature suggests may require either pharmacotherapy or a combination of psychotherapy and drug therapy for an optimal treatment response (AHCPR Clinical Practice Guidelines: Treatment for Major Depression, 1993). Employing this rather strict criterion, however, will ensure that the majority of ENRICHD patients will be provided an opportunity to benefit from the CBT/Group intervention alone.

Some depressed patients may not achieve an adequate response to CBT. As noted in the Individual Cognitive Behavior Therapy section of the Manual of Operations, patients with major depression who have not achieved at least a 50% reduction in BDI scores by the 6th week of CBT treatment will be referred to the study psychiatrist for consideration of antidepressant therapy. Treating psychotherapists should also consider referring patients for a psychopharmacology assessment at any time during treatment if, in their clinical judgment, the patient is not responding adequately to CBT.

Finally, socially isolated patients or depressed patients who are undergoing or have completed the CBT/Group intervention may develop major depression during the course of the intervention period and should be referred for psychopharmacology evaluation if moderately severe depression (HDS $\geq$ 20) is present or if the response to "refresher" CBT is deemed inadequate.

11.2 Eligibility for Psychopharmacology

Candidates for antidepressant treatment will:

1. Fulfill DSM-IV criteria for Major Depression

   and

2. Score $\geq$ 24 on the **baseline** 17-item Hamilton Depression Scale rating

   or

   Have an inadequate response to individual CBT, i.e., < 50% reduction in BDI ratings after 5 weeks of therapy; be judged to have an inadequate response to CBT during "refresher" sessions following depression relapse

   or

   Score $\geq$ 20 on the 17-item Hamilton Depression Scale during the 12 month period after after enrollment completing the CBT/Group therapy intervention

Candidates for antidepressant therapy will be referred to community providers for depression management rather than receive treatment by the ENRICHD psychiatrist if they fulfill any of the following criteria:

1. DSM-IV Major Depression with Psychosis

2. Judged to be a serious suicide risk (see MOO Depression Intervention)

3. Severe major depression requiring electroconvulsive therapy

4. Active alcohol or substance abuse

5. History of sensitivity to sertraline or other newer generation antidepressants.

6. Medical condition judged to be a contraindication to SSRI treatment (e.g., liver failure, drug-drug interactions)

7. Patient or primary physician/cardiologist unwillingness to accept pharmacological treatment

11.3   Evaluation of Patients who are taking Psychopharmacological Medications at the time of Enrollment.

The ENRICHD psychiatrist at each site needs to review the safety and apparent efficacy of any antidepressants used a patients on antidepressants at the time of enrollment. The review will occur through discussion of the case with the case-coordinator (or other individuals involved in the patient's assessment) and should occur within three weeks of enrollment.

1. Safety. The safety of the medication will be considered from a statement of potential harmful effects of the medication as used in patients with cardiovascular disease and interactions with other medications the patient may be taking. A decision to intervene with the treating physician will be based on the discretion of the local ENRICHD psychiatrist.

2. Efficacy. The efficacy of antidepressants the patient may be taking at the time of enrollment will be considered in terms of medication type, dose, length, and the patient's response. The decision to intervene (e.g., to call the local psychiatrist or other physician treating the patient) will be left with the local ENRICHD psychiatrist.

The ENRICHD psychiatrist should review the status of patients on medications at entry 3 and 6 months and more often as indicated.

11.4   Psychopharmacology Evaluation and Treatment Protocol

Patients will be referred to ENRICHD psychiatrists for evaluation and possible antidepressant treatment (with the exceptions noted above). Study psychiatrists will employ a standard history and diagnostic assessment to confirm the presence of the psychopharmacology eligibility criteria and will determine by appropriate physical examination or laboratory findings that depression symptoms are not attributable to underlying medical or metabolic conditions (e.g., hypothyroidism, electrolyte disturbances).

Informed consent for antidepressant treatment will be obtained.

Concurrence for initiating antidepressant treatment will be obtained from the patient's primary physician/cardiologist.

11.5   Sertraline Administration

Sertraline will be prescribed as the initial antidepressant for qualified patients. This agent was selected because it offers a preferred profile for safety and effectiveness in the treatment of major depression in the context of cardiovascular disease (Glassman et al, 1993; Preskorn et al, 1992; Preskorn et al, 1994; Preskorn et al, 1995; Ketter et al, 1995; Nemeroff et al, 1996). Patients with a history of sensitivity to or a prior lack of response to sertraline will be prescribed an alternative agent, according to the guiding principles described below.

Sertraline will be provided without charge, packaged in bottles of 30 scored tablets.

Patients will be evaluated weekly as needed and feasible for the first 3-5 weeks of treatment; thereafter, patients will be assessed at 2-4 week intervals as needed and as feasible.

The starting dose of sertraline will be 50 mg per day, given in the morning with meals. This dose will be maintained for at least 2 weeks. In the absence of dose-limiting adverse effects, the dose may be increased to 100 mg per day for 2 weeks and further increases, if necessary, to a maximum daily dose of 200 mg per day are permitted. In frail patients, sertraline treatment can be initiated at 25 mg per day for the first week, increasing the dose to 50 mg after one week as described above. Doses may be decreased at any time if necessary due to adverse effects. In the absence of an adequate therapeutic response, patients unable to tolerate 25 mg per day or unable to tolerate an increase to a higher dose after 4 weeks of therapy will be considered for alternative antidepressant treatment (see below).

Sertraline treatment will be maintained throughout the 12 month intervention period for patients who achieve a therapeutic response.

ENRICHD psychiatrists will monitor concomitant drug administration to identify possible drug incompatibilities, e.g., coumadin, terfenadine, and will alert the primary physician/cardiologist to the need to monitor anticoagulation status for patients receiving coumadin. The potential for drug-drug interactions is high in ENRICHD patients, who will likely be prescribed an array of cardiovascular agents. It is important that ENRICHD psychiatrists keep abreast of the rapidly evolving literature indicating that antidepressants possess potent, but variable, influences on the hepatic P450 isoenzyme systems determining the metabolic fate of many cardiac drugs (Preskorn et al, 1994; Preskorn et al, 1995; Ketter et al, 1995; Nemeroff et al, 1996).

Short-acting benzodiazepine hypnotics or anxiolytics (oxazepam, lorazepam, temazepam) or chloral hydrate will be permitted for short term use (3 - 14 days) when sleep or anxiety are causing significant distress or interfering with function. The amount and dose will be carefully recorded.

11.6   Alternative Antidepressant Treatment

Patients with a history of sensitivity to or a prior inadequate response to sertraline, those unable to tolerate sertraline due to emergent adverse effects, and those who fail to achieve an adequate response during the ENRICHD trial will be considered for alternative antidepressant treatment.

The selection of an alternative agent will be made at the discretion of the treating psychiatrist based upon the specific needs of each patient. Selection will be limited to the agents listed in Table 1 after

considering the potential advantages and disadvantages for each agent. Starting and maximum doses for each agent are provided in Table 2.

Starting doses will be maintained for at least 2 weeks. Smaller starting doses than those recommended in Table 2 may be employed for selected patients, if needed. In the absence of dose-limiting adverse effects, doses may be gradually increased over 2-4 weeks to the maximum recommended dose levels. Doses may be decreased at any time if necessary due to adverse effects. In the absence of an adequate therapeutic response, patients unable to tolerate the recommended starting dose or unable to tolerate an increase to a higher dose after 4 weeks of therapy will be referred to community providers for further management of their depression.

Alternative antidepressant medications will be prescribed at the patients' expense. Medication will be dispensed in the minimum quantity necessary to provide coverage for the interval between follow-up visits.

11.7   Psychopharmacology Maintenance and Termination

The frequency of periodic follow-up assessments during the course of psychopharmacology will be determined at the discretion of the treating psychiatrist, with a minimum of at least monthly visits during the maintenance phase of psychopharmacology is maintained.

Patients who achieve a therapeutic response to antidepressant treatment will be maintained on medication for 12 months, at which time antidepressant therapy can be withdrawn. Patients who require extended psychopharmacology will be referred for further treatment in the community.

Rarely during the 12 month intervention period, patients might develop psychosis, be judged at risk for suicide, require hospitalization or otherwise require more intensive intervention than can be effectively provided by ENRICHD psychiatrists. Such patients will be referred for appropriate ongoing care in the community.

11.8   REFERENCES

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TABLE 1

Agent*	Reported Advantages	Potential Disadvantages
Sertraline (Zoloft)	Intermediate half-life - once/daily dosing Linear kinetics Minimal age effects on clearance Non-anticholinergic No sign. effect on cardiac conduction, BP	Moderate effects on P-450 2D6 hepatic isoenzyme -- drug interaction risk
Paroxetine (Paxil)	Intermediate half-life - once/daily dosing Fewer GI adverse effects reported No sign. effect on cardiac conduction, BP	Anticholinergic Non-linear kinetics Age effects on clearance Potent effects on P-450 2D6 -- drug interaction risk
Venlafaxine (Effexor)	Minimal effects on hepatic P-450 system	Short-half life (twice/day dosing required) Hypertensive in older patients in higher doses Prominent nausea Modestly increases serum cholesterol
Nefazodone (Serzone)	Sedating Non-anticholinergic No sign. effect on cardiac conduction Infrequent sexual dysfunction	Short-half life (twice/day dosing required) Non-linear kinetics Potent effects on P-450 3A3/4 -- drug interaction risk Mildly hypotensive
Bupropion (Wellbutrin)	Non-anticholinergic No sign. effects on cardiac conduction, EF, BP Infrequent sexual dysfunction	Short-half life (twice/day dosing required) Risk of seizures, especially at higher doses Restlessness can occur
Nortriptyline (Pamelor)	Established efficacy in severe depression Defined optimal plasma concentrations (50-150 ng/ml)	Anticholinergic Orthostatic hypotension **Contraindicated in presence of cardiac conduction delay**

* Fluoxetine (Prozac) excluded due to its prolonged elimination half-life

TABLE 2

Agent	Starting Dose mg/day	Maximum Dose mg/day
Nortriptyline (Pamelor)	25	100
Sertraline (Zoloft)	50	200
Paroxetine (Paxil)	10	50
Venlafaxine (Effexor)	75	225
Nefazodone (Serzone)	50	600
Bupropion (Wellbutrin)	75	450

7. ENHANCING RETENTION AND CONVERSION OF RELUCTANCE

7.1 DEFINITIONS

The following definitions should be used when discussing participation level in ENRICHD participants who are randomized to receive counseling.

1. Reluctant Participants: Those who:

   repeatedly cancel appointments;

   repeatedly do not show up for appointments;

   repeatedly indicate that now is "not a good time";

   screen calls and do not respond to messages.

2. Hard Refusals: Those who state, in no uncertain terms, that they DO NOT WANT to participate in the study and DO NOT WANT any further contacts with anyone associated with the project.

3. Integrated Participants: Those who faithfully follow through and attend appointments or, if they cancel, follow through and attend the next appointment. Integrated is defined only in terms of contact; not in terms of success with goals of treatment.

7.2 REASONS FOR PARTICIPATION

There are possibly four main reasons why the participant originally agreed to participate in the trial:

1. He/She perceived possible benefits from treatment and wanted to feel less depressed and more supported;

2. His/Her spouse, significant other, family, etc. wanted him/her to participate;

3. He/She agreed for reasons other than personal benefit, such as contributing to science, pleasing the recruiting RN, benefiting future patients, etc.;

4. He/She did not really understand what he/she was signing on to.

Reluctance may be due to the fact that the original reason is no longer compelling or valid. As such, an understanding of the reason for current reluctance can be aided by determining why the participant initially agreed to participate. The recruiting case coordinator is an excellent source of information about this and should be consulted very early. Moreover, it is a good idea to meet

family members and discuss the goals and requirements of participation before beginning treatment.

7.3 COMMON BARRIERS TO PARTICIPATION

It is useful to keep in mind that the participant's stated reasons are not necessarily THE reason, i.e., the basis for which the participant does not intend to continue. Thus, "I don't have the time" may be a cover for "I am embarrassed that I need this." A convenient way to think about this is the following:

His/Her reason (the stated reason);

A reason (a reason that partly explains the participant's reluctance, but is not the only reason);

THE reason(s) (the actual reason or reasons why the participant is refusing).

We must strive to understand THE reason in order to know how to intervene. Among the various reasons that could fall into any of these categories and thus serve as barriers to participation are the following.

1. Distrust of:

-- research and researchers: may be selling something; may jeopardize insurance; Tuskeegee (in African Americans);

--strangers, projects they have never heard of before;

--doctors/health care providers, carried over from this, or previous, encounters with health care or mental health system

2. "Price" of treatment is greater than perceived benefits. Among the "prices" are:

--Competing obligations or interests (e.g., being "too busy", going back to work);

--Embarrassment, emotional stress of counseling

3. Never participates in "things like this"

4. Friends, family, doctor advised against it, or are unsupportive

5. Lack of information; unwillingness of hear information

6. Dislike of counseling/therapy, anything "messing with head"

7. Loss of faith that the counseling can do anything to help, despite the continued existence of depression, low social support

8. Do not see the need:

    --don't believe that feelings have anything to do with the heart;

    --don't experience any distress and thus have no keenly-felt goals;

    --avoidant coping style leads to suppression/denial of distress; participant does not feel comfortable talking about problems;

    --"rugged individualist" does not accept help from anyone;

    --denies occurrence of heart attack.

    --no longer feels depressed or unsupported and thus no longer needs help.

9. Logistical problems in getting to the treatment setting

10. Won't tell you what the barriers are

11. Uncomfortable in groups

12. Co-morbidity:

    --psychiatric co-morbidity interferes with therapeutic engagement; borderline personality types find something wrong with whatever you say or do

    --physical comorbidities/symptoms result in feeling ill, preoccupation with physical problems, not up to participating in behavioral treatment

13. Did not understand:

    --that this was a trial

    --what was required of them

14. Does not want to be reminded of the MI and would rather focus on return to "normal".

15. Counselor discomfort with the process of reluctance conversion.

7.4 CONCEPTUALIZATION

The following conceptualization guides the suggested approaches to converting reluctant participants.

1. Reluctance is conceptualized in ENRICHD as a set of attitudes and behaviors that lead the participant to draw away from involvement in the trial. Reluctance is influenced by multiple factors including, for example, participant attitudes/behaviors, counselor attitudes/behaviors, an inability to establish the therapeutic alliance, and environmental/logistical problems.

2. Reluctance conversion is conceptualized as efforts to increase participant involvement in the trial by:

   --identifying and addressing participant attitudes/behaviors associated with reluctance;

   --identifying and addressing counselor attitudes/behaviors associated with difficulties in converting reluctance;

   --extending time spent in the cultivation of the therapeutic alliance;

   --identifying and solving environmental/logistical barriers to receipt of treatment.

7.5 BASIC APPROACHES TO RELUCTANCE CONVERSION

Here are some strategies to try. This is a fluid situation and the best approach is based upon the counselor's judgment of efficacy, given the unique characteristics of the participant and the situation.

7.5.1   Foster A Relationship (Barrier: Distrust)

a. Engage in supportive, non-directive contacts characterized by unconditional positive regard for the participant. Listen, reflect feeling, reflect content, make eye contact (if possible). Note: eye contact may not be desirable in some cultures, such as the Asian cultures. Be sure to use cultural sensitivity.

b. Try to find a commonality in experience

c. Maximize chance to have a face-to-face contact

d. Meet them on their own terms. Go with their agenda; not your own. Try to understand their concerns FROM THEIR PERSPECTIVE. Practice the listening skills we are using to teach patients to garner more social support (see 1a.). Keep quiet until they finish, use body language that conveys your interest in what they have to say, reflect back what you've heard (to be sure you've got it right), and, BE PREPARED TO BE CHANGED BY WHAT YOU HEAR.

e. Use time as a friend; not as an enemy. Be patient and use it to your advantage

f. Keep the door open at the end of any contact (e.g., "Would it be O.K. if I checked in on you in 1-2 weeks?" "Could I send you some literature about this program?")

g.   Use flexibility in ways to approach participant. Vary time of contact, type of contact, counselor who does the contact, reason for contact, etc.

Note: Be sensitive to the number of people with whom the participant interacts with. Too many individuals can be dysfunctional.

h.   Work toward name recognition in the community, via news media, talk shows, etc.

i.   Look for the "buying" question, e.g., "How long will this take?"

j.   Do not make a follow-up contact too soon. Going back too soon will result in a closed door.

7.5.2   Provide Information (Barrier: Information)

a.   Provide information in very small, understandable pieces

b.   Explain confidentiality, what is going to be done with private information

c.   Take advantage of opportunities to educate about mind-body connections, e.g., "When you feel sad (lonely, angry) like this, it is bad for your heart"

7.5.3   Obtain Support (Barrier: Others advised against it or are unsupportive; Counselor discomfort)

a.   Involve family/friends/doctor. While a discussion with family members may be helpful, such a decision must be made carefully, with consideration of confidentiality and how the participant might react to such a contact.   Foster good relationships with family and significant others by taking a moment to chat with them before or after appointments, when they answer the telephone, etc. If you do not have a relationship with the family, or if your are concerned about confidentiality issues, offending the participant, etc., consider asking the recruiting RN to talk to them.

b.   Use the problem-solving module to problem-solve with other counselors, case managers, or other staff on how to approach the participant

c.   Guard against low counselor morale by obtaining emotional support from fellow counselors, other staff members, PI, other co-investigators. Be sure to plan "morale boosting" activities such as lunches, happy hours, etc.

7.5.4   De-Pathologize Treatment (Barrier: Dislike of therapy; avoidant coping; not wanting to be reminded of the MI)

a.   Focus on recovery; not on feelings. Ask open questions about risk factors, visits to the MD, symptoms, etc.

b. Present the trial in a way that is something like this:

> "We are not seeing you in this study because there's something WRONG with you, but because we believe that anyone who has had a heart attack can benefit from training that will help you deal with negative emotions and build stronger, more supportive relationships. It's the same principle that leads us to suggest physical exercise and good diet. We know it helps build up your body, heart, and blood vessel's ability to function more healthily. In the same way, we are trying to build up your mental/emotional abilities to handle stress better. By providing you with this mental/emotional TRAINING, we believe it will also help to build up your body, heart, and blood vessel's ability to function more healthily and help you to recover better."

c. Focus on other areas of the participant's life that are not related to the MI to avoid reminding him/her of the event.

7.5.5   Empathizing (Paradoxical Intention). (Barrier: Don't see the need)

Give the participant space to disagree. Say something like, "This trial is very demanding and takes a lot of time. You really have to be ready to participate in it. Some people know that they are just not ready at this time to make that type of commitment right now. I am really glad that you shared the fact that you are not ready right now to take part. If at some time in the future, you find that you get to the point where you are ready to participate, you can let us know by contacting us at . . . . I will probably check in with you after a little while to see how you are doing. Once again, thanks for letting us know that you are just not ready to participate right now."

Then call them back, as soon as you believe it is most opportune, to see where things stand. If their status is unchanged, repeat the statement above. Caveat: Be careful using this strategy. For effectiveness, the counselor must believe that the participant really does want to get involved.

7.5.6   The Direct Approach (Barrier: Never participates in "things like this"; Won't tell you what the barriers are)

A direct approach can be a fresh, helpful one in some cases, and can encourage the participant to be direct with you. For example, "You were so interested in being in this trial initially, but I sense a reluctance now. What accounts for that?" or "I sense that it is hard for you to do the things we are asking of you. What would make it easier or doable?"

7.5.7   Recall Original Motivation To Participate (Barrier: Don't see the need)

The participant was "sold" on the idea initially, and it may be possible to do so again by reminding him/her what he/she expected to gain.

a. If the participant believes he/she is no longer depressed or unsupported, and therefore no longer in need of treatment, discuss relapse and emphasize the value of "overlearning" as a way to inoculate oneself against possible harmful effects of future stressful events on the heart.

b. If the participant no longer receives encouragement from the family, discuss with family members the participant's plan to drop out. Restate the goals and benefits of participation and encourage them to discuss this with the participant. If you are reluctant to contact family members because of confidentiality concerns, consider asking the recruiting RN to call them. Suggest a meeting with key family members and the participant to discuss the planned drop out.

c. If the participant originally decided to participate for altruistic reasons, but now no longer finds these reasons compelling in light of the perceived costs, explain the importance of the trial and how the dropout hurts the ability of the trial to achieve it's goals. Explain that a dropout is a potential "waste" of his/her, and others', tax dollars. Appeal to the participant's ethical, moral, religious, humanitarian side. Remind him/her that he/she made a commitment to participate and encourage him/her to follow through.

7.5.8   Alter Counselor Attitudes and Feelings (Barrier: Counselor Discomfort)

a. Leave participant reluctance at THEIR door. Each new contact should be approached with a fresh, optimistic outlook.

b. It is unpredictable when a participant may convert. Conversion is a function of the number of reluctant participants contacted. Thus, success at reluctance conversion goes hand and hand with making many contacts with those who do not convert.

c. A basic principle in reluctance conversion is "You will spend the majority of your time on the minority who are reluctant." This investment is time well spent if you are successful in converting even a small percentage of this minority

7.5.9   When To Quit

In a clinical trial, intention-to-treat analysis is the standard approach to determination of treatment effects on the primary outcome. Regardless of whether counseling was delivered or not, outcomes for an intervention participant will be analyzed as if they had actually received treatment. Thus, the study is penalized whenever a counselor "gives up" on a participant.

Here are some guidelines for when to quit attempting to convert a reluctant participant.

a. Quit when you receive a hard refusal, e.g., "I do NOT want to hear from you again.

Please do not call, send any information, or attempt to see me again."

Instinctively, you will know when you have received a hard refusal. Hard refusals are uncommon.

b. When 6 months from time of randomization have elapsed.

c. In situations where the participant shows by his/her behaviors that he/she does not want to participate, but is unwilling/unable to give a hard refusal, keep trying the strategies above, at intervals that are negotiated with the participant. Conversion of reluctance is frequently unpredictable and related to circumstances in the participant's own life of which the counselor is unaware (e.g., new stressors; having a good day; downturn in his/her physical condition, etc.).

8. CHAPTER 8: QUALITY CONTROL

8.1 OVERALL PLAN

The overall functions of quality assurance are: training; supervision and monitoring of the intervention; establishing inter-rater reliability of the DISH measurement and standardization of other measurements; and monitoring of eligibility and enrollment criteria.

8.1.1 The overall training plan involves:

- Training of the Counselors

- Training of the interviewers:

- Training in all data collection/data management protocols

- Training of the case managers

8.1.2 The overall plan for supervision and monitoring of the intervention involves:

- Adherence to treatment protocol: Treatment Manual; written checklist of clinician adherence to protocol

- Monitoring of performance: weekly site supervision; across-site supervision; audiotapes

- Process Variables to assess if mediating effects of the intervention are working

8.1.3 The overall plan for standardization of the measurements involves:

- A three month pilot study on all measurements for feasibility and respondent burden purposes

- Computer checklist of interviewers' adherence to data collection protocol

- Computer checklist of interviewers' adherence to data collection of eligibility criteria protocol

- Central Medical Endpoints Committee to review adherence to measurement of primary medical endpoints

- Central ECG Core Lab to review all electrocardiograms for "new onset" q waves

- Case manager monitoring data collection at each site and serving as a liaison to the Coordinating Center for the editing, updating, and transmission of study data.

- Weekly and then monthly conference calls of case managers across sites

8.1.4 The overall plan for monitoring eligibility and enrollment criteria is:

● Computer checklist of interviewer's adherence to eligibility criteria

● Quality Control data collected by the Coordinating Center to monitor and correct operational data collection

● Case manager monitoring of data collection at each site and serving as a liaison to the Coordinating Center for the editing, updating, and transmission of study data.

● Weekly and then monthly conference calls of case managers across sites

8.2 TRAINING: SPECIFIC STAFF RESPONSIBILITIES

The following clinic functions/responsibilities have been identified in relation to training in the study protocol: Counselors, case managers, and interviewers. Each is described below:

8.2.1 Training of the Counselors

The overall goal of training the Counselors is to assure equal and adequate implementation of the Psychosocial Intervention across sites. The Psychosocial Intervention relies upon cognitive behavioral and social learning treatment approaches. Highlights of this approach include behavioral activation (including activation of the social network), active problem solving, attention to automatic thoughts, and appropriate skills training (e.g., communication skills) to support these efforts. In addition, the Intervention includes a focus on stress reduction skills, and enhanced coping ability and post MI adjustment/recovery. Initially, individual sessions serve as the basis for treatment. Transition to group-based treatment occurs as sufficient numbers of participants making progress in treatment are gathered at each site. Given this make-up of the Intervention, the training of Counselors is aimed at the use of the requisite cognitive behavioral and social learning strategies, as well as the conduct of individual and group-based sessions with these strategies, according to the description in Chapter 5 of the Protocol (Intervention chapter). In addition, all training is in the context of maximal psychological and physiological adjustment and adaptation after acute myocardial infarction.

8.2.1.1 Qualifications of Counselors

The "gold standard" for delivery of the intervention is assured through the identification, training, and maintenance of qualified counselors. Personal and behavioral qualities of the Counselors are discussed in Chapter 5 of the ENRICHD Protocol. Counselors may have either a doctoral or a master's degree in a suitable discipline, and clinical experience in CBT, counseling, group therapy, and therapeutic strategies to enhance social support.

8.2.1.2 Training of the Counselors

Training of the Counselors is done in three different modes: training for cognitive/behavioral and social support therapy; training for group therapy; and intensive supervision for 12 weeks by audiotape.

1. **Training for Cognitive Behavioral and Social Support Therapy**. A group of eight Counselor supervisors (one from each clinical site) as well as all other Counselors convened at the Beck Institute in Philadelphia the week of August 24-28, 1996 for a five-day intensive workshop. The sessions taught by Dr. Aaron Beck, Dr. Judith S. Beck, and other faculty from the Beck Institute in partnership with selected investigators from the ENRICHD Clinical Trial, covered interventions for both depression and perceived low emotional support in acute myocardial infarction patients, with components specific to minority populations, low SES, and post-MI patients.

2. **Training for Group Therapy**. A group consisting of 8 counselor supervisors and one counselor from each site convened at the Beck Institute in Philadelphia in October 12-15, 1996 for a four-day intensive workshop on group therapy. The sessions were taught by investigators from the ENRICHD Clinical Trial in partnership with Drs. Aaron and Judith Beck. (See MOO, Vol 1, Vers 1). The counselors who did not come for group therapy training in Philadelphia were taught through role-modeling in ongoing group therapy sessions at each site. This training deals with enrolled participants as cardiac patients, issues concerning clinical physiology, stress, and feelings. Training was devoted to session-by-session explanation of the Manual of Operations for group therapy. Then the workshop participants were divided into three groups and, under the supervision of a Leader and Co-Leader, begin working through an open enrollment session including performing exercises.

3. **Intensive Supervision for 12 Weeks by Audiotape**. As soon as participants enter treatment, each counselor was required to complete 12 weeks of supervised therapy with a suitable participant. Weekly tapes are sent to the Beck Institute by each counselor, followed by an hour of supervision for each counselor with their supervisor via telephone weekly. Thus there is one hour of tape listening and one hour of supervision per week. At the end of 12 weeks, Beck Institute advises which counselors are qualified for official study using a Cognitive Therapy Competency Scale implemented in other multi-site studies. (Table 1).

4. **Remedial Work or Training New Counselors**. For those counselors who, at any point in the three years, do not qualify for inclusion into the study, based on Beck Institute monitoring as outlined above, either a remedial course of intensive training or dismissal will occur. The supervisor from the Beck Institute will consult with the site supervisor for extensive, in-depth individual mentoring of the counselor including further evaluation of therapy tapes until a satisfactory score on the Cognitive Therapy Competency Scale has been attained.

5. **Training New Counselors.** Counselors who have been hired after the initial training will

undergo training or an accelerated schedule. Initially, the newly hired counselor will review the audio/visual tapes made at the 1997 Therapists Training sessions, read the two syllabi prepared for the 1997 Therapists Training Sessions; and read "Cognitive Therapy" by Judith S. Beck. These tapes can be acquired from the Coordinating Center). Arrangements will be made for them to go to the Beck Institute for a 2-3 day accelerated course in cognitive behavioral therapy. Upon returning to the respective sites, the counselors will have 12 weeks of intensive supervision by audiotape by the Beck Institute, as described before. For group therapy, the newly hired counselors will co-lead the group with a counselors who went to the Group Therapy training sessions in 1996.

Refer to the following process for authorization of additional funds for consultation from the Beck Institute.

5. Authorization of Additional Funds for Consultation from Beck Institute. The process for authorization of funds from the Coordinating Center for remedial work, training new counselors, or direct consultation time with Drs. Aaron and Judith Beck is as follows.

The contract between the ENRICHD Program and the Beck Institute provides for direct consultation time with Drs. Aaron and Judith Beck on an "as-needed" basis. Since the Becks will be reimbursed on an hourly basis, it is important to set down some rules about <u>who</u> has the authority to access their time, what is the scope of <u>appropriate subject matter</u> for these consultations, and monitoring and consultation expenses (for the total group and by site). The following guidelines are proposed to share access, use their consultation time to the best advantage, and simultaneously monitor accruing expenses.

1. The usual mechanism of contact between an ENRICHD site (i.e., the Psychotherapy Supervisor or Principal Investigator) will be the regularly scheduled conference call between Beck Institute staff and all the Psychotherapy Supervisors. The routine focus of this conference call includes: fundamental and applied questions about Cognitive Therapy, problems with particularly difficult cases, adjustments tailored to the situation of post-MI patients, and supervisory problems. By discussing patient-specific, therapist-specific, and site-specific problems in this format, we expect that all Psychotherapy Supervisors will share knowledge and concerns, thereby minimizing site-effect drift in therapy technique over time. These calls were initially once a week for six months; twice a month for six months; and once a month for the rest of the study.

2. When a Psychotherapy Supervisor, Principal Investigator, or any other person designated by a Principal Investigator feels a need to discuss a problem with Drs. Aaron or Judith Beck--at greater length or in private, or when remedial supervision is required for a specific Counselor--the Supervisor or PI should contact a member of the "QA Committee" and make a formal request for consultation time, specifying the following:

   - the reason for the consultation, including an explanation of why the matter

cannot be pursued within the confines of the monthly conference call for Psychotherapy Supervisors;

- the minimum and maximum number of hours of consultation time requested;

- when the consultation is likely to take place; and

3. A member of the QA committee will notify the Coordinating Center and justify the additional consultation time.

4. The goals of the Coordinating Center are:

   (a) To oversee and prudently manage the budget funds allocated for consultation time with Drs. Aaron and Judith Beck;

   (b) To enable all sites to access a modest amount of direct consultation time with Drs. Aaron and Judith Beck on an equitable basis;

   (c) To enable sites to arrange for remedial work for staff psychotherapists who begin to fail quality assurance monitoring;

   (d) To enable sites to arrange for accelerated training for replacement psychotherapists recruited after the beginning of the study;

   (e) To assist Psychotherapy Supervisors with unique or particularly difficult supervision problems;

   (f) Generally, to assign a priority level to all formal requests for consultation time with Drs. Aaron and Judith Beck--fulfilling important requests so long as funds are available, postponing or denying less urgent requests when funds are low.

5. The Coordinating Center will communicate its decisions directly to the applicant and the Beck Institute, so that Drs. Aaron and Judith Beck will have knowledge of the persons authorized to access ENRICHD Program consultation time and funds.

8.2.2 Training of the Interviewers/Data Collectors

Initial training was conducted in June, 1996 for the pilot study and for those interviewers/case managers who will be responsible for training the rest of the interviewers at each site. The model was "train-the-the-trainer." The training was planned at this time in order to accommodate training for both the 3-month pilot study and the first year of the ENRICHD clinical trial. However, since most of the interviewers/case managers were hired close to study enrollment, the same training was repeated in September for the Overall Trial.

Training for the pilot study took two days and included the following activities: overview of the study and study protocol; review of the eligibility criteria; specific instructions on interviewing for the DISH and the BLESSED; review of the Screening/Recruitment Visits; specific instructions on ascertaining the medical eligibility criteria from the charts; and data management procedures. In addition, data collection on all the psychological measurements were done: introduction to the laptop computer-based system with screen data entry and editing, edits, and data transmission. Role playing was used for training on the DISH. Videotapes were taken of the training and were sent to each site for training of interviewers/data collectors, which might have to be done if attrition of data collectors occurs during the study. The following agenda describes the contents of the ENRICHD Pilot Study Training Manual:

Introduction to ENRICHD Design and Goals

Overview of ENRICHD Pilot Study

Medical Eligibility Criteria

Screening Logs and Informed Consent

Medical Record Abstraction Training

DSM-IV Diagnosis of Depression & Hamilton Rating

General Principles of Interviewing

Interviewer Training for DISH and SBT

Social Isolation and Psychosocial Forms

Minority Recruitment

Data Management Procedures

8.2.2.1 Quality Assurance of Data Collectors/Interviewers

Upon successful completion of training, the data collectors/interviewers will be routinely evaluated for quality assurance. The quality of their data forms, timeliness, and completeness of work will be routinely assessed. Quality control forms will be gathered from the sites for regular quality control checks.

8.2.3 Training the Case Managers

The case-manager (or case coordinator) will be responsible for initial contacts and education regarding risk factors of cardiovascular disease and recovery after myocardial infarction before randomization and for insuring attendance at follow-up exams for both the usual care and intervention participants. For the intervention participants only, the case manager will be responsible for assistance in their care and treatment during the course of treatment. The case-manager will facilitate attendance at sessions, give limited instrumental social support, facilitate medical treatment, and coordinate psychopharmacology (refer to Chapter 3 of the ENRICHD Protocol). In addition, depending upon the clinical site's specification, the case-manager might coordinate other interviewers/data collectors' activities regarding screening and enrollment and data collection of measurements. Duties and responsibilities of the case manager are discussed in Chapter 3, of the ENRICHD Protocol.

a. Training of Case Managers

Case managers will be centrally trained in September 1996 in the overall Training for the Clinical Trial. The topics for training will include: screening, recruitment, and eligibility procedures and forms; medical record abstraction; a panel discussion by Case Coordinators on enrollment and adherence principles, minority recruitment, training for health education; psychosocial measurement procedures and forms; data management system features; follow-up and endpoints procedures and forms; data management system utilities and practice session; randomization procedures and telephone randomization system; and data transfer procedures for paper forms. (Refer to ENRICHD MOO Vol. 1, Version 1, 1996).

8.3 SUPERVISION AND MONITORING OF THE INTERVENTION

8.3.1 Adherence to Treatment Protocol

Adherence to treatment protocol will be accomplished by the development of an Intervention Operational Manual describing the goals of each session and a written checklist of clinician adherence to treatment protocol.

a) Intervention Manual

b) Written Checklist of Clinician Adherence to Treatment Protocol, Required Forms, and Measures

Clinicians can monitor the integrity of their own performance daily within general prescribed techniques on an appropriate tracking form. These forms will also ensure adherence to the protocol and standardization across sites. Protocol adherence developed for each session using the Intervention Manual as the reference. The protocol will be monitored frequently by supervisory staff on an individual basis and the supervisory staff will provide feedback to the clinicians.

8.3.2 Monitoring of Performance of Intervention

Supervision of counselors is an important way to enhance treatment fidelity. Ongoing supervision and feedback is critical in ensuring that interventions are implemented in the manner intended. Supervision should include two components: (1) continuous monitoring of treatment implementation, and (2) provisions for corrective action (Sechrest et al., 1979). The literature suggests that careful supervision is key to the success of cognitive behavior therapy intervention trials. For example, the failure of the NIMH Treatment of Depression Collaborative Research Program to demonstrate that cognitive behavior therapy was superior to a control condition has been attributed to lax supervision. While counselors in that trial received intensive training and supervision during the pilot phase of the study, the supervision and monitoring of counselors during the trial was minimal. During that trial, counselors participated in monthly consultation calls, occasional group calls, and additional calls if videotape monitoring revealed significant departures from the protocol. In contrast, other controlled trials which have incorporated at least weekly supervision have demonstrated the efficacy of cognitive behavioral therapy (Hollon, 1992; Rush, 1977). This underscores the importance of continuous supervision of counselors in addition to training (Shaw & Pilkonis, personal communications, 1996).

Since the ENRICHD trial is an efficacy trial, supervision of counselors has a high priority. In an efficacy trial one is interested in testing the intervention(s) under ideal circumstances, which includes well trained counselors who deliver the treatment as planned and in a competent manner. To ensure this optimal implementation, ongoing supervision and feedback is important.

8.3.2.1 Local Clinical Supervision of Counselors.

There are four goals for local clinical supervision of at counselors at the eight ENRICHD centers. They are as follows:

1. To ensure that the intervention protocols as specified by the manual of operations are implemented and to provide corrective feedback to counselors.

2. To supervise the clinical work of the counselors to ensure quality care of participants.

3. To monitor the needs of participants.

4. To make decisions regarding treatment planning with respect to: a) implementation of modules; b) aspects of the intervention to emphasize; c) transition to group; and d) referral to pharmacotherapy.

In order to conduct a responsible trial, it is recommended that the supervision protocol outlined below is implemented.

8.3.2.2 Individual and Group/Case Conference Supervision

Individual and group/case conference supervision are strongly recommended. Individual supervision offers an opportunity to focus on particular counselors' cases. The group/case conference supervision could provide a forum for counselors to benefit from each others' work, to capitalize on opportunities for consultation and collaboration, to receive additional didactic training, and to benefit from the support of the other counselors and supervisor. The supervisor has the discretion to determine the balance between individual and group.

8.3.2.3 Frequency of Contacts

Weekly supervision is essential throughout the trial. Two hours of direct supervision per week per counselor is the minimum. The two-hour weekly supervision can be done individually or with a group of counselors. The supervisor will have the discretion to increase the amount of supervision as needed for particular counselors. This is particularly likely in the case of inexperienced counselors or for counselors with difficult participants. In addition, counselors should be encouraged to seek supervision on an as-needed basis.

8.3.2.4 Supervision Format

In order to ensure that the procedures are appropriate for the participants and to avoid counselor drift, it is essential that supervisors make direct observations of counselor work. This can be accomplished by a variety of procedures including reviewing audiotapes of the sessions. It is recommended that one tape per counselor per week be reviewed by the supervisor, with that review serving as the basis for supervision sessions. In addition, as the trial progresses and counselors demonstrate competency with the Intervention, the counselors at the site may meet together without the site supervisor and review their tapes, collecting comments and feedback. These comments and feedback could then be utilized in group supervision with the site supervisor, thereby providing a more time cost-effective method of supervision.

Prior to supervision, it is important for counselors to review their own tapes and to be prepared to bring up points/issues about their sessions with the supervisor.

Supervisory Log

Documentation of supervision will be accomplished with the use of a supervisory log. The log involves having the counselor indicate the date of the contact, the duration of supervision, the counselor(s), and a general comment about type of supervision (e.g., individual supervision for 6 individual cases). Dr. Judith Beck also developed forms for evaluation of the ENRICHD Site Supervisors and the Beck Institute ENRICHD Supervisor. Refer to Table 2.

Progress Note

A brief progress note is recommended for each session contact. The following information is to be obtained: a) date, b) assessment of compliance, c) general impression of participant, and d) issues to be followed up next session.

Counselor and Supervisor Networks

Separate trial-wide email networks are recommended for counselors and for supervisors. This will provide an opportunity to share information and to benefit from consultation across the trial. In addition, supervisors will participate in conference calls once a week for the first 6 months; twice a week for the second 6 months; and then monthly for years 3 and 4. These conference calls will be done in conjunction with the Beck Institute. In addition, during years 3 and 4, there will be additional monthly phone calls among the ENRICHD investigators without the Beck Institute. The conference calls are intended to provide a context to discuss issues related to supervision and implementation of the intervention.

8.3.3 Across-Site Monitoring of Counselors' Individual and Group Sessions.

Audiotapes will be done on all participants. Audiotapes will help to ensure integrity and specificity of the treatment (i.e., clinician is treating the problem specified by the participant) and to also discriminate between strong and weak treatments. **About 20% of the tapes will be randomly selected at each site for review by the Beck Institute**. The tapes will be used both for within-site and across-site review of the therapy. Beck Institute will monitor integrity of the therapy by all counselors by randomly selecting 20% of the participants at each site, then randomly selecting two individual session tapes for each participant (a beginning session and a mid-to-late session of individual therapy) and two tapes per group during group therapy for Years 1, 2, and 3. Counselor difficulties will be brought up in supervisors' phone supervision sessions, or sooner, if needed. If difficulties persist, Beck Institute will undertake remedial work with errant counselors, if required, and will establish a time limit for remedying cognitive therapy practice. Counselors who are unable to improve by the deadline will be discussed as possibly needing replacement.

8.3.3.1 ENRICHD Intervention Quality Control Sampling Plan

8.3.3.1.1 Individual Therapy

Each calendar year (July 1 - June 30) for each counselor, the Beck Institute will review tapes of two individual therapy sessions with each of four randomly selected participants. For each participant, one tape will be randomly selected from session 1-3, and one from the last 4 sessions. Counselors will not be told that a participant has been selected while therapy is ongoing for that participant. This will be implemented through the following procedure:

1.   Each June, the clinical centers will send a list of ENRICHD counselors to the Coordinating Center.

2.   The Coordinating Center will retrospectively randomly select two sessions within individual therapy for each counselor. For each selected participant, the Coordinating Center will randomly select one of sessions 1-3 and one of the last 4 sessions.

3.   The Coordinating Center will notify a designated staff member at the clinical center (by email) that the qualifying participant for that counselor should have tapes sent to the Beck Institute for monitoring. The sessions for which tapes are to be sent will also be specified. The PI of each center will identify the individual to be responsible for identifying the participants and shipping the selected tapes. The person should not be counselor, and should not be a blinded outcome assessor.

4.   The designated staff member will mail the selected tapes to the Beck Institute as soon as it is available. None of the Intervention staff should be aware that a tape has been selected. The Case-Coordinator will notify the Coordinating Center (by email) of the ID of the selected participant and the date the tape was mailed to the Beck Institute and the session numbers.

5.   The Beck Institute will evaluate the internal consistency of the delivery therapy and rate the counselor by the Cognitive Therapy Competency Scale (Table 1).

To improve communications among the clinical site, coordinating center and the Beck Institute, monitoring of the quality assurance individual and group session intervention tapes at the Beck Institute will continue with the following administrative procedures:

a)   To increase the quality of the feedback received on the monitored tapes, the Beck Institute will email suggestions to the counselor supervisor.

b)   The Beck Institute will fax the cognitive rating scale to both the intervention counselor and the supervisor.

c)   When the Coordinating Center prompts the sites to send in their randomly selected tapes for quality assurance, the Beck Institute will receive a copy of that email. Similarly when the site dispatches the selected tapes to the Beck Institute, they will email the Beck Institute and copy the coordinating center providing, the date, tape session number and name of counselor.

8.3.3.1.2 Group Therapy

Each calendar year (July 1 - June 30) for each clinical center, the Beck Institute will review tapes of two group therapy sessions for each of two randomly selected groups. For each group, one tape will be randomly selected from the first 3 sessions, and one from the last 3 sessions. Counselors will not be told that a group has been selected. This will be implemented through the following procedure:

1.   The Coordinating Center will retrospectively randomly select two sessions for the same group. For each selected group, the Coordinating Center will randomly select one of the first three sessions and one of the last 3 sessions.

2.   The Coordinating Center will notify the clinical center designated site center (by email - with a copy to the Beck Institute of the email) that the group should have tapes sent to the Beck Institute for monitoring.

3.   The designated center member will mail the selected early tapes to the Beck Institute as soon as it is available. None of the Intervention staff should be aware that a tape has been selected. The designated center member will notify the Coordinating Center (by email) of the first session date for the selected group and the date the tape were mailed to the Beck Institute.

4.   The Beck Institute will evaluate the tapes using Group Therapy Rating Scale (Refer to Table 4). The provision of communications will be the same as described above for monitoring of tapes of individual therapy.

8.3.3.2 Supervising Individual and Group Supervisors.

Beginning October 1996, supervisors will convene weekly for the first six months through 90-

minute telephone conferences to discuss supervision issues. A Beck Institute supervisor will be moderator for the group. At the seventh month, conferences will occur bi-weekly. Conference calls will continue for the duration of the study (i.e., Years 2, 3, and 4) on a monthly basis following the first year (or less if deemed appropriate).

8.3.4 Process Variables

8.3.4.1 Definition of Process Variable

Process measures refer to psychosocial measures that are required for one or more of the following purposes: (1) clinical evaluation, (2) monitoring administration of the intervention, (3) monitoring the subject's progress in, and successful completion of, treatment, (4) testing hypotheses about the mechanisms of action of the various components of the intervention, and (5) testing hypotheses about individual differences in response to treatment.

Process variables. Process variables are categorized as either nonspecific or condition-specific. Nonspecific measures are used to document the administration of the intervention. Specific measures are used to assess various aspects of depression, social support, and/or the intervention components that target these risk factors.

8.3.4.2 Process Measures

In an effort to streamline the protocol, the number of process variables was reduced from 38 to 9 as of April, 1998. A detailed description of the process variables can be found in the ENRICHD Process Measures and Clinical Tools Manual.

The following nine process measures are mandatory effective April 1, 1998.

1. DSM-IV Axis I Diagnosis

2. 17 - Item Hamilton Depression Scale

3. Social Network in Adult Life (SNAL)

4. CBT Performance Criteria

5. Social Performance Criterion Scale

6. Beck Depression Inventory (BDI)

7. Non Study Treatment Form (NST)

8. Modified Duke Social Support Scale (MDuke)

9. Delivery of Intervention Checklist (DIC)

The following 28 process measures are optional clinical tools.

1. DSM-IV Axis II Diagnosis

2. DSM-IV Axis V

3. Case Summary Worksheet

4. Progress Notes

5. Termination Summary

6. Brief Cope Scale

7. McLeod Conflict Scale

8. Group Session Mastery Form

9. Activity Chart

10. Clients Session Feedback Form

11. Dysfunctional Thought Record (DTR)

12. Testing Your Thoughts

13. LOG Version of DTR

14. Automatic Thoughts Worksheet

15. Belief Barriers to Social Support

16. Beliefs Worksheet

17. Coping Cards

18. Emotion Chart

19. Emotional Intensity Scale

20. Guide to Booster Sessions

21. Guide to Self-Therapy Sessions

22. Group Homework Assignment Record

23. Homework Schedule Cards

24. Nonverbal Communication Form

25. Problem Solving CBT Homework Sheet

26. Problem Solving Homework Sheet

27. Session Bridging Worksheet

28. Functions of a Social Network

Two process measures were discontinued**:** 1) Treatment Expectation Scale (TES); and 2) the 17-Item Self Efficacy Scale.

For the sake of historical documentation, the initial discussion of process variables has remained intact in this chapter (pages 15-17).

Key clinical forms and measures to be employed in the <u>Cognitive Therapy for Depression (CT) individual intervention</u> were reviewed and were classified into three groups:

- "<u>Process measure</u>" -- routinely administered for all participants, and coded on a summary sheet to be submitted to the Coordinating Center

- "<u>Routine clinical tools</u>" -- routinely administered for all participants. Any difficulties completing these forms as recommended should be at the discretion of the site supervisor

- "<u>Optional clinical tools</u>" -- counselors are encouraged to use these forms and measures, but the counselor's own judgment is sufficient for deciding whether to use or skip these forms

8.3.4.3 Process Measures for Cognitive Behavioral Therapy

Hamilton Depression Scale (17-item SIGH-D)	Counselor	Counselor repeats HAM-D at session 0 if intake HAM-D was done two or more weeks ago
Beck Depression Inventory (21-item version)	Participant	Weekly before sessions
Individual Therapy Homework Form	Counselor	Weekly
Automatic Thoughts Questionnaire (Kendall & Hollon, p.1980)	Participant	Session 0 and Session #6, at end of sessions
Case summary Worksheet (J. Beck, p.315-318)	Counselor	One at initial evaluation and one at conclusion of individual therapy
Required Forms and Measures (David Clark)	Counselor	

8.3.4.4 Routine Clinical Measures

Therapy Notes 　　(J. Beck, p. 61)	Counselor	Weekly
Therapy Report Form 　　(J. Beck, p. 42	Participant	Weekly
Dysfunctional Thoughts Record 　　(J. Beck, p. 126		Weekly - Initially by counselor, gradually by participant

8.3.4.5 Optional Clinical Measures

Activity Chart 　　(J. Beck, p. 202)	Participant	Weekly
Activity Ratings 　　(J. Beck, p. 203)	Participant	Weekly
AT Adaptive Response Card 　　(J. Beck, p. 113)	Participant	Ad lib
Coping Cards 　　(J. Beck, p. 215-216)	Participant	Ad lib
Session Bridging Worksheet 　　(J. Beck, p. 49)	Participant	Weekly
Dysfunctional Attitudes Scale 　　(Burns, p. 241-249)	Participant	Session 0 and Session #6, at end of session
Emotion Chart 　　(J. Beck, p. 99)	Participant	Ad lib
Emotional Intensity Scale 　　(J. Beck, p. 101-102)	Participant	Ad lib
Automatic Thoughts Worksheet 　　(J. Beck, p. 119)	Participant	Ad lib
Beliefs Worksheet 　　(J. Beck, p. 151-152)	Participant	Ad lib

8.3.4.6 Optional Clinical Measures, cont.

Problem-Solving Worksheet (J. Beck, p. 195)	Participant	Ad lib
Homework Schedule Cards (J. Beck, p. 263)	Participant	Ad lib
Reason for Not Doing Self-Help Assignments (A. Beck, et al., p. 408)	Participant	Ad lib

8.3.4.7 Process Measures for Low Perceived Social Support

Activity Chart (J. Beck, p. 202)	Participant	Weekly
Activity Ratings (J. Beck, p. 203 - modified to rate "degree of support" and "degree of satisfaction")	Participant	Weekly
Duke Social Support Questionnaire	Participant	Session 0 and six-month evaluation point
McLeod Interpersonal Conflict Scale	Participant	Session 0 and six-month evaluation point
Individual Therapy Homework Form	Counselor	Weekly

8.3.4.8 Routine Clinical Measures

Social Network in Adult Life assessment and diagram	Counselor	Session 0 and end of individual therapy
People in my life	Participant	Session 0 and end of individual therapy

8.3.4.9 Optional Clinical Measures

Network improvement form

Help from people in your social network

Belief barriers to social support

Non verbal communication

Problem solving

Key clinical forms and measures to be employed in the Psychopharmacology individual intervention were reviewed and two groups were defined:

- "Process measure" -- routinely administered for all participants, and coded on a summary sheet to be submitted to the Coordinating Center immediately at the conclusion of the individual therapy

- "Routine clinical tools" -- routinely administered for all participants. Any difficulties completing these forms should be discussed with the Site Supervisor.

8.3.4.10 Process Measures for Psychopharmacology

- Medication dose and frequency over time

- Frequency and duration of all contacts with pharmacocounselor or clinical manager

- Measures of functional impairment -- self-report and clinician-rated

8.3.4.11 Routine Clinical Measures

- Concurrent medications

8.3.4.12 Process Measures for Group Therapy

- Degree of active participation in group therapy sessions

- Group size, recorded weekly

- Group therapy homework form, recorded weekly

- Post-therapy evaluation questionnaire

- Self-efficacy in group form (4 items), recorded weekly

- Activity logs, recorded weekly

8.3.4.13   Process Measures for All Three Therapies (i.e. Non-Specific Measures)

- Treatment Expectations Form (by participant at Session O and six-month evaluation point.

- Patient Satisfaction Form (session 0 and 6 months)

- Self-efficacy scale (by participant at session 0, end of individual, and end of group therapy)

- Quality of patient-counselor relationship (by patient; one-time rating)

- Compliance with homework in all therapy conditions

- Attendance at all individual and group sessions

8.3.4.14 Process Measures for Follow-up Phone Calls

- Beck Depression Inventory (monthly)

- Activity Chart and Ratings (monthly)

8.4 STANDARDIZATION OF MEASUREMENTS

8.4.1 Monitoring of the Interviewers/Data Collectors

The work of the interviewers/data collectors will be monitored through the completeness and timeliness of data transmissions to the Coordinating Center. Depending on the volume of activity of a clinical site, forms of adherence to data collection protocol and adherence to data collection of eligibility protocol will be checked by the interviewers/data collectors, computerized, verified, and transmitted weekly or every two weeks on a regular schedule. The responsibilities of the interviewers/data collectors include:

1) Collecting data on all the primary endpoint measurements

2) Monitoring data quality control by submitting computer checklist of adherence to data collection protocol and eligibility protocol

3) Serving as a liaison to the Data Coordinating Center for the editing, updating, and transmission of study data

4) Running computerized patient and study status reports

8.4.2 Medical Endpoints Classification Committee

The responsibility of this committee is to validate the evidence of the primary endpoints of mortality and recurrent myocardial infarction and other medical endpoints according to criteria. The committee will be composed of cardiologists, one member from each site. Refer to the Chapter in Manual of Operations on Medical Endpoints Data Collection and Review Procedures.

8.4.3 Electrocardiology

Electrocardiograms will be collected for two purposes: validation of the medical eligibility criteria and to identify new-onset q waves as a criterion for detection of recurrent myocardial infarction, one of the primary endpoints.

8.4.3.1 Quality Assurance of the Index ECG

Quality assurance of the ECG component in large hospitals that recruit significant numbers of patients will be very little problem. It will likely be easy to obtain all the eligibility ECGs in those individuals. There is significant pressure to reduce the enzyme criterion to levels where false-positives are common, and if this is the case and there is no scrutiny of ECGs, the ENRICHD trial could have major difficulties. Therefore, the recommendation is for the cardiologist at the local ENRICHD sites read 100% of the index ECGs for the first six months of Year 2. They will track inter-rater reliability between their diagnosis and that of the clinical center reader.

8.4.3.2 Core ECG Laboratory

The responsibility of this laboratory is to read all the electrocardiograms from all sites of the ENRICHD clinical trial, specifically for the purposes of identifying new-onset q waves. Electrocardiograms will be taken at baseline, 6-month follow-up, and 18-month follow-up and annually thereafter for the length of study. The St. Louis University Core Lab is directed by a cardiologist and cardiology fellows trained to performance criteria and reproducibility in q-wave criteria and detection. Refer to the ECG Manual of Operations for description of the Core ECG Laboratory.

8.4.4 DISH Quality Assurance

8.4.4.1 Reliability and Diagnostic Validity of the DISH

Case Coordinators and follow-up staff are required both to administer the DISH at screening/baseline and specified follow-up assessments, and to interpret the results in accordance with the ENRICHD modified DSM-IV criteria for depressive disorders. Symptoms, observations, and comments are recorded on the DISH itself. The interviewer's diagnostic impressions are recorded on the Diagnostic Summary Form (DSF) or the Diagnostic follow-up (DFU) Form.

To ensure that reliable and valid data are being obtained from the DISH, three different types of quality control procedures are employed. These include (1) Inter-rater reliability checks, (2) diagnostic reviews, and (3) clinical validity checks.

Inter-rater reliability checks are performed by having a second, trained interviewer attend the interview session (or watch a videotape of it). The reliability checker silently observes the interview and independently records symptoms, observations, and comments on a separate copy of the DISH. To improve their interviewing skills, the primary interviewer and the reliability checker should compare notes after the interview has been completed and discuss any disagreements. However, they may not alter their forms in order to eliminate disagreements.

Reliability checks are conducted to determine the extent to which trained interviewers agree with one another about the participant's symptoms and about how to code them on the DISH. During the first three months of enrollment, 10% of all interviews at each site will be subjected to inter-rater reliability checks. These reliability checks should be conducted by the project coordinator, Counselor supervisor, or other trained, experienced DISH interviewer. It is expected that each interviewer will have at least three reliability checks by the end of first 6 months of enrollment. Subsequently, 5% of all interviews will be subjected to inter-rater reliability checks, to ensure ongoing quality control and to minimize observer drift. It is expected that one reliability check per month per interviewer will be needed to reach this goal. Similar procedures will be followed for new interviewers hired after the start-up of enrollment.

Reliability checkers should attend the actual interview session, if possible. Reliability checks may also be performed on videotaped interviews if the interview is clearly audible and the participant's facial expressions and nonverbal behavior clearly visible. Audiotapes are not sensitive to nonverbal cues and hence are not acceptable for DISH reliability checks.

The realistically attainable upper limit of inter-rater reliability differs across items on the DISH, primarily because some items require more clinical judgment than others. For example, there is seldom disagreement as to whether a patient has gained or lost a substantial amount of weight, but the inter-rater reliability of the Hamilton scale's "insight" item is notoriously poor. Nevertheless, the quality control goal is to reach at least 70% agreement per item per interviewer.

Diagnostic reviews are performed by ENRICHD counselors on the Case Coordinators' baseline interviews the Follow-up Interviewers' 6-month interviews. Preferably, the baseline interviews of participants randomized to the intervention arm are reviewed by the counselor to whom the participant was assigned. The counselor reviews the completed DISH and DSF or DFU forms and reaches his or her own diagnostic impression based upon the Case Coordinator's or Follow-up Interviewer's findings. The counselor then records his or her judgment on the DSF or DFU form.

The purpose of this diagnostic validity check to ensure that the Case Coordinators and Follow-up Interviewers apply the modified DSM-IV criteria appropriately and that their diagnostic impressions agree with those of an experienced mental health professional, when given the same interview findings to draw upon.

Each Case Coordinator and Follow-up Interviewer is required to submit all of his or her DISH interviews for diagnostic review until diagnostic agreement with the reviewer has been achieved in 20 cases. After this point, the interviewer is no longer required to submit DISH interviews for diagnostic review. However, the counselors are expected to continue to review the baseline DISH and DSF in all of their own cases, in order to familiarize themselves with new participants. They are expected to discuss questions and disagreements with the interviewers.

Clinical validity checks on participants randomized to the intervention arm are performed by the Coordinating Center. This is done by comparing the Case Coordinator's baseline DSF to the counselor's Clinical Evaluation Data (CED) form from his or her initial clinical evaluation. The purpose of this check is to determine the extent to which the Case Coordinators' diagnoses agree with those of mental health professionals who independently evaluate the participants.

Since ENRICHD participants are recruited during an acute medical crisis, rapid changes in psychiatric condition are frequently encountered. For example, a participant might be very depressed during the index hospitalization but feel much better after being discharged to his or her home environment. The more time that elapses between the administration of the baseline DISH and the counselor's initial clinical evaluation, the more likely it is that the participant's psychiatric condition will have changed. Although the counselors are required to complete the initial clinical evaluation as soon as possible after randomization, delays are unavoidable in some cases.

Thus, the time between the baseline interview and the initial clinical evaluation is taken into account when clinical validity analyses are conducted. The greatest weight is placed on data from initial clinical evaluations that are completed shortly after the patient is randomized. A clinical validity kappa of 0.70 is the minimum acceptable level for each interviewer.