The CARE System: User-Friendly CBT

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Acornerstone of cognitive-behavioral therapies (CBT) is enhancing the quality of the client's life outside the consulting room. To anyone familiar with the literature on treatment efficacy and effectiveness, this should come as no surprise. One of the most powerful nonspecific variables predictive of positive outcomes in CBT is becoming a better observer of the complex and interdependent relationships that exist among thoughts, feelings, and behaviors. It is the development of such awareness, in conjunction with clinician competence and compassion, that may often determine the success or failure of a given course of CBT.

CBT often begins with a series of in-session instructions or exercises designed to teach the client about how learning history may affect one's maladaptive behaviors, feelings, and cognitions. As therapy progresses, the clinician collects information about the particulars of the client's life and present circumstances to ensure that these interventions and instructions are relevant to this client. The skilled clinician knows that the case formulation is critical, because the ultimate success of the treatment will rest on whether what is being taught in the consulting room is relevant to what is happening outside the consulting room. Thus, the concept of generalization is of the utmost importance in the CBT treatment paradigm.

CBT is rich in procedures and interventions that have withstood experimental scrutiny and are readily available in the form of various treatment and procedural manuals (e.g., Barlow, 2001; Leahy & Holland, 2000). On the other hand, our reading of the literature also suggests that additional clinical tools might be needed to address the problem of dissemination and, specifically, increase the likelihood that practitioners will use efficacious treatments. Dissemination thus brings us closer to rendering efficacious therapies effective. To promote this objective, this paper will present an easy-to-remember and user-friendly clinical template that can be captured by the simple mnemonic CARE (cognitions, actions, relaxation, emotional expression). CARE is designed to assist the client in strengthening adaptive behaviors learned in therapy, generalizing these behaviors to their natural environments, and thereby enhancing the self-awareness that is so important to the ultimate success of therapy.

Let us begin with several disclaimers about what CARE is and what it is not. First and foremost, CARE is not a substitute for careful data collection and case formulation; however, attention to the domains of the CARE system could be of assistance in the assessment process. CARE is also not a comprehensive theoretical system with clearly delineated therapeutic dictums that follow logically from it. Those who use CARE must work hard to identify and analyze the patterns of reinforcement that maintain problem behaviors. Good outcomes in therapy need to be guided by good theoretical understanding.

So what is CARE and why should we care about it? CARE is an easy way to remember that most, if not all, client problems and therapeutic interventions in CBT involve some combination of four basic elements that can be captured in a simple four-category system:

> Cognitions
> Actions
> Relaxation
> Emotional Expression

On another level, CARE is a rhetorical tool that calls to mind the power and the potential of the CBT approach. CARE focuses attention on the critical interplay of thinking, feeling, and doing in both the patient's life and clinician's interventions. CARE reminds therapists to think in the broadest possible terms regarding techniques, constructs, and formulations. It brings to mind the clinical flexibility and inventiveness that seems common to many effective therapists.

CARE can also function as a mantra to be used by clients in their day-to-day lives. CARE may serve to strengthen focus and attention, as new patterns of behavior and reinforcement are being learned, established, and reinforced. As a methodology for assessment and intervention, being mindful of the domains of CARE first directs the attention of patients to their experience of the various levels of arousal and affect that accompany both thinking and acting. Using the CARE model might enable them to more easily identify how much of their current behavioral repertoires are being shaped by patterns of experiential avoidance that are themselves being supported by behavioral chains that include cognitions, actions, responses to stress, and emotional states (Hayes, 2005). Keeping CARE in mind may then set the stage for reducing avoidance by directing attention toward the development of personalized strategies for cognitive flexibility and restructuring, behavioral change, arousal management, and emotional acceptance.

Cognitions. In the CARE system, cognitions assist both the therapist and the client by keeping in the forefront of their awareness the powerful role that dysfunctional thinking plays in the origins and maintenance of the client's concerns and difficulties. At the same time, the term cognitions also refers to the equally powerful role that thinking can play in the amelioration of these same problems and concerns. In recent years it has become evident that there are at least two levels of thinking, and many different interventions, that the effective practice of CBT requires.

The first level refers to the moment-to-moment thoughts that are causing problems for the client. This kind of cognition, captured in a powerful way by Beck's term "automatic thinking," is very often the first place that the therapist will intervene and the first level of new awareness that the client might reasonably achieve in the course of a therapeutic encounter. Clients are cautioned that these automatic thoughts can have far-reaching effects and consequences.

For the clinician, working with cognitions at this level from the beginning of treatment can have both therapeutic and strategic benefits. In the first place, the research literature has documented the efficacy of cognitive interventions for a broad spectrum of mood disorders ranging from anxiety and phobia through depression (Beck, Rush, Shaw, & Emery, 1979). Accordingly, the prescriptive use of thought records (Beck et al., 1979) and mood logs, or the simple suggestion that the client "pay attention to your angry thoughts over the next week" can have immediate and salutary effects and may enable the client to quickly identify irrational or dysfunctional thoughts, learn to challenge them, and effectively replace them with thoughts that are more helpful. Clients may return to their next session with a new awareness of how often they entertain irra-

tional thoughts or are reactive to situations in ways that cause more problems than they resolve.

In keeping with the broad spectrum clinical focus that characterizes modern CBT, the CARE system also includes a second, more complex and heuristic level of cognition. In recognition of this "deeper" level of thinking, the CARE system provides for the use of new tools to evaluate complex thought structures and schemas (see Young, Weinberger, & Beck, 2001). For example, Young, Klosko, and Weishaar (2003) presented a system of 18 maladaptive schemas that form early in life as a result of repetitive interactions with significant others. The client and therapist work together to identify and systematically examine these schemas. Clients come to better understand and identify dysfunctional patterns as a result of this exploration, feeling more understood by their therapists and, more importantly, by themselves.

In the CARE system, action refers to behaviors the client performs, performs inadequately, avoids, or desires to learn. Initially, clients are encouraged to look for instances in which they are acting against their own best interests or avoiding key problems. Clients are empowered to expand their behavioral repertoires via exposure exercises and other learning strategies (as appropriate). The rationale for including this domain is twofold. The first has to do with the power and efficacy of behaviorally focused CBT interventions across a broad spectrum of problem behaviors (Martell, 2003). The second rationale, of no less importance than the first, is the heuristic value of the CBT paradigm in directing the attention of clients to the relation of behavioral action to affect and cognition.

In the CARE system, action interventions are likely to include assertiveness training, response prevention, scheduling positive activities, decisional-balance exercises (e.g., Burns, 1989), and the expression of emotions in effective and appropriate ways. In keeping with the goal of strengthening a client's mindfulness about the roles of self-awareness and self-direction in the initiation of behaviors, any time the client opts to work within one of the other categories, this would also be identified as an action intervention. Engagement and practice are consistently emphasized over avoidance throughout treatment.

The relevance and importance of dysfunctional states of arousal in the origins and maintenance of problem behaviors is a core concept in CBT. Accordingly, the CARE system emphasizes the crucial role that relaxation plays in effective treatment experiences. Clients are first taught about the many "faces" of anxiety, including muscle tension, shortness of breath, body temperature changes, as well as obsessive, compulsive, and avoidant response. Clients are encouraged to practice relaxation in a variety of different forms and to do so regularly. This can include deep muscle relaxation, autogenic training, deep breathing, self-hypnosis, and meditation. In the CARE system we are always cognizant of the need to better bridge the gap between procedures shown to be efficacious under experimental conditions and those that are effective in real-time therapeutic conditions; accordingly, clients are encouraged, in collaboration with their therapists, to fashion shortened versions of each of these techniques in order to accommodate their real-life situations.

The final clinical pillar of the CARE system is that of emotional expression (EE). In the CARE system EE refers to any activity in which emotions are expressed for reasons other than to effect a change in other people. During the course of the clinical evolution of the CBT paradigm, the place of emotions and emotional regulation has undergone significant changes. Early formulations of CBT treated affect as a variable to be subsumed within more powerful constructs of cognition and behavior. However, in practice, clinicians were forced to acknowledge various affective states and resultant behavioral patterns that did not fit the prevailing formulations. Moreover, researchers of other models were reporting that the expression of affect was viewed as a therapeutic factor in treatment by clients themselves (e.g.,Yalom, 1995). It became clear then that empirically minded researchers would need to explore these troubling and often chronic feelings and suggest ways in which they might be addressed in CBT.

In recent years CBT researchers (e.g. Greenberg, 2002; Leahy, 2002; Pennebaker, 1997, 2004; Young et al., 2003) have argued that affect has an important role to play in CBT and that many clients come to us with long-term deficits in this area. Not surprisingly, they are often the same clients that present with more complex personality disorders and respond poorly to treatment. In this regard, the recent interest in the cognitive-behavioral treatment of personality disorders mentioned above is of direct relevance to the question of emotional expression and its effects. Clients with problems related to emo-tional expression may be described as "avoidant" or present as "repressed" or "nonassertive" by some practitioners. Others may cycle through episodes of avoidance followed by sudden shifts toward behavioral excess. In the end, unexpressed emotional problems are thought to contribute to disturbances in mood, self-image, and interpersonal relationships that may have profound and long-lasting consequences.

EE takes into account both the simple expression of feelings as well as a consideration of more complex forms of emotional expression. Several techniques may be used to help clients explore their emotions in a constructive manner. Pure emotional release techniques include writing unsent letters and verbalizing feelings out loud in a safe environment. Therapists can also use imagery techniques to help the client to express uncomfortable emotions. In some cases, clients may be asked to confront people in vivo and express feelings directly to them. Clinicians are asked to contextualize these experiences to increase the client's awareness of how these patterns affect emotional regulation. In addition, clinician and client alike must be prepared for the possibility that the same "habits" of thinking, feeling, and behaving that are causing difficulties outside the consulting room may cause disruptions within the consulting room. Clinicians using the CARE system and dealing with the challenges of EE will certainly benefit from familiarizing themselves with the work of master therapists such as Marsha Linehan, who has written about both the CBT skills training that can contribute to better emotional regulation and behavioral control, as well as therapy management techniques that can maximize the effectiveness of the collaboration of client and clinician (see Linehan, 1993).

A final point to note is that all categories of CARE are not always relevant. For instance, a simple phobia might only focus on cognitions, action, and relaxation. Or, an extremely inhibited male with marital difficulties might have to focus almost exclusively on EE at the beginning of therapy. The CARE Coping Behaviors form (Figure 1, p. 195) is used to help clients to keep track of specific problems and interventions according to the four categories. Typically, this form is completed in collaboration with the therapist during sessions. It can be used as a guide for either specific homework assignments or as a reminder of what to do between sessions.

In order to get a better feel for the CARE system in practice, below we present a brief

case summary. It is designed to highlight the basic algorithms that guide assessment and intervention strategies.

Abby is a 36-year-old married woman with no children. She entered therapy because she was depressed as a result of her inability to conceive a child. She and her husband had tried unsuccessfully to conceive for 2 years on their own and then for over a year of fertility treatments. Her husband was making a substantial living in financial services and Abby had been working as a freelance graphic artist. During the 12 months preceding therapy her mood had become more and more depressed, she lost interest in friends and other activities and she was neglecting her physical self-care and appearance. In addition, she was spending less and less time attending to her professional clients.

Abby began therapy when she was confronted with the choice of doing in-vitro fertilization in an effort to become pregnant. She was scared that if she failed at this it would be too devastating for her to bear. She was also anxious about the invasive medical procedures involved. Regarding treatment goals, Abby said that it was most important for her to be able to go through with the in-vitro procedures, to get over her depressed mood, and to return to her work.

Her background included a childhood in an intact family with little emotional connectedness. She described her father as a workaholic who was generally extremely demanding and critical during the times he spent with her. Her mother was described as a good homemaker who obviously loved her children but who was emotionally unavailable and rigid.

Her husband was described as being a likable person but insensitive to her needs and feelings. When she would confront him about problems he would generally respond well to her, but she was frustrated by his lack of caring and reaching out to her. She felt that for years she had to do a disproportionate amount of work in keeping up the household and in keeping the relationship going.

Assessment with the Young Schema Questionnaire (Young et al., 2003) and follow-up discussion showed her core schemas to be emotional deprivation, self-sacrifice, and unrelenting standards. Her Beck Depression Inventory (BDI) score at the beginning of therapy was 33. The intake procedure took two sessions to complete. During the third session the CARE system was explained to her in the following manner:

"Abby, we agreed during the last session that the first problem we would work on would be helping you to get through the in-vitro procedures. I'd like to explain to you a little bit about how we'll do that and where we go from here. In treating these kinds of problems we've found that there are a number of ways of looking at the problem, and each one leads to its own treatments and solutions. For the most part these approaches are going to be complimentary to each other and the more each one of them is effective the more it will help in all the other areas. It might be like taking on the responsibility for the public health of a city. There's rarely one magic bullet that solves all problems. But we might put resources into things like sanitation, public education, and health care in order to improve the health of the citizens.

To help you to keep track of these parts of the problems and the treatments, we've devised a simple acronym: CARE. Each letter stands for a different part of your experience. *C* stands for cognitions, which basically means any thoughts you have that might be contributing to the problem. For instance, when we were talking about schemas last week we talked about your tendency to think you have to do everything perfectly. We might try to question some of those patterns. *A* stands for actions, or the things that you are actually doing, like speaking up for yourself, or facing challenges. You had talked about how you've been avoiding certain aspects of the fertility treatments and how doing so has resulted in your being even more scared of them. *R* stands for relaxation; when we spoke last time you indicated that you don't have any set relaxation or meditation procedures which you use, even though you tend to get very anxious when you're upset. This is something we'll look into helping you with. And finally, *E* stands for emotional expression. You had indicated that you have a tough time connecting with your husband about how you need his support and how hurtful this experience has been for you. Now let's look at this a little more closely and see if we can identify some other aspects of the problem and look at some treatment options."

Together, the therapist and Abby came up with the following list of problem behaviors related to the presenting complaint about the in-vitro procedures:

Cognitive:	*If I can't have children, I'm a total failure.*
	I'll never get over this depression.
Actions:	*Avoidance of medical situations, such as doctor's appointments and reading about her options.*
	Lack of pleasurable activities.
Relaxation:	*No skills in relaxation or meditation.*
Emotional Expression:	*Not discussing hurt or feeling of loss.*
	Not discussing resentments about the infertility.

Abby decided she would like to work on the EE issues first, so it was decided to invite her husband to the next session. He was taught to validate Abby's feelings as a means of encouraging her to talk. He was a willing participant and was eager to learn and practice his new skills. Abby reported an immediate improvement in her mood and an increase in their communication. In subsequent sessions the following treatments were utilized:

Cognitive restructuring. Abby was taught to identify and challenge negative thoughts. In addition, she was taught "defusing techniques" (Hayes, 2005). The negative thoughts were connected primarily with the schemas identified earlier. For instance:

- **Emotional deprivation**: *I never get what I want.*
- **Self-sacrifice**: *My husband will fall apart if I don't give in.*
- **Unrelenting standards**: *I have to stay on this until it's perfect.*

Scheduling activities. Abby was instructed to chart her hourly activities and her mood during each time period. She was pleased to see that her overall mood was not as bad as she had thought it was, and saw that when she was active she was almost always in a good or neutral mood. She and her therapist worked on steadily increasing the amount of time she spent doing things where she felt competent, such as her graphic arts profession, and activities which she enjoyed, such as spending time with close friends and relatives.

Relaxation training. Several relaxation and meditation techniques were taught and Abby was encouraged to practice them between sessions. She was also requested to buy *Total Relaxation* (Harvey, 1998) and to practice the relaxation exercises contained in it. She found that breathing exercises were particularly helpful and was able to use them to lower her overall arousal level.

Emotional expression. Abby was encouraged to continue talking to her husband about her needs and feelings. She also began to take more chances in expressing feelings to close friends and relatives. Her skills quickly improved in these areas as she reported almost immediate success in conversations with various people.

After the 8th session, Abby's BDI score was 11, and after 12 sessions it was 7. She had completed an in-vitro cycle after her 10th session. When she failed to conceive she reported intense sadness for about a week but no significant increase in other depressive symptoms. She stated that her husband and friends were very supportive and she was able to express all her feelings to them. At a follow-up session 4 weeks after the 12th session Abby reported that she had conceived on her second try and was coping well with the pregnancy, with no return of the depressive symptoms. In addition, she reported that she was maintaining her progress in all of the target areas.

To summarize, it is the intention of the CARE system to help the therapist and client organize the numerous possibilities for positive change. The CARE system is explained to the client as being similar to a four-legged stool. There is no one intervention that is likely to be a panacea. Rather, it is our responsibility to find several ways for the client to become active in solving problems. A four-legged stool will be more stable than one with fewer legs. So, the more ways we have to solve the problem, the more stable the solution will be. In this way, the CARE system puts a premium on the value of skills acquisition and generalization to the client's natural environment. The mnemonic itself is designed to remind the client of the skills and tools available to him or her in the arsenal of efficacious CBT techniques. Finally, while we believe that the CARE acronym may serve as a useful framework for keeping the work of therapy focused, effective, and relevant to the needs of the client, we acknowledge that the benefits of the CARE approach still require empirical validation.

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Figure 1. CARE Coping Behaviors

Target
Behavior:_____

COGNITIVE—Identify and confront the automatic thoughts and underlying schemas. Use strategies such as: look for the evidence, consider the odds, identify distortions. Use Thought Records or Flashcards.

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ACTION—What can I do to fix this? Speak up for myself? Pay attention to other peoples' needs?

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RELAXATION—Is anxiety part of the problem? Can I use any short-term or long-term relaxation strategies to cope better?

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EMOTIONAL EXPRESSION—What emotions am I failing to express completely? What exercises can I use to express them?

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