CLIENT TREATMENT MANUAL

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Disclaimer: The information in this manual is intended for use as part of a comprehensive treatment program, and by itself does not constitute psychological or mental health treatment. If you are in need of treatment, I recommend that you consult with a qualified health-care professional.

The purpose of this manual is to provide you with information about the treatment process and to give you resources to work with as you embark on your course of treatment. It's important that you take the time to read it and become familiar with the contents, as the best results are obtained when you (the client) are committed to working in a collaborative manner during the treatment process. The type of therapy we will be doing is very action-oriented, in that we will often discuss behavioral objectives which you will commit to implement during the time between sessions. In my experience, one of the most important factors that determines who improves versus who doesn't has to do with an individual's commitment to following through on what is discussed during a session. This *active* stance towards treatment is similar to the approach you would take towards taking a course in school. During the course, the instructor's job is to provide you with information in a manner that is clear and understandable to you, and to give you resources and guides to help you learn the material. The grade that you eventually get in the course has to do in a large part with how seriously you take the course and how much effort you put into studying and thinking about what is being covered. As a university professor as well as a practicing psychologist, I'm often struck by what often appears to be a discrepancy between the expectations of my students and many clients in the mental health system. I think that some individuals in the mental health system have been socialized to take a relatively passive stance towards treatment and expect the therapist to somehow fix the problem. This is illustrated by the fact that the word *patient* is derived from the same Latin root that underlies the word *passive* (which is why I refer to you as *client*). In the old-school medical model, patients are supposed to be passive and allow the physician to do most of the thinking and provide the "cure" for the presenting problem. Our medical colleagues have more recently recognized that for many presenting problems, the active collaboration of the "patient" is perhaps the most crucial factor in determining treatment outcome.

So…this is a good time to ask yourself the following questions: Are you willing to take this course of treatment as seriously as you would take a college course? Are you willing to study and do homework? What grade do you want to get?

It's also very important to keep in mind the fact that *I am not your boss, I am your consultant!* I will do my very best to guide you along the path that I know from my training and experience will help you move towards healthy goals. However, the person who you are ultimately accountable to is you, not me.

On the following pages I'm going to give you some specific suggestions that will improve the probability that you will have a positive outcome from treatment.

Suggestions

1. It is a good idea to have a recent physical examination to rule-out possible physical causes to your problem.

2. Physical exercise or some other physical activity (such as Yoga) have been shown to have a positive impact on mood and cognition. It does not have to be strenuous, as activities such as regular walking are beneficial. What is important is that the activity is practiced on a routine basis (such as at least 3X per week).

3. I strongly suggest that you record our sessions and/or take notes. Bring a recording device and/or note-pad into your sessions and listen to each session at least once before your next session or review your notes.

4. Internet resources can be both helpful and harmful. I like to quote the clothier Sy Sims, who says "an educated consumer is our best customer". I believe that an educated client is the best client. Availing yourself of information related to your problem and treatment can be very helpful. However, some of what you may read on the web can provide misleading or inaccurate information. I encourage you to discuss what you read on the web with me or other qualified health-care providers.

5. I will make recommendations regarding certain books which I have found helpful as an adjunct to treatment. I've also found that this is an area where clients often don't follow-up or do so in an inconsistent manner. If you were taking a college course, the expectation of keeping up with the readings is something that's taken for granted. In many ways, this course of treatment can have a greater longer-term impact than most of the courses that you may have taken, so it certainly deserves to be taken as seriously as a course in school.

6. The first book recommendation is The Happiness Trap by Russ Harris. It's very reader-friendly, and it reinforces much of what we'll be talking about in treatment. Take your time reading it. I strongly encourage you to make use of the website that is associated with the book (www.thehappinesstrap.com) to download the exercises in the Free Resources section and to take the time to actually do the exercises. There are also additional resources that you can purchase from the site.

7. Remember, if you keep doing what you've always done you'll keep getting what you've always gotten. At times I will suggest that you do things differently than you've done in the past, especially when it comes to confronting your fears. I understand that this will be uncomfortable for you at times, however the relatively brief period of discomfort that you may experience is on the balance of things far less than the long-term suffering that can be the result of inadequately addressed psychological problems. The following several pages have metaphors, reflections and thoughts that are helpful in getting across some of the concepts of the treatment process.

The Treatment of Anxiety Disorders

The category of anxiety disorders is subdivided into several separate disorders, however there is considerable overlap between these disorders, and many people have characteristics of more than one. The anxiety disorders are: Obsessive Compulsive Disorder, Panic Disorder, Phobias (which includes Social Phobia), Generalized Anxiety Disorder and Post-Traumatic Stress Disorder. It is also not unusual for people with anxiety disorders to have co-occurring (referred to as co-morbid) disorders such as depression or a substance-abuse problem (alcohol, marijuana and tranquilizers are the most common substances of choice among those with anxiety disorders). There are two widely-used treatment modalities for anxiety disorders. There is also a third treatment modality which is not yet as widely known, however it has substantial empirical support in the clinical research literature. This third modality will be described at the end of this section. The first two will be described below:

The psychological treatment for anxiety disorders that has the most extensive support in terms of scientific research is a type of therapy called *Cognitive Behavioral Therapy* or *CBT.* A recent outgrowth of CBT that is gaining increasing research support is an approach known as *Acceptance and Commitment Therapy* or *ACT.* Both of these approaches use similar techniques although some of their assumptions differ. They both emphasize the importance of *exposure* to the situations, thoughts and feelings that are associated with anxiety. Needless to say, treatment at times can be unpleasant, and requires motivation and a willingness to work and tolerate discomfort on the part of the client. This includes a willingness to practice exercises or complete behavioral tasks outside of the treatment sessions. Research has consistently shown that individuals who follow-through with outside objectives have a better treatment outcome.

The other line of treatment for anxiety disorders is medication treatment. Primary care physicians often prescribe medications for anxiety, however for more complicated cases, prescribing is often done by a psychiatrist (a psychiatrist is a physician who has specialized in psychiatry, just as other physicians have specialized in cardiology, gastro-intestinal disorders, obstetrics, etc.). Increasingly, Advanced Practice Nurses (who have a Master's degree and practice under the supervision of a physician) are also seeing patients and prescribing medication.

There are two main categories of medications used for treating anxiety. The first category is *benzodiazepines*. Examples are Xanax, Ativan, Klonopin and Valium. These tend to alleviate anxiety quickly. Their disadvantages are sedation and the fact that they can create a physical and psychological dependence with long-term use. However, some people can do well with these medications on a long-term basis provided that they have close medical supervision. However, you should also be aware that there are some researchers in the field who hold the opinion that benzodiazepines *can actually interfere with the psychological treatment of anxiety.*

The second category involves certain antidepressant medications that influence a brain chemical called *serotonin.* The most commonly prescribed ones are in a category known as *SSRI's* (which stands for Selective Serotonin Reuptake Inhibitors). Examples of these are Prozac, Zoloft, Paxil, Luvox, Celexa and Lexapro. These typically take longer to work than benzodiazepines (3 weeks or more) and need to be taken every day. There are also some other antidepressants that aren't SSRI's, which are sometimes used for treating anxiety disorders. Some prescribers prefer to prescribe antidepressants (as opposed to benzodiazepines) for the long-term management of anxiety because they are not prone to being abused. Disadvantages include the fact that some people have difficulty tolerating these medications because they experience unpleasant side-effects. Also, although these medications aren't technically considered to be "addictive" some people have a difficult time coming of these medications. However many people tolerate these medications well. Sometimes, for more complicated cases, categories of medications other than benzodiazepines and antidepressants are used, although these are most often prescribed by a psychiatrist.

Each treatment approach has its advantages and disadvantages. Psychological treatments tend to take a longer time before they become effective as compared to medication, however research has shown that the positive effects are more likely to be maintained after treatment, whereas symptoms are more likely to return after medication treatment has been discontinued. Psychological treatments require more motivation and commitment than medication treatments. Some people who take medications experience side-effects that are unpleasant or interfere with their functioning or quality of life. Some people prefer to try to address their symptoms without taking medication. Neither approach is effective for 100% of individuals, and it is not unusual for people to be on a combination of treatments. Research has been mixed as to whether people do better on combination treatment than monotreatment (one type of treatment), although it is generally accepted that if an individual experiences little or partial improvement with one treatment, the other treatment should be added. In order to decide on which treatment or treatments are best for you, and to get the most out of the treatment(s) you receive, it would be helpful to consider the following points:

1) <u>Consider your preference of how you would like to address your problem.</u> Personal preference is a significant factor affecting treatment outcome. The pros and cons of psychological and medication treatments were briefly discussed previously. Consider these and try to make an informed decision that you feel comfortable with and which you believe you can commit to. Combination treatment is not always necessary but is also not uncommon.

2) <u>The most realistic goal of treatment is not a complete reduction of psychological discomfort.</u> Rather, it is being able to live a full and meaningful life. Anxiety disorders can result in severe life-limitations, and it is natural to have the thought that you'll start living your life fully once you get rid of all your anxiety (referred to as "When-Then Thinking"). However, an anxiety-free life is something that even people without anxiety disorders don't experience. I've seen people who put their lives on hold, and who become professional patients, going from doctor to

doctor or trying endless combinations of medications or other treatments waiting to attain a state of "Nirvana" that never comes. Certainly, it is understandable to want symptom relief, as symptoms are unpleasant and uncomfortable. Both types of treatments (psychological and medication) can relieve symptoms to some extent, however, they will not totally eliminate all discomfort. Being willing to live a full and meaningful life along with any remaining discomfort is the key to ultimate therapeutic success.

3) Your treating professionals are not your bosses. We are your consultants. Ultimately, you are the judge of what works best for you. Ask yourself if our information or interventions are helping you improve your overall quality of life. As your consultants, our responsibility is to provide you with our knowledge and expertise to help you address your problem. Your responsibility is to consider our input seriously and then to decide what you want to do with that information. This means that you are free not to utilize the information or interventions we make available to you. However, if you choose not to follow a professional's suggestions, it is very important that you let them know and explain why you have made this choice. Although in many instances your professional may be able to discuss other options with you, in other instances there may not be other options they can offer you that in their opinion can effectively address the problem. If you're frequently "yes, butting" your professional, something's not working.

4) Even if your professionals care very much about your treatment, you can't expect them to care more than you do. Sometimes I've heard people say "My doctor, therapist, etc. was upset with me because I didn't do so and so…" I've often wondered why these people are less upset with themselves than their treating professionals seem to be if they haven't followed through on an agreed upon course of action to address their problem. Ultimately, they are the ones who have to live with the consequences of their decisions. Taking your recovery seriously is of prime importance. Of course, taking your recovery seriously involves finding and collaborating with treating professionals who also take it seriously.

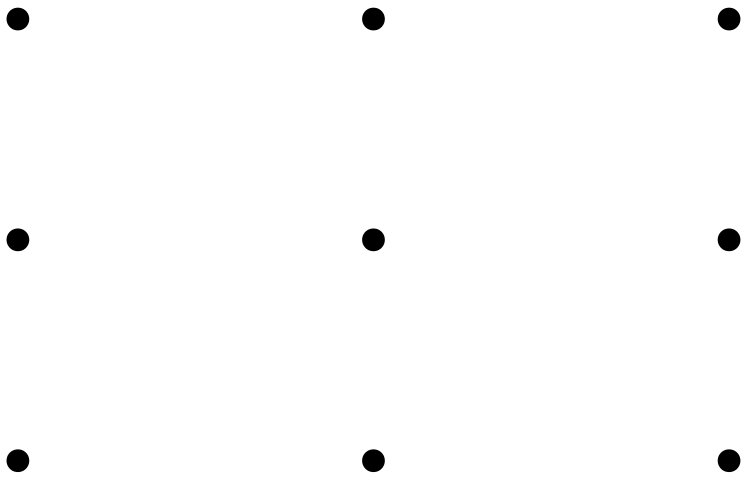
5) If you're not experiencing some improvement in your quality of life after a reasonable amount of time, consider other options. Remember, complete symptom elimination is not always a realistic goal, however improved quality of life is. If you do not feel that you have a good working relationship with your professional, it is time to seriously consider finding another professional. If you have not put a good effort into following through with the plans that you and your professional have worked on, it is time to decide whether or not you are willing to give the treatment a legitimate chance. If you are in one type of treatment and believe you could be doing better, consider either adding or switching to another treatment. I have found that sometimes clients view taking medication as a sign of defeat. My own view is that if the goal of treatment is to help someone live as full and meaningful a life as possible, and if medication can help them progress towards that goal, then it can be a useful ally rather than a sign of defeat. This

> does not take away from the achievements that people have attained from their hard work in CBT (or for that matter, ACT). Some people eventually are able to come off their medication as they become more proficient at applying what they have learned in therapy. Other people are on a lower dose, or fewer types of medications because of effort they put into their treatment. People who are on combination treatments invariably have a better quality of life with CBT or ACT than they would have attained through medication alone. To quote from the famed psychiatrist Karl Menninger, M.D., "There will never be a pill that can fill empty lives, heal broken hearts or teach people how to love".

A third treatment modality is Cranial Electrotherapy Stimulation (CES). In addition to having over 40 years of clinical research supporting its efficacy, CES has been widely used by the military both stateside and on the front lines, as well as with the general population. CES involves the administration of very small pulsating electrical currents to the head via electrodes. It is painless and has an extremely low incidence of side-effects. Although there are a number of CES devices on the market, I have been trained in and recommend the device manufactured byAlpha-Stim ®, which is the best-researched and most widely-used device. Alpha Stim ® devices are FDA-cleared for the treatment of anxiety, insomnia, depression and pain. Although I have an Alpha-Stim ® device in my office, it is for demonstration and teaching purposes. If you are interested in this modality, you will need to purchase (or rent) one from an approved distributor, and you would administer your treatments at home. You will need to have a prescription from a licensed health care professional, which I can provide as a licensed psychologist. I will discuss CES and Alpha-Stim ® further in the Common Questions section at the end of this manual. You can also learn more about Alpha-Stim ® products by visiting their website (www.alpha-stim.com).

A VISUAL ILLUSTRATION OF THE TREATMENT PROCESS

Your Task: Using four straight lines draw a line through each of the nine dots. Where you finish one line, you must start the next (you can't pick up your pencil from the paper and continue somewhere else). It's best if you use a pencil rather than a pen.



Hint for Nine-Dot Puzzle:

Did you stay inside the box? The answer lies in going outside of the box. Draw a straight line up on the left side and go past the top dot. With your second line, pass through the top middle dot and the second dot down in the third row. Continue down until you can make a left with your third line and draw through the bottom dots. Your fourth line will go up and to the right from the lower left dot, thought the middle dot and end at the upper right dot.

How is this like treatment? Some people stay with the familiar, even if the answer is not to be found there, and will resist going" outside of the box". They will prefer the security of known misery to the insecurity of unknown happiness. In treatment, you will be challenged to go outside of your comfort zone at times, and this can be uncomfortable. You will learn, however, that the "box" is a product of your own creation and that the restrictions it places on your life are arbitrary.

“Go to the edge” the voice said
“No!” they said “We will fall!”
Go to the edge” the voice said
“No!” they said “We will be pushed over!”
“Go to the edge” the voice said
So they went
And they were pushed
And they flew

-Zen Poem

COMMON COGNITIVE DISTORTIONS

Cognitive distortions involve ways in which we think about situations that are not based on logical, reality-based considerations. The type of thinking we will focus on here involves "self-talk", or what we say to ourselves "in our heads". Whether we are aware of it or not, our minds are constructed so as to run an ongoing verbal commentary regarding ourselves and our environment. Sometimes this commentary is skewed in a way that is not only inaccurate, but also serves to demoralize us, contribute to unpleasant emotions or influence us to behave in ways that are not consistent with what we truly value in life. An analogy is a historical figure during World War II named "Tokyo Rose" who broadcast Japanese propaganda in an attempt to demoralize our troops. For the most part, our troops recognized the source, and did not take Tokyo Rose's messages seriously. However, this is often not so when we broadcast our own negative propaganda to ourselves, and we feel and behave as if these messages are literally true. The first step in addressing this is to become aware of some of the more common types of propaganda messages and unhelpful self-talk that we may buy-into. These are often referred to as Cognitive Distortions, and the following is a brief description of some of the more common types.

1) All or nothing thinking: Situations are viewed in a black-white manner in which either something is perfect of it's a failure. It's a common distortion in self-described perfectionists, i.e., "If my house isn't spotless, it's a mess", "If I make a mistake the whole thing is ruined", "If I can't be 100% sure, then it's dangerous", "If I don't feel 100% OK, then I'm not well". This leads to "the cup is half empty" perspective as you'll always focus on what is wrong instead of what is right.

2) Catastrophizing: The negative impact of situations is exaggerated, i.e., "If I don't (get there on time, do something right, have things go smoothly etc;) **or** If I feel (anxious, embarrassed, sad, uncomfortable, etc.) it will be (horrible, a disaster, I won't be able to stand it)".

3) Emotional Reasoning: An assumption is made that one's negative emotions reflect the way things <u>really</u> are, i.e., " If I feel this bad when I have that thought, then the thought must be true".

4) What if's: Asking repeated "what if" questions to which there are no clear-cut answers, i.e.," related to future events, i.e., "What if I (panic, something bad happens, do something harmful), etc." The implication is that if your "what if" happens, you won't be able to handle it or couldn't stand it.

5) If only's: Also known as the "fonelies". Going back into the past as though we could somehow change events that have already occurred. "Shoulda-coulda-woulda's" are also in this category.

6) Overestimation of probability: Thinking (and subsequently feeling) that something that has a low probability of occurring actually has a high probability of occurring, i.e. "If I get on this airplane it's probably going to crash", "If I'm exposed to germs, I will probably die".

7) Should statements: Telling ourselves that we should or should not think, feel or do certain things, i.e., "I should always (be in control, be cheerful, keep a perfect house) **or** (I shouldn't feel (tired, scared, angry, etc.). We may also apply this to others, i.e., "you should do things my way" and the world, i.e. "things should be the way I want them to be, not as they are". Albert Ellis, Ph.D. who was a famous psychologist, used to say to his clients "stop **shoulding** on yourselves and others!"

8) Labeling: Attaching a negative label to oneself because of unwanted thoughts or feelings, i.e. "I'm (horrible, weak, unworthy, etc.) because (I had a bad thought, felt frightened, angry, etc.)."

9) Magical Thinking: Believing in a connection between thoughts, behaviors and events that have no logical basis in reality, i.e., "If I don't do this behavior, something horrible will happen", "If I think this thought or say this thing, it will come true".

10) Mental Fusion: Believing that our thoughts are literally true, instead of being what they are…just thoughts. The concept of how we fuse with our thoughts and then respond behaviorally and emotionally, often in inflexible and maladaptive ways, is at the heart of the mindfulness approach.

EMDR

At some point during treatment I may incorporate a technique called EMDR into our work together. EMDR stands for *Eye-Movement Desensitization and Reprocessing*, and it is well-validated in the scientific literature for the treatment of Post Traumatic Stress Disorder and phobias. A good summary of the research can be found on the EMDR Institute website. EMDR involves using mental imagery while experiencing bilateral stimulation (which can involve back and forth eye-movements or other sensory stimulation such as alternating tones or hand-tapping). Although there are quite a few studies that have demonstrated its effectiveness, it is not without controversy, largely due to the fact that there is as yet no clearly supported theory to explain why the bilateral stimulation component adds anything to the treatment. There are other, well-validated treatments for PTSD that utilize imagery in a similar manner to EMDR but do not involve bilateral stimulation, which has led some to claim that EMDR is simply a variant of these other types of treatments. Although this appears to me to be a reasonable position given our state of knowledge at this time, I believe that some of EMDR's critics have been unreasonable in going on to denigrate the overall procedure because of the continued questions about what role, if any, the bilateral stimulation has on the treatment effect. I would also point out that there is some research to suggest that the bilateral stimulation is, in fact, an active ingredient. Even EMDR's critics don't deny that it has a significant treatment effect. Regarding this controversy and some of EMDR's critics, I can't help but thinking of the humorous quote "Well, it works in practice, but does it work in theory?"

I was trained in EMDR over 15 years ago, and have used it with hundreds of clients. I have also used some of the other imaginal exposure formats discussed in the scientific literature, and I have found that in my clinical judgment, EMDR seems to work better. I have also used EMDR for presenting problems other than PTSD with very good results. A summary of the scientific literature on EMDR and a discussion of this type of treatment can be found on the EMDR Institute website (www.emdr.com). An interesting book about EMDR that is written for the general public which can give you some accounts of how it has been used is *EMDR: The New Breakthrough Eye Movement Therapy for Overcoming Anxiety, Stress and Trauma* by Francine Shapiro and Margot Silk-Forrest.

THE FOUR OPTIONS
Adapted from Marsha Linehan, Ph.D.

I've found this to be helpful in establishing a framework for what are realistic and unrealistic options for treatment. I summarized this from an excellent DVD by Marsha Linehan entitled *From Suffering to Freedom: Practicing Reality Acceptance*.

When we encounter a problem or crisis in our lives, we have four options that we can choose from in how to deal with it. The first three can be used together in a complementary manner as they are associated with healthy coping. These options are:

1) Radical Acceptance: This option involves an acceptance of reality as it is **right now**. The term "radical" is used to indicate that acceptance is total, and involves our emotions as well as our thoughts. The word "surrender" is also sometimes used to convey this concept. It is important to understand that acceptance does not necessarily imply telling ourselves that a situation is "OK" or to minimize ecologically valid feelings that may accompany difficult situations. In fact, acceptance involves making room for these feelings rather than fighting, denying or trying to control them even though they may be painful. It is also important to understand that radical acceptance is an orientation rather than a destination, and to not be hard on yourself when you find that you have slipped into non-acceptance mode. Self-talk that indicates when we are in non-acceptance often involves phrases such as "If only…" "Why me…" "Shoulda-coulda-woulda…" "Why should I hafta…" etc.
When you find yourself saying these things to yourself, stop and ask yourself if saying this is helping the situation in any way. If it's not, bring yourself back with an orientation towards acceptance. Note that acceptance does not necessarily imply passivity, which brings us to option #2.

2) Constructive Action: If there is something constructive that we can do to change a situation in a positive way, then it is important to take action at the appropriate time. Taking constructive action involves first asking yourself if a behavior will move you towards or away from a desired objective. Some behaviors are done to provide temporary relief from a situation. This can be OK provided that they don't ultimately move you farther away from what you want to accomplish. Taking a break from a difficult task, taking a vacation, engaging in hobbies or entertainment, going out to dinner and spending quality time with others are examples of behaviors that may not directly move you in the direction of changing a situation, but they add to the quality of life and can help you "recharge" yourself. It's important that these behaviors not be used as excuses to avoid dealing with what you need to deal with, however. Engaging in "escape" or "avoidance" behaviors, losing your temper and becoming involved in tasks or activities that allow you to give yourself a reason for not addressing a situation are examples of non-constructive action. You can ask yourself "does engaging in this behavior solve more problems than it causes or cause more problems than it solves?" You can also ask yourself, "If not now, when?"

3) Change how you think about a situation: What you tell yourself about a situation (self-talk) can be helpful or unhelpful. I would suggest that you review the section of this manual that discusses some of the more common cognitive distortions so you can start to recognize when you are engaging in unhelpful self-talk. Noticing what's going through your mind, and if it is unhelpful, asking yourself whether there are other ways to think **that are believable to you** can be very helpful in putting things into perspective. It's important not to try to convince yourself of something that you cannot believe, as it won't ring true for you. This will not necessarily mean that you'll silence the unhelpful voice, however you can contrast it with other more helpful self-talk. At times, it may be difficult to come up with alternate perspectives that work for you. At these times, try to notice your thoughts as being **just thoughts** that are going through your mind (sometimes referred to as mental chatter).

The above three options are about accepting and working with life on life's terms. You may have noticed that these themes are succinctly summed up in the Serenity Prayer.

Grant me the serenity to accept the things I cannot change
The courage to change the things I can
And the wisdom to know the difference

Don't be discouraged when you find yourself not using these options and recognize that you are falling short of how you would like to handle a situation, as **falling short is part of the human condition**. When you notice that you've gotten off-track, practice self-compassion and gently guide yourself back on track.

You'll find that during times when you are not working with the above options you will be choosing option #4, which is:

4) Be unhappy: There is no viable fifth option.

Clients sometimes tell me that it's hard to work with the first three options. I agree with them. However, the fourth option is harder in the long run. One behavior that indicates that you're choosing option #4 is complaining to others without taking any action. Complaining provides some temporary relief in that we do it to get sympathy from others, which can make us feel better in the moment or help us to feel justified in doing what we're doing (even if what we're doing isn't helpful), but it rarely, if ever does anything to improve a situation.

QUOTES TO THINK ABOUT

We can try to control the uncontrollable by looking for security and predictability, always hoping to be comfortable and safe. But the truth is that we can never avoid uncertainty and fear. So the central question is not how we avoid uncertainty and fear but how we relate to discomfort. How do we practice with difficulty, with our emotions, with the unpredictable encounters of an ordinary day? When we doubt that we're up to it, we can ask ourselves this question: "Do I prefer to relate to life directly and live a full and meaningful life, or do I choose to live and die having been dominated by fear?"
- Pema Chodron

It is only by practicing through a continual succession of agreeable and disagreeable situations that we acquire true strengths. To accept that pain is inherent and to live from this understanding is to create the causes and conditions of happiness.
- Suzuki Roshi

Radical acceptance is the only way out of hell--it means letting go of fighting reality. Acceptance is the way to turn suffering that cannot be tolerated into pain that can be tolerated.
- Marsha Linehan

We are what we repeatedly do.
- Aristotle

Being happy doesn't mean everything is perfect. It means that you've decided to look beyond the imperfections.
- Author Unknown

If you want to build self-esteem, do esteemable things.
- AA slogan

Common Questions

This is a brief question and answer section for some of the more common questions that I'm asked about treatment. It certainly does not cover all of the questions that come up, and I strongly encourage you to ask any questions that may come up for you as you go through the treatment process.

What treatment approach do you take? I practice largely within a Cognitive Behavioral perspective, although more recently I have been incorporating the mindfulness approaches to treatment (especially Acceptance and Commitment Therapy or "ACT"). Also, as I mentioned earlier in this manual, I often utilize EMDR, which I find works very well with the ACT perspective.

What is Cognitive Behavior Therapy? The basic premise of Cognitive Behavioral Therapy (or CBT) is that how we think about ourselves, our situation and our future has a strong effect on what we feel emotionally and how we behave. It's not unusual for everyone at times to develop "bad habits" in thinking that are unhelpful. Learning to recognize unhelpful ways of thinking and challenging these thoughts with more helpful ways of thinking is at the heart of CBT. It's important however, that these other, more helpful thoughts are believable and realistic to you and not simply platitudes. Once you have adopted more helpful ways of thinking, it is then very important to change your behavior in a way that is consistent with these new thoughts. This may be difficult at first, but as time goes by you'll find that it becomes easier. CBT has an impressive amount of research in the scientific literature supporting its effectiveness for a wide variety of problems.

What is the "Mindfulness" perspective? The mindfulness approaches developed out of the Cognitive Behavioral approach, and although there is some overlap, there are also some differences. Mindfulness involves learning to "observe" our thought processes without necessarily having to change them, and to accept what we are feeling emotionally at any given time instead of trying to avoid or control feelings that we believe are unpleasant. With practice, distressing thoughts or unpleasant feelings lose their power, and you'll notice that they come and go, like clouds in the sky. The mindfulness approaches are relatively recent on the clinical scene. However, there is a rapidly growing body of scientific literature that supports its effectiveness for a wide variety of problems. The mindfulness approach that I most frequently refer to is called *Acceptance and Commitment Therapy*, which is commonly referred to as "ACT".

Are approaches other than CBT and mindfulness helpful? For many presenting problems, the research shows that the quality of the therapeutic relationship rather than the orientation of the practitioner is the most important variable in therapeutic outcome. Psychoanalytic and Humanistic approaches (the other most common perspectives used by practitioners) are certainly helpful to many individuals. However, certain presenting problems (especially anxiety disorders) seem to respond best to CBT or mindfulness approaches.

About how long is the treatment process? This can vary significantly depending on the degree of complexity of the presenting problem and extent to which you are willing to work in treatment. However, most clients are seen for between 8 and 20 sessions. The time between sessions is often stretched out as treatment progresses, so the overall time-frame can be 6 to 12 months. After reaching their therapeutic goals, some clients choose to come in for occasional "booster" sessions every 3 to 4 months.

What about medications? Medications can be very helpful for some people, but others respond well to psychotherapy alone. I would estimate that about 50% of my clients are on some psychotropic medication. Whether to take medication is a personal choice, and I will respect your choice either way and work with you. However, if you become "stuck" or are having trouble following through with the objectives we discuss in our sessions I may suggest that you get an evaluation for medication.

Do you prescribe medication? As a psychologist, I am considered a non-medical clinician and I do not prescribe medication. However, I have a post-doctoral diplomate in psychopharmacology, and it's OK to discuss your medications with me. I can give you information that is in the public domain, such as which classes of medications are used for which disorders, common side-effects, etc., and help you make informed choices. However, I cannot and will not tell you what specific medication you "should" take as that is up to your prescriber. I also cannot and will not tell you to do something other than what your prescriber tells you although I may suggest questions that you may want to ask your prescriber. I will also consult with your prescriber if it appears to be indicated. Some of my clients have medications prescribed by their primary care physicians. Others see a psychiatrist or another type of specialist. I frequently refer clients in need of a medication review to an Advanced Practice Nurse (APN) who can prescribe, and with whom I often collaborate closely.

You mentioned Cranial Electrotherapy Stimulation (CES) earlier in the manual. What does the clinical research say? CES has compared favorably to medication treatment with fewer reported side-effects. As with many medications, it may take several weeks of regular administration of CES to see significant results. Administration is quite easy to do, and typically involves 20 minute daily treatments. After several weeks you may be able to reduce the frequency of treatments to 3 days per week, and eventually to an as-needed basis. During the treatments you can watch TV or read, or you can simply sit or lie quietly.

Does insurance cover CES devices? Alpha-Stim ® manufactures the CES products that I have been recommending because the majority of clinical studies have used their devices. Alpha-Stim makes two products, the Alpha-Stim AID® (for anxiety, insomnia and depression) and the Alpha-Stim M® (for anxiety, insomnia, depression and pain). At the present time, insurance is not covering CES devices for anxiety, insomnia and depression (such as the Alpha-Stim AID®) however it *may* cover a CES device for the treatment of pain (such as the Alpha-Stim M®). Regarding purchase of a CES device, you first need to have a prescription from a licensed healthcare professional (which I can provide). You can then purchase an Alpha-Stim ® directly from the company (www.alpha-stim.com), or you can rent to own from Allevia Health, which is an authorized distributor (www.alleviahealth.com).

If CES is so effective, why haven't I heard about it before? This is a question that has me quite puzzled, as there have been over 100 published clinical studies going back 40 years. My sense is that the companies that produce CES devices don't have a fraction of the money and resources to market their products as compared to the pharmaceutical industry.

Can I use CES if I'm taking medication? Yes you can. CES may facilitate the effectiveness of your medication, and it is possible that you may be able to reduce your dose after several weeks of regular use of an Alpha-Stim ® device (in collaboration with your medication prescriber, of course).

Are there good books or other resources that you recommend? There are a number of very good books and other resources that can be helpful to you. I consider *The Happiness Trap* by Russ Harris to be the basic "textbook" for this "course" in treatment. There are other books and websites that I'd be happy to share with you that are also worthwhile. However, it's important to note that you won't be able to simply "read" your way out of your situation, just as you can't simply "read" how to play tennis or to be in shape to run a 5 mile race. Reading can give you useful information, however the extent to which you work to actively put into practice what you've learned is the major factor underlying improvement.