Rehabilitation Research and Training Center on Evidence-Based Practices in Vocational Rehabilitation

RRTC-EBP-VR

Phase IV Studies

Evidence-Based Practice Counselor Toolkit
Vocational Rehabilitation Curriculum
For People with Disabilities

May 2016
RRTC-07-2013

Rehabilitation Research and Training Center on Evidence-Based Practices in VR

Phase IV Studies

Evidence-Based Practice Counselor Toolkit

Vocational Rehabilitation Curriculum

For People with Disabilities

Fong Chan
Principal Investigator, RRTC Phase IV

Timothy N. Tansey
Co- Principal Investigator, RRTC Phase IV
University of Wisconsin-Madison

Jessica Brooks
Consultant/Development Team Leader

Garrett Huck
Research Assistant

Joseph Pfaller
Lead Research Assistant

Wei-Mo Tu
Research Assistant

Kanako Iwanaga
Research Assistant

Kerry Thompson
Research Assistant

Emre Umucu
Research Assistant

Jia-Rung Wu
Research Assistant

Table of Contents

Contents | Page

Introduction to Evidence-Based Practice (EBP)

Objectives

- To understand key terms, concepts, and processes related to EBP.
- To practice using clinical skills and research tools for applying EBP.
- To learn how to integrate EBP into rehabilitation counseling, particularly in the area of vocational rehabilitation (VR).

What is EBP, and why is EBP important?

> Evidence based practice integrates research based knowledge into rehabilitation counseling services. EBP should involve the integration of the best and most current research evidence with clinical/educational expertise and relevant stakeholder perspectives in the pursuit of making the best possible decisions for a particular consumer. EBP is not a practice that is driven by research evidence alone. The key ingredient to this definition is integration.

Evidence-based practice has been gaining acceptance as a useful approach for increasing consumer involvement, controlling costs, and improving quality and accountability of healthcare and rehabilitation service delivery. EBP ensures that people with disabilities receive the most effective services.

Additionally, EBP promotes ethical practice by better protecting consumers from harmful services (nonmaleficence), improving the efficiency of how scarce resources are used (justice), and allowing people with disabilities the opportunity to exercise self-determination and informed choice (autonomy) based on the provision of knowledge regarding rehabilitation services and care (Chan et al., 2009, 2011).

Below is a list of EBPs in VR that lead to successful employment outcomes for people with disabilities.

Table 1: Relevance and Level of Evidence Ratings for VR Practice

VR Service	Relevance	Level of Evidence
Transition Services	1	12
Assistive Technology	2	14
Individual Placement and Support Model of Supported Employment (IPS)	3	3
On-the-Job Training	4	15.5
Demand Side Employment Strategies	5	21
Benefits Counseling	6	19
Motivational Interviewing	7	4
Customized Employment	8	20
Community Based Work Program (Adults)	9	18
Working Alliance	10	6
Person Centered Planning (PCP)	11	22.5
Soft Skills Training	12	22.5
Dual Customer Approach	13	26
Job Club	14	15.5
Family Involvement & Support	15	17
Social Skills Training	16	13
Cognitive Behavioral Therapy	17	1
Assertive Community Treatment (ACT)	18	2
Positive Psychology Interventions	19	8
Project Search	20	11
Solution-Focused Brief Therapy	21	5
Health Promotion Interventions	22	10
Person Centered Therapy	23	7
Online Community of Practice for VR Counselors	24	25
Social Media	25	24
Tele-Health/Tele-Rehabilitation	26	9

(Leahy, Del Valle, Landon, Sherman, & Chan, 2015)

When?

Working-age SSDI beneficiaries have been shown to benefit from EBP in vocational rehabilitation services. These individuals complete trial work periods at higher rates and they often suspend or terminate from the SSDI program due to employment. It has also been supported that postsecondary education as a VR intervention improves employment outcomes and job quality for adults with disabilities. Finally, supported employment is an EBP in VR that has been well established as an effective service for enhancing the employment outcomes of adults with disabilities including special education students, younger adults who were SSDI beneficiaries, individuals with developmental or intellectual disabilities, and people with severe mental illness (See Appendix E: Evidence Based Practice in Vocational Rehabilitation).

How? (Instructions/Handouts)

In order to integrate EBP into VR practice, you can follow "four steps": (1) Formulate well-defined, answerable questions; (2) Seek the best evidence available to answer your questions; (3) Critically evaluate the evidence; and (4) Apply the evidence to your individual consumer (Chan et al., 2009, 2011).

STEP 1: Formulate well-defined, answerable questions

This step determines what evidence to look for and where to search for the best evidence using two types of questions, which are questions about a general setting or questions about context and a specific case within that context.

Examples:

- Would this intervention be effective for my consumer?
- Does the evidence supporting this intervention apply to my consumer?
- Should my consumer receive this intervention? When? For how long?

Step 2: Seek the best evidence to answer your questions

The most reliable approach to searching for best evidence in psychosocial and rehabilitation treatment is through rehabilitation research sites funded through the National Institute on Disability Rehabilitation Research (NIDRR), academic databases, or scholarly websites (See Appendix A, B). If you use keywords related to the clinical problem coupled with the terms "systematic review", "meta-analysis", or "randomized controlled trial" you can find stronger EBP (See Step 3).

For example, consider this: entering the terms systematic review, meta-analysis, acupuncture, and chronic pain in Google resulted in 66,600 entries. It may be difficult to know which resource is the most reliable. On the other hand, a search using the same terms with Academic Search Elite, CINAHL Plus with Full Text, MEDLINE, and PsycINFO resulted in 50 entries. Please refer to the section "Let's try to search! " to think more about how best to use websites.

Step 3: Critically evaluate the evidence

The points that you need to understand to effectively evaluate research (RRTC-EBP VR, 2015) are:

b.a   The sample group studied: What groups of people were studied? To better understand the sample group studied, look in the "Method" section of the article. This section may also be called "study design" or "study methods." Does the sample group share key characteristics with your consumer?

b.b   The context in which the group was studied: What were the environmental factors and circumstances at the time of the study? Were resources or supports available that may not be available to your consumer?

b.c   The criteria to be included in the sample group: What were the criteria for inclusion in the sample group? Look at the characteristics of the individuals included in the sample group. Who was included in or excluded from the sample group, and why?

b.d   The timeframe of the research: Is the research timely or outdated?

b.e   The relevance of the sample group to your individual consumer: Is the sample representative of a larger group (i.e., a group with a specific disability)? What were the characteristics of those who agreed to participate? Why did people drop out? How was missing data handled?

Levels of EBP

This five-level hierarchical framework offers a way for practitioners to evaluate the strength of evidence for use in VR service delivery. Each level builds on the level below it, with Level 5 representing the weakest evidence available, and Level 1 representing the strongest evidence available. When making evidence-based decisions, it is important to select from the highest-level research design available for a specific topic.

Strong

↑

Level 1:	Strong evidence from at least one systematic review of multiple well-designed randomized controlled trials.	
Level 2:	Strong evidence from at least one properly designed randomized controlled trial of appropriate size.	
Level 3:	Evidence from well-designed trials without randomization, single group pre-post, cohort, time series, or matched case-controlled studies.	
Level 4:	Evidence from well-designed non-experimental studies from more than one center or research group.	
Level 5:	Evidence from opinions of respected authorities, based on clinical evidence, descriptive studies, or reports of expert committees.	

Weak

(Chan et al., 2009, 2011, 2016)

Note: Emerging and Promising Practices

Although, it's important to select from the highest-level research design available for a specific topic, there may be a scarcity of "acceptable" evidence for effective interventions in the field of VR. Therefore, it may be necessary to evaluate information on a continuum of innovative practices ranging from emerging to promising EBP.

Emerging practice is generally based on guidelines, protocols, and standards that have demonstrated effectiveness. It offers knowledge about what works and what does not work in various situations and has a plan to measure program outcomes, but does not yet have evaluation data to demonstrate effectiveness of the specific practice. **Promising practices** encompass all of the emerging practice elements, with the addition of programmatic quantitative or qualitative data demonstrating positive outcomes; however, they do not yet contain research data to support replication of the practice.

Emerging and promising practices are essential components in establishing a foundation for developing and implementing EBP. Evidence-based practices generally develop over time and begin with emerging practice that may mature into promising practice.

Useful Concepts

Here are several concepts that describe terms used with studies of higher-level evidence.

Randomized Clinical Trials (RCTs)	RCTs are the gold standard of scientific testing for new interventions. RCTs possess three characteristics: (a) An experimental group which receives the experimental intervention or treatment ; (b) A Control, or Comparison group which receives standard care or a comparison intervention that is different from the experimental treatment; and (c) Random Assignment, or Randomization to experimental and control or comparison groups.
Systematic Reviews	Systematic reviews answer a specific clinical question by inviting scholars with expertise in the substantive area to conduct the review using predetermined rules for capturing the evidence, appraising the available evidence, and synthesizing the results in a manner that is easily accessible to clinicians. Strong evidence from at least one systematic review of multiple well-designed randomized controlled trials (RCTs) is considered the highest level of best evidence and is frequently labeled a meta-analytic review.
Meta-analysis	Meta-analysis is a subtype of systematic review. A meta-analysis is a mechanism by which professionals can understand the effectiveness of a practice/ intervention domain in quantitative terms.
Effect size	Effect Size is a statistical finding that quantifies the effectiveness of a particular intervention, relative to some comparison. It provides us with answers of "How well does it work in a range of interventions?" A common index of effect size is Cohen's d, which is the standardized difference between the sample mean of the treatment group and the sample mean of the control group. A typical way to interpret the size of an effect is the following: <table><tr><th>Effect Size</th><th>r</th><th>d</th><th>Success rate of treated Clients</th></tr><tr><td>Small effects</td><td>.10</td><td>.20</td><td>55 %</td></tr><tr><td>Medium effects</td><td>.30</td><td>.50</td><td>62 %</td></tr><tr><td>Large effects</td><td>.50</td><td>.80</td><td>69 %</td></tr></table>

Step 4: Applying the Evidence to the Individual Consumer

Once the evidence has been critically evaluated, you can apply your professional expertise to determine if the intervention meets the needs of your individual consumer. It is recommended that the intervention not only correspond with research findings, but also be tailored to the context in which the intervention will be delivered (RRTC-EBP VR, 2015).

Variables to consider include:

- What resources are available to my consumer?
- What agency and professional resources are available to me as a practitioner?
- Is it cost-effective for my agency?
- Could differences between the sample and the individual consumer affect the intervention outcome?
- Is other, similar research available, and are the findings consistent?
- If other research is available, did the studies use a sample group most relevant to my consumer?
- Does the intervention pose a significant risk to my consumer?

Let's Try To Search EBP!

Example 1

A middle-aged Japanese man with a substance use disorder is referred to you for vocational rehabilitation counseling. He is ready to reenter the workforce as he is in recovery and engaged in treatment. As a counselor, you want to know what is the best practice to support him to find and maintain a job.

Step 1: Formulate well-defined, answerable questions

Background questions could be "What are the most effective interventions for substance use/misuse?" and "Are there any significant risks linked with these interventions?" Another question could include "Among middle-aged Japanese men with substance use disorders

(consumer), is there any evidence that vocational rehabilitation (intervention) is superior to other interventions or treatments (comparison) to find and maintain a job (outcome)?"

Step 2: Seek the best evidence available to answer your questions

Use one of the recommended websites (since he has a substance use disorder, SAMHSA may be a starting point.)

a. Go to the "SAMHSA National Registry of Evidence based Programs and Practices" www.samhsa.gov/nrepp

b. Type in the keyword "vocational rehabilitation" in the search bar for "Find an Intervention." nrepp.samhsa.gov/AdvancedSearch.aspx

c. Among the results, select and open "Customized Employment Supports," which is research of IPS. nrepp.samhsa.gov/ProgramProfile.aspx?id=100
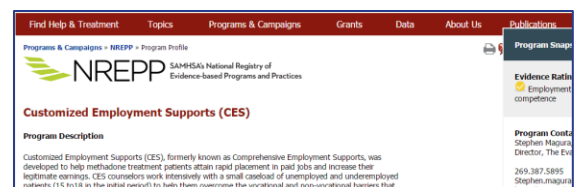
Step 3: Critically evaluate the evidence:

After you open *"Customized Employment Supports,"* please scroll down. You will find the following image. If you click the *"Resources for Dissemination and Implementation,"* you can find a relevant review of research and the "Implementation Information." You can also find the cost of the intervention.

http://nrepp.samhsa.gov/ProgramProfile.aspx?id=100#hide4

Step 4: Apply the evidence to your individual consumer.

Example 2

You decided to use "IPS" for your client with the substance use disorder (Study 1 case). You want to know whether the IPS agency that you sent your client to is truly an IPS agency that conforms to all IPS practices. You want to search a scale that provides you with information of fidelity. Let's search the database.

Step1: Formulate well-defined, answerable questions

Is there an available scale that measures fidelity to IPS?

Step 2: Seek the best evidence available to answer your questions

Use one of the recommended websites (since this may be scale-related vocational rehabilitation, try to use RRTC-EBP VR website).

a.   Go to Rehabilitation RRTC-EBP VR: http://research2vrpractice.org
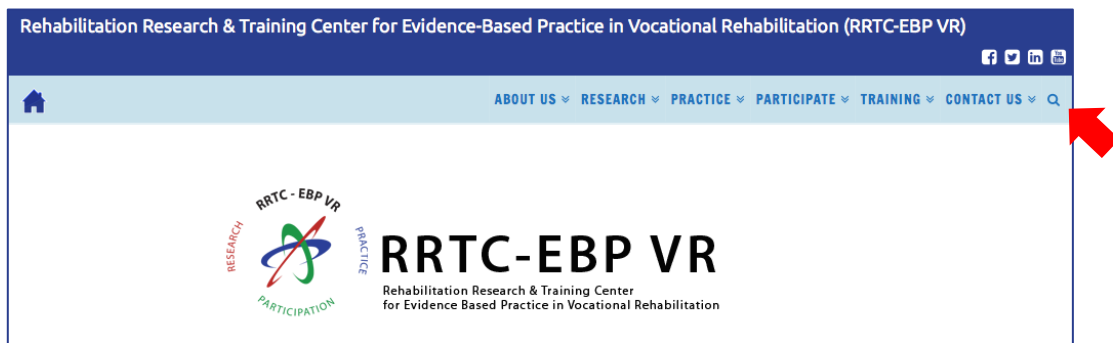
b. Click *"a magnifying glass mark"* on the top right-hand corner. The search page will show up.

c. Type in the keyword *"supported employment"* and press the Enter key. You will find the search results.

d. Among the results, open "IPS Supported Employment Fidelity Tools Related to Vocational Rehabilitation," which is the second item from the top. http://research2vrpractice.org/ips-supported-employment-fidelity-tools-related-to-vocational-rehabilitation

e. If you click *"webpage"* at the bottom in the explanation, you will go *"IPS DARTMOUTH SUPPORTED EMPLOYMENT CENTER's home page"* and find some tools related IPS.

Appendix A: Academic Databases

Databases	Description
Academic Search Elite	A multi-disciplinary database that covers virtually every area of academic study
CINAHL Plus with Full Text	The world's most comprehensive source of full text for nursing & allied health journals
MEDLINE	The most authoritative medical information database
PsycINFO	The most comprehensive database for psychological research

Appendix B: Scholarly Websites

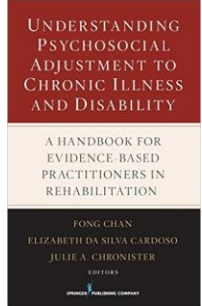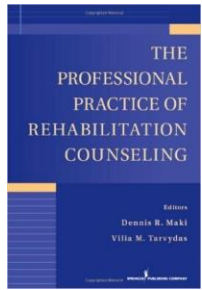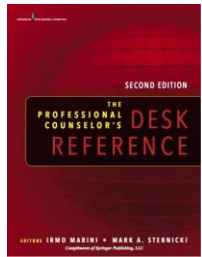| Websites	Description	URL
Rehabilitation Research & Training Center on Evidence-Based Practice in Vocational Rehabilitation (RRTC-EBP VR)	It provides resources related to the knowledge and training program of evidence-based VR practices.	http://research2vrpractice.org
The Cochrane Collaboration	It is internationally recognized as the highest standard in evidence-based health care resources.	http://www.cochrane.org
Agency for Healthcare Research and Quality	It provides comprehensive, science-based information on common, costly medical conditions and new healthcare technologies and strategies.	http://www.ahrq.gov
The Campbell Collaboration	It *is the peer-reviewed online mon*ograph series of systematic reviews prepared under the editorial control of the Campbell Collaboration.	http://www.campbellcollaboration.org/lib/
Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence based Programs and Practices	It provides resources to support the selection and adoption, implementation, and evaluation of EBP related to mental health promotion, substance abuse prevention, and mental health and substance abuse treatment.	http://www.nrepp.samhsa.gov/LearnLanding.aspx
U.S. Department of Education, Institute of Educational Sciences' The What Works Clearinghouse	It is a source of high quality of scientific evidence for what works in education.	http://ies.ed.gov/ncee/wwc/

American Congress of Rehabilitation Medicine	It provides supporting research that promotes health, independence, productivity, and quality of life of people with disability	http://www.acrm.org/consumer_professional/Evidence_Based_Practice.cfm
Virginia Commonwealth University RRTC	It provides resources of the advanced research, training, and technical assistance for improving the employment outcomes of individuals with physical disabilities.	http://www.vcurrtc.org/about/index.cfm
Institute for Community Inclusion	It provides a research and training program that promotes the full inclusion of people with disabilities in the society.	http://www.communityinclusion.org/
NRTC on Blindness and Low Vision	It provides resources for the improvement of workforce participation for Individuals who are Blind or Visually Impaired	http://www.blind.msstate.edu/
IPS Dartmouth Supported Employment Center	Detailed Information and tools related IPS including the IPS fidelity scale	http://www.dartmouthips.org/resources/vocational-rehabilitation/

Appendix C: Useful Articles

Articles	Description
Pettus-Davis, C., Grady, M. D., Cuddeback, G. S., & Scheyett, A. (2011). A practitioner's guide to sampling in the age of evidence-based practice: Translation of research into practice. *Clinical Social Work Journal*, *39*(4), 379-389.	This article provides practitioners with tools to interpret research, specifically the sampling process. This article discusses how sampling fits with the translation of research and describes sampling procedures.
Leahy, M. J., Chan, F., Lui, J., Rosenthal, D., Tansey, T., Wehman, P., ... & Menz, F. E. (2014). An analysis of evidence-based best practices in the public vocational rehabilitation program: Gaps, future directions, and recommended steps to move forward. *Journal of Vocational Rehabilitation*, *41*(2).	This article provides a brief overview of the research undertaken by the Rehabilitation Research and Training Center on Evidence-Based Practice in Vocational Rehabilitation (RRTC-EBP VR) in Phase II of their studies, and what was learned from the comprehensive review of the literature and multi-state case studies in terms of promising practices in state VR agencies.
Campbell, K., Bond, G. R., & Drake, R. E. (2011). Who benefits from supported employment: a meta-analytic study. *Schizophrenia bulletin*, *37*(2), 370-380.	This article identifies which subgroups of clients with severe mental illness benefited from evidence-based supported employment using a meta-analysis.
Wehman, P., Chan, F., Ditchman, N., & Kang, H. J. (2014). Effect of supported employment on vocational rehabilitation outcomes of transition-age youth with intellectual and developmental disabilities: A case control study. *Intellectual and developmental disabilities*, *52*(4), 296-310.	This article examines the effect of supported employment interventions on the employment outcomes of transition-age youth with intellectual and developmental disabilities served by the public vocational rehabilitation system and reveals an increase in employment rates.

Lundahl, B., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice*, *20*(2), 137–160.	The article investigates the unique contribution motivational interviewing has on counseling outcomes and how MI compares with other interventions.
O'Neil, J., Mamun, A., Potamites, E., Chan, F., & Cardoso, E. (2015). Return to work of SSDI beneficiaries who do and don't access state vocational rehabilitation agency services: Case control study. *Journal of Disability Policy Studies*, 26, 111-123.	This article examines the relationship between services provided by state vocational rehabilitation agencies and return-to-work outcomes of Social Security Disability Insurance (SSDI) beneficiaries, and reveals the effectiveness of state vocational rehabilitation.

Appendix D: Useful Books

Chapter Title	Book title	
Chan, F., Chronister, J., & da Silva Cardoso, E. (2009). An introduction to evidence-based practice approach to psychosocial interventions for people with chronic illness and disability. Pp. 3-16	F. Chan, E. da Silva Cardoso, & J.A. Chronister (2009), Understanding psychosocial adjustment to chronic illness and disability: A handbook for evidence-based practitioners in rehabilitation (pp. 3-16). New York: Springer.	
Chan, F., Sung, C., Muller, V., Wang, C. C., Fujikawa, M., & Anderson, C. A. (2011). Evidence-based practice and research utilization. Pp. 391-412.	Maki, D. R., & Tarvydas, V. M. (2011). *The professional practice of rehabilitation counseling*. Springer Publishing Company.	
Chan, F., Keegan, J., Muller, V., Kaya, C., Flowers, S., & Iwanaga, K. (2016). Evidence-based practice and research in rehabilitation counseling. Pp. 605-610.	Marini & M. A. Stebnicki (2016), *The professional counselor's desk reference* (2nd ed., pp. 605-610). New York: Springer Publishing Company.	

Appendix E: Evidence-Based Practice in Vocational Rehabilitation

	Description	Population	Systematic review
Counseling, Psychotherapy	Counseling involves a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals. *Psychological and vocational counseling is one of the major job functions and knowledge domains of rehabilitation counselors.*	General	Systematic reviews show that the majority of people who engage in counseling/psychotherapy show improvement (Norcross & Lambert 2011). A reasonable and defensible point estimate for the efficacy of counseling/psychotherapy would be 0.80, or the average-treated person does better than 79% of untreated persons (Wampold, 2001).
Working Alliance	Working alliance is the bond between a counselor and client, as well as agreement on the goals and tasks of therapy. "The strength of the working alliance is a function of the closeness of fit between the demands of the particular kind of working alliance and the personal characteristics of patient and therapist" (p. 253 Bordin, 1979).	General	Horvath, Del Re, Flückiger and Symonds (2011) examined the relation between the alliance in individual therapy and treatment outcome. Working alliance has a moderate effect on counseling/psychotherapy outcome (d=0.57). Working alliance, along with therapist effects, is one of the strongest validated factors influencing counseling and therapy success (Wampold, 2001).

Skills Training	Labor market training (e.g., on-the-job training, job readiness training, and job-seeking skills training) is an effective VR intervention.	People with sensory disabilities, Physical disabilities, and Chronic illnesses.	Bolton and Akridge (1995) examined the efficacy of a range of skills training, including relationship skills, problem-solving skills, and labor market training for VR consumer. They found that outcome measures resulted in an effect size of $d = 0.93$, suggesting substantial benefit to the typical person with a disability receiving rehabilitation counseling in state/federal VR agencies. Rosenthal et al. (2006) analyzed the data updated after Bolton and Akridge's (1995) study and obtained a more conservative effect size estimate of $d = 0.79$, indicating that at the conclusion of treatment, VR consumers in the intervention group scored higher than consumers in the no treatment control group.
Supported Employment	Supported employment is a well-defined approach to help people with disabilities participate in the competitive labor market, helping them find meaningful jobs and providing ongoing support from a team of professionals.	People with intellectual disabilities/developmental disabilities, people with severe mental illness.	Wehman, Chan, Ditchman, and Kang (2014) found that out of individuals who received supported employment as a VR intervention, 58% obtained successful employment closures compared to the 37% employment rate of those who did not receive supported employment ($d = 0.42$).

Individual Placement and Support (IPS)	IPS is an evidence-based supported employment program based on a place-then-train philosophy. It emphasizes rapid job search and individualized job placement in competitive work, followed by ongoing support from an employment specialist to help clients keep their jobs (Drake, Bond, & Becker, 2012).	People with psychiatric disability	Campbell, Bond, and Drake (2011) conducted a meta-analysis to evaluate the effect of the IPS model of supported employment with traditional vocational interventions for people with severe mental illness. They found large effect sizes favoring the use of IPS in job acquisition (0.96), total weeks worked (0.79), and job tenure (0.74).

Motivational Interviewing	Motivational interviewing is an empirically supported, client-centered, semi-directive counseling approach designed to promote client motivation and reduce motivational conflicts and barriers to change (Chan et al., 2012).	General (substance use disorders)	A meta-analysis of 72 studies examined the efficacy of MI. The majority of the reviewed studies (71%) had a focus on alcohol, smoking and drug use. Generally MI was found to have a large effect size of 0.77 immediately after treatment, a medium effect size of 0.3 at more that 3-6 months and dropped to a small effect size of 0.11 at follow-ups longer than 12 months (Hettema, Steele, & Miller, 2005). Lundahl, Kunz, Brownell, Tollefson and Burke (2010) conducted a meta-analysis reviewed studies over a 25-years period with substance use health-related behaviors, engagement in treatment and gambling variables as targeted outcomes. MI interventions on average required significantly less time (over 100 fewer min) to produce equal effects. MI was found to be effective for increasing clients' engagement in treatment and their intention to change.
Vocational Rehabilitation	Vocational rehabilitation is a process that enables people with disabilities to overcome barriers to accessing, maintaining or returning to employment or other useful occupation. (Above EBPs are subprograms in VR)	General	O'Neil, Mamun, Potamites, Chan, and Cardoso (2014) conducted a carefully designed case control of a 10-year period of the study, and concluded that employment outcomes of the state VR agency enrollee group are substantially better than those of non-enrollee counterparts, and the timing of their employment outcomes are strongly associated with the timing of VR enrollment.

References

Bolton, B., & Akridge, R. A. (1995). A meta-analysis of skills training programs for rehabilitation clients. *Rehabilitation Counseling Bulletin*, *38*, 262–273.

Borenstein, M., Hedges, L. V., Higgins, J. P. T., & Rothstein, H. R. (2009). *Introduction to meta-analysis*. Chichester, UK: Wiley.

Campbell, K., Bond, G. R., & Drake, R. E. (2011). Who benefits from supported employment: a meta-analytic study. *Schizophrenia bulletin*, *37*(2), 370-380.

Chan, F., Chronister, J., & da Silva Cardoso, E. (2009). An introduction to evidence-based practice approach to psychosocial interventions for people with chronic illness and disability. In F. Chan, E. da Silva Cardoso, & J.A. Chronister (Eds.), Understanding psychosocial adjustment to chronic illness and disability: A handbook for evidence-based practitioners in rehabilitation (pp. 3- 16). New York: Springer.

Chan, F., Keegan, J., Muller, V., Kaya, C., Flowers, S., & Iwanaga, K. (2016). Evidence-based practice and research in rehabilitation counseling. In I. Marini & M. A. Stebnicki (Eds.), *The professional counselor's desk reference* (2nd ed., pp. 605-610). New York: Springer Publishing Company.

Chan, F., Sung, C., Muller, V., Wang, C. C., Fujikawa, M., & Anderson, C. A. (2011). Evidence-based practice and research utilization. In D. Maki & V. M. Tarvydas (Eds.), *Professional practice of rehabilitation counseling* (pp. 391–412). New York, NY: Springer Publishing.

Del Valle, R., Fleming, A. R., Kim, M., & Leahy, M. J. (2011). Literature review: Best practice models of effective vocational rehabilitation (VR) service delivery (Phase II Report). East Lansing, MI: Rehabilitation Research and Training Center Effective VR Service Delivery Practices.

DePalma, J.A. (2002). Proposing an evidence-based policy process. Nursing Administration Quarterly, 26(4), 55-61.

Eden, J., Levit, L., Berg, A., & Morton, S. (2011). *Finding what works in health care: Standards for systematic reviews*. Washington, DC: Institute of Medicine, National Academies Press.

Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1*(1), 91–111.

Horvath, A. O., Flückiger, C., & Symonds, D. (2012). Alliance in individual psychotherapy. *Psychotherapy*, *48*, 9–16.

Johnson, K., Brown, P., Harniss, M., & Schomer, K. (2010). Knowledge translation in rehabilitation counseling. Journal of Applied Rehabilitation Counseling, 24(3 & 4), 239-250.

Leahy, M. J., Chan, F., Lui, J., Rosenthal, D., Tansey, T. N., Wehman, P.,...Menz, F. E. (2014). An analysis of evidence-based best practices in the public rehabilitation program: Gaps, future directions and recommended steps to move forward. *Journal of Vocational Rehabilitation*, *41*(2), 147–163.

Lundahl, B., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice*, *20*(2), 137–160.

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work. *Psychotherapy, 48*, 4–8.

O'Neil, J., Kang, H. J., Sanchez, J., Muller, V., Aldrich, H., Pfaller, J., & Chan, F. (2015). Effect of college or university training on earnings of people with disabilities: A case control study.

O'Neil, J., Mamun, A., Potamites, E., Chan, F., & Cardoso, E. (2015). Return to work of SSDI beneficiaries who do and don't access state vocational rehabilitation agency services: Case control study. *Journal of Disability Policy Studies*, 26, 111-123.

Rehabilitation Research & Training Center on Evidence-Based Practice in Vocational Rehabilitation (2015). *Integrating research into VR practice.* Retrieved October 1, 2015, from http://research2vrpractice.org/trainingonlineintegrating-research/

Rosenthal, D. A., Chan, F., Wong, D. W., Kundu, M., & Dutta, A. (2006). Predicting employment outcomes based on race, gender, disability, work disincentives, and vocational rehabilitation service patterns. *Journal of Rehabilitation Administration*, *29*, 223–243.

Schlosser, R.W. (2006). The role of systematic reviews in evidence-based practice, research, and development (Technical Brief No. 15). Austin: National Center for the Dissemination of Disability Research.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum.

Wehman, P., Chan, F., Ditchman, N., & Kang, H. J. (2014). Effect of supported employment on vocational rehabilitation outcomes of transition-age youth with intellectual and developmental disabilities: A case control study. *Intellectual and developmental disabilities*, *52*(4), 296-310.

MODULE 1: Individual Placement and Support (IPS)

Objectives

- To recognize the IPS model and key terms related to the IPS approach
- To learn about effective tools for applying the IPS approach
- To learn how to integrate IPS methods and programs into services

What is IPS, and why is IPS important?

The Individual Placement and Support model is a systematic approach to helping people with mental illness to find and maintain competitive employment (Becker, 2003). Differing from traditional vocational approaches that rely on extensive pre-employment training or a "train Then place" framework, IPS places emphasis on "place train" involving rapid placement in competitive jobs and providing support during the job position (Wehman, 1988).

Key Points

- IPS is an evidence-based practice
- Practitioners focus on each person's strengths
- Work promotes recovery and wellness
- Practitioners work in collaboration with state vocational rehabilitation counselors
- IPS uses a multidisciplinary team approach
- Services are individualized and long-term

(Dartmouth Psychiatric Research Center, 2014)

Evidence of effectiveness and cost-effectiveness of IPS

- IPS approaches help clients to achieve employment rates nearly twice as high, accumulate three times the earnings, and find their first job several months earlier in comparison to clients from other vocational programs.
- After gaining employment, IPS clients work twice as many weeks and three times as many hours per year than clients in other vocational programs.
- IPS participants typically work at least half-time, averaging over 10 months of job tenure in an initial job.
- Half of those obtaining a job through IPS programs maintain steady employment for over a 10-year period. If supported employment were widely available, the nation could save $368 million annually in Medicaid, Social Security and other federal and state programs.
- The IPS model has been shown to reduce community mental health treatment costs, and psychiatric hospitalization days and emergency room usage.

(Becker, Whitley, Bailey, & Drake, 2007; Bond et al., 2012; Bond, Drake, & Campbell, 2014; Drake et al., 2012)

Effects of IPS on Non-Vocational Outcomes

Competitive employment is associated with economic, psychosocial, and clinical improvements among people with SMI. In general, it has been proven that work is positively related to health outcomes for people with SMI such as improved psychiatric symptoms and fewer psychiatric hospitalizations, which contributes to reduce mental health costs and higher quality of life (Bond et al., 2007). Compared with people who do not participate in IPS programs, people who obtain competitive employment through IPS achieve higher self-esteem, quality of life, and social inclusion, as well as improved control of psychiatric symptoms (Kukla, Bond, & Xie, 2012). These boosts to well-being persist at 10-year follow-ups (Becker et al., 2007). People with SMI often report that the IPS model is a high quality treatment and central to their recovery.

How? (Instructions/Handouts)

IPS Program Components

- Designed to fit individual needs: Programs are tailored to meet the specific needs of each person.
- Cooperation: Employment specialists work as part of the mental health team and everyone works together to help achieve success.
- Flexible approach: Programs are adapted to help people overcome specific challenges. Services and support are available as long as needed.
- Results supported by research and evidence: Numerous studies and careful research have shown IPS programs to be effective

(Dartmouth IPS Supported Employment Center)

IPS principles

1	**Eligibility based on client choice**	People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.
2	**Focus on competitive employment**	Agencies providing IPS services are committed to competitive employment as an attainable goal for people with serious mental illness seeking employment.
3	**Integration of mental health and employment services**	IPS programs are closely integrated with mental health treatment teams.
4	**Attention to client preferences**	Services are based on each person's preferences and choices, rather than providers' judgments.
5	**Time-Unlimited Support**	Job supports are individualized and continue for as long as each worker wants and needs the support.
6	**Rapid job search**	IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling.
7	**Systematic job development**	Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.

8	**Individual job supports**	Employment specialists help people obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements.

Although the IPS model views the process of obtaining a job as the official start of the approach, the employment specialist should make sure that employment support and other services are provided before or at the beginning of a job. For instance, helping with the interview or preparing for the interview, whether or not to disclose information about disability, meeting with the employer, etc. The level and type of supports depends on the individual's needs and can be provided whether on the job or outside of the job (Bond et al., 2008).

When? (Indications/Contraindications)

The IPS model was designed for community mental health centers originally, but because of its effectiveness, peer agencies, housing programs, and general health centers are integrating IPS services (Whitley et al., 2012). Recently, the IPS model has been proven to also be applicable to diverse populations such as people with co-occurring mental illness and substance abuse (Mueser, Campbell, & Drake, 2011), veterans with posttraumatic stress disorders (Davis et al., 2014), veterans with spinal cord injury (Ottomanelli, Barnett, & Toscano, 2014), and young adults with autism spectrum disorders (Bond, Drake, & Campbell, 2014)

Not only is the IPS model useful for people with specific disabilities, but IPS also provides benefits to people regardless of educational levels (Campbell, Bond, & Drake, 2011), ethno-racial backgrounds (Mueser et al., 2014), and prior work histories (Campbell et al., 2011). Additionally, both young adults (Bond & Drake, 2014) and old adults benefit from IPS (Twamley, Jeste, & Lehman, 2003). Moreover, other research illustrates that long-term Social Security beneficiaries (Frey et al., 2011) or parents with mental illness (Nicholson, 2014) can also find advantages from the IPS approach.

Individuals with severe mental illness and other severe disabilities who want to obtain competitive employment should try to find access to IPS services. Most referrals to IPS services will be through a clinician or by self-referral. Some clinicians will need support on how to talk to their clients about employment and how to initiate referral to IPS services—the tools provided in the appendices may help.

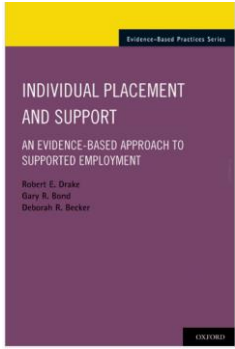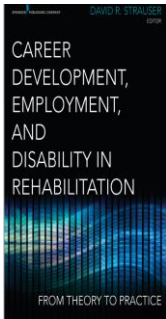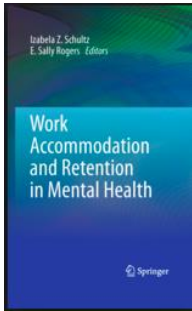| Name	Content
Tips for mental health clinicians on how to talk about employment with their service users	Appendix A
A worksheet about work for the clinician to complete with the service user (Dartmouth)	Appendix B

Resources

Name	Description	URL
Dartmouth supported employment center	Core concept	http://www.dartmouthips.org/
Dartmouth supported employment center/Families & Consumers	Family members and consumers are advocating for IPS	http://www.dartmouthips.org/resources/families-consumers/
Dartmouth supported employment center/Program	The implementation process	http://www.dartmouthips.org/resources/programs/program-implementation-and-fidelity/
Dartmouth supported employment center/Vocational rehabilitation	Vocational rehabilitation programs collaborate with IPS specialists	http://www.dartmouthips.org/resources/vocational-rehabilitation/
Dartmouth supported employment center/Trainers & Fidelity	Trainers & Fidelity Reviewers	http://www.dartmouthips.org/resources/trainers/training-tools-about-ips-supported-employment/
Dartmouth supported employment center/International IPS Learning	Overview International IPS Learning	http://www.dartmouthips.org/international-ips-learning-community/

Dartmouth supported employment center/How to apply	Application guidelines	http://www.dartmouthips.org/international-ips-learning-community/how-to-apply/
Dartmouth supported employment center/Training & Consultation services	IPS training courses	http://www.dartmouthips.org/training-consultation-services/
Paths to Employment Resource Center (PERC)	IPS Description	http://www.percthinkwork.org/education/courses/ips
Centre for Mental Health	Individual Placement & Support (IPS) in UK	http://www.centreformentalhealth.org.uk/individual-placement-and-support
Western Australian Association For Mental Health (WAAMH)	Individual Placement & Support (IPS) in Australian	https://waamh.org.au/development-and-training/individual-placement–support-ips.aspx

Books/Articles

Book Title	Chapter Title	URL
U.S. Substance Abuse and Mental Health Services Administration (2009)	Supported Employment, Evidence Based Practices Kit: building your program	http://store.samhsa.gov/shin/content//SMA08-4365/BuildingYourProgram-SE.pdf
	Supported Employment, Evidence Based Practices Kit: Training frontline staff	http://store.samhsa.gov/shin/content//SMA08-4365/TrainingFrontline%20Staff-SE.pdf
U.S. Substance Abuse and Mental Health Services Administration (2009)	Supported Employment, Evidence Based Practices Kit: Evaluating Your Program.	http://store.samhsa.gov/shin/content//SMA08-4365/EvaluatingYourProgram-SE.pdf

NAMI	Road to Recovery: Employment and Mental Illness	http://www.nami.org/work
Robert E. Drake, Gary R. Bond, and Deborah R. Becker (2012) Individual Placement and Support: An Evidence-Based Approach to Supported Employment		
David R. Strauser (2014) Career Development Employment and Disability in Rehabilitation	Paul H. Wehman, Pamela S. Targett, and Michael D. West (2014) Supported Employment/ Customized Employment p.325-341	
Schultz, Izabela Z. Roger, E. Sally (2011) Work Accommodation and Retention in Mental Health	Terry Krupa (2011) Approaches to Improving Employment Outcomes for People with Serious Mental Illness	

Other materials

Name	Description	URL
VR and mental health partnership	This VTR is provided by Dartmouth supported employment center	http://www.dartmouthips.org/videos/vr-and-mental-health-partnership/
IPS unit meeting with VR counselor	This VTR is provided by Dartmouth supported employment center	www.dartmouthips.org/videos/ips-unit-meeting-with-vr-counselor/
Employment Stories: meet Jim and Lee Roy	Two very different people who share their experiences about finding employment and having a disability	www.percthinkwork.org/resources/item/stories_jim-and-lee-roy/
Supported employment – introductory Video	This film gives viewers basic information about the Supported Employment (SE) program, including the following: * Practice principles; * Practice philosophy and values; * Basic rationale for services; and * How the evidence-based practice has helped consumers and families.	www.youtube.com/watch?v=DoLO_p04uKY&feature=relmfu/ The entire Supported Employment Evidence-Based Practices (EBP) KIT can be downloaded at http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365

Case Studies

Two anonymous service users with mental health problems who received help with finding employment from an employment service in a London Mental Health Trust were invited to write their accounts regarding to their experiences.

The employment specialists who assisted them in this journey were also invited to write their accounts.

Case 1: Statement of their journey
D had not worked for 17 years when he was referred to the employment specialist and he could speak very little English.

"I met my ES after I had heard about the Employment Services within CNWL. I was interested in working because I wanted to improve my health. I was sat at home suffering from my mental health and I felt very depressed, thinking what will happen with my life. I often thought about what my life would be like if I held down a job but there was one thing stopping me! I spoke no English at all four years ago! When I met my ES she discussed what my motivations were and whether I wanted to work. I felt at last there was someone to help. We struggled during the first session, my ES spoke very slowly and I answered back with one word answer. She even drew pictures to help me understand. I knew she wanted to help me move on and find work. My ES helped me create a CV, which was also challenging. I had worked previously 17 years ago in this country but it was for a Gujarati speaking company however, I struggled here too as I could not communicate with many people, I found it a struggle using the bus service, paying on the buses, I lost a lot of confidence which resulted in me leaving this role and I became very unwell.

Soon after meeting my ES we started to job search in the community. I was looking for either a cleaning role, factory work, or anything I can use my hands with. We visited many factories around London on several occasions and then I met my ES's colleague who speaks the same language as I do. We straight away worked together as a three on practicing interviewing techniques, how to address my hygiene, how to meet and greet employers. It was such a relief and I understood the hard work that my ES was putting into my journey back to work. It was so helpful that she suggested I spoke to her colleague who is also an Employment Specialist. My ES then organized for me to go to an interview with a large retailer. The interpreting ES spoke to me over the phone and prepped me for my day. Both of the Employment Specialists

met and wrote a letter explaining my history and my capabilities. They even wrote that I am willing to do a work trial, and that if they were happy with this, to contact them to translate and arrange this!

The manager was impressed with the way we all communicated and offered me a work trial. My ES explained to the manager that she should demonstrate what I should do, and my interpreter relayed this to me so I copied everything I saw! I had no clue in what the lady was saying but I just imitated her. My ES also helped me explain my mental health to my manager as I felt she should know that sometimes I may need extra support and she can call my ES for support.

I am now in part time job as a cleaner. I cannot believe I have finally got a job it has changed my life. I feel happy within myself, the bad thoughts from my head have disappeared. I have made friends at work who speak Gujarati and they help me practice my English! I feel more confident travelling around in London and being around people that do not speak my language. My home life has improved as well. I cook for myself and socialize with people in my accommodation site where I live.

My ES and I meet regularly and she asks how my job is going and helps me with my benefits. We have also met to write this story and the interpreter is helping my ES. Finally, I want this story to help others in a similar situation. Anyone can work; if you receive the correct help and support no barrier will stop you from working."

(Miller, L., Clinton-Davis, S., & Meegan, T., 2014, P.199).

Suzanne Clinton-Davies-The employment specialist who supported D
A journey well-travelled – supporting a client on his recovery journey back to employment

"In 2012 I was given the honor, and it has genuinely felt like this, to support a gentleman recapture a huge part of himself and begin the journey to accessing paid employment. Little did we both know how creative and challenging it would be [y] but the rewards have been great. As a new Employment Specialist in the Brent Community Rehabilitation Team I decided with my Team Leader to "spread the word" about the IPS model (individual placement and support) to as many supported accommodation sites as I could. This meant giving short focused talks at the

houses and in-patient community wards to service users/residents and to the many staff who are the back bone of the service.

At one such talk approximately 6 residents attended along with a couple of staff. I knew that at least one if not two people were non-English speakers, but nonetheless I tried to convey the essence of my speech with some improvisations and handouts.

"We also found that there remains a stigma around mental health within various communities and it is a subject that remains taboo and something to be feared."

At the end a few people requested to hear more about how I could help, but one man stood out. This was D. He repeatedly stated in his broken English that he wanted to work and had a persistence and drive that I have rarely seen. So we agreed to meet and thus began our winding journey. Our first sessions would have been comical to film, between his faltering English and my limited acting abilities but slowly I grew to build a picture. Here was a man who had travelled from a village in India, with little in the way of formal education or training, to a man who had acquired various trade skills and then on coming to the UK had become severely unwell. Fast forward 20 years he now stood before me, unemployed, hopeful, excited and declaring that he wanted to work with his hands, be it in cleaning, carpentry or repairing bikes.

However creative we were with the CV, D had not worked for many, many, years and getting a job interview through traditional routes was going to prove challenging. We needed links, a network of Gujarati speakers who could help, or so I thought. We found Gujarati speakers in Kilburn and Wembley and were pointed in the direction of the temples to assist us. We also found that there remains a stigma around mental health within various communities and it is a subject that remains taboo and something to be feared. We journey on; I developed links with a well-known cycle shop and found a Gujarati manager who was prepared to train him up. I navigated through the HR department to have his CV selected only to find that the job we were going for had changed. All back staff – i.e. those working behind the scenes repairing, were now expected to have customer service skills and be able to communicate and repair bikes at the front of the shop. Without English, this was impossible. Au revoir to that job!

We made links with a Gujarati restaurant proprietor but the hours were impossible, we contacted a well-known stationer who needed a cleaner and then Head Office reduced their budget. Finally we forged a connection with a company to which a high street retailer had

contracted out their cleaning [y] Having established a warm, albeit rather superficial connection with the manager, I now needed to ensure that D could manage a very basic interview and work trial. For this I enlisted a wonderful Gujarati and English speaking colleague who supported D with what to say and how to say it. We wrote a script and always listened to D's preferred views and thoughts. D was adamant that he wanted to inform any company he worked for, before signing a contract, that he had experienced mental health difficulties. It was most important to him as it was a part of his identity and he wanted people to be informed in case he hit challenging times again.

So, having arranged a work trial and brokered an interview we met with the local manager of the cleaning company to sign up. On the application form were general questions about physical and mental health and D insisted that we tell the interviewer about his mental health. It was perhaps one of the worst interviews/contract signings I have ever had to witness. As I explained in general terms about D's mental health, the manager sat back in her chair and unfaltering told him and myself that there was no possible way she could take him on. He was a danger to himself, to others, he might swallow poisonous chemicals, he could hurt someone, he would fail to turn up and the list went on. In very basic terms I tried to relay to D that the interview was not going so well. The truth was that I was horrified and incredulous that this kind of blatant discrimination was happening in 2014. It was at this point, that the manager of the retailer walked in, himself a Gujarati speaker and I asked whether I could take time out of the interview with the contracted cleaning company and have a word off line. We left the room and warmly greeting me he asked what was happening. I sadly told him that under his roof, a subcontractor was making highly discriminatory remarks, that the Equality Act was here to protect all people and he should be aware of the predicament I was in with my client. I requested that he discretely speak with the cleaning manager and remind her of the Equality Act and how until the moment we had mentioned mental health she had been pleased to sign D up. Perhaps she should re consider and at least allow him the chance to prove himself. If it went wrong she had my contact details and we could review. All credit to the Retail manager, he rose from the chair, walked back into the interview room and asked the cleaning manager for a word. Ten minutes later we were signing the contract.

I would like to say that everything from that day to this has been easy, but it wouldn't be true!! What is true is that D has become a fantastic cleaner, the manager has increased his hours and D has made the transition into less supportive accommodation and is building a very different and positive life. He describes how he loves going to work and has made new friends. D is a role

model to all who wish to hope and believe they can go back to work. We still meet regularly and my current supervisor a Gujarati speaker helps clarify questions and appointments where necessary. At the end of the day 'where there is a will, there really is a way.' We just need the clients to tell us that they do want to work; our role is to have the skills and knowledge to navigate the complexities of work and support them to find the best way in and then keep them in employment. It has been a wonderful learning and eye opening journey for both of us and with D's support we have communicated this story to many service users and staff [y]. To my fellow colleagues, peer support workers and service users I offer a quote that resonates deeply with me 'let us be agents of hope for without hope there is no future.
' Lord Sacks, 2005." (Miller, L., Clinton-Davis, S., & Meegan, T., 2014, P.200).

Case 2: Graduate with Bipolar Disorder

B was a graduate with a diagnosis of bipolar disorder who had been unemployed for two years when he was referred to the employment specialist.

"I suffer from Bipolar Effective Disorder and it has taken me a long time to come to terms with this. The first time I suffered an episode was in my late teens. Many people around me, both family and friends were shocked to see this happen to someone as positive and outward going as myself but the truth of the matter was that I suffered from serious burn out from my school and social life that had caused something in me to not be right.

It has taken me many years since then to reach a balance both in the way in which I think and perceive myself and with the way I deal with my day to day life. I have had a lot of help along the way. If it wasn't for the support I have had from my mental health team, I wouldn't be the same person I am today.

University was very hard for me. Not really because of the workload but mostly because I had suffered another manic depressive episode in my first year there. The manic episode which I went through, lasted 8 months which resulted in me having to voluntarily drop that year and start all over again, which meant that my depressive episode happened while I was re-taking my first year in university. This is the time when I met a care worker called Simon and he would meet up with me on a week by week basis to see how I was doing and see how he could help to make me feel different about myself and to see things from a different point of view. This made going through the last few years of University a lot easier as he helped me reach a good balance on which to conduct myself.

Having graduated university, I went out in the big open world with a 2:2 and a keen desire to reach my goals. Little did I know but this was the time of the beginning of the recession and what that meant for graduates like me was that finding a job, any job would prove harder than the previous generation of graduates. It was an uphill struggle to find a decent form of secure employment. Although having found work here and there, starting off on an internship and then later on a 6 month contract and finding temporary work, I was unable to find a permanent position. I had to learn that in order to get what you want, you seriously had to go out and get it. This again proved for me to be an incredibly hard time.

I then had a period of 2 years of unemployment, I didn't suffer from any severe episodes of my mental health at this time but it still affected my job seeking, making it hard to stay motivated.

Even though things were again incredibly difficult I remember how much care I got again from the Westminster Mental Health Team as my consultant psychiatrist referred me to an Employment Specialist. Little did I know her help would be invaluable in giving me the support and confidence I would need to find not only a job, but the right job for me. Meeting her was very good for me, as I recall I had reached a very low point where I did not want to meet up with many friends as my situation wasn't getting any better. She introduced me to people of all ages who were looking for work in weekly and fortnightly artist network meetings in central London. I met people who were going through similar struggles and were in a similar position as me. These meetings really gave me a boost to try harder and push for more opportunities out there. She was a great support and gave me regular support on finding work, looking at opportunities available online and through her contacts. I felt so happy to have this support to look for work at a time when I wasn't feeling great about myself.

Since finding secure employment, I feel like a new person. I hate to sound overconfident or even patronizing to anyone reading this, but I feel like a new man. In ways such as the way I think, act and even the way I carry myself. I can't stress enough how much better I feel having found work. Now I am not shy to talk about my career or even what I do. Whereas before it was very much hiding the fact that I was unemployed, now I look forward to the opportunity to open up about my life. I feel like I walk more confidently and am not shy to speak to strangers, however funny that may seem, I really feel like a happier, more outward going positive person.

I really am glad to have found work and cannot imagine going back to a world of boredom, loneliness and significant signs of the onset of depression. I feel like my life has changed in such a great way that I hope I can encourage other people to do the same and find work. Because it really is worth it, it is a life changing process because it gives you the motivation, the purpose in life to achieve things you couldn't imagine achieving when you're alone at home. And at the end of it, even a monthly reward of a pay check, so that you can treat yourself and others. I hope this story helps you, as you can see that it can happen to anyone, not just me. As long as you put in some effort, put in some hard work as well as get the help you need to push yourself and achieve you really can be a better person."

(Miller, L., Clinton-Davis, S., & Meegan, T., 2014, P.201).

Tina Meegan – The employment specialist who supported B

"While working at the South Westminster Recovery team as an Employment Specialist, B was referred to me by his Consultant Psychiatrist to support him to return to employment. He had many strengths, a degree, strong administration skills, an interest in the arts, good communication skills and was motivated to gain employment. However, after two years of unemployment he had become isolated and had lost confidence.

He became a member of the Artist's Employment Network at the South Westminster Recovery team, which supports service users with an interest in the arts to find employment. B has a particular interest in the film industry, he networked with other members of the group with a similar interest and then co-worked on a project. This is a very supportive network and he was an active member who gained confidence from the network, made friends, supported others and had the opportunity to hear about employment opportunities in the arts industries.

Initially he gained some work in a large book shop. He then moved onto a job as an Administrator in an HR Department at a London Hospital which he was keen to do. After speaking to his Consultant Psychiatrist regarding his situation he decided to leave the job at the hospital. He was finding it difficult to cope with a number of challenges that were not related to his mental health.

I supported B in negotiating with his employer, and also deciding whether he should leave the role. I encouraged him to be open with his employers and they were very supportive, but he

ultimately decided to leave the post at that stage. Within a short space of time we started looking for another job matching his skills and interests.

B then gained an administration role within a film production company – his ideal industry which he has successfully sustained for over a year and a half now. His journey to work has been inspiring, and very much supported by myself and the clinical team working together.

He is now confident in owning his mental health and willing to share his journey and encourage others."

(Miller, L., Clinton-Davis, S., & Meegan, T., 2014, P.202)

Another case study you might find interesting: "I Did it, You Can Too."

A 26-year-old man with a wry sensory of humor, a steady job and aspirations of achieving a doctorate. He also happens to live with bipolar disorder.

http://www.nami.org/Blogs/NAMI-Blog/November-2013/I-Did-It-You-can-too-%E2%80%9D

Useful Terms

Supported employment	Supported employment assists people with the most severe disabilities so that they are able to obtain competitive employment directly – on the basis of the client's preferences, skills, and experiences – and provides the level of professional help based on the client's needs (Salyers, M. P., Becker, D. R., Drake, R. E., Torrey, W. C., & Wyzik, P. F. 2004).
Vocational Rehabilitation (VR)	Vocation Rehabilitation provides career counseling and job search assistance for people with disabilities, including mental illness. VR program structures vary from state to state. To learn more about your specific state program, visit your state's VR agency. -See more at: http://www.nami.org/supportedemployment#sthash.gNV0Sfob.dpuf
Competitive employment	Competitive jobs have permanent status, pay at least minimum wage and are not aside for people with disabilities and that is anyone can apply (Salyers, M. P., et al., 2004).
Job coaching	Job coaches are individuals who specialize in assisting individuals with disabilities to learn and accurately carry out job duties. Job coaches provide one-on-one training tailored to the needs of the employee. They may first do a job analysis to identify the duties, followed by developing a specific plan as to how they can best train the employee to work more and more on his/her own until completely self-sufficient and able to perform job duties accurately and effectively without assistance (Beyer and Robinson, 2009).
Clubhouses	Clubhouses are community-based centers open to individuals with mental illness. Clubhouse members have the opportunity to gain skills, locate a job, find housing, and pursue continuing education. Members work side-by-side with staff to make sure the program operates smoothly. Members also have the opportunity to take part in social events, classes and weekend activities. More information: http://www.nami.org/supportedemployment#sthash.gNV0Sfob.dpuf

Employment specialist	**Overall function:** Helps clients find and keep competitive employment that is consistent with their vocational goals. **Responsibilities:** Engages clients and establishes trusting, collaborative relationships directed toward the goal of competitive employment in community settings **Qualifications:** Education and experience equivalent to undergraduate degree in mental health, social services, or business. Experience working with people with serious mental illnesses, experience providing employment services, and knowledge of the work world are preferred. Ability to work as an effective team member is essential. (Dartmouth Psychiatric Research Center, 2012).
IPS Supported Employment Supervisor	**Overall function:** Ensures good employment outcomes for clients in the IPS supported employment program. For example, at least 45-50% employment on the IPS team and an average of 12 job starts per employment specialist each years. **Responsibilities:** Hires and trains employment specialists. Evaluates job performance and helps each specialist see goals for improved performance. **Qualifications:** Master's degree in rehabilitation counseling or related field. Previous experience as an employment specialist assisting clients with serious mental illness in obtaining and maintaining competitive employment is desired. Previous supervisory experience is desired. (Dartmouth Psychiatric Research Center, 2012)

Appendix A: Top Tips for Talking about Work on an Ongoing Basis

Remember

You are asking your clients about their interests in work because you know it can improve a person's physical and mental wellbeing whether or not they are experiencing symptoms, taking drugs or drinking alcohol to excess and that an historical culture of low expectations may mean a client needs help from you to consider whether work may be an option for them.

Preferences

Ask what their dream job would be, what they wanted to be when they were at school, what type of job they may want to do?

History

Ask about work history, did they have a favorite job- why was it good? A least favorite job? Who was your favorite boss? Why?

Friends/ Family

Do they know others who are working? What do they do? Would this be something they might like to try?

Future

Ask the person to describe their life 5 years from now. Where will they be living? What relationships will they have in their life? What will they be doing with their time?
You may wish to use the attached worksheet which is designed to help you and your clients begin some meaningful discussions about employment. Before you use it you may want to consider the following strategies that other clinicians have found helpful:

- Try not to encourage the person in one direction or the other. In other words don't tell the person they have to work **or** that they shouldn't think about work at the moment. Try to just be curious about the person's feelings & thoughts about work.
- Take your time, you don't have to complete the worksheet in one meeting. Use open ended questions so the person shares all of their ideas, you may ask 'what else?' after an answer to a question.

- If someone says they will lose their benefits and be worse off if they work, ask how they know this. Explain employment specialists can do 'better off calculations' and that it is very rare a person is worse off financially if they work.
- When using the rating scales ask the person why they chose a particular point and not more or less than that
- Design a next step. For example
    o Arrange a meeting with an employment specialist to learn how they can help a person return to work
    o Show the person some example 'better off' calculations
    o Plan to have more discussions about work
    o Introduce the person to someone else who has gone back to work
    o Help with barriers identified, for example help find options for childcare.

Adapted from Dartmouth PRC

http://www.centreformentalhealth.org.uk/3-referrals-to-an-ips-service

Appendix B: So, you're thinking about work...

It may help to talk to someone if you are thinking about work so you can consider the possible benefits and discuss any concerns you may have. You can use this worksheet with your care coordinator or support worker as a way of discussing your hopes for work and planning the best way to get started.

What are your hopes regarding a job? How will employment benefit your life?
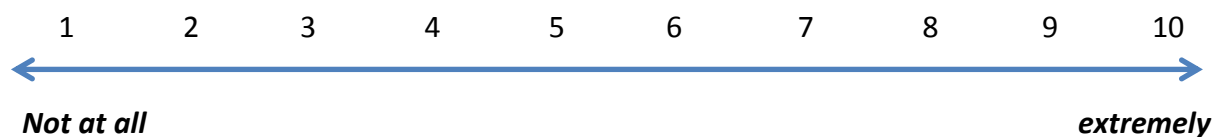
What are your concerns about working?

Do you know how your benefits would be affected by working part or full time?

What type of assistance would be most helpful to you?

◯ Help contacting employers
◯ Help finding vacancies
◯ Help talking to my boss if there are problems
◯ Help explaining convictions to employers
◯ Information about different types of job
◯ Help explaining periods of unemployment

◯ Helping manage benefits while working
◯ Help building a career over time
◯ Someone to talk to about my job
◯ Practice interviewing
◯ Help explaining my mental health issues
◯ Help with job training/ education

Other:

On a scale of 1 – 10, how important is a job to you?

1	2	3	4	5	6	7	8	9	10

⟵――――――――――――――――――――――――⟶

Not at all   *extremely*

Comments:

46

On a scale of 1 – 10, how important is a job to you?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

←――――――――――――――――――――――――――→

Not at all   **extremely**
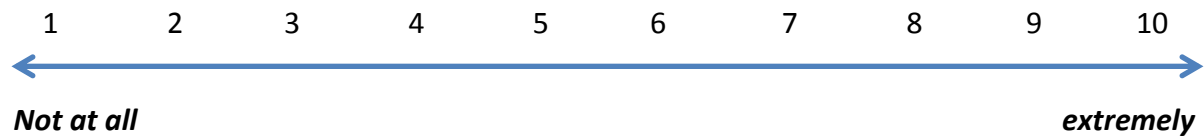
Comments:

How soon would you like to begin looking for a job?

○ Within a week

○ Next month

○ In a few months

○ In six months

○ Not sure- I would like to just keep talking about this at the moment

The plan for right now is to:

Table Example: Process of IPS in DVR

IPS Process Steps	Prior to IPS	Referral to IPS/DVR	IPS Services Begin	Job Obtained and Maintained	Case Transfer to Longer Term support
IPS Job Seeker	Receiving Services from MH Team	Meet with ES and then DVR	Participate in job seeking related activity	Maintain job, keep in touch with ES/DVR	Maintain job, keep in touch with MH Team/ES
MH Team (Includes ES and DVR)	Meet regularly, discuss progress and employment, providing expertise	MH Team member makes referral to ES	Provide feedback to ES regarding job search and other issues	Provide feedback to ES regarding job and other issues	Supports Employment- Refers to ES if issues arise.
ES	Attend and participate in MH team meetings at least weekly, providing expertise	Initial meeting with consumer Begin: Consult with DVR, Application, Career Profile, Employer Contacts	Complete work on Career Profile, Employer contacts Explore job prospects	Provide individual support, fade as possible	Transfers support to MH team
DVR	Attend and participate in MH team meetings at least monthly, providing expertise	Initial meeting with consumer Begin: Consult w/ ES, Application, Eligibility, OOS.	Determine phase of IPS- Consult with ES, Authorize services going forward (Career Profile/Job Dev Plan), complete IPE, Provide IPE Services as needed	Provide expertise and IPE services as needed	Case Closure Provide post- employment services if needed

References

Becker, D. (2003). R. and Drake, RE "A Working Life for People with Serious Mental Illness.": New York: Oxford University Press.

Becker, D., Whitley, R., Bailey, E. L., & Drake, R. E. (2007). Long-term employment trajectories among participants with severe mental illness in supported employment. Psychiatric Services, 58(7), 922-928.

Bond, G. R., & Drake, R. E. (2014). Making the case for IPS supported employment. Adm Policy Ment Health, 41(1), 69-73. Doi:10.1007/s10488-012-0444-6

Bond, G. R., Drake, R. E., & Becker, D. R. (2008). An update on randomized controlled trials of evidence-based supported employment. Psychiatr Rehabil J, 31(4), 280-290. Doi:10.2975/31.4.2008.280.290

Bond, G. R., Drake, R. E., & Campbell, K. (2014). Effectiveness of individual placement and support supported employment for young adults. Early intervention in psychiatry.

Bond, G. R., Salyers, M. P., Dincin, J., Drake, R. E., Becker, D. R., Fraser, V. V., & Haines, M. (2007). A randomized controlled trial comparing two vocational models for persons with severe mental illness. Journal of Consulting and Clinical Psychology, 75(6), 968-982.

Bond, G. R., Drake, R. E., & Becker, D. R. . (2012). Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. World Psychiatry, 11(1), 32-39.

Campbell, K., Bond, G. R., & Drake, R. E. (2011). Who benefits from supported employment: a meta-analytic study. Schizophr Bull, 37(2), 370-380. Doi:10.1093/schbul/sbp066

Dartmouth IPS Supported Employment Center (2014, March). IPS Practice and Principles. http://www.dartmouthips.org/wp-content/uploads/2014/04/ips-practice-and-principles.pdf May. 22, 2016

Dartmouth Psychiatric Research Center (2012, July). Employment Specialist Job Description (pp1-3). http://www.dartmouth.edu/~charky1/page40/page50/styled-13/files/job-descriptions-july.2012.pdf May. 22, 2016

Dartmouth Psychiatric Research Center (2012, July). IPS Supported Employment Supervisor Job Description (pp4-6). www.dartmouth.edu/~charky1/page40/page50/styled-13/files/job-descriptions-july.2012.pdf. May. 22, 2016

Drake, R. E., Bond, G. R., Thornicroft, G., Knapp, M., & Goldman, H. H. (2012). Mental Health Disability: An International Perspective. Journal of Disability Policy Studies, 23(2), 110-120.

Davis, L. L., Pilkinton, P., Poddar, S., Blansett, C., Toscano, R., & Parker, P. E. (2014). Impact of social challenges on gaining employment for veterans with posttraumatic stress disorder: an exploratory moderator analysis. Psychiatr Rehabil J, 37(2), 107-109. Doi:10.1037/prj0000058

Frey, W., Drake, R., Bond, G., Miller, A., Goldman, H., & Salkever, D. (2011). Mental Health Treatment Study: Final report to social security administration. Rockville: Westat.

Kukla, M., Bond, G. R., & Xie, H. (2012). A prospective investigation of work and nonvocational outcomes in adults with severe mental illness. Journal of Nervous and Mental Disease, 200(3), 214-222.

Mueser, K. T., Bond, G. R., Essock, S. M., Clark, R. E., Carpenter-Song, E., Drake, R. E., & Wolfe, R. (2014). The effects of supported employment in Latino consumers with severe mental illness. Psychiatric rehabilitation journal, 37(2), 113-122.

Mueser, K. T., Campbell, K., & Drake, R. E. (2011). The effectiveness of supported employment in people with dual disorders. Journal of dual diagnosis, 7(1-2), 90-102.

Miller, L., Clinton-Davis, S., & Meegan, T. (2014). Journeys to work: the perspective of client and employment specialist of "Individual Placement and Support" in action. Mental Health and Social Inclusion, 18(4), 198-202. Nicholson, J. (2014). For parents with mental health conditions: The chance to "have it all" at work and at home. Psychiatric rehabilitation journal, 37(2), 153.

Ottomanelli, L., Barnett, S. D., & Toscano, R. (2014). Individual placement and support (IPS) in physical rehabilitation and medicine: the VA spinal cord injury experience. Psychiatr Rehabil J, 37(2), 110-112. Doi:10.1037/prj0000079

Salyers, M. P., Becker, D. R., Drake, R. E., Torrey, W. C., & Wyzik, P. F. (2004). A ten-year follow-up of a supported employment program. Psychiatric Services.

Twamley, E. W., Jeste, D. V., & Lehman, A. F. (2003). Vocational rehabilitation in schizophrenia and other psychotic disorders: a literature review and meta-analysis of randomized controlled trials. J Nerv Ment Dis, 191(8), 515-523. Doi:10.1097/01.nmd.0000082213.42509.69

Whitley, R., Strickler, D., & Drake, R. E. (2012). Recovery centers for people with severe mental illness: a survey of programs. Community Ment Health J, 48(5), 547-556. Doi:10.1007/s10597-011-9427-4

MODULE 2: Solution-Focused Brief Therapy (SFBT)

Objectives

- To understand SFBT and the process of SFBT.
- To identify key treatment techniques and problems most suitable for SFBT.
- To learn how to integrate SFBT into Vocational Rehabilitation (VR) practice.

What is SFBT, and why is SFBT important?

Developed by Steve de Shazer and Insoo Kim Berg, SFBT is a practical counseling approach that is time-limited and primarily concerned with finding positive solutions to difficult behavioral problems, rather than focusing on causes, deficiencies, or problems. It has become a popular modality across many specialty areas, such as family and group counseling, mental health, and substance abuse, in a broad array of settings including health care and rehabilitation agencies, social services, prisons, schools, and residential programs. The importance of SFBT is that it explores current resources and future hopes rather than present problems and past causes.

The purpose of this module is to provide a general overview of major concepts related to SFBT including its basis for change, counseling techniques, effectiveness, and rehabilitation applications.

How?

SFBT incorporates a variety of concepts, approaches, and techniques during the treatment process to solve clients' behavioral and life problems. SFBT has its own unique techniques that practitioners can use in counseling sessions.

Developing a basis for Change

Because solution-focused therapists believe that individuals possess inside themselves the essential ingredients for developing new thinking patterns and implementing behavior changes, practitioners work collaboratively with their clients to question and discuss how the client has been successfully coping with problems, using solution-focused techniques to construct a new or modified perception of reality during the process of counseling.

> In order to co-construct solutions, the practitioner refrains from an in-depth conceptualization of the problem and diverts the client's attention to the solution. Using the client's expertise, the core of the solution lies within identifying what currently works, doing more of what works, and discarding what does not.

Counseling Techniques

The **strategic use of questioning** is both the **primary method of communication** as well as the **key intervention tool** in SFBT. Solution-focused therapists infrequently make interpretations, and very rarely directly challenge or confront a client.

> Specific questioning is thought to allow the therapist to assist the client with developing a vision of their preferred future by drawing on their past successes, strengths, and resources to make the vision a reality. Questions are almost always focused on the present or the future, as it is believed that there is minimal value in dwelling on the referral problem or past issues (de Shazer et al., 2007).

The five type of questions in SFBT include **coping questions**, **exception questions**, **miracle questions**, **scaling questions**, and **relationship questions**. SFBT also has two specific techniques to support therapeutic sessions **"compliments and feedback"** and **"assignments outside of therapy."**

Coping questions are questions at the beginning of therapy sessions or early in the first sessions. It may include inquiries regarding how the client has managed to find solutions. These questions may provide the therapist with information about previously used coping strategies.

For example, individuals with disabilities may avoid social interaction due to their perception of negative attitudes from the society. Coping questions in the early sessions may help clients see that their coping strategies are not appropriate and will not work forever.

This type of questioning will not only elicit information about coping strategies that may be working for a client, but it may also provide information about strategies that can continue to be utilized in the future.

Exception questions help clients identify times when things were different for them. An exception is described by de Shazer (1988) as whatever was happening when the problem was not occurring or when the problem occurred to a lesser degree.

For example, people with disabilities may have internalized anger due to the nature of psychosocial adjustment. Therapist can ask clients about times when they were not angry with themselves. With answers, clients may be more aware of their reactions to themselves and their disabilities.

Although exceptions may seem similar to the idea of past strategies that have worked, they are marked by one key difference: Exceptions are the "something" that happened instead of the problem with or without the individual's intention.

Miracle questions are another commonly used technique that is presented during early therapy sessions. Miracle questions assist a client with articulating a better future in which their problems no longer exist.

When asking the miracle question, the therapist describes a "miracle-scenario" followed by a question that assists clients with identifying what types of changes might be necessary for their problems to end. The miracle question also provokes the client to notice different events in the world when the problem disappears.

Berg and Dolan (2001, p.7) provide the following example of a miracle scenario:
"I am going to ask you a rather strange question [pause]. The strange question is this: [pause] After we talk, you will go back to your work (home, school), and you will do whatever you need to do the rest of today, such as taking care of the children, cooking dinner, watching TV, giving the children a bath, and so on. It will become time to go to bed. Everybody in your household is quiet, and you are sleeping in peace. In the middle of the night, a miracle happens and the problem that prompted you to talk to me today is solved!

But because this happens while you are sleeping, you have no way of knowing that there was an overnight miracle that solved the problem. [pause] So, when you wake up tomorrow morning, what might be the small change that will make you say to yourself, 'Wow, something must have happened—the problem is gone!'"

Clients may provide a number of responses to this question. Given time to ponder this question, clients will often be able to identify examples of how their lives might be different if their problems were no longer present. There are times when clients hesitate in answering the miracle question by stating that they do not believe in miracles. If this scenario occurs, the therapist can rephrase the questioning and avoid the term "miracle" to gain a sense of the desired outcome.

Scaling questions involve rating scale questions pertinent to a client's goals that may assist with measuring progress, identifying exceptions, exploring the next steps, or assessing self-determination.

For example, therapists may ask clients to consider their emotional distress on a scale (usually from 1 to 10, with one being the worst desirable situation and 10 being the most desirable). If a client says 5, the therapist may ask what 5 means to client as well as what 4 and 6 mean to a client to increase the client's awareness.

If the client feels that they have made progress in a positive direction, this may facilitate discussion regarding exceptions and how those exceptions occurred. In addition, this may stimulate discussion regarding what the client needs to do in order to continue to move in a positive direction on the scale.

Relationship questions elicit information from the client about the importance of the perceptions of meaningful others, and whether these viewpoints influence if and how the client can succeed in solving the problem. Relationship questions presuppose that other people will notice something different about the client once problems have been solved.

For example, therapists may ask clients how others (who are close to the client) notice the client's problem. With that, both the therapists and clients gain more insight into relationships clients have and how those relationships influence the disability and chronic illness.

This type of questioning may provide further information about what kinds of things a client expects will be different once their problems are gone.

Compliments and feedback are moments therapists take a short break at the end of each session to provide compliments and feedback. Compliments may validate the tasks the client does well, highlight what works, and promote the continuation of these useful behaviors and strategies.

This technique also allows the therapist to acknowledge how difficult the client's struggles are and in turn, sends the message that the therapist is attentive and cares.

De Shazer (1988) suggests that compliments and other feedback may "normalize" the client's experience by underscoring that many problems are common and understandable. In addition, this type of feedback may help to restructure the meaning of the problem by demonstrating that an individual is making progress in spite of ongoing struggles.

Assignments outside of therapy include homework, outside of the therapy, for clients. Trepper et al. (2012, p. 5) suggest that therapists "gently nudge clients to do more of what has previously worked or to try changes they have brought up that they would like to try."

For example, if the client reports that their physical stamina at work is improving based on spending time at the gym exercising, a therapist might suggest continuing this behavior.

Sometimes, the client may even make suggestions for experimental activities. Whether it is the therapist suggesting the experiments or the client, both follow the basic philosophy that "what emanates from the client is better than if it were to come from the therapist" (Trepper et al., 2012, p. 12). **Table 1** summarizes question types and provides examples.

Table 1: Types of Questions and Examples

Techniques	Description of Techniques	Example
Coping questions	Coping questions elicit information about coping strategies that may be working for a client, and it may provide information about strategies that can be utilized in the future.	An example of a coping question is "How have you managed to keep your problems from getting worse?"
Exception questions	Questions that assist clients with identifying exceptions – when problems are not present – may help to determine reasons why the problem was not interfering with their day-to-day activities.	An example of an exception question is "In what situation do you feel better already?"
Miracle questions	Miracle questions help a client with envisioning a better future in which their problems no longer exist.	An example of a miracle question is "Imagine that the problems that bring you here have disappeared by tomorrow. What would tomorrow be like?"
Scaling questions	Scaling questions may assist a client with measuring progress, identifying exceptions, exploring the next steps, or assessing self-determination.	An example of a scaling question is "On a scale of 1 to 10, with 1 meaning that the problem is the worst it's ever been, and 10 meaning that the

		problem is solved, where do you feel that you are today?"
Relationship questions	Relationship questions inquire if the perceptions of significant others are meaningful, and whether these viewpoints influence the client's success in solving the problem.	An example of a relationship question is "What will your coworkers notice that is different about you once you solve this problem?"

Note: More explanation on question types is provided in the text

When?

Research has demonstrated SFBT is at least equal in effectiveness to traditional counseling approaches, however, it has been suggested SFBT may be more practical due to its significant effect in a limited time frame.

SFBT has been proven effective for a wide variety of mental health issues including substance abuse, post-traumatic stress disorder, personality disorders, and depression (Berg & Dolan, 2001).

SFBT is appropriate for eclectic and integrated approaches to counseling as it works well in combination with other approaches, such as motivational interviewing (Lewis & Osborn, 2004).

In vocational rehabilitation practice, rehabilitation practitioners are likely to have large caseloads. By using SFBT, rehabilitation practitioners can provide quality services in an environment where time management is essential. There is external pressure for rehabilitation professionals to provide cost-effective, empirically supported treatments due to the changing fiscal environment with state and federal budget cuts and the implementation of systems of managed care.
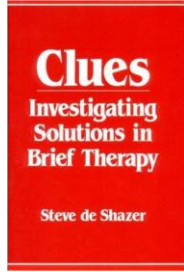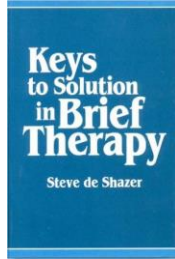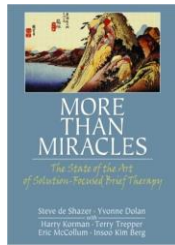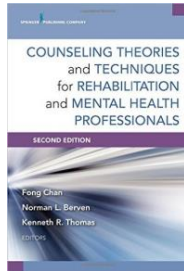
SFBT has not yet been applied to various disability populations, however, it has been proven to be effective in addressing mental health issues such as depression, anxiety, and substance abuse, in addition to aiding women with disabilities who are affected by domestic violence.

Considering these factors, solution-focused brief therapy provides a resolution to the concerns of key stakeholders in the rehabilitation field. For persons with disabilities who seek services for various vocational and psychosocial issues, the person-centered, goal-oriented, and strengths-based approach of SFBT has the potential to maximize rehabilitation outcomes while simultaneously promoting client autonomy.

Appendix A: Helpful Websites

Web Sites	Description	URL
Academic Search Elite	A multi-disciplinary database that covers virtually every area of academic study	www.ebscohost.com/academic/academic-search-elite
CINAHL Plus with Full Text	The world's most comprehensive source of full text for nursing & allied health journals	health.ebsco.com/products/cinahl-plus-with-full-text www.cochrane.org/
MEDLINE	The most authoritative medical information database	www.nlm.nih.gov/bsd/pmresources.html
PsycINFO	The most comprehensive database for psychological research	www.apa.org/pubs/databases/psycinfo/index.aspx
Institute for Solution-Focused Therapy	It provides resources about SFBT	www.solutionfocused.net/what-is-solution-focused-therapy/
Solution-Focused Therapy Association	It provides resources about SFBT	www.sfbta.org/about_sfbt.html

Appendix B: Useful Books

Book Title	
de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York: W. W. Norton.	
De Shazer, S. (1985). *Keys to solution in brief therapy*. Ww Norton.	
de Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I. K. (2007). *More than miracles: The state of the art of solution-focused brief therapy* (1st ed.). London, England: Routledge.	
Chan, F., & Thomas, K. R. (Eds.). (2015). *Counseling Theories and Techniques for Rehabilitation and Mental Health Professionals*. Springer Publishing Company.	

References

Bakker, J. M., & Bannink, F. P. (2008). Oplossingsgerichte therapie in de psychiatrische praktijk [Solution focused brief therapy in psychiatric practice]. *Tijdschrift voor Psychiatrie, 50*(1), 55–59.

Bannink, F. P. (2007). Solution-focused brief therapy. *Journal of Contemporary Psychotherapy*, *37*, 87-94.

Bavelas, J. B., McGee, D., Philips, B., & Routledge, R. (2000). Microanalysis of communication on psychotherapy. *Human Systems: The Journal of Systemic Consultation & Management, 11*, 47-66.

Berg, I. K., & Dolan, Y. (2001). *Tales of solutions: A collection of hope-inspiring stories*. New York: Norton.

Berg, I. K., & Miller, S. D. (1992). *Working with the problem drinker: A solution focused approach.* New York: Norton.

Berg, I. K., & Steiner, T. (2003). *Children's solution work.* New York, NY: Norton.

Biggs, H. C., & Flett, R. A. (2005). *Rehabilitation professionals and solution-focused brief therapy*. Australian counselling and supervision conference.

Burwell, R., & Chen, C. (2006). Applying the principles and techniques of solution-focused therapy to career counselling. *Counselling Psychology Quarterly*, *19*, 189-203.

Brenes, G. A., Guralnik, J. M., Williamson, J. D., Fried, L. P., Simpson, C., Simonsick, E. M., & Penninx, B. W. (2005). The influence of anxiety on the progression of disability. *Journal of the American Geriatrics Society, 53,* 34-39.

Cardoso, E., Wolf, A. W., & West, S. L. (2009). Substance abuse: Models, assessment, and interventions. In F. Chan, E. Cardoso, & J. A. Chronister (Eds.), *Understanding psychosocial adjustment to chronic illness and disability: A handbook for evidence-based practitioners in rehabilitation* (pp. 399-434). New York, NY: Springer Publishing Company.

Chang, J. C., Martin, S. L., Moracco, K. E., Dulli, L., Scandlin, D., Loucks-Sorrel, M. B., & BouSaada, I. (2003). Helping women with disabilities and domestic violence: Strategies, limitations, and challenges of domestic violence programs and services. *Journal of Women's Health, 12*, 699-708.

Corcoran, J., & Pillai, V. (2009). A review of the research on solution-focused therapy. *British Journal of Social Work*, *39*, 234-242.

De Jong, P., & Berg, I. K. (1998). *Interviewing for solutions.* Pacific Grove California: Brooks/Cole. De Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York: W. W. Norton.

De Shazer, S., & Berg, I.K. (1997). ''What works?'' Remarks on research aspects of solution-focused brief therapy. *Journal of Family Therapy, 19,* 121-124.

De Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I. K. (2007). *More than miracles: The state of the art of solution-focused brief therapy* (1st ed.). London, England: Routledge.

Gingerich, W.J., & Eisengart, S. (2000). Solution focused brief therapy: A review of the outcome research. *Family Process, 39,* 477-498.

Henden, J. (2011). Appendix A: The evidence base for solution focused therapy. In J. Henden (Ed.), *Beating combat stress: 101 techniques for recovery* (pp. 115-124). Hoboken, NJ: Wiley.

Lewis, T. F., & Osborn, C. J. (2004). Solution-focused counseling and motivational interviewing: A consideration of confluence. *Journal of Counseling and Development, 82,* 38-48.

Ormel, J., & Von Korff, M. V. (2000). Synchrony of change in depression and disability: What next? *Archives of General Psychiatry, 57,* 381-382.

Trepper, T. S., McCollum, E. E., De Jong, P., Korman, H., Gingerich, W. J., & Franklin, C. (2012).

Solution-focused brief therapy manual. In C. Franklin, T. Trepper, W. Gingerich & E. McCollum (Eds.), *Solution-focused brief therapy: A handbook of evidence-based practice* (pp. 20-36). New York, NY: Oxford University Press, Inc.

MODULE 3: Behavioral Activation (BA)

Objectives

- To understand major concepts related to BA.
- To identify when to integrate BA into rehabilitation counseling.
- To learn how to use key counseling techniques of BA.

What is BA, and why is BA important?

Behavioral activation (BA) is a well-established, empirically validated treatment for enhancing subjective well-being and ameliorating symptoms of depression. BA interventions aim to help people feel positive thoughts and emotions, and ultimately, reengage in their lives.

Behavioral activation emphasizes there is a link between a person's mood and participation in activities. BA is grounded in the belief that: changes in behavior lead to changes in mood. People with depression, for example, may find fewer activities pleasant and engage in pleasant activities less frequently, which leads to a further depressed mood. In BA, each client is encouraged and taught how to increase the frequency and quality of pleasant activities and events in his or her life and to decrease patterns of avoidance, withdrawal and inactivity, which leads to improvements in subjective well-being.

When? (Indications/Contraindications)

Behavioral activation interventions have a simple and well-structured format, which enables anyone to use these interventions. In addition, they can be delivered in a variety of formats including group therapy or brief individual therapy. Therefore, it can be easy to combine BA with other types of therapies. Moreover, BA interventions are also appropriate for self-help applications such as computer-based interventions, which may be advantageous for people who want to receive services with minimal costs or limited contact with counselors or therapists (Mazzucchelli et al., 2010).

Behavioral activation interventions are popular in the field of positive psychology, and the effectiveness of BA for individuals with depressive disorders to reduce symptoms and promote subjective well-being has been well established through a number of controlled and uncontrolled studies. Behavioral Activation interventions have also been successfully implemented among individuals with depression and comorbid medical problems, such as cancer, HIV, obesity, co-existent anxiety problems, substance abuse disorder and schizophrenia. Therefore, BA interventions appear to have strong potential to enhance the health and well-being for people with various types of disabilities.

How? (Instructions/Handouts)

The counseling techniques used with BA are consistent with several general components: establishing a therapeutic relationship and presenting the model; developing treatment goals; conducting a functional analysis of daily events; and treatment review and relapse prevention (Jacobson, Martell, & Dimidjian, 2001).

Establishing a Therapeutic Relationship and Presenting The Model: Behavioral activation interventions emphasize the relationships among mood, activity, and environment. Clients should be encouraged to stay optimistic, try the activities first regardless of their mood or energy level, and then pay attention to how they feel after engaging in a certain activity that they found positive. The role of the BA therapist is to work collaboratively with clients as "collaborators" or "consultants".

Developing Treatment Goals: Once the BA treatment model has been presented to the client, the BA therapist and the client work together to identify secondary problem behaviors and life

circumstances that may have caused or maintained the depression in order to set short- and long-term goals. The goal should be the action itself, focused, specific and operational, such as when and where they will engage in specific activities.

Conducting a Functional Analysis of Daily Events: Behavioral activation treatment plans should be created based on a functional analysis and the functional analysis guides the overall course of treatment. The therapist and the client need to collaboratively analyze triggers for depression as well as responses that are caused by the triggers, which often includes avoidance patterns and routine disruption.

Treatment Review and Relapse Prevention: In the final sessions of BA, it is essential to prepare a plan for preventing relapse. Therapists and clients should review the progression of the treatment from the initial presenting problems in order to develop a relapse prevention plan. In addition, each client needs to acquire functional analysis skills to prevent relapse.

Here are the key points of the BA counseling techniques.

Counseling Techniques	Key Points
Establishing A Therapeutic Relationship and Presenting The Model	• Counselors should be "collaborators" or "consultants" to clients. • Behavioral activation interventions focus on the relationships among mood, activity, and environment. • Engaging in activities regardless of mood or energy level is important. Directed activation can improve depressed mood, help clients change the problems in their lives, and protect them from depression in the future.
Developing Treatment Goals	• The goals should be the action itself, rather than the outcome of the action. • The goals need to be focused, specific, and operational. • Judgments should be suspended until clients find changes in their mood.
Conducting A Functional Analysis of Daily Events	• The therapists and clients need to collaboratively analyze contextual triggers for the depression and responses that are caused by the triggers.

	• The adequacy of the functional analysis should also be analyzed.
Treatment Review and Relapse Prevention	• Each client needs to acquire functional analysis skills to recognize environmental triggers and the responses to prevent relapse.

(Jacobson, Martell, & Dimidjian, 2001)

Appendix A: Useful Articles

Articles	Description
Dimidjian, S., Barrera Jr, M., Martell, C., Muñoz, R. F., & Lewinsohn, P. M. (2011). The origins and current status of behavioral activation treatments for depression. *Annual Review of Clinical Psychology*, *7*, 1-38.	This article summarizes the origins of a behavioral model of depression. It also highlights how BA has evolved as well as examines its emerging application to a broad range of populations and problems.
Jacobson, N. S., Martell, C. R., & Dimidjian, S. (2001). Behavioral activation treatment for depression: Returning to contextual roots. *Clinical Psychology: Science and Practice*, *8*(3), 255-270.	This article provides a brief overview of BA intervention techniques and the history of its development.
Mazzucchelli, T. G., Kane, R. T., & Rees, C. S. (2010). Behavioral activation interventions for well-being: A meta-analysis. *The journal of positive psychology*, *5*(2), 105-121.	This study reports on a meta-analysis of randomized controlled studies to examine the effect of BA on well-being and reveals its effectiveness for promoting the well-being of a range of populations in both clinical and non-clinical settings.

References

Dimidjian, S., Barrera Jr, M., Martell, C., Muñoz, R. F., & Lewinsohn, P. M. (2011). The origins and current status of behavioral activation treatments for depression. *Annual Review of Clinical Psychology*, *7*, 1-38.

Jacobson, N. S., Martell, C. R., & Dimidjian, S. (2001). Behavioral activation treatment for depression: Returning to contextual roots. *Clinical Psychology: Science and Practice*, *8*(3), 255-270.

Mazzucchelli, T. G., Kane, R. T., & Rees, C. S. (2010). Behavioral activation interventions for well-being: A meta-analysis. *The journal of positive psychology*, *5*(2), 105-121.

MODULE 4: Psychological Capital (PsyCap)

Objectives

- To understand PsyCap and key terms related to PsyCap.
- To learn about effective tools and strategies for increasing PsyCap.
- To learn when to integrate PsyCap interventions into rehabilitation practice, especially vocational rehabilitation.

What is Positive Psychological Capital (PsyCap)?

PsyCap is a psychological state that positively impacts attitudes, behaviors, and performance of employees involved in organizations. PsyCap has been extensively studied in organizational behavior, and it brings the positive psychology field to the workplace. PsyCap is made up of four dimensions:

1. *Hope* – defined as persevering toward goals, and when necessary, redirecting paths to goals in order to succeed

2. *Optimism* – described as having a positive mindset about succeeding now and in the future

3. *Efficacy* – described as having the confidence to take on and put in effort to succeed at difficult tasks; and

4. *Resilience* – defined as the ability to push forward or bounce back from difficult obstacles

An employee is at his or her best when the four aforementioned psychological resources are targeted in PsyCap interventions. In other words, the impact of the whole PsyCap is greater than the effects of its individual parts (hope, optimism, efficacy, and resilience). The following sections of this module provide a general overview of major concepts related to PsyCap, including its strategies, effectiveness, and rehabilitation applications.

How?

An individual's PsyCap can be tapped into through specific training strategies within a <u>small group setting</u>. The group sessions can last from <u>one to three hours,</u> depending on the number of group members. The strategies used with each of the four resources of PsyCap are further described as follows.

Strategies

Hope

The development of hope is one of the most important steps of PsyCap training – Hope merges together all the PsyCap resources. The primary emphasis in this stage of training is on goal design, pathway generation, and overcoming obstacles.

Goal Design: <u>Hope development</u> begins with goal design. Goal design is when individuals <u>identify goals</u> that are personally important, reasonably challenging, and in line with the following characteristics:
- Having a specific beginning and end point to measure success
- Having an approach mindset rather than avoidance allowing individuals to positively move toward goal accomplishment
- Breaking down goals into sub-goals to experience smaller successes

These characteristics can help create ongoing motivation for employees to achieve the goals they designed. Once the goals are made, employees are encouraged to brainstorm and determine as many "pathways" to the goals as possible.

Pathway Generation: Pathways are the different options to <u>achieve a goal</u>. Once pathways are created an individual employee should share their pathways with the small group. *Sharing pathways* with group members will help the individual think of new pathways and how to make changes to their current pathways.

The pathways that seem unreasonable to the individual will then be thrown out, and the individual will then focus on the <u>reasonable pathways</u>. Reasonable pathways are options that will realistically help an individual achieve a goal. Looking at the reasonable pathways, the individual will then think about any difficult obstacles that could get in the way of that option.

Overcoming Obstacles: There are many benefits when it comes to thinking in advance about overcoming obstacle, such as:

- it helps individuals think in advance about their goals
- it helps individuals think about how to plan for potential problems
- it helps individuals to think from different perspectives.

Once an individual thinks about the difficult obstacles for their reasonable pathway they then will share with the group again. They will share their thoughts and feelings about how they would overcome potential difficult obstacles. They will also learn alternative perspectives from group members to <u>avoid the chance</u> that they <u>do not</u> go with the option they have been planning for during this time. This process is known as "pathway blockage". Pathway blockage is when individuals, even though they have planned to go with a certain option, choose to go with a different option.

Optimism

The **development of hope** has **a positive impact on improving feelings of optimism**. During the process of hope development, individuals have started to think and plan in advance for difficult obstacles. Therefore, individuals will be more likely to minimize these difficult obstacles, meaning not view them as something that is hard. This creates feelings of optimism.

When individuals feel more confident in identifying and planning to avoid pathway blockage and overcome potentially difficult obstacles, the expectation to complete a goal increases. When expectations to complete a goal increase, optimism also goes up.

Example: Some consumers are unable to manage independent transportation and are often unable to obtain a driver's license. Therefore, transportation to and from work could pose major challenges in getting and keeping employment. However, during their process of hope development, consumers are able to anticipate, plan for, and overcome the transportation issue. After this process, they would feel more confident in facing the difficult obstacle, and therefore, become more optimistic for future transportation situations.

Efficacy

There are four sources of efficacy:
1. Task mastery
2. Vicarious learning or modeling
3. Emotional arousal
4. Social persuasion

When these four sources are combined they make up efficacy. Efficacy is the belief that one can accomplish a certain goal or task.

With the process of **building efficacy**, group facilitators or rehabilitation counselors and other group members serve as role models. Group members share how they move toward their goals. They also hear success stories from each other on how they achieved each sub-goal. In other words, small successful experiences are modeled by group members for each other (i.e., vicarious learning). Building from this solid foundation, anxiety or uncertainty about achieving goals (i.e., emotional arousal) will be decreased through positive expectations of goal accomplishment. Support from group facilitators and other group members (i.e., social persuasion) will also decrease emotional arousal.

Resilience

Encouraging individuals to maintain or improve task performance after experiencing a setback is the major focus of developing resilience. Three components are involved in this phase

- identifying resources,
- determining and avoiding potential difficult obstacles
- looking from a different perspective.

1. ***Identifying Resources:*** individuals are asked to <u>identify resources</u> that they can use to <u>achieve a goal</u>. After identifying a list of resources, the facilitator and group members identify additional resources that the individual did not list as resources at the beginning. Individuals are then encouraged to use these resources when necessary.

2. ***Determining and Avoiding Potential Difficult Obstacles:*** individuals are asked to <u>identify and avoid potential difficult obstacles</u> that might slow down their progress toward goals. The reason why individuals are asked to avoid difficult obstacles is because it stops the individual from experiencing worries about potential difficult obstacles (Luthans et al., 2006).

3. ***Looking from a Different Perspective:*** individuals might still experience <u>setbacks</u> while working toward goals. Therefore, this step focuses on looking from a different positive perspective. Individuals are asked to <u>identify recent personal setbacks</u>, and they are then instructed to write down their immediate reactions to that setback. Next, the <u>facilitator</u> gives more detail about examples of this view of reality and helps the person look at the process from a different positive perspective. This different perspective gives the individual an example of how to think, act, and emotionally respond in a resilient way. This reframing, or looking from another perspective, helps the individual understand an ideal process of resilience when a setback occurs.

Review of All Psychological Capital Interventions

Psychological resources	Primary focus of the psychological resource
Hope	- Goal design and pathway generation - Implementing obstacle planning
Optimism	- Building efficacy and confidence

	• Developing positive expectancy
Efficacy	• Experiencing success and modeling others • Persuasion and arousal
Resilience	• Building strengths and avoiding risks • How to affect the influence process

Source: Adapted from Luthans et al., (2010).

When?

The effectiveness of PsyCap has been shown in research studies that summarize the results of many different research studies, called meta-analyses (Avey, Reichard, Luthans, & Mhatre, 2011). These meta-analyses have been seen in the organizational behavior and psychology fields. Some of the major findings are explained below.

- For populations experiencing unemployment, research shows individuals who have higher levels of PsyCap are more likely to actively job search (Chen & Lim, 2012).
- For populations who are employed, research shows individuals who have higher levels of PsyCap are more likely to have higher levels of organizational commitment, work engagement, job performance, satisfaction, and psychological well-being (Siu, Cheung, & Lui, 2015).
- Individuals who have higher levels of PsyCap have also been found to have lower levels of turnover intentions, job stress, and anxiety (Avey et al., 2011).

Rehabilitation Applications

Although the four resources (i.e. hope, optimism, efficacy, resilience) of PsyCap have been studied as individual factors in rehabilitation settings (e.g., Smedema, Pfaller, Moser, Tu, & Chan, 2013; Tansey et al., 2015), a structured PsyCap training targeting all four of the resources has not yet been applied to disability populations in traditional rehabilitation settings, including vocational rehabilitation programs. Given its effectiveness in work and other organization settings, PsyCap training may be useful to consumers in rehabilitation settings as well as to rehabilitation counselors and other staff members.

Appendix A: Helpful Websites

Web Sites	Description	URL
Academic Search Elite	A multi-disciplinary database that covers virtually every area of academic study	https://www.ebscohost.com/academic/academic-search-elite
CINAHL Plus with Full Text	The world's most comprehensive source of full text for nursing & allied health journals	https://health.ebsco.com/products/cinahl-plus-with-full-text http://www.cochrane.org/
MEDLINE	The most authoritative medical information database	https://www.nlm.nih.gov/bsd/pmresources.html
PsycINFO	The most comprehensive database for psychological research	http://www.apa.org/pubs/databases/psycinfo/index.aspx

Appendix B: Useful Books

Book Title	
Luthans, F., Youssef, C. M., & Avolio, B. J. (2007). *Psychological capital: Developing the human competitive edge*. Oxford University Press.	
Luthans, F., Youssef-Morgan, C. M., & Avolio, B. J. (2015). *Psychological capital and beyond*. Oxford University Press.	

References

Avey, J. B., Reichard, R. J., Luthans, F., & Mhatre, K. H. (2011). Meta-analysis of the impact of positive psychological capital on employee attitudes, behaviors, and performance. *Human Resource Development Quarterly, 22*, 127-152.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*, 191-215.

Bandura, A. (2008). An agentic perspective on positive psychology. In S. J. Lopez (Ed.), *Positive psychology: Exploring the best in people* (Vol. 1, pp. 167-196). Westport, CT: Greenwood Publishing.

Blake, J., Brooks, J., Greenbaum, H., & Chan, F. (in press). Attachment and employment outcomes for people with spinal cord injury: The intermediary role of hope. *Rehabilitation Counseling Bulletin*.

Bond, G. R., & Drake, R. E. (2008). Predictors of competitive employment among patients with schizophrenia. *Current Opinion in Psychiatry, 21*, 362-369.

Chan, F., Cardoso, E., & Chronister, J. A. (2009) *Understanding psychosocial adjustment to chronic illness and disability: A handbook for evidence-based practitioners in rehabilitation*. New York, NY: Springer.

Chen, D. J., & Lim, V. K. (2012). Strength in adversity: The influence of psychological capital on job search. *Journal of Organizational Behavior, 33*, 811-839.

Karatepe, O. M., & Karadas, G. (2015). Do psychological capital and work engagement foster frontline employees' satisfaction? A study in the hotel industry. I*nternational Journal of Contemporary Hospitality Management, 27*, 1254-1278.

Luthans, F., Avey, J. B., Avolio, B. J., Norman, S. M., & Combs, G. M. (2006). Psychological capital development: Toward a micro-intervention. *Journal of Organizational Behavior, 27*, 387-393.

Luthans, F., Avey, J. B., Avolio, B. J., & Peterson, S. J. (2010). The development and resulting performance impact of positive psychological capital. *Human Resource Development Quarterly, 21*, 41-67.

Luthans, F., Avolio, B. J., Norman, S. M., & Avey, J. B. (2006). Psychological capital: Measurement and relationship with performance and satisfaction. *Gallup Leadership Institute Working Paper*. Lincoln, NE: University of Nebraska.

Luthans, F., Avolio, B. J., Walumbwa, F., & Li, W. (2005). The psychological capital of Chinese workers: Exploring the relationship with performance. *Management and Organization Review, 1*, 247-269.

Martin, A. J. (2005). The role of positive psychology in enhancing satisfaction, motivation, and productivity in the workplace. *Journal of Organizational Behavior Management, 24*, 113-133.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56*, 227-239.

Peleg, G., Barak, O., Harel, Y., Rochberg, J., & Hoofien, D. (2009). Hope, dispositional optimism and severity of depression following traumatic brain injury. *Brain Injury, 23*, 800-808.

Rubin, S. E., & Roessler, R. T. (2001). *Foundations of the vocational rehabilitation process*.
Austin, TX: Pro-Ed.Siu, O. L., Cheung, F., & Lui, S. (2014). Linking positive emotions to work well-being and turnover intention among Hong Kong police officers: The role of psychological capital. *Journal of Happiness Studies, 16*, 367-380.

Smedema, S. M., Pfaller, J., Moser, E., Tu, W. M., & Chan, F. (2013). Measurement structure of the Trait Hope Scale in Persons with spinal cord injury: A confirmatory factor analysis. *Rehabilitation Research, Policy, and Education, 27*, 206-212.

Strauser, D. R., & Berven, N. (2006). Construction and field-testing of the Job Seeking Self-Efficacy Scale. *Rehabilitation Counseling Bulletin, 49*, 207-218.

Tansey, T. N., Kaya, C., Moser, E., Eagle, D., Dutta, A., & Chan, F. (2015). Psychometric validation of the Brief Resilience Scale in a sample of vocational rehabilitation consumers. *Rehabilitation Counseling Bulletin*, doi: 10.1177/0034355215573539.

MODULE 5: Positive Psychotherapy (PPT)

Objectives

- To learn about the principles of Positive Psychotherapy
- To understand key Positive Psychotherapy Techniques
- To learn how to integrate Positive Psychotherapy into rehabilitation settings

What is PPT, and why is PPT important?

PPT is an umbrella term that refers to counseling interventions designed to increase positive emotions, engagement, and life meaning. In contrast to traditional counseling interventions, PPT focuses on improving happiness and well-being. Research has found that positive emotions and positive character strengths lead to increased happiness and improved rehabilitation outcomes.

This module will outline the basics of PPT, discuss specific techniques, and explore how rehabilitation professionals can use PPT to increase happiness, improve well-being, and lead to better rehabilitation outcomes.

How?

PPT tools can be used both as standalone self-help interventions or in conjunction with mental health or rehabilitation treatment. PPT techniques are universally applicable across disability types, easily implemented, and proven to be effective.

Developing a basis for Change

Research has found that the presence of positive emotions increases happiness and alleviates mental health symptoms. Specifically, there is benefit from the sustained effect on well-being that comes from feelings of self-fulfillment, purpose, and life meaning.

How can one feel greater fulfillment, purpose, and meaning? Evidence shows that these can be attained through activities such as using one's character strengths or participating in volunteer activities. Accordingly, positive psychotherapy interventions were designed to help increase these key emotions to have the greatest benefit to overall well-being.

> Emerging evidence supports that happiness not only engenders well-being, but is causally related to success. Happy people feel better, are more productive, and obtain greater success. Accordingly, increasing happiness is advantageous to help people achieve their goals.

Popular examples of these techniques will be presented in the proceeding section.

Counseling Techniques

All techniques are designed to help an individual attend to positive aspects of life and to break the pattern of attending to the negative.

Three good things. The human mind has a tendency to focus on negative events rather than the positive. As a result, positive experiences are overshadowed or ignored. In order to help break this pattern, "three good things" requires individuals to record positive events each day. Participants are asked to reflect on the reasons why the positive events occurred.

> Ask clients to record three positive events from the day for a week. Be sure to include a reflection on the cause of those positive events.

Over time, individuals can retrain their thoughts to focus more on the positive events rather than the negative, a change that has been shown to improve happiness.

Using your strengths. A key to happiness is to help individuals maximize their potential and to utilize their strengths. By completing a strengths assessment (i.e., authentichappiness.org), people can more easily identify their own strengths.

After completing the assessment, individuals are asked to use one of their character strengths each day for seven days.

> Ask clients to complete a strengths inventory at authentichappiness.org and use one of their character strengths each day for seven days.

By using character strengths, individuals are more likely to achieve a state of flow – described as an optimal balance of productivity and focus. A state of flow is more commonly referred to as "being in the zone," where an individual is immersed in an activity and is able to give all attention to the task at hand. These experiences can help individuals to maximize their potential and bolster components of happiness.

Gratitude visit. The expression of gratitude is found to improve happiness. As a result, helping individuals express their gratitude for others can increase positive emotions. The "gratitude visit" requires individuals to identify someone for whom they have not had a chance to express gratitude or appreciation and then asks them to compose a letter expressing their appreciation. After composing the letter, it can either be delivered to the recipient or can be read aloud to the individual.

> Ask a client to compose a letter expressing gratitude to an individual in their life. Then the individual can choose to share that letter with the target of their gratitude.

One study found that the gratitude visit increased feelings of happiness for a month.

Active-constructive responding. How people respond to someone's good news has important implications for the development of close or intimate relationships. Responses have been categorized on two dimensions, including constructive-destructive and active-passive. Individuals who tend to respond to good news with an active-constructive voice have stronger

relationships and feelings of closeness. Active-constructive responses refer to responding to a shared experience or good news with enthusiasm and positivity (e.g., "so happy to hear about your promotion, how did it feel!?") In this activity, participants are taught about the different types of responses and practice using active-constructive responses.

Active-constructive responses refers to responding to a shared experience or good news with enthusiasm and positivity (e.g., "so happy to hear about your promotion, how did it feel!?")

Savoring. Savoring is described as a form of mindfulness in which people attend to the present moment. Specifically, individuals attend fully to positive experiences as they occur, thereby amplifying the positive effects from the positive experience. In this activity, individuals are asked to focus on one positive experience every day, paying particular attention to the emotional state in that moment.

Ask a client to focus on one positive experience each day as it happens.

One study found that savoring decreased symptoms of depression.

Life summary. Life summary poses the question: How do you want your life to be remembered? Individuals are then asked to write an essay describing how they would like their life to be remembered. Afterword, individuals are asked to assess how well they are using their time and energy to meet those goals. This activity can help individuals reevaluate their priorities and better identify their goals.

Ask clients to compose an essay about how they would like their life to be remembered. Then discuss whether they are living in a way to meet their goal.

Table 1: Positive Psychotherapy Techniques

Techniques	Description of Techniques	Example
Three good things	To retrain the mind to attend to positive events rather than negative events.	Record three positive events daily for seven days.
Using your strengths	The use of character strengths can help individuals maximize their potential and more frequently achieve a state of flow.	Use one character strength each day for seven days.
Gratitude visit	Individuals who show more gratitude are found to be happier.	Write a letter expressing gratitude to someone – then read it aloud to them.
Active-constructive responding	Responding in an active-constructive way helps to form bonds and increases feelings of closeness.	Learn to respond to good news with enthusiastic and supportive statements.
Savoring	Mindfulness has both physical and psychological benefit and is shown to increase happiness.	Actively attend to one positive activity each day.
Life summary	Helps individuals to prioritize goals and values.	Write an essay about the things for which you would like to be remembered – then evaluate how you are meeting those goals.

Note: More explanation on question types is provided in the text

When?

A growing body of research supports the notion that happiness should not be a tertiary goal of rehabilitation, but rather is integral to overall well-being and life success. Positive psychotherapy techniques have been developed to help aid in the pursuit of increased happiness, and these techniques are found to be highly effective. Two recent meta-analytic studies found that positive psychotherapy interventions lead to improved well-being and reduced symptoms of depression. Such evidence supports the integration of positive psychotherapy into rehabilitation settings.
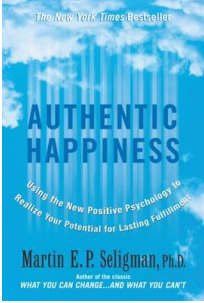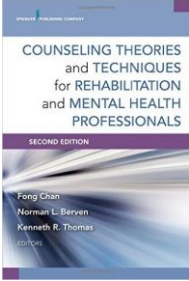
Rehabilitation Applications

Evidence strongly supports that individuals who are happier have better rehabilitation outcomes. Moreover, helping individuals with disabilities increase their happiness is consistent with rehabilitation philosophy by emphasizing strengths and assets over limitations. The efficacy of positive psychotherapy interventions across a variety of populations in diverse settings supports their wider implementation in rehabilitation settings.

Additionally, many positive psychotherapy techniques are straightforward and easy to administer, with many techniques implemented in the form of homework. The brevity of these techniques mean that they can be easily integrated into other rehabilitation interventions. By using positive psychotherapy techniques individuals can increase their happiness and learn to focus less on the negative events in life and thereby increase their likelihood of success.

Appendix A: Helpful Websites

Web Sites	Description	URL
Academic Search Elite	A multi-disciplinary database that covers virtually every area of academic study	https://www.ebscohost.com/academic/academic-search-elite
CINAHL Plus with Full Text	The world's most comprehensive source of full text for nursing & allied health journals	https://health.ebsco.com/products/cinahl-plus-with-full-text
MEDLINE	The most authoritative medical information database	https://www.nlm.nih.gov/bsd/pmresources.html
PsycINFO	The most comprehensive database for psychological research	http://www.apa.org/pubs/databases/psycinfo/index.aspx
Authentic Happiness	Character strength assessment	authentichappiness.org
Positive Psychology Center	Resources and research on positive psychology	Positivepsychology.org

Appendix B: Useful Books

Book Title	
Seligman, M.E.P. (2002). Authentic happiness: Using the new positive psychology to realize your potential for lasting fulfillment. New York: The free press.	
Chan, F., & Thomas, K. R. (Eds.). (2015). Counseling Theories and Techniques for Rehabilitation and Mental Health Professionals. Springer Publishing Company.	

References

Bishop, M. (2005). Quality of Life and Psychosocial Adaptation to Chronic Illness and Disability Preliminary Analysis of a Conceptual and Theoretical Synthesis. *Rehabilitation Counseling Bulletin, 48(*4), 219–231.

Bishop, M., Chapin, M. H., & Miller, S. (2008). Quality of life assessment in the measurement of rehabilitation outcome. *Journal of Rehabilitation, 74*(2), 45–55.

Bolier, L., Haverman, M., Westerhof, G. J., Riper, H., Smit, F., & Bohlmeijer, E. (2013). Positive psychology interventions: a meta-analysis of randomized controlled studies. *BMC Public Health, 13*(1), 1.

Csikszentmihalyi, M. (1996). Flow and the psychology of discovery and invention. New York: Harper Collins.

Emmons, R. A., & McCullough, M. E. (2003). Counting blessings versus burdens: an experimental investigation of gratitude and subjective wellbeing in daily life. *Journal of Personality and Social Psychology, 84*(2), 377.

Gable, S. L., Gonzaga, G. C., & Strachman, A. (2006). Will you be there for me when things go right? Supportive responses to positive event disclosures. *Journal of Personality and Social Psychology, 91*(5), 904.

Gable, S. L., Reis, H. T., Impett, E. A., & Asher, E. R. (2004). What do you do when things go right? The intrapersonal and interpersonal benefits of sharing positive events. *Journal of Personality and Social Psychology, 87*(2), 228.

Lyubomirsky, S., King, L., & Diener, E. (2005). The benefits of frequent positive affect: does happiness lead to success? *Psychological Bulletin, 131*(6), 803.

Seligman, M. E. (2002). Positive psychology, positive prevention, and positive therapy. Handbook of positive psychology, 2, 3-12.

Seligman, M. E., & Csikszentmihalyi, M. (2000). Positive psychology: an introduction. *American Psychologist, 55*(1), 5.

Seligman, M. E. P., Park, N., & Peterson, C. (2004). The Values In Action (VIA) classification of character strengths. *Ricerche di Psicologia, 27*(1), 63-78.

Seligman, M. E., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist, 61*(8), 774.

Seligman, M. E., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: empirical validation of interventions. *American Psychologist, 60*(5), 410.

Sheldon, K. M., & King, L. (2001). Why positive psychology is necessary. *American Psychologist, 56*(3), 216.

Woods, S., Lambert, N., Brown, P., Fincham, F., & May, R. (2015). ''I'm so excited for you!'' How an enthusiastic responding intervention enhances close relationships. *Personal Relationships, 32*(1), 24-40.

MODULE 6: Acceptance and Commitment Therapy (ACT)

Objectives

- To understand ACT and the core principles of ACT.
- To identify key processes and treatment techniques of ACT.
- To learn how to integrate ACT into rehabilitation counseling, particularly in the area of vocational rehabilitation (VR).

What is ACT, and why is it important?

Developed by Steven Hayes, ACT is an example of a new generation of cognitive behavioral therapy. It can be defined as a psychological intervention focusing on traditionally nonclinical treatment techniques such as acceptance, mindfulness, and spirituality. The ACT approach has proven to be an effective and widely used therapy when treating a variety of cases such as clients with depression, chronic pain, obsessive-compulsive disorder, severe mental illness, or acquired brain injury.

The purpose of this module is to provide a general overview of major concepts related to ACT including its basis for change, counseling techniques, effectiveness, and rehabilitation applications.

How?

Like all other psychotherapy interventions, ACT has specific techniques that practitioners should use in counseling sessions. In this section, you will find what techniques are important and necessary for ACT.

Initial Steps: Developing a basis for change

The *first step* of change for the clients is to notice, accept, and embrace the cognitive, emotional, and physiological experiences in which they are trying to avoid. The *second step* is to assist clients in clarifying their values and allow them to discover whether their behaviors are well-

matched with their values. Lastly, the *third step* is to assist clients in taking <u>actions</u> in accordance with their values.

Counseling techniques

ACT <u>is not based on</u> the <u>psychology of abnormality</u>. Instead, ACT assumes that clients, themselves, are capable of making a significant change with their maladaptive behaviors during therapy. Clients are never viewed as broken, damaged, or beyond hope, but they are viewed as people who have rich, meaningful, and <u>value-based lives</u>.

Hayes (2004) reported that "the general <u>clinical goals of ACT</u> are to undermine the grip of the literal verbal content of cognition that occasions avoidance behavior and to construct an alternative context where behavior in alignment with one's value is more likely to occur" (p. 651).

During the process of counseling, ACT's core principles are used as **techniques** to help clients develop ***psychological flexibility,*** which is defined as "the process of contacting the present moment fully as a conscious human being and persisting or changing behavior in the service of chosen values" (Hayes et al., 2006, p. 9). In the therapy session, the processes of ACT are overlapping and interrelated, and psychological flexibility is at the center of the ACT therapy process.

The **six core processes** in ACT include acceptance, cognitive defusion, contact with the present moment, self as context, values, and committed action.

Acceptance of thoughts and other private events is taught to clients as an alternative to avoiding experiences. Acceptance in ACT is not an end in itself; rather it is fostered as a method of increasing values-based action. The goal is to increase the flexibility of psychological reactions as well as behavioral responses to difficult situations and personal experiences.

For example, with the onset of a disability, clients may try to avoid facing new challenges due to adjustment issues. Acceptance can help clients let go of such struggles with problems (e.g., pain, anxiety) and <u>embrace the difficulties</u> in life, which opens the door for therapists to work with clients to become more aware of values systems.

Cognitive defusion techniques aim to change the undesirable functions of private events such as thoughts, rather than trying to change their form, frequency, or situational sensitivity. In other words, such techniques aim to create more <u>psychological flexibility</u> and modify contexts in the presence of difficult thoughts and emotions.

For example, people with depression may have undesirable feelings and thoughts (e.g., I am so alone) about their daily life. The aim of **cognitive defusion** is to create new response patterns (e.g., I am **thinking** that I am so alone) to reduce the literal quality of or attachment to undesirable thoughts.

Contact with the present moment can divert our attention away from thoughts about the past and future. Mindfulness and attentional control exercises can promote focused, voluntary, and non-judgmental contact with the present moment and with psychological and environment events as they occur. The goal is to have clients **mindfully experience** the world so that their behavior is more thoughtful and flexible, meaning their actions will be more consistent with the values that they hold.

For example, people with post-traumatic stress disorder may have difficulty with focusing on the present because of their flashbacks about trauma-related experiences, causing them to exert less control over their behavior. However, techniques such as actively describing private events can make clients more flexible by helping them to live in the present moment.

Self as context allows individuals to describe the conceptualized **self** or their **self-narrative** when they are asked about themselves. The conceptualized self can reduce psychological flexibility because attempts to be right about thoughts or experiences related to the self can lead to the rejection of contradictory content. Due to relational frames such as "**here vs. there**" and "**I vs. you**", human language leads to a sense of self as the only perspective. **Counseling, mindfulness exercises, metaphors, perspective taking, and experiential processes** can foster contact with the sense of self. Self as context is important because it increases awareness of one's own flow of experiences without attachment to them or an investment in which particular experiences occur – paving the way for other ACT processes such as acceptance and committed action.

Values are chosen qualities of purposive action that are lived out moment by moment. ACT uses a variety of exercises to help clients choose life directions while emphasizing values that may be linked to avoidance or other maladaptive patterns. **Values writing** is one of the most commonly used techniques.

For example, clients may be asked to write about what they most deeply care about and how that has touched their lives, or to write themselves a letter from a wiser future about what to hold dear in the present. In ACT, all of the previously mentioned counseling techniques such as acceptance or defusion are not end goals, instead, they help to build the foundation for a more values-driven life.

Committed action extends values to other contexts while developing larger patterns of effective action. A client may commit a very small action, but the important point is to stay open, aware, and connected to values. In the case of a client's failure to meet commitments, therapists should stay curious and nonjudgmental to remain a valuable source of information about barriers to value-based action. If clients cannot achieve abstract goals that are self-selected, counselors with the ACT orientation may help clients to develop more concrete goals.

Table 1: ACT techniques, description of techniques, and examples

Techniques	Description of Techniques	Example
Acceptance	Teaching clients alternative ways to avoid negative experiences as a method of increasing values-based action	Processing current problems and embracing difficulties in life
Cognitive defusion	Changing the undesirable functions of private events such as thoughts, rather than trying to change their form, frequency, or situational sensitivity	Creating new response patterns to negative daily life events (e.g., I am <u>thinking</u> that I am so alone)

Self as Context	People tend to describe the conceptualized self or their self-narrative when they are asked about themselves	Mindfulness exercises, metaphors, and perspective-taking experiential processes foster contact with the sense of self
Values	Chosen qualities of purposive action that can never be obtained as an object but can be expressed moment to moment	Values writing exercises such as writing about important matters or issues, or writing a letter from a wiser future about what to hold dear in the present
Committed Action	The aim is to further values in the context of openness and awareness while developing larger patterns of effective action	Starting with small steps and realistic goals selected by both client and counselor

When?

The founder of rehabilitation psychology/counseling, Beatrice Wright (1983; please click to link to see more information about Dr. Wright), developed a model of adjustment to disability based on disability acceptance. Disability acceptance involves incorporating disability as part of an individual's positive self-concept. Wright's concept of acceptance is similar to *ACT's process of acceptance and other related techniques*. Accordingly, ACT may help to supply rehabilitation practitioners with other counseling strategies for disability acceptance. For instance, rehabilitation practitioners can assist clients in noticing, accepting, and embracing the cognitive, emotional, and physiological experiences related to disability that they try to avoid. Then, rehabilitation practitioners can assist clients in clarifying their values. Lastly, the ACT approach assists clients in taking actions in accordance with their values, which may result in better disability adjustment and higher subjective well-being.
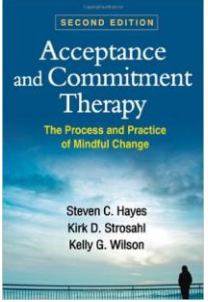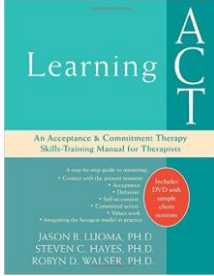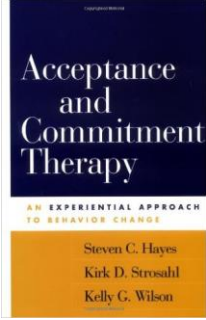
Although ACT is a relatively new treatment approach and further research is needed to fulfill the criteria of empirically supported treatments, ACT therapy has <u>useful</u>, <u>efficient</u>, <u>action-oriented</u>, and <u>straightforward</u> <u>techniques</u> that may provide rehabilitation counselors with new strategies to add to their toolkit. There are not specific studies on whether ACT is effective for state vocational rehabilitation agencies and ACT has not yet been applied to a wide variety of disability populations, however, it has been proven to be effective in assisting people with disabilities such as <u>depression</u>, <u>chronic</u> <u>pain</u>, <u>severe</u> <u>mental</u> <u>illness</u>, <u>obsessive</u> <u>compulsive</u> <u>disorder</u>, and <u>acquired</u> <u>brain</u> <u>injury</u>.

Considering these promising results, rehabilitation counselors may find that ACT is a <u>practical</u> and <u>effective</u> <u>treatment</u> in facilitating <u>behavioral</u> <u>changes</u> for a variety of clinical populations. For persons with disabilities who seek services for various vocational and psychosocial issues, ACT has the potential to enhance acceptance, commitment, and value-based action, which may lead to improved disability and rehabilitation outcomes.

Appendix A: Helpful Websites

Web Sites	Description	URL
Academic Search Elite	A multi-disciplinary database that covers virtually every area of academic study	https://www.ebscohost.com/academic/academic-search-elite
CINAHL Plus with Full Text	The world's most comprehensive source of full text for nursing & allied health journals	https://health.ebsco.com/products/cinahl-plus-with-full-text http://www.cochrane.org/
MEDLINE	The most authoritative medical information database	https://www.nlm.nih.gov/bsd/pmresources.html
PsycINFO	The most comprehensive database for psychological research	http://www.apa.org/pubs/databases/psycinfo/index.aspx
Association for Contextual Behavioral Science	It provides resources about ACT	https://contextualscience.org/act
ACT in Popular Media	It provides resources about ACT in popular media	https://contextualscience.org/act_in_popular_media
ACT in Specific Populations	It provides resources about ACT with specific populations	https://contextualscience.org/special_populations

Appendix B: Useful Books

Book Title	
Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). Acceptance and commitment therapy: The process and practice of mindful change. Guilford Press.	
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapists. New Harbinger Publications.	
Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change. Guilford Press.	

References

Bach, P., & Hayes, S. C. (2002). The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *70*, 1129-1139.

Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy*, *35*, 639-665.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, *44*, 1-25.

Hayes, S. C., Pistorello, J., & Levin, M. E. (2012). Acceptance and commitment therapy as a unified model of behavior change. *The Counseling Psychologist*, *40*, 976-1002.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change.* New York: Guilford Press.

Kangas, M., & McDonald, S. (2011). Is it time to act? The potential of acceptance and commitment therapy for psychological problems following acquired brain injury. *Neuropsychological Rehabilitation*, *21*, 250-276.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford Press.

Montgomery, K. L., Kim, J. S., & Franklin, C. (2011). Acceptance and commitment therapy for psychological and physiological illnesses: A systematic review for social workers. *Health & Social Work*, *36*, 169-181.

Öst, L. G. (2008). Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy*, *46*, 296-321.

Powers, M. B., Zum Vörde Sive Vörding, M. B., & Emmelkamp, P. M. (2009). Acceptance and commitment therapy: A meta-analytic review. *Psychotherapy and Psychosomatics*, *78*, 73-80.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. T. (2001). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse.* New York: Guilford Press.

Twohig, M. P., Hayes, S. C., Plumb, J. C., Pruitt, L. D., Collins, A. B., Hazlett-Stevens, H., & Woidneck, M. R. (2010). A randomized clinical trial of acceptance and commitment therapy versus progressive relaxation training for obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology*, *78*, 705-716.

Vowles, K. E., Witkiewitz, K., Sowden, G., & Ashworth, J. (2014). Acceptance and commitment therapy for chronic pain: Evidence of mediation and clinically significant change following an abbreviated interdisciplinary program of rehabilitation. *The Journal of Pain*, *15*(1), 101-113.

Wells, A. (2000). *Emotional disorders and metacognition: Innovative cognitive therapy.* Chichester, UK: Wiley.Wicksell, R. K., Dahl, J., Magnusson, B., & Olsson, G. L. (2005). Using acceptance and commitment therapy in the rehabilitation of an adolescent female with chronic pain: A case example. *Cognitive and Behavioral Practice*, *12*, 415-423.

Zettle, R. D., Rains, J. C., & Hayes, S. C. (2011). Processes of change in acceptance and commitment therapy and cognitive therapy for depression: A mediation reanalysis of Zettle and Rains. *Behavior Modification*, *35*, 265-283.

MODULE 7: Mindfulness-Based Interventions

Objectives

- To understand mindfulness-based strategies and related interventions
- To learn about effective tools for applying mindfulness
- To learn when to integrate mindfulness into rehabilitation practice

What is Mindfulness, and why is Mindfulness important?

Mindfulness is defined as "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally". Mindfulness-based interventions focus on the ability to pay attention intentionally through a process of meditation. Paying attention can be internal in which a person focuses on their inner thoughts, emotions, or body, or it can be external in which a person focuses on their environment in tune with sights, sounds, or smells. Regardless of the internal or external mindfulness, a non-judgmental attitude and an acceptance of observations is warranted (Kabat-Zinn, 1994, 2003)

Evidence for the effectiveness of mindfulness-based practices

Through regular practice of mindfulness, attention and awareness of the internal and external processes will develop a greater sense of control, and positively impact individuals' day-to-day behavior (Grossman, Niemann, Schmidt, & Walach, 2004).

Potential general benefits of mindfulness practices

- Improved attention and self-awareness
- Decreased ruminative thinking
- Attenuated emotional reactivity
- Enhanced self-compassion and emotional regulation
- Lower blood pressure
- Possible improved immune function
- Increased tolerance and or acceptance of pain
- Possible reduced cortisol levels
- Possible enhanced cognition

When? (Indications/Contraindications)

Fostering a mindful awareness of personal strengths, resources, and assets, as well as symptoms and ways to cope, can be an ongoing struggle for people with a range of disabilities. Therefore, a mindfulness-based intervention that can potentially be used to enhance attention and awareness could lead to a positive shift in fundamental perspectives toward health and disability (Grossman, Niemann, Schmidt, & Walach, 2004).

Brief Summary; Target illness/population of group-based Mindfulness-based interventions

Mindfulness-based intervention	Target illness/population
Mindfulness-based stress reduction (MBSR)	Various (e.g., anxiety disorders, heart disease, chronic pain, cancer, psoriasis)
Mindfulness-based cognitive therapy (MBCT)	Various (e.g., mood-disorders, anxiety disorders, bipolar disorder, chronic fatigue)
Mindfulness-based relapse prevention	Prevention of relapse following rehabilitation from substance-use disorders
Mindfulness-based eating awareness therapy	Binge-eating disorders
Mindfulness-based childbirth and parenting	Maternal well-being during and post pregnancy
Mindfulness-based art therapy	Psychological health and quality of life in cancer patients
Mindfulness and acceptance-based group therapy	Various psychopathologies (e.g., mood disorders, anxiety disorders)
Mindfulness-based stress management	Stress and anxiety
Mindfulness-based mental fitness training	Stress and trauma resilience for military personal

(Shonin, Van Gordon, & Griffiths, 2013)

Mindfulness-Based Stress Reduction (MBSR)

MBSR is one of the most popular mindfulness-based interventions and was developed by Dr. Jon Kabat-Zinn as a secular method of utilizing Buddhist mindfulness in mainstream psychology and medicine.

In addition to mindfulness meditation, MBSR includes education about stress as well as training in coping strategies and assertiveness. The mindfulness component includes sitting meditation, a body scan, and hatha yoga. The body scan is a process during which attention is moved from region to region of the entire body.

The hatha yoga practice incorporates stretches, postures, and breathing exercises aimed at relaxing and strengthening the musculoskeletal system. Finally, MBSR involves the cultivation of a number of attitudes, including becoming an unbiased witness to one's own experience, acceptance of things as they actually are in the present moment, and not censoring one's thoughts and allowing them to come and go (Marchand, 2012).

MBSR is an 8-week intensive training in mindfulness meditation, based on ancient healing practices, which meets on a weekly basis. During the 8-week session, new daily life experiences (i.e. food, work, stress) are presented to group members while applying mindfulness concepts (Cullen, 2011). Week by week, MBSR intends to make participants more aware of themselves in order to decrease stress (Kabat-Zinn, 2011).

Many studies indicate that MBSR is effective for depression as well as anxiety symptoms, including PTSD, social anxiety disorder, and generalized anxiety disorder. In addition, MBSR has been shown to decrease pain and increase pain coping and acceptance. It also improves insomnia. It may be beneficial for psychological functioning among healthy people including healthcare professionals.

Mindfulness-Based Cognitive Therapy (MBCT)

MBCT is another widely used mindfulness-based intervention and was developed by Zindel Segal, Mark Williams, and John Teasdale (2002). MBCT is based on MBSR and integrates components of cognitive behavioral therapy with those of mindfulness to prevent relapse of depression. The basic foundational principles of MBCT focus on the clients' acquisition of attention skills through mindfulness techniques, which help clients understand their negative moods or thinking.

Although it incorporates CBT concepts, MBCT does not want to change the thinking of the negative automatic thoughts, rather it promotes a non-judgmental approach to the negative thought potentially to decrease the severity of the thought itself in the future (Segal et al. 2002). More specifically, the program teaches recognition of negative mood with the aim of separating

from self-perpetuating patterns of ruminative, negative thoughts that contribute to relapse (Marchand, 2012).

MBCT is effective in the treatment of a number of psychiatric conditions, including unipolar depression relapse prevention, residual unipolar depression, treatment-resistant unipolar depression, bipolar disorder, generalized anxiety disorder, panic disorder, hypochondriasis and social phobia.

The strongest evidence is for relapse prevention in unipolar illness. It was shown that effectiveness for relapse prevention was similar to antidepressants at 1 year and that augmentation with MBCT could be useful for reducing residual depressive symptoms (Fjorback, Arendt, Ørnbøl, Fink, & Walach, 2011; Grossman, Niemann, Schmidt, & Walach, 2004).

Generally, MBCT involves an 8-week group treatment program, which has expanded its audience to include individuals who have experienced depression in the past (e.g., individuals with cancer, bipolar disorder, or insomnia). NREPP (2012) suggests that a group format for MBCT is necessary for the program to be carried out with a "didactic and experiential nature" as opposed to a therapeutic one. In the group treatment format, sessions are split into two main topical areas: Learning to pay attention and mood management through CBT and mindfulness.

For example, sessions that focus on learning to pay attention, counselors may have clients work on awareness and intentionality of breathing or discuss what it means to be on "automatic pilot" and not being present. With sessions that focus on mood management, counselors will help clients learn signs or warnings that may impact their relapse of depression and will help clients recognize when thoughts are not reality, but are just thoughts that one is having. As the weekly sessions are completed, mindfulness skills are retained, and 4-12 months later an evaluation of application is discussed with clients. The follow-up session helps reinforce skills and identify obstacles preventing the practice of MBCT (NREPP, 2012).
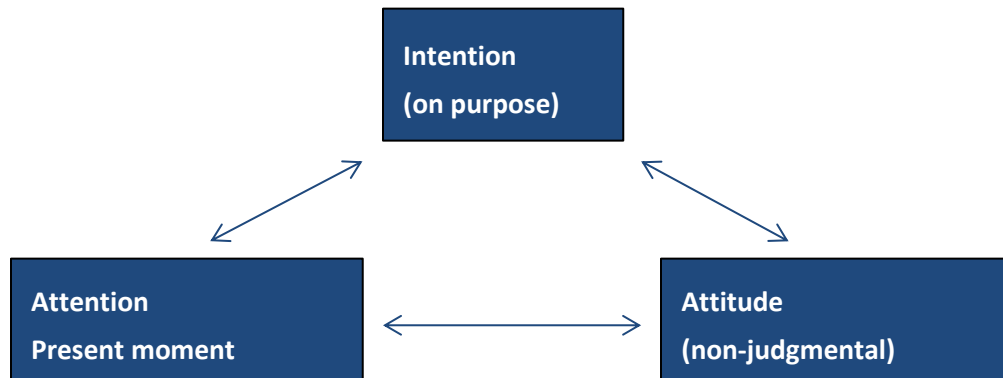
Brief summary of MBSR and MBCT

Intervention	Description of Intervention	Technique Examples	Areas of symptom improvement
Mindfulness-Based Stress Reduction (MBSR)	Group-based program; 8-10 weekly meetings for 2-2.5 hours and one 7-8 hour day typically around week six; Focuses on stress, coping, and meditation skills with a homework component	E.g., Body Scan; Sitting Meditation; Hatha Yoga	Depression Pain tolerance Anxiety Psychological functioning
Mindfulness-Based Cognitive Therapy (MBCT)	Group-based program; 8 weekly meetings for 2 hours and four 2-hour sessions 4-12 months after the 8 week course; Focus on prevention of depression relapse, awareness and acceptance of thoughts, emotions, and bodily sensations with a homework component	E.g., Group Topics- "Thoughts are not facts"; "Staying Present"	Unipolar depression relapse prevention Acute unipolar depression Residual unipolar depression Treatment-resistant unipolar depression Bipolar disorder Anxiety

How? (Instructions/Handouts)

Three essential components of mindfulness: Intention, Attention, and Attitude

Mindfulness invites us to reflect on why we're paying attention, our intention and to notice how we're paying attention, and our attitude. These components are not thought of as separate stages, but rather intertwined aspects of a single process.

```
                    ┌──────────────────┐
                    │ Intention        │
                    │ (on purpose)     │
                    └──────────────────┘
              ↙                            ↘
┌──────────────────┐            ┌──────────────────┐
│ Attention        │ ←――――――――→ │ Attitude         │
│ Present moment   │            │ (non-judgmental) │
└──────────────────┘            └──────────────────┘
```

Intention	Intention means knowing why we are doing what we are doing. Being aware of our goals and connecting with our larger vision helps motivate us, keeping us focused on what's most important and moving in the right direction.
Attention	Paying attention involves awareness of our moment-to-moment experience, as it is, including recognizing when we are not paying attention. Meditation in one sense is simply training in calming the mind and focusing the attention. Mindfulness involves bringing this skill of relaxed attention to everyday activities—at any time, any place, any circumstance.
Attitude	Attitude means being aware of your perspective and inclination, and how this affects your thinking and behavior. It involves acknowledging that one's underlying frame of mind can have a profound effect on how any given circumstance unfolds. Whether we are working with a judgmental attitude, or one that is friendly and openly colors our attention and affects how our intention is realized, our attitude deeply influences our experience.

Appendix A: Examples of Mindfulness-Based Interventions for Clients

Benefits	Practical mindfulness-based interventions to use with clients
Emotion regulation	"Can you stay with what is happening right now? . . . Can you breathe with what is happening right now?" "What can you tell me about your experience right now? Notice any changes in your feeling, however subtle."
Decreased reactivity & increased response flexibility	- Slowly scan your entire body starting at your toes. Notice any sensations in your body without trying to change them. - Can you allow and accept this feeling and stay in touch with it without reacting to it? If not, what is happening in your experience that's reacting to this feeling?
Interpersonal benefits	- For couples: Face each other, look into each other's eyes and notice what reactions, feelings, and thoughts arise. - For couples: Face each other, look into each other's eyes, and practice sending loving-kindness to one another. - Therapist and client can practice mindfulness meditation together during the therapy session. - Informal daily practice can include: walking and eating meditations, such as mentally saying "lifting . . . . stepping forward. . heel touching. . toe touching . . lifting . . . " when walking.

(Davis & Hayes, 2011)

Appendix B: Examples of Mindfulness-Based Interventions for Trainees and Therapists

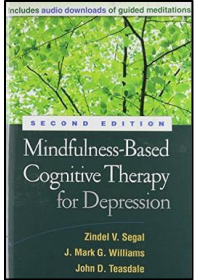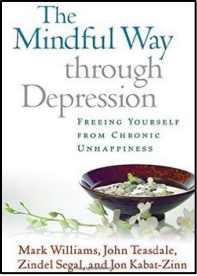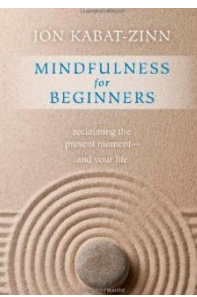| Benefits	Practical mindfulness-based interventions for trainees' and therapists' mindfulness
Empathy	In trainee dyads in "therapist" & "client" roles: Have therapists track their internal responses to client, and what makes them feel more and less empathetic toward a client. In dyads, pause after each person speaks and consciously relax. While pausing, with acceptance and curiosity ask yourself: What is happening now? What am I feeling now? What might this person be experiencing?
Compassion	Visualize an image, color, or memory that elicits feeling friendly towards yourself. Visualize sending this feeling towards an image of yourself, or a challenging client. Practice sending loving-kindness toward oneself, toward a loved one, toward a 'neutral' client, toward a challenging client, and toward all beings.
Counseling skills	In dyads, sit in silence with eyes open. Pay attention to your internal experience in the presence of another person, practicing to bring your attention back to the breath when it wanders. In trainee dyads in "therapist" & "client" roles: Have therapists let go of judgments and the desire to say 'something' and practice fully listening to clients. Have therapists track when their attention wanders off and practice returning attention to back to present moment.
Decreased stress & anxiety	Bring your attention to your experience of breathing. Imagine seeing a client. Pay attention to any feelings of anxiety and fear. Notice how they shift from moment to moment, allowing what is to be there. In dyads, have each person track their own internal feelings, thoughts, & sensations as they stand at varying distances from each other. Practice with an accepting attitude towards internal reactions with eyes open, with eyes closed, facing each other, & with their backs facing each other.
Other benefits for therapists	Therapists can practice formal sitting mindfulness meditation individually or in groups. In between sessions, take one minute each to: (1) Ask 'what is my experience right now?', (2) Notice the sensation of each in and out breath, (3) Expand your awareness to your whole body with an attitude of acceptance.

(Davis & Hayes, 2011)

Appendix C: Useful Web-sites for learning Mindfulness

Websites	Description	URL
NIH National Center For Complementary And Integrative Health (NCCIH) Meditation: in Depth	It provides holistic information about meditation including science evidence of the effectiveness.	nccih.nih.gov/health/meditation/overview.htm
American Mindfulness Research Association (AMRA)	AMRA serves as professional resource to the sciences and humanities, practice communities and the broader public on mindfulness from the perspective of contemplative practice.	goamra.org
Center for mindfulness	It provides detailed information about MBSR and MBCT as well as professional education. It also provide research and resources related mindfulness	www.umassmed.edu/cfm
Mindfulnet.org	It provides holistic information about mindfulness including science evidence of effectiveness of mindfulness. It also provides applications for mindfulness.	www.mindfulnet.org/page2.htm
The Center for Healthy Minds at the University of Wisconsin–Madison	It provides training program for children and workers as well as science evidence of effectiveness of mindfulness.	www.investigatinghealthyminds.org
UCLA Health UCLA Mindful Awareness Research Center	It provides detailed information of mindfulness and workshops or other training information. It also provides research and resources related mindfulness.	marc.ucla.edu
The center for contemplative mind in society	It provides training or workshops of mindfulness, as well as learning resources.	www.contemplativemind.org

Appendix D: Useful VTR for learning Mindfulness

Websites	Description	URL
Center for mindfulness -Video	It provides some VTRs that are lecture videos or presentation videos of mindfulness.	http://www.umassmed.edu/cfm/about-us/resources/videos/
Center for mindfulness -UMMS interest groups	It provides many mindful training videos as well as videos on how they actually provide mindfulness training.	https://www.cfmhome.org/
mindful.org	It provides a variety of videos such as case study videos or the publisher's roundtable on mindfulness videos	www.mindful.org/category/video

Appendix E: Useful Books for learning Mindfulness

Chapter Title	Book title	
Segal, Z. V., J. M. G. Williams and J. D. Teasdale (2013). Mindfulness-based cognitive therapy for depression. New York, Guilford Press.	This book introduces mindfulness-based cognitive therapy (MBCT) for depression, an 8-week program with proven effectiveness. Step by step, the authors explain the "whys" and "how-tos" of conducting mindfulness practices and cognitive interventions that have been shown to bolster recovery from depression and prevent relapse.	
Williams, J. M. G. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: Guilford Press	In this book, four uniquely qualified experts explain why our usual attempts to "think" our way out of a bad mood or just "snap out of it" lead us deeper into the downward spiral. They demonstrate how to sidestep the mental habits that lead to despair, including rumination and self-blame, so you can face life's challenges with greater resilience. Guidance CD is included.	
Kabat-Zinn, J. (2011). *Mindfulness for beginners: Reclaiming the present moment--and your life*. Sounds True.	This book shows how to transform your relationship to the way you think, feel, love, work, and play. You can use this book in three unique ways: as a collection of reflections and practices to be opened and explored at random; as an illuminating and engaging start-to-finish read; or as an unfolding "lesson- a-day". It Is a primer on mindfulness practice.	

References

Corcoran, K. M., Farb, N., Anderson, A., & Segal, Z. V. (2010). Mindfulness and emotion regulation: Outcomes and possible mediating mechanisms. In A. M. Kring & D. M. Sloan (Eds.), *Emotion regulation and psychopathology: A transdiagnositc approach to etiology and treatment* (pp. 339–355). New York: Guilford Press.

Cullen, M. (2011). Mindfulness-based interventions: An emerging phenomenon. *Mindfulness*, *2*, 186-193.

Davidson, R. J., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D., Santorelli, S. F., & Sheridan, J. F. (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine, 66,* 149–152. doi:10.1097/01.psy.0000116716.19848.65

Davis, D. M., & Hayes, J. A. (2011). What are the benefits of mindfulness? A practice review of psychotherapy-related research. *Psychotherapy*, *48*(2), 198.

Fjorback, L. O., Arendt, M., Ørnbøl, E., Fink, P., & Walach, H. (2011). Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy–a systematic review of randomized controlled trials. *Acta Psychiatrica Scandinavica*, *124*, 102-119.

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research*, *57*, 35-43.

Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life*. New York, NY: Hyperion.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice*, *10*(2), 144-156.

Kabat-Zinn, J. (2011). *Mindfulness for beginners: Reclaiming the present moment and your life*. Sounds True.

Marchand, W. R. (2012). Mindfulness-based stress reduction, mindfulness-based cognitive therapy, and Zen meditation for depression, anxiety, pain, and psychological distress. *Journal of Psychiatric Practice®*, *18*(4), 233-252.

National Registry of Evidence-based Programs and Practices (NREPP). (2012). Mindfulness-based cognitive therapy: An information resource. Retrieved from http://legacy.nreppadmin.net/ViewIntervention.aspx?id=239.

Segal, Z. V., Teasdale, J. D., Williams, J. M., & Gemar, M. C. (2002). The mindfulness-based cognitive therapy adherence scale: inter-rater reliability, adherence to protocol and treatment distinctiveness. *Clinical Psychology & Psychotherapy*, *9*, 131-138.

Shonin, E., Van Gordon, W., & Griffiths, M. D. (2013). Mindfulness-based interventions: towards mindful clinical integration. *Frontiers in Psychology*, *4*, 194.

Siegel, D. J. (2007a). Mindfulness training and neural integration: Differentiation of distinct streams of awareness and the cultivation of well-being. *Social Cognitive and Affective Neuroscience, 2,* 259–263.

Siegel, D. J. (2007b). *The mindful brain: Reflection and attunement in the cultivation of wellbeing.* New York: Norton.