Angry Patients and Soft Eyes: Connecting with the Help-Rejecting Patient

Skill is successfully walking a tightrope over Niagara Falls. Intelligence is not trying.

—Anonymous

Few moments in general medicine are as vexing to health care providers as the visit with an angry patient who is making demands. Whatever the demand—whether more tests or more medications—the visits often invite the provider to take a defensive posture, feel exhausted at the end of the visit, or both. It is difficult for providers to feel "present" in a visit with a demanding patient—and often in the *next* visit as well. For this reason (and others), many primary care providers pale when they see the name of a demanding patient on the clinic schedule. One provider put it this way: "When I see that patient's name on my schedule, my heart sinks because I don't know what I can do to help!"

What is it exactly that makes the demanding patient so difficult to deal with? First, patients like this often have real and significant medical problems that are not "curable" in the conventional sense. Some of these conditions might involve a relatively straightforward medical diagnosis (such as diabetes or cardiovascular disease), whereas others might have a less certain organic etiology (for example, chronic low-back pain). Combine this with a high level of psychological distress and a low level of psychological flexibility, and the patient–provider interaction can easily heat up.

Second, demanding patients typically have learning histories that promote their stimulation of negative behaviors in others, including medical providers. They often have suffered abuse or emotional neglect, experienced critical and rigid parenting, or both. They tend to be fused with emotionally charged evaluations such as right–wrong, good–bad, blame–shame, and fair–unfair. Their self-stories may portray them as victims who are misunderstood, ignored, or rejected. Not surprisingly, they approach people, particularly people in authority roles, in a highly defended way, often

looking for the slightest sign that they are about to be punished in some way. Following the old adage, "The best defense is a good offense," they seek to gain control of interactions, to reduce the possibility that they will be hurt. Like the school-yard bully, they learn to use aggressive behavior to disguise their basic sense of vulnerability. When interactions with demanding patients go bad, it is nearly always because the issue has shifted to "not being listened to, understood, or helped." This is at the core of the demanding patient's self-story, and when the self-story is triggered, the interaction can quickly become polarized.

Let's consider possible TEAMS that an angry, demanding patient might have and how the patient's TEAMS might interact with a provider's TEAMS. Review sample worksheets A.1 and A.2.

SAMPLE WORKSHEET A.1

Common TEAMS Experienced by Demanding Patients

Thoughts	My provider doesn't listen to me and doesn't really care about me. He is just like all the other doctors and nurses who have misunderstood and misdiagnosed my problems: I have to make him understand how bad things are or he won't do anything. My health is failing, and no one seems to be doing anything about it. I am going downhill fast.
Emotions	Fear, anxiety, frustration, anger.
Associations	Image of standing up to authority who is yelling, threatening. Vague association of vulnerability to danger.
Memories	Being bullied and abused by father.
Sensations	Heart racing, headache.

Simultaneously, the primary care provider may be experiencing TEAMS similar to those suggested in sample worksheet A.2.

SAMPLE WORKSHEET A.2

Common TEAMS Experienced by Primary Care Providers During Visits with Demanding Patients

Thoughts	I wonder what new kind of complaint he is going to throw at me today. He doesn't understand that I have nothing else I can do to address his problems. He doesn't follow my instructions anyway; he probably has caused a lot of his medical problems by being so irresponsible. I'm going to try to keep control of the number of problems we discuss today. I'm going to tell him we have time to address only one problem.
Emotions	Apprehension, frustration, anger.
Associations	Feeling impotent, exposed as an ineffective provider.
Memories	Last visit with him and negative feelings associated with it.
Sensations	Jittery.

As you can see from this analysis, their respective TEAMS prepare the patient and provider to "butt heads." Both parties are imputing intentions to the other, such that their real motives (in the case of the patient, seeking help and gaining some measure of relief; in the case of the provider, wanting to deliver appropriate medical care with compassion) cannot drive the interaction. This chapter's question is this: how can PCPs address this diverse, high-impact group, so that their behavior in medical settings becomes more workable and their negative impact on the system is lessened?

Our first recommendation, and perhaps the most difficult to follow, is to look at the patient "with soft eyes." This involves accepting the presence of your own negative evaluations but not letting them control your behavior. While you can't control the patient's expectations and attitudes going into the visit, you can "neutralize" the interaction by steering clear of confrontational, limit-setting, divisive, and judgmental statements. Instead, try tuning in to your breath, relaxing your shoulders, looking into the patient's eyes, and then saying, "Hello, how are you?" *slowly* in the first few minutes of the interview. Notice your own TEAMS and try to acknowledge them with an ever-so-small smile. Remind yourself of this simple truth: no one likes to suffer, and the demanding patient is suffering. The

patient may not know what to do about it, and it is likely that what the patient is doing is not working. If you can see this part of your patient, you will be in a much better position to respond with soft eyes.

Our second recommendation is to use a "positive reframe" strategy with the patient's requests. A positive reframe puts a "soft spin" on what could be a polarizing statement. For example, the patient might say something like, "This medicine isn't working at all. I still can't fall asleep for hours. I want Valium because that worked for me before." You can either say, "I don't think Valium is the right drug for us to use" (a confrontational limit), or "It's obvious that you value your health, and improving your sleep is a positive goal, one I want to support. It can be frustrating when things don't come around as quickly as you'd like" (a positive reframe). In the latter example, you remove the fuse that is buried in the demand, making it much easier to redirect the discussion to alternatives to using one particular drug.

A third recommendation is to focus the discussion not on the content of the patient's evaluations, but rather on the process of evaluating per se. The point is not to demonstrate "I'm right, and you're wrong," but to notice that the theme of "right and wrong" is present. This will help you move the interaction back to your goal of helping the patient make progress. For example, if a patient says something like, "You treat me like I'm an addict, even though I've never abused drugs," you can respond by saying either, "I don't believe you are an addict, and I don't treat you that way," or better yet, "So, one thing your mind is telling you is that I'm treating you like an addict and that's not fair because you don't abuse drugs. I can see that if my mind gave me that kind of thought, I'd get pretty bent out of shape too. What other kinds of thoughts is your mind giving you about our interaction right now?" As the latter example demonstrates, moving the patient and the patient's mind into a speaker-listener relationship is a great way to defuse the patient from provocative evaluations while modeling acceptance of the fact that provocative content is present in the room. While it may seem that this type of strategy would open a Pandora's box that would be impossible to control in a short medical visit, it is in fact a far more efficient way to address a patient's sense of victimization. If you can keep the discussion from devolving into a contest over who has what intentions, there is space to do something positive.

A final recommendation concerns how to say no to a demand when you must. Situations requiring a clear no include when there is no medical indication for a treatment the patient requests, or you estimate the risk of ordering a new test, or trying a new drug or other intervention, to outweigh the benefit. No, to a demanding patient, is equated with being misunderstood, rejected, ignored, and everything else scary in the world. So, if you were the patient, you definitely wouldn't want to hear a knee-jerk no response (as you would quite

possibly have the thought that you were *being jerked around* or *dismissed*). A mindful no has a better chance of moving the interaction forward, and part of developing a mindful no involves focusing on acceptance of what cannot be controlled or changed. For example, the patient might say, "You have to do *something* to help with my headaches. They are destroying my life. I can't stand the pain. Valium at least lets me relax enough so that I can sleep." Here are two ways a provider could respond: "I'm sorry, but I won't prescribe Valium because it isn't a medicine for headaches," or "When you are in so much pain, it's tempting to want a way out. I would too. Consider this: we have tried everything that I think might have a chance of helping your headaches; sadly, we've had no luck, and for that, I'm sorry. It doesn't seem as if the headaches are going to go away, and for now at least, they may continue to be a part of your life. I want to support you in pursuing a better quality of life, even though you have headaches. Valium is not indicated for your headaches, and I think it could hamper our efforts to help you achieve a better life." The art of real behavior change includes saying no when it is the truth, and doing so in a way that is sincere and not defensive.

For now, let's consider the case of Bud and Dr. Jones, his family physician. As the chapter-introductory box indicates, we illustrate one of the interviewing tools (the Three-T and Workability Questions) and then demonstrate the use of the CPAT in planning treatment. We target two processes and illustrate three techniques.

Angry, Demanding Patient Interventions	
The Three-T and Workability Questions Core Process Assessment Tool (CPAT) Real Behavior Change Pocket Guide	
Process	**Technique**
Step Back from TEAMS and Unworkable Rules	Thought Watching Velcro
Accept TEAMS and Focus on Action	Book Chapter

CASE EXAMPLE: BUD AND DR. JONES

Bud is a twenty-eight-year-old Caucasian man who lives with his parents and a younger brother. Dr. Jones has provided care to Bud and his family for some time. Bud's visits to the clinic tend to be unplanned and crisis based.

Reason for Visit. Bud comes to the clinic without calling first and demands to be seen because he can't sleep.

Medical Status. Bud has one leg that is significantly shorter than the other, which results in hip pain. He also has a history of headaches, depression, and eating problems. He takes a nonsteroidal anti-inflammatory drug (NSAID) for headaches and hip pain, an antidepressant for chronic depression, over-the-counter medication for stomach upset, and a variety of over-the-counter medications for long-term sleep problems. Bud restricts his eating in an effort to control problems with digestion. He is underweight and possibly undernourished.

Patient Concern. He wants Valium (diazepam) and "that Ambien CR stuff" (zolpidem) so he can "sleep like the people on the TV commercials."

Patient's Life Context. Bud's parents adopted him when he was three years old, and they know little about his early history. He has never lived independently but does work part-time in the family dry-cleaning business. Bud is bright and has made several attempts to attend college but always ends up getting into an argument with someone and giving up. He has a history of multiple medical and mental health problems. He refuses mental health care, declaring, "They are all nuts at that place, and they try to poison you with their stupid meds." He enjoys watching television, playing video games, doing martial arts, and reading. When relaxed, Bud can talk at length about science fiction and what he believes will happen in the future. He values reading, imagination, "being smart," and being ready. When he was younger, he took martial arts classes, but now he only practices intermittently by himself. He is not particularly close to his brother and has few friends. Dr. Jones suspects that Bud uses street drugs occasionally.

Behavior-Change Interview

Dr. Jones uses the Three-T and Workability Questions during the exam to clarify how Bud's long-term sleep problems might have suddenly worsened.

SAMPLE WORKSHEET A.3 Bud's Responses to the Three-T and Workability Questions

Area	Questions	Patient Responses
Time	When, recently, did your sleep problems start to get worse than they already were?	Three weeks ago, it started to get really bad, even though I always have trouble falling asleep.
Triggers	Did something happen that set this off?	Got in an argument with my brother about smoking pot; brother said I was going nowhere in life because I was a druggie, which I'm not. I tend to think about what he said when I lie down to go to sleep, which gets me mad. This is an example of what people do to me all the time: they judge me and don't believe my side of the story.
Trajectory	Have your sleep problems stayed the same since they started three weeks ago, gotten worse, or improved?	"Started out taking one hour to get to sleep; now it's more like two."
Workability Questions	What have you tried to cope with this problem? How have these strategies worked over time? Are you getting the kind of results you want? When you use these strategies, are you getting some accidental negative results in other areas?	"Get Ambien." "Not well, because the nurse wouldn't prescribe it." "Now that you mention it, I did get kind of spaced out when I was taking Ambien, but maybe it wasn't the Ambien; maybe it was something else I was taking."

Dr. Jones summarizes information from the Three-T and Workability Questions this way: "Bud, I know you've had problems sleeping for a long time, but it sounds as if this interaction with your brother really set off some painful thoughts and feelings that you are taking to bed with you." Bud responds, "That's right, Doc, and the only way I'm going to be able to sleep is if you give me Ambien. That's the only drug that knocks me out enough so I can just stop thinking. I've asked your nurse twice this week to give me some Ambien, but all she says is that you won't give it to me, and she won't tell me why. I don't know why you wouldn't want to help me, but maybe you don't care about what I'm going through." When asked the workability questions, Bud starts to recall some unintended negative consequences from using Ambien.

Planning and Providing Treatment

Prior to his visit with Bud, Dr. Jones refers to the CPAT and anticipates some possibly helpful interventions. Conspicuous points of the six core processes of psychological rigidity for Bud include his tendency to get stuck in TEAMS and unworkable rules and also stuck in his limiting self-stories. Bud historically has also demonstrated a variety of ways to actively avoid painful TEAMS. Minutes into the visit, Dr. Jones can sense that Bud's active attempts to avoid his anger, resentment, and sense of rejection during daylight hours are producing a "rebound effect" as he tries to settle in and enter his sleep cycle. Dr. Jones wonders if Bud's rumination at night also serves the purpose of helping him avoid the pain of his brother's acusation. Despite Bud's demand for drugs, Dr. Jones decides to focus the intervention on helping Bud defuse from his painful TEAMS so that he can practice acceptance rather than emotional avoidance. Helping Bud find an accepting posture with painful TEAMS might reduce nighttime rumination and improve his sleep onset. In our case example, we illustrate a variety of techniques to provide you with a range of possibilities. Of course, we don't recommend using all of the illustrated techniques in a single visit with a patient.

SAMPLE WORKSHEET A.4
Bud's Core Process Assessment Tool (CPAT)

Six Core Processes: Psychological Rigidity	Patient Rating Today	Six Core Processes: Psychological Flexibility
Lives in the past or future	__X______________	Experiences the present moment
Disconnected from values	________X________	Strongly connected with values
Engages in impulsive, self-defeating action or inaction	________X________	Sustains value-consistent action
Stuck in limiting self-stories	________X________	Uses observer self to see self-stories
Stuck in TEAMS and unworkable rules	__X______________	Steps back from TEAMS and unworkable rules
Actively avoids TEAMS	__X______________	Accepts TEAMS and focuses on action

STEP BACK FROM TEAMS AND UNWORKABLE RULES

Dr. Jones understands that Bud has several sticky TEAMS that he fuses with on a daily, if not hourly, basis, including the thought *People judge me and don't believe or understand me,* emotions of frustration and anger, and associations of being rejected by other people earlier in his life. These TEAMS push his behavior around and lead to agressive, demanding behavior in the medical setting, as well as other areas of his life.

Thought Watching. Dr. Jones introduces the idea of watching thoughts, and Bud seems to be interested.

Dr. Jones: Bud, I know you are really invested in protecting your health, and sleeping well is one of the best ways you can promote your health. To do that, it

> seems as if you have to overcome an obstacle your mind keeps giving you when you lie down to go to sleep. Basically, your mind doesn't want to go to sleep; it wants to give you a bunch of "hot thoughts" to chew on. It tells you your brother is judging you unfairly, this is the way everyone treats you, no one wants to listen to your side of the story, my nurse and I are just like everyone else, and we don't believe you and don't want to help you either. I call these "hot thoughts" because they are like hot stove burners. When you touch them, you get immediate pain, and the more they come around, the more upset you get. When you get upset, you can't calm your body down enough to sleep. So, we need to find a way to help your mind go to sleep. We can't make it stop giving you thoughts, because that's what minds do; that's their job. What you *can* do is simply watch the thoughts and imagine that they are hot burners. As long as you don't reach out and touch them, you won't get burned. You could look at a red-hot burner in your kitchen all day long and be none the worse for wear. To get burned, you would have to reach out and touch it. You could even imagine that each thought you have at night *is* a red-hot burner; your job is just to see the burner without reaching out to touch it.

Velcro. Dr. Jones goes on to address the difficulty of simply watching these difficult thoughts: "Bud, the problem with thoughts like *No one believes me*, *Everyone is judging me*, or *Dr. Jones and his nurse don't really care about me and don't want to help me* is that they are so negative that they capture your attention, and the more you focus on these thoughts, the more thoughts like this you get." Dr. Jones explains that we all have thoughts throughout the day that come and go. Many thoughts are no big deal, because we all have the ability to ignore or dismiss thoughts that are not useful. Dr. Jones explains that the thoughts Bud is having at night are not just "come and go" thoughts but thoughts that imply they "are terribly important and worthy of immediate attention." He talks about Velcro and suggests that Bud's nighttime thoughts are like thoughts that have Velcro on them, thoughts that would immediately attach to an imaginary Velcro strip on his forehead, which makes them difficult to watch or accept. Dr. Jones takes out a pad of sticky notes and writes down a few of Bud's hottest thoughts. He suggests they play a game: "Let's put these sticky notes on your forehead one at a time after I read each out loud to you. After I stick the thought to your forehead, I want you to take the sticky note off, read it out loud, and then put it in your lap. Then I will put another sticky note on your forehead, and we'll repeat the game."

ACCEPT TEAMS AND FOCUS ON ACTION

Dr. Jones also wants to help Bud build skills that will help him stay in an observer role and simply accept the presence of his losing self-story. If he can practice acceptance in the presence of this negative content, it will undermine the need to ruminate endlessly as a way to avoid the painful emotions that come up with the story.

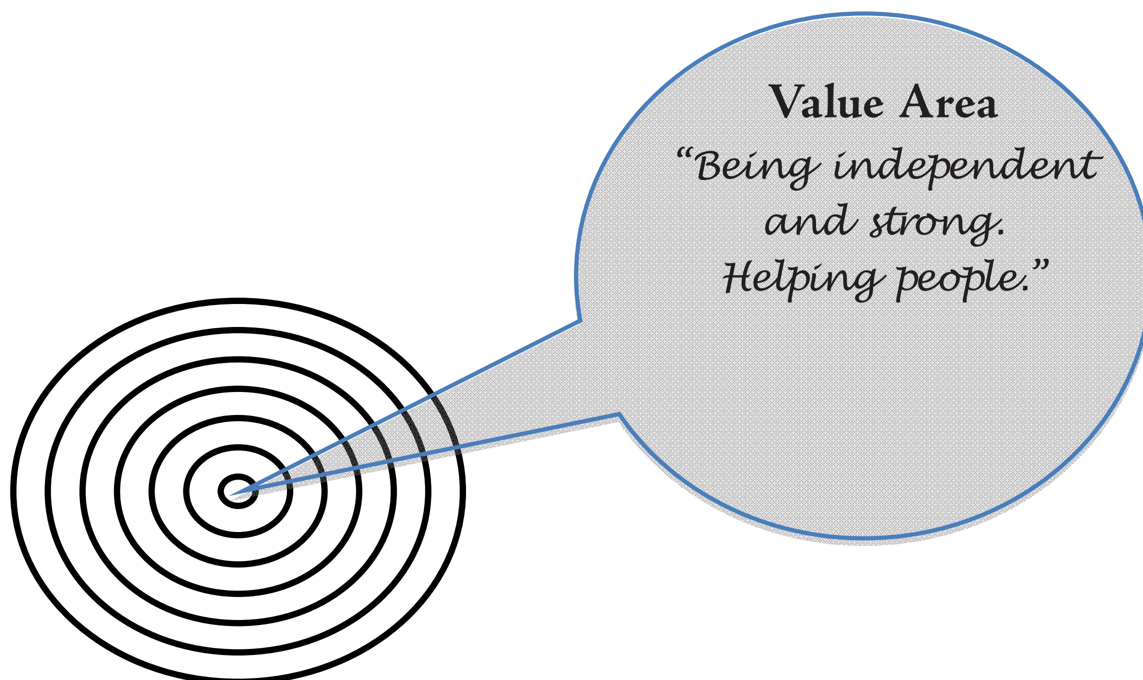
Book Chapter. This technique helps the patient begin to see self-stories from an acceptance context, specifically that it is possible to have painful life experiences without having them "define" who you are. They are part of a book in which no one chapter is more important than the other chapters. Dr. Jones approaches this technique in the following way.

Dr. Jones: Bud, like me, my nurse, and everyone I know of, you have a storybook about your life: the good times, the bad times, and so on. Your storybook contains lots of stuff—some painful and some not—stuff about being made fun of because of your leg, stuff about other people letting you down, stuff about being judged and rejected, and stuff about being in the martial arts. I have lots of chapters in my life storybook; some I like and some I don't. Maybe the chapter you are reading right now is called "My Pain and Disappointments." A lot of the stuff in this chapter did happen to you, and it *was* painful and *was* disappointing. But the book's title is *My Life Story*, not *My Pain and Disappointments*. There are other chapters in this book: "My Vision for Life," "My Best Moments," "People I've Loved," "My Spiritual Self," and so on. Your life story isn't about one chapter; it's the whole book. When the chapter "My Pain and Disappointments" is open, you can just accept that it's just one chapter in the book, knowing that there are other chapters too. Maybe you could say something like, "Oh, this is the pain and disappointments chapter. I've read you before." It's important to honor every chapter in your life storybook, while still remembering that there are other chapters and that you can choose what you want to do even when the book is open to the chapter called "Pain and Disappointments."

Bud responds well to the various techniques. In response to the idea of "thought watching," he reports that he did something like that when he was studying the martial arts and thinks he might get back into that: "It will improve my concentration, Doc." He takes the sticky notes and puts them in his pocket, telling Dr. Jones he won't show them to anybody but will use them to help remind him about the disappointments chapter and then tear them up.

In the Bull's-Eye Worksheet, they focus on strategies for dealing with sleep-disturbing negative thoughts, ruminations, and attachment to a losing self-story (like *People judge me, but they don't understand me and don't really care about me*). Dr. Jones asks Bud about the values in his book chapter called "What Matters Most." Bud responds that being independent and strong and helping others matter to him. They complete the Action Steps area of the Bull's-Eye Worksheet and come up with the short-term and long-term plans for behavior change indicated in sample worksheet A.5. (To support your mastery of the techniques and their connection with the six core processes of psychological flexibility, we note the process name after each plan.) Dr. Jones gives Bud a one-page handout with sleep-hygiene guidelines. In ending the visit, Dr. Jones asks Bud to return in two to three weeks to review his sleep issues and progress in using the "thought watching, Velcro, and book chapter tricks." Dr. Jones smiles and says, "It'll be interesting to see which one you find the most useful in your day-to-day life."

SAMPLE WORKSHEET A.5
Bud's Bull's-Eye Worksheet



Action Steps (Short-Term):

1. *At bedtime, imagine that your negative thoughts about being judged, disbelieved, and uncared for are hot stove elements. Your job is to look but not touch* (Step Back from TEAMS and Unworkable Rules).
2. *Imagine that each negative thought is written on a yellow sticky note or has Velcro on it; if it sticks to your forehead, imagine taking it off and putting it on the bed next to you* (Step Back from TEAMS and Unworkable Rules).
3. *When the chapter you are reading is "My Pain and Disappointment," try to accept your reactions to its contents, even though they are uncomfortable. Remind yourself that it's just one chapter and you have other chapters* (Step Back from TEAMS and Unworkable Rules).
4. *Follow sleep-hygiene guidelines (for example, if you can't sleep, get out of bed after twenty-five minutes; do something boring until you are ready to go back to bed; don't watch TV; don't smoke at night; don't take daytime naps; go to bed and get up at the same time each day; do something relaxing before going to bed).*

Action Steps (Long-Term):

Take some time to try to name the other chapters of your life story based on your life values. Name the different themes the various chapters of your life would contain (Accept TEAMS and Focus on Action).

Providing Follow-Up Care for Bud

Bud returns in three weeks, stating that his sleep has improved a little; he might sleep well for two or three nights and then have a lot of insomnia the next night. Wisely, Dr. Jones asks Bud what he does differently on the nights he sleeps well versus the nights he doesn't. He sleeps better when he remembers to use the "hot burner" strategy and the Book Chapter technique. Listening to classical music before bed also seems to help. Dr. Jones compliments Bud on putting effort into trying these strategies. He emphasizes that learning to step back from thoughts and emotions is a skill refined with practice. Similarly, he encourages Bud to remember that every life story has a couple of painful chapters that are no more important than all the other chapters. Bud has in fact taken some time to find titles for some other chapters of his life story, and one is "Being a Strong Man." He says that chapter is about studying the martial arts and that he might just expand this chapter by starting up his study

again. Dr. Jones congratulates Bud on his use of the Book Chapter approach and encourages him to use it to continue to strengthen his tie to important life values.

SUMMARY

Congratulations! You are now equipped with some basic new skills for dealing with demanding and challenging patients. Remember that:

- Difficult patients tend to have many distressing TEAMS that activate distressing TEAMS in you, and this interaction is what makes a difficult patient "difficult."
- Difficult patients tend to experience interactions with others as punitive and invalidating, so they bend over backward to avoid confrontation, criticism, and harsh limit setting.

You can provide better care to such patients if you follow these guidelines:

- Try to find ways to reframe the patient's demands, so that the demand reflects a positive value the patient is carrying.
- To get beyond your own distressing TEAMS, look at the patient with "soft eyes" and remind yourself that no one likes or deserves to suffer.
- Difficult patients benefit when you focus on the process of evaluation as it unfolds in the medical exam, rather than focus on the content of their demands.
- Learning to say no in a mindful, purposeful way, rather than as a knee-jerk response to pressure, will help build your relationship with the difficult patient.
- Demanding patients tend to need help with two processes in particular: Stepping Back from TEAMS and Unworkable Rules and Accepting TEAMS and Focusing on Action.
- Difficult patients will benefit from interventions such as Thought Watching and Velcro that help them defuse from provocative right–wrong, good–bad, fair–unfair evaluations.

You're Okay but Not for Long: Addressing Health-Risk Behaviors

Nature does require
Her time of preservation, which perforce
I, her frail son amongst my brethren mortal
Must give my attendance to.

—William Shakespeare

Risk—potential harms associated with different health behaviors—is in the eye of the beholder. For people of all ages, immediate rewards (for example, enjoying the experience of eating a large dessert or relaxing during a "cigarette break") and avoidance of discomfort (for example, the stress of going for a fast walk compared with the ease of watching television) may dominate in decision making. Rates of poor choices that contribute to increased risk of developing health problems are alarmingly high among adolescents and adults. A recent study found that 54 percent of adolescents (with publicly available Web profiles) displayed unhealthy behaviors on their websites (such as references to engaging in substance abuse, unprotected sex, and violent behaviors) (Moreno, Parks, Zimmerman, Brito, & Christakis, 2009). On the other hand, display of interest in religion, a sport, or a hobby was linked with decreased displays of risky behaviors.

The goals of Healthy People 2010 are to increase years and quality of healthy life and to eliminate disparities among subgroups of the population (Keppel, Pearcy, & Klein, 2004). This chapter suggests ways newer behavioral therapies can support PCPs in pursuing these important directions. We provide an adolescent case example, because this is the time of life when health-promoting or health-threatening behavior patterns are often cemented into place. There is reason to have great hope for what can be done for youth in primary care. A recent Cochrane Systematic Review suggested that behavioral lifestyle interventions,

compared to standard care or self-help, can produce a significant and clinically meaningful reduction of overweight in children and adolescents (Oude Luttikhuis et al., 2009). Let's take a look at an ACT approach identifying common TEAMS that come into play with engaging in risky behaviors and avoiding temporary discomforts of engaging in healthy choices (see sample worksheet B.1).

SAMPLE WORKSHEET B.1
Common TEAMS Involved in Health-Risk Behaviors

Thoughts	"I'm not going to live very long anyway." "I'm not going to make a habit of it." "Everybody else does it."
Emotions	Negative (as in "I can't stand the way I feel") and positive (as in "I want to feel more of this").
Associations	Heath-harming behavior (such as eating snack foods) associated with having a good time (for example, peers wanting to be together to enjoy the food) as seen in media and advertising. Vague association of danger with fun and popularity.
Memories	Of relatives who've engaged in health-risk behaviors and survived, and of relatives who didn't engage in health-risk behaviors and died early.
Sensations	Adrenaline rush, sensations of peacefulness, powerfulness.

This chapter will help you learn strategies for intervening with patients who engage in a variety of health-risk behaviors. Our case example concerns a female adolescent who is under-exercising, overeating, and experimenting with cigarettes and alcohol. We will demonstrate use of the Love, Work, Play, and Health Questions in this chapter, when Tracy meets Dr. Jackson for the first time. Dr. Jackson will teach Tracy some strategies for defusing TEAMS and actively accepting TEAMS in the name of pursuing a healthy mind and body.

Interventions for Health-Risk Behaviors	
The Love, Work, Play, and Health Questions Core Process Assessment Tool (CPAT) Real Behavior Change Pocket Guide	
Process	**Technique**
Step Back from TEAMS and Unworkable Rules	What's in the Soup Today? Dressing Up Words That Push You Around
Accept TEAMS and Focus on Action	Take-a-Stand Letter

CASE EXAMPLE: TRACY AND DR. JACKSON

Tracy is a fifteen-year-old African American girl who lives with her parents and three older brothers. She is a tenth-grade student who likes to write poems and thinks she'd like to be a creative writer when she grows up.

Reason for Visit. Tracy comes to the clinic for a planned new-patient visit with Dr. Jackson.

Medical Status. Tracy is forty pounds overweight. Her most recent medical treatment was in a military treatment facility, but she is now establishing care in the civilian world because her father recently retired from the Army.

Patient Concern. Tracy and her mother just "want to make sure everything's all right."

Patient's Life Context. Tracy is new to the community and has made several friends at her new school. She explains that military life teaches you to be good at making friends. Her mother reports that Tracy has "gained more weight" in recent months and that she worries about her. Tracy looks down when the mother voices this concern. Dr. Jackson asks

Tracy's mother if she can speak with Tracy alone for a few minutes, so that the two of them can get to know each other. After the mother leaves the room, Tracy admits to overeating, particularly after school, and to smoking cigarettes with her new friends on weekends. She doesn't like exercise, and physical education is her least favorite class. She explains that the teacher is nice to her and lets her walk the track at her own pace, because she isn't good at any of the sports played in the class. She doesn't have a boyfriend and is not sexually active. She gets along with her parents and her brothers, but she complains that her dad is "stressed out" and her brothers "are really mean" sometimes but "mostly okay."

Gathering Information

Dr. Jackson uses the Love, Work, Play, and Health Questions to get to know Tracy. Sample worksheet B.2 summarizes Dr. Jackson's questions and Tracy's responses.

SAMPLE WORKSHEET B.2

Tracy's Responses to the Love, Work, Play, and Health Questions

Area	Questions	Patient Responses
Love	Where do you live? With whom? How long have you been there? Are things okay at your home? Do you have loving relationships with your family or friends?	Oklahoma City. With my parents and three brothers. Six months. Pretty good at home. Parents are okay. Have two new girlfriends. Some of the kids at school are rude; brothers rude too sometimes.
Work	Do you work? Study? If yes, what is your work? Do you enjoy it? If no, are you looking for work?	I study a lot, particularly things I want to learn about, like poetry. I write poems. I want to be a writer or maybe a fashion designer. Dad says I should get a job that pays.

Play	What do you do for fun? For relaxation? For connecting with people in your neighborhood or community?	Watch movies, play video games. Same. Talk on phone a lot too. We go to church on Sundays, but I haven't met any kids I like there.
Health	Do you use tobacco, alcohol, or illegal drugs? Do you eat well? Sleep well? Do you exercise on a regular basis for your health?	I've been smoking a little—but don't tell my mom. No drugs, though. I drank alcohol some in the past but not now. I eat too much junk food, and I don't like vegetables. I sleep fine, maybe too much on the weekends. I like to dance, but I don't like sports at all.

Dr. Jackson summarizes information from the Love, Work, Play, and Health Questions and uses that to mentally map Tracy's status on the CPAT.

Planning and Providing Treatment

On the CPAT, Dr. Jackson estimates that Tracy is probably having trouble with stepping back from TEAMS and that she probably actively avoids TEAMS. Tracy seems to be a bright girl with a good imagination and lots of creativity. To reform her eating and physical-activity habits, she will need help with becoming more aware of TEAMS associated with eating and exercising and with learning how to make commitments to behavior change. She clearly understands the concept of values. When asked, Tracy tells Dr. Jackson, "The most important things in the world to me personally are my family, being a good friend, and treating other people like I want to be treated." While Tracy does not state health for its own sake as a value, Dr. Jackson hopes to use Tracy's passion for family and friends to kindle her commitment to caring intentionally for her body and mind.

SAMPLE WORKSHEET B.3
Tracy's Core Process Assessment Tool (CPAT)

Six Core Processes: Psychological Rigidity	Patient Rating Today	Six Core Processes: Psychological Flexibility
Lives in the past or future	______X________	Experiences the present moment
Disconnected from values	____________X____	Strongly connected with values
Engages in impulsive, self-defeating action or inaction	______X________	Sustains value-consistent action
Stuck in limiting self-stories	______X________	Uses observer self to see self-stories
Stuck in TEAMS or unworkable rules	______X________	Steps back from TEAMS and unworkable rules
Actively avoids TEAMS	______X________	Accepts TEAMS and focuses on action

STEP BACK FROM TEAMS AND UNWORKABLE RULES

Dr. Jackson explains to Tracy that she wants to talk a little about having a healthy lifestyle and about how the mind and body are related to this issue. She explains that first of all, good health is associated with eating small-to-medium portions of a variety of healthy foods three times daily, along with cardiovascular exercise for thirty minutes per day. She explains that most people don't follow these guidelines because it's very difficult, but there are ways to gradually work toward doing so by getting to know yourself better. She tells Tracy that she would like to teach her a few new tools that might help her come closer to following these guidelines, despite their difficulty.

What's in the Soup Today? Given Tracy's interest in words and poetry, and the high probability that "sticky" TEAMS prevent her from engaging in more mindful and intentional patterns of eating and exercise, Dr. Jackson decides to introduce this metaphor. The following is an excerpt from their visit.

Dr. Jackson: We all have a lot going on in our minds and bodies all the time; we have thoughts, really strings of words, like *I can eat whatever I want to!* We also have emotions, such as maybe sadness and a lump in our throats when someone says something mean to us. We have associations, such as *watching televsion equals feeling relaxed.* We have memories that are like movie reruns of things that happened to us in the past. Then, we have all these sensations, like being short of breath or feeling warm when we are flushed because we're embarrassed. Lots going on, right?

Tracy: Yes, ma'am. I never really thought about it like that, but I think it's like that for me.

Dr. Jackson: Well, I'd like you to imagine that there's another part of you that just holds all that stuff, the thoughts and feelings, like a bowl that holds soup. Your job, as the bowl, is to hold all the ingredients in the soup: your thoughts, the pictures in your mind, the feelings in your body. Let's experiment for a few minutes to see if you can be the bowl that holds the ingredients of your mind and body. Tell me what goes into your bowl when you start thinking about the two things I would like to help you do every day, namely, eating healthy foods and exercising twenty to thirty minutes.

Tracy: I don't know. Well, I guess I think *I don't like vegetables, and I don't like exercise. I don't have to do that if I don't want to.*

Dr. Jackson: Can you just put those thoughts in the bowl?

Tracy: Yeah.

Dr. Jackson: What else comes up? Let's pretend you are sitting in front of a bag of potato chips after school, nobody's home to even notice whether you eat the whole bag, and you think *I want to make healthy choices and exercise, as Dr. Jackson said to do.* What happens in your bowl at this moment?

Tracy: I guess I would probably start making excuses like *I'm tired. I just want to relax and have fun watching TV and snacking,* and maybe my mouth would start watering.

Dr. Jackson: Can you hold those in your bowl of "mind soup" and keep looking at the chips?

Tracy: It's funny, but it seems like the urge to eat the chips is less, and I was even thinking, *I don't want that; it's not that good anyway.* Still, Dr. Jackson, I think my bowl gets pretty crowded sometimes, and sometimes, like when I'm eating the wrong thing, I don't know what I'm thinking or feeling.

Dr. Jackson: That's true for most of us, but we can get better at being the bowl and watching the ingredients if we practice. Are you willing to practice being the bowl of soup and naming the ingredients, say, three times a day for three to five minutes?

Tracy: Yes, I have a timer on my cell phone, so I could time it.

Dr. Jackson: Just a warning, Tracy. Sometimes you'll catch some really sticky thoughts or feelings, ingredients that are so pushy you have a hard time remembering to be the bowl. For example, you might criticize yourself. Do you notice that you criticize yourself about your eating or exercise choices, or even your body?

Tracy: Sure, I say *I'm fat.* Happens all the time.

Dr. Jackson: Perfect, good catch. When you notice *I'm fat* and its "friends," just put them in the bowl. Maybe it's like okra or something you really don't want in your bowl, but you've got it and you don't have to push it away or argue with it; you can just name it.

In wrapping up the visit, Dr. Jackson introduces an additional defusion strategy as a homework assignment.

Dressing Up Words That Push You Around. This technique, developed by Louise Hayes, is often well accepted by adolescents with artistic interests. In concluding the visit with Tracy, Dr. Jackson asks Tracy to write the word "fat" on a piece of paper and then to

decorate the paper as if it were a party invitation. She explains that this might help Tracy feel a little more open to that word when it shows up in the bowl. She also asks Tracy to take a thirty-minute walk at a fast pace every day after school and to try the What's in the Soup Today? practice for the first few minutes of the walk. Tracy responds that she will take the dog and go immediately after school—before turning on the television and starting to snack.

Providing Follow-Up Care for Tracy

Tracy returns for follow-up care two weeks later. She tells Dr. Jackson that she walked every day after school except once, when she had bad cramps. Dr. Jackson congratulates her on this accomplishment and asks if Tracy used the What's in the Soup Today? exercise. Tracy responds that she practiced some, usually in the morning and again on the walk, and that she sometimes used it at school when she got upset about something. She gives Dr. Jackson the card she made, with "fat" written in large capital letters. She decorated it with colorful party hats and balloons, and girls doing the hula dance edged the border. They both laugh, and Dr. Jackson picks up on the dance image.

Dr. Jackson: Tracy, would you like to learn to do the hula? It's a great form of exercise.

Tracy: Well, maybe. I was talking with my mom about getting some kind of dance video to use for exercise and fun.

Dr. Jackson also decides to introduce the idea of committed behavior change in this visit, because Tracy is making progress with stepping back from sticky TEAMS. Committed behavioral action involves accepting TEAMS over and over again in pursuit of a meaningful course of action.

ACCEPT TEAMS AND FOCUS ON ACTION

Dr. Jackson chooses the Take-a-Stand Letter to help Tracy become more skillful in making committed behavior changes, because she feels it will align with Tracy's interests in writing.

Take-a-Stand Letter. Dr. Jackson explains this exercise to Tracy: "I want you to write a letter to yourself about your commitment to pursuing a healthy mind and body. Healthy

lifestyle behaviors help us create a body that's able to do the things we want to do, like help our families and be a good friend to our pals. There are three key areas in a healthy lifestyle: how we eat, our exercise, and getting enough rest and relaxation time. I have a little form I can give you to help you get started on your Take-a-Stand Letter (see sample worksheet B.4). I want you to take it home with you and bring it back when you come to see me again in two weeks. In the meantime, I want you to continue with the exercise plan and the What's in the Soup Today? practice. Do we have a plan?"

SAMPLE WORKSHEET B.4
Tracy's Take-a-Stand Letter

I, *Tracy*, on this date, *May 24, 2010*, commit to the following healthy-lifestyle behaviors:

Concerning eating, I will…
Eat small portions (and not while watching television or movies).

Concerning exercise, I will…
Take daily walks and dance more.

Concerning rest and relaxation, I will…
Listen to music and rest in my bed when I am tired.

The values that make these commitments worth pursuing are…
Being healthy and being a good friend.

SUMMARY

You can help many patients move toward a healthy lifestyle by using techniques suggested in this chapter. Let's review the most important concepts:

- Work with the patient to identify specific TEAMS that come up when the patient considers engaging in a health-promoting behavior. Self-criticism is often part of TEAMS, so it may be helpful to mention this.
- Teach the patient the What's in the Soup Today? technique to use in the morning and to perhaps repeat briefly when beginning a daily thirty-minute walk.
- Help the patient create humor around painful "soup ingredients" by making a card with the painful TEAMS element on it into a party invitation. For patients who wouldn't like the idea of drawing, ask them to create funny nicknames for painful soup ingredients (or TEAMS). This will help them step back from TEAMS and learn to acknowledge and accept limiting self-stories while pursuing valued directions.
- Teach patients to write and rewrite the Take-a-Stand Letter to support sustained changes consistent with optimal physical and mental health.
- Given that most patients will struggle with one or more elements of sustaining a healthy lifestyle for a prolonged period of time, it is important for you to model both humor and acceptance.
- Finally, remember that any patient can change at any point in time, so enter the room with soft eyes and optimism on every visit.

CHAPTER REFERENCES

Keppel, K. G., Pearcy, J. N., & Klein, R. J. (2004). Measuring progress in Healthy People 2010. *Healthy People 2010 Statistical Notes, 25,* 1–16.

Moreno, M. A., Parks, M. R., Zimmerman, F. J., Brito, T. E., & Christakis, D. A. (2009). Display of health risk behaviors on MySpace by adolescents: Prevalence and associations. *Archives of Pediatrics and Adolescent Medicine, 163*(1), 27–34.

Oude Luttikhuis, H., Baur, L., Jansen, H., Shrewsbury, V. A., O'Malley, C., Stolk, R. P., et al. (2009). Cochrane review: Interventions for treating obesity in children. *Evidence-Based Child Health: A Cochrane Review Journal, 4*(4), 1571–1729.

PATIENT EDUCATION: **Bull's-Eye Values Clarification**

Please make a few notes about each of these sentences and bring your results to our next visit:

1. As a mother or father (daughter or son), it is important for me to be:

2. As a worker, I hope people can see that I am:

PATIENT EDUCATION: What Are Your Self-Stories?

The purpose of this exercise is to start noticing how your mind works at making up stories about who you are in the world. Our stories change depending on the situation or what's usually the case. If they can change, it probably means that the stories we tell about ourselves may not be true with a capital "T," but may be more like stories we've learned to say and then try to conform to.

Try an experiment to get to know different parts of your "self." We are aware of some parts of ourselves, but other parts are more difficult to see. Write three to four sentences for each of the following situations and bring this to your follow-up visit.

1. Imagine meeting someone you want to befriend and telling that person about yourself: "I am…"

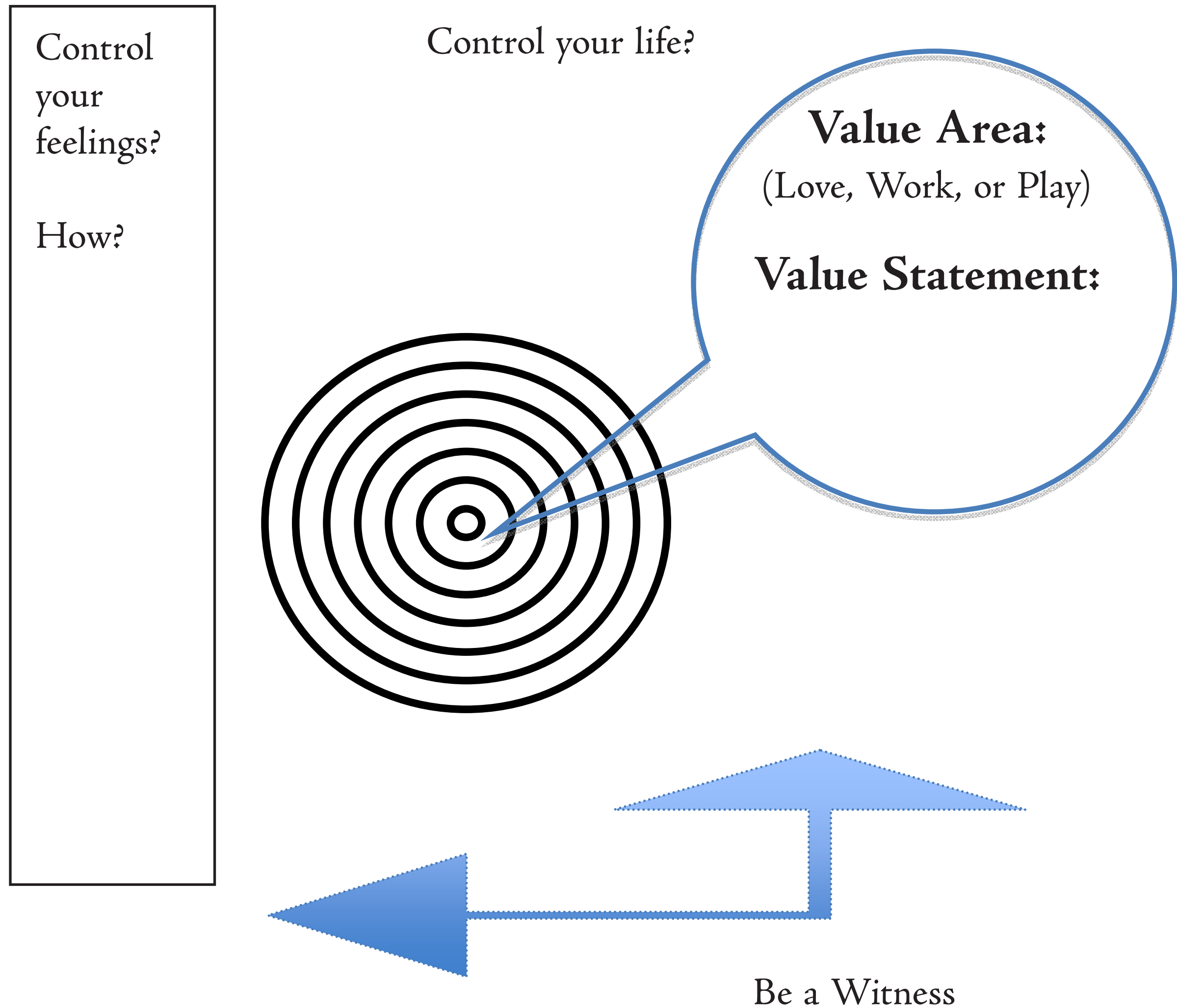
2. Imagine being falsely accused of something and needing to clear yourself: "I am…"

3. Imagine applying for a job and telling the interviewer about yourself: "I am…"

PATIENT EDUCATION: TEAMS Sheet

In my mind, I see and make room for:				
Thoughts	Emotions	Associations	Memories	Sensations

PATIENT EDUCATION:
Lose Control of Your Feelings, Gain Control of Your Life



APPENDIX A

Acceptance and Action Questionnaire (AAQ-II)

Following is a list of statements. Rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1	2	3	4	5	6	7
Never true	Very rarely true	Seldom true	Sometimes true	Often true	Almost always true	Always true

1. It's okay if I remember something unpleasant.	1 2 3 4 5 6 7
2. My painful experiences and memories make it difficult for me to live a life that I would value.	1 2 3 4 5 6 7
3. I'm afraid of my feelings.	1 2 3 4 5 6 7
4. I worry about being unable to control my worries and feelings.	1 2 3 4 5 6 7
5. My painful memories prevent me from having a fulfilling life.	1 2 3 4 5 6 7
6. I am in control of my life.	1 2 3 4 5 6 7
7. Emotions cause problems in my life.	1 2 3 4 5 6 7
8. It seems as if most people are handling their lives better than I am.	1 2 3 4 5 6 7

9. Worries get in the way of my success.	1 2 3 4 5 6 7
10. My thoughts and feelings do not get in the way of how I want to live my life.	1 2 3 4 5 6 7

Scoring Instructions: Reverse-score items 2, 3, 4, 5, 7, 8, and 9. Reversing a score means you take the number opposite of the number circled (for example, a circled score of 2 is scored as 6, a score of 3 as 5, and so on). After reverse-scoring items 2, 3, 4, 5, 7, 8, and 9, sum all scores to get the total score.

Interpreting Scores: Higher scores (20 to 70) suggest greater psychological flexibility. The mean score for a university student and community sample was 50.72, while the mean for a sample of people seeking treatment for substance abuse was 39.80. Remember, your scores will change over time and you can use real behavior change strategies to raise your score.

(For more information, see Bond et al., 2010.)

APPENDIX B

Primary Care Provider Acceptance and Action Questionnaire (PCP-AAQ)

Name: ______________________________ Date: ________________

Rate the truth of each statement as it applies to your experience in providing medical care *at this moment*. Use the following scale from 0 to 6 and place a number in the box by each item.

0	1	2	3	4	5	6
Never true	Very rarely true	Seldom true	Sometimes true	Often true	Almost always true	Always true

	1. I am comfortable sitting quietly when my patient is crying.
	2. I accept that I cannot make my patients change unhealthy habits or manage their diseases better.
	3. I allow myself to experience anger, sadness, or frustration in my daily practice of medicine.
	4. I won't sacrifice my personal time to catch up on office work, even though it would help me feel less stressed at work.
	5. I'm able to empathize with my patients even when I'm running behind schedule.
	6. The pressure of daily practice doesn't prevent me from enjoying myself at work.

	7. Helping patients with emotional problems is a rewarding part of my medical practice, even though it can be emotionally draining at times.
	8. I am able to manage difficult interactions with staff or colleagues, even though my own thoughts or emotions may be negative.
	9. I don't take my work stress home with me.
	10. Accepting my negative reactions to a stressful situation is part of how I cope with it.
	11. I allow myself to feel guilty when I make a medical error.
	12. Despite the stress of daily practice, I still act according to my values as a person and as a professional.
	13. I am aware of tension in my body when work is stressful.
	14. I don't have to control my negative thoughts and feelings at work to do a good job.
	15. When I'm frustrated with a patient, I am still able to provide the same quality of care as I do for a patient I like.
	16. I don't ruminate excessively about a difficult medical decision after the fact.
	17. I don't avoid calling a patient back even if I know the patient is angry or unhappy with me.
	18. I am able to continue with my daily practice as usual after an interaction with an emotionally challenging patient.
	19. I use daily routines that help me stay focused, aware, and attentive to patients' needs.
	20. I don't struggle with my emotions before, during, or after I see a difficult, hostile patient.
	Total Score

Scoring Instructions: Add your responses. The sum of your twenty responses is your total score.

Interpreting Scores: Higher scores suggest greater psychological flexibility (range: 0 to 120). Remember, your scores will change over time, and you can use real behavior change strategies to raise your score.

APPENDIX C

Primary Care Provider Stress Checklist (PCP-SC)

Name: ______________________________ Date: ________________

Below is a list of specific situations that may cause stress for people working in medical settings. Rate the extent to which each situation is stressful for you *at this moment*. Use the following scale to choose your response. For example, if you find a situation “Highly Stressful,” record 5 in the “Response” column, and if it is “Not Stressful” or absent for you, record 0. To get a picture of what stresses you the most, follow the directions for scoring at the bottom of the form.

0	1	2	3	4	5	6
Not Stressful	Very Mild Stress	Mild Stress	Moderate Stress	Greater than Moderate	Highly Stressful	Extremely Stressful

INTERACTIONS WITH PATIENTS	
Response	**Stressful Situation**
	Patients who don't manage their chronic diseases.
	Patients who abuse or are addicted to alcohol or drugs.
	Patients who complain of chronic pain and are seeking narcotics.
	Patients who are angry and demanding.
	Patients complaining of depression, anxiety, and other common psychological problems.
	Patients who have unhealthy lifestyles (overeat, under-exercise, overwork).
	Patients who perpetrate violence or abuse on children, domestic partners, elderly relatives.
	Category Total

PRACTICE MANAGEMENT	
Response	**Stressful Situation**
	My schedule is too tight to address more than one or two problems.
	Patients wait too long because of office work-flow problems.
	Chart and other important records information is not available.
	Not enough time to address multiple medical and mental health problems in complex patients.

	Not enough time to address multiple medical and mental health problems in complex patients.
	Dealing with interruptions and other annoyances during clinic/workday.
	Category Total
ADMINISTRATIVE ISSUES	
Response	**Stressful Situation**
	Unrealistic productivity standards from my employer/practice partners.
	Billing and coding processes are hard to understand and/or time consuming.
	Preauthorization for patient procedures and medications.
	Support-staff turnover and lack of training impact practice flow.
	Communicating with managers who seem to be more concerned with "numbers" than with quality of care.
	Work hours are too long.
	Category Total
EDUCATION/LEARNING	
Response	**Stressful Situation**
	Learning new procedures.
	Being required to make medical decisions with limited information.

	Lack of opportunity to reflect on knowledge before applying it.
	Lack of opportunity to discuss medical issues with colleagues.
	Difficulty applying new guideline information during visits with patients.
	Keeping up with new medical information.
	Category Total
RELATIONSHIPS WITH COLLEAGUES	
Response	**Stressful Situation**
	Communication difficulties with specialists.
	Strained or nonexistent communication with mental health clinicians.
	Lack of support from colleagues for work–home balance.
	Dealing with colleagues who make medical errors.
	Working with unmotivated colleagues in a team setting.
	Feeling isolated.
	Category Total

BALANCE BETWEEN WORK AND THE "REST OF LIFE"	
Response	**Stressful Situation**
	Lack of support of my medical career from friends and/or family.
	Not eating a healthy diet and exercising regularly.
	Missing family activities and occasions because of work demands.
	Difficulties taking time to see or make friends.
	Not finding time to do little things that give me pleasure.
	Continuing to think about medical issues after work hours.
	Category Total

Scoring Instructions:

1. Record the sum of your responses to each of the PCP-SC areas in the "Total" column. Then transfer these scores to the table below.
2. Divide each score in the "Total" column by the number indicated in the "Divide by" column (this number represents the maximum level of stress for that area). For example, if you have a "Total" of 30 for "Interactions with Patients," you will get a .71 when you divide by 42.
3. To calculate the "Stress Score," multiply the score that results from dividing the "Total" score by the "Divide by" number and then multiply by 100. For example, you would multiply .71 by 100 to obtain a "Stress Score" of 71.
4. Record "Stress Scores" for each category in the "Stress Score" column. Stress scores will range from 0 to 100, with 0 suggesting no stress and 100 indicating maximum stress.

5. To calculate your total "PCP-SC Score," sum the scores in the "Total" column, divide by 222, and then multiply by 100. Like the "Stress Score" for each category, the "PCP-SC score" will be between 0 and 100, with 0 suggesting no stress and 100 indicating maximum stress.

Remember, your scores will change over time and you can use ACT strategies to address areas that contribute most to stress in your medical career at this time.

PCP-SC Source of Stress	Category Total	Divide By	Stress Score
Interactions with Patients		42	
Practice Management		36	
Administrative Issues		36	
Education/Learning		36	
Relationships with Colleagues		36	
Balance Between Work and the "Rest of Life"		36	
Total PCP-SC Score		222	

Interpreting Scores: Higher scores indicate greater stress in both individual Stress scores and the Total PCP-SC Score. Remember, you can lower your scores by applying real behavioral change strategies. See chapter 11 for specific ideas.

APPENDIX D

Real Behavior Change Interviewing—The Three-T and Workability Questions

Time	When did this start? How often does it happen? Does it happen at a particular time? What happens just before the problem? Immediately after the problem? How long does it last when it is present? Is it here all the time or is it episodic?
Trigger	What do you think is causing the problem? Is there anything that, or anyone who, seems to set it off?
Trajectory	What has this problem been like over time? Have there been times when it was less of a concern? More of a concern? Has it been getting better or worse over time? How about recently?
***W**orkability Questions*	What have you tried to cope with this problem? How have these strategies worked over time? Are you getting the kind of results you want? When you use this strategy, are you getting some accidental negative results in other areas?

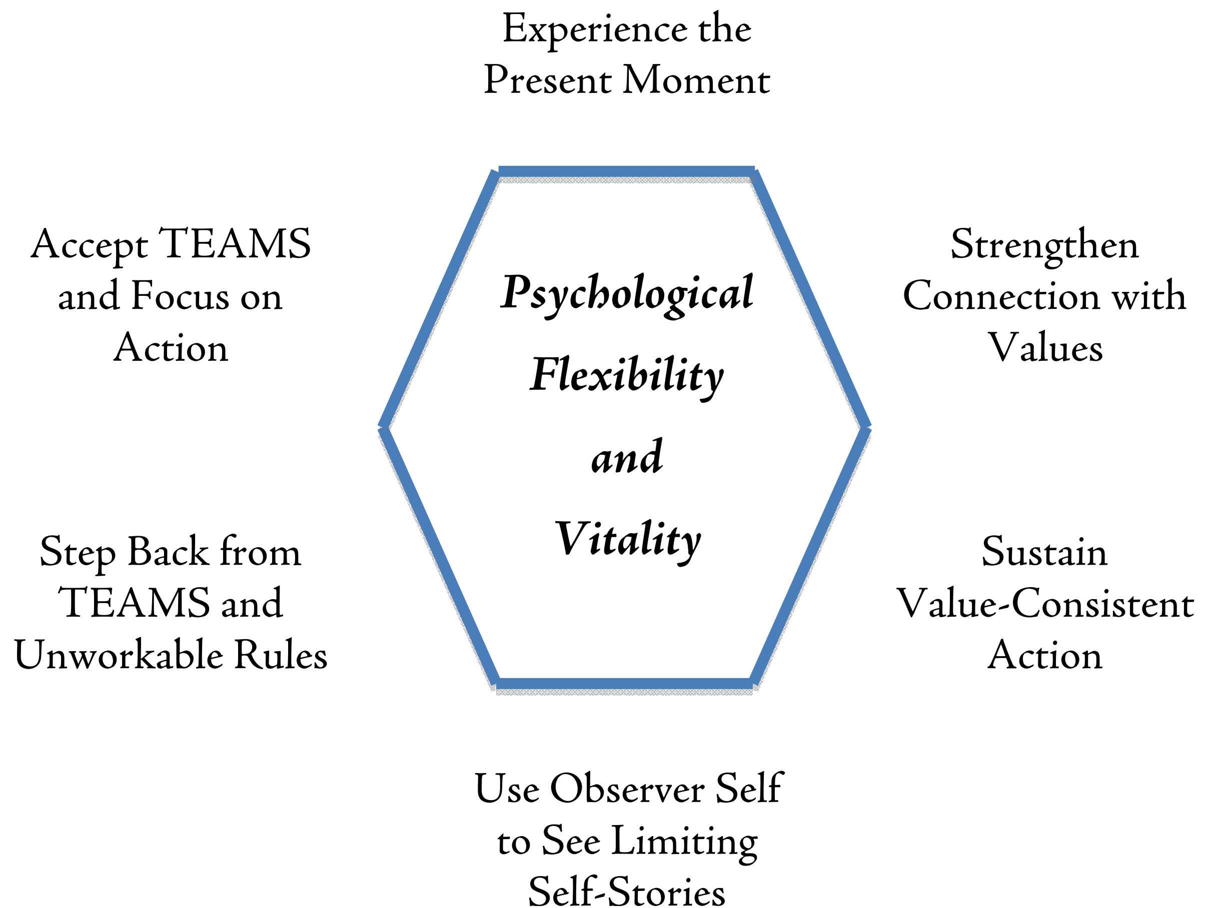
APPENDIX E

Real Behavior Change Interviewing—The Love, Work, Play, and Health Questions

Love	Where do you live? With whom? How long have you been there? Are things okay at your home? Do you have loving relationships with your family or friends?
Work	Do you work? Study? If yes, what is your work? Do you enjoy it? If no, are you looking for work? If no, how do you support yourself?
Play	What do you do for fun? For relaxation? For connecting with people in your neighborhood or community? Do you have friends? What do you do together?
***H**ealth*	Do you use tobacco, alcohol, or illegal drugs? Do you exercise on a regular basis for your health? Do you eat well? Sleep well?

APPENDIX F

Six Core Processes—Psychological Flexibility



APPENDIX G

Core Process Assessment Tool (CPAT)

Six Core Processes: Psychological Rigidity	Patient Rating Today	Six Core Processes: Psychological Flexibility
Lives in the past or future	________________	Experiences the present moment
Disconnected from values	________________	Strongly connected with values
Engages in impulsive, self-defeating action or inaction	________________	Sustains value-consistent action
Stuck in limiting self-stories	________________	Uses observer self to see limiting self-stories
Stuck in TEAMS and unworkable rules	________________	Steps back from TEAMS and unworkable rules
Actively avoids TEAMS	________________	Accepts TEAMS and focuses on action

How to Use the CPAT to Conceptualize and Plan Treatment:

1. Mark an "X" for each of the six core processes to indicate the patient's current position on a continuum ranging from rigid to flexible.
2. An "X" on the left-hand side indicates rigidity, while an "X" on the right indicates flexibility. If you like, you can use a rating scale ranging from 0 (most rigid) to 10 (most flexible) that will allow you to calculate a total flexibility score (ranging from 0 to 60).
3. Select one or more processes to target in a patient visit.
4. Refer to the Real Behavior Change Pocket Guide (appendix H) to choose one or more techniques for the process you plan to target.
5. You may choose a process that represents a patient's strength or weakness. In some cases, you will sense that a patient needs to gain strength in one process before working on another. For example, a patient with a history of trauma may benefit from learning more about how to experience the present moment before learning skills that help him or her sustain value-consistent action.
6. Remember that you will often help a patient in several processes, even if you target only one, because all of the processes overlap.
7. Using the CPAT on a regular basis provides you with a global impression of the patient's relative strengths and weaknesses and a sense of the patient's progress over time.

APPENDIX H

Real Behavior Change Pocket Guide

Six Core Processes: Psychological Flexibility	Technique	Demonstration Chapter
Experience the Present Moment		
	Time Line	8 (anxiety, depression)
	Three (or Five) Senses	8 (anxiety, depression)
	Balloon Breath	9 (trauma)
Strengthen Connection with Values		
	Retirement Party/ Tombstone	11 (provider wellness)
	Bull's-Eye: Value Identification	5 (chronic disease)
	Bull's-Eye: Value–Behaviors Discrepancy	5 (chronic disease)
	Bull's-Eye: Professional and Personal Values Assessment	11 (provider wellness)
Sustain Value-Consistent Action		
	You Are Not Responsible; You Are Response Able	9 (trauma)
	All Hands on Deck	7 (chronic pain)

	Bull's-Eye: Action Steps	5 (chronic disease) 6 (substance abuse) 9 (trauma)
	Burnout Prevention and Recovery Plan	11 (provider wellness)
Use Observer Self to See Limiting Self-Stories		
	What Are Your Self-Stories?	9 (trauma)
	Be a Witness	6 (substance abuse) 9 (trauma)
	Circles of Self	8 (anxiety, depression)
	Miracle Question	8 (anxiety, depression)
Step Back from TEAMS and Unworkable Rules		
	Playing with Sticky TEAMS	5 (chronic disease)
	TEAMS Sheet	7 (chronic pain)
	Velcro	11 (provider wellness)
	Clouds in the Sky	11 (provider wellness)
Accept TEAMS and Focus on Action		
	Eagle Perspective	7 (chronic pain)
	Book Chapter	5 (chronic disease)
	Rule of Mental Events	6 (substance abuse)
	Lose Control of Your Feelings, Gain Control of Your Life	6 (substance abuse)

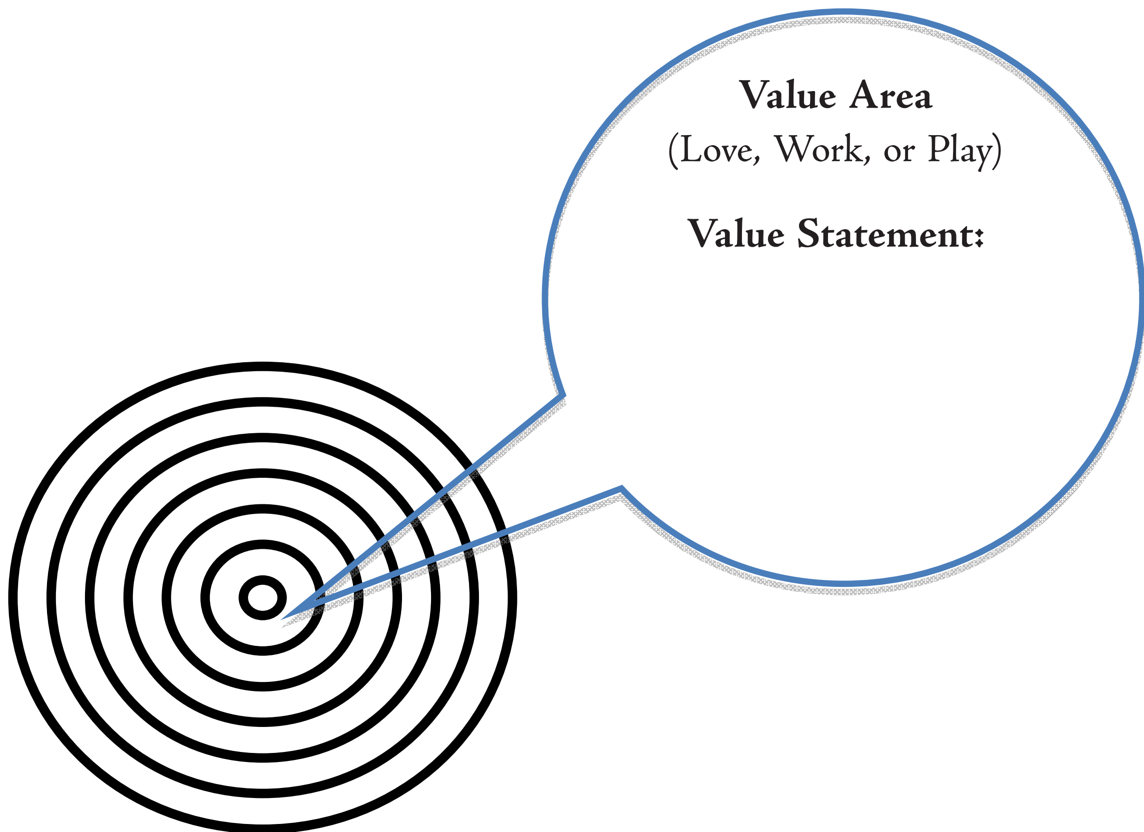
Note: The Bull's-Eye Worksheet provides a structure for using all three of the Bull's-Eye intervention components (Value Identification, Value–Behavior Discrepancy, and Action Steps) with patients on an ongoing basis.

How to Use the Real Behavior Change Pocket Guide:

1. Print a copy of the pocket guide and keep it on a clipboard or in another place where you can find it easily at your clinic.
2. Refer to the brief descriptions of the techniques in chapter 4 as needed.
3. Study applications of the techniques in the case examples in the chapters indicated on the pocket guide.
4. Practice a technique (ideally with a colleague, a preceptor, or a friend) prior to using it.
5. When charting, indicate the process you targeted and the intervention you used.
6. With practice, you will become skillful at using a variety of techniques for each process.

APPENDIX I

Patient Education—Bull's-Eye Worksheet



1	2	3	4	5	6	7
Not Consistent	Slightly Consistent	Somewhat Consistent	Consistent	Remarkably Consistent	Very Consistent	Bull's-Eye!

Action Steps:

1.

2.

3.

Guide for Using the Bull's-Eye Worksheet

1. Ask the patient to choose love, work, or play as a focus for a short discussion about values. Have the patient explain what's important to him in each area of life.
2. Listen closely, reflect what you heard, then write a statement on the Bull's-Eye Worksheet using the (global, abstract) words the patient used when talking about the value.
3. Explain to the patient that the bull's-eye on the target represents hitting your value target on a daily basis (and explain that most of us fall far short of that on a day-to-day basis, but knowing what the target is helps us make choices, set goals, and implement plans).
4. Ask the patient to mark an "X" on the target (or choose a number, with 0 being most distant from values and 7 being completely consistent with values) to indicate how close to the bull's-eye value statement her behavior has come over the past two weeks.
5. Ask the patient to plan one or more specific behavior experiments for the next two weeks that the patient believes will make his behavior more value consistent (closer to the bull's-eye target).
6. If time allows, rate the patient's current functioning level in one or more core areas on the CPAT (appendix G). This will provide a baseline against which you can judge the impact of the Bull's-Eye Worksheet.
7. If time allows, choose a core process area and a corresponding technique from the Real Behavior Change Pocket Guide (appendix H) to use in the visit.
8. At follow-up, ask the patient to re-rate value consistency (see step 4, above) and then to identify barriers to engaging in behaviors planned in the prior visit. Often, identifying barriers will point to the core process the patient needs to address in that visit to develop greater flexibility.

APPENDIX J

Provider Tool—Retirement Party Worksheet

Instructions: For each of the following four life areas, describe your core values. For example, if you were at your own retirement party, what would you like to hear other people say about what you stood for, the mark you left generally, what your behavior over the years demonstrated about your personal beliefs?

Studying or Practicing Medicine (for example, your efforts to learn or practice):

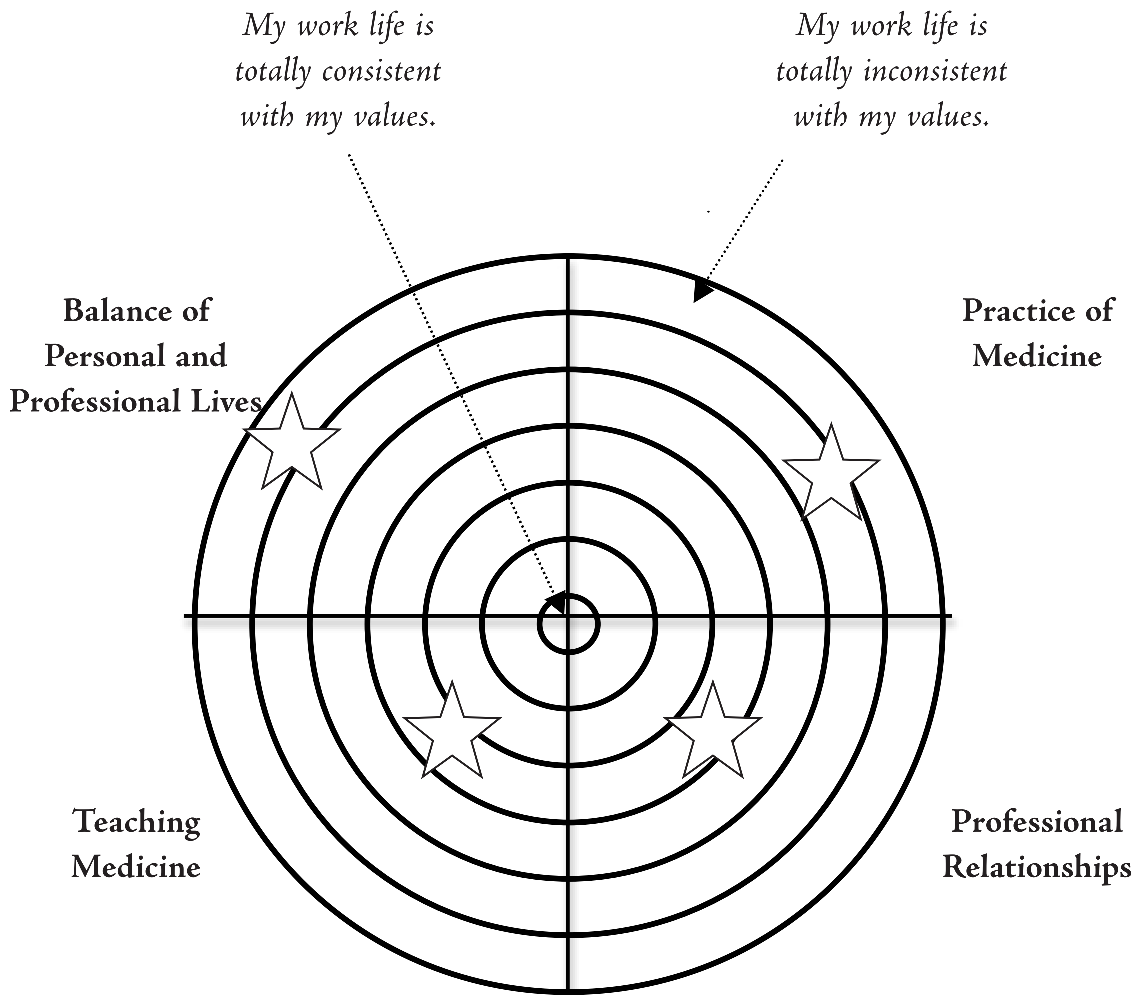
Professional Relationships:

Teaching Medicine (for example, your efforts to prepare others for medical careers):

Balancing Professional and Private Lives:

APPENDIX K

Provider Tool—Bull's-Eye Professional and Personal Values Assessment



Instructions: Place an "X" or draw a star in each of the four quadrants to represent the degree to which you have been living according to your values in each area during the past month.

APPENDIX L

Burnout Prevention and Recovery Plan

To help reduce your risk of burnout, describe specific behaviors you intend to use, when you will use them, and how often for each of the following four skill areas. Try to respond to at least two areas initially and add more plans later. The more specific your plan, the more likely you are to follow it!

Practice of Acceptance:

Practice of Mindfulness (for example, present-moment awareness, contacting observer self):

Practice of Contact with Personal Values:

Practice of Value-Consistent Daily Action: