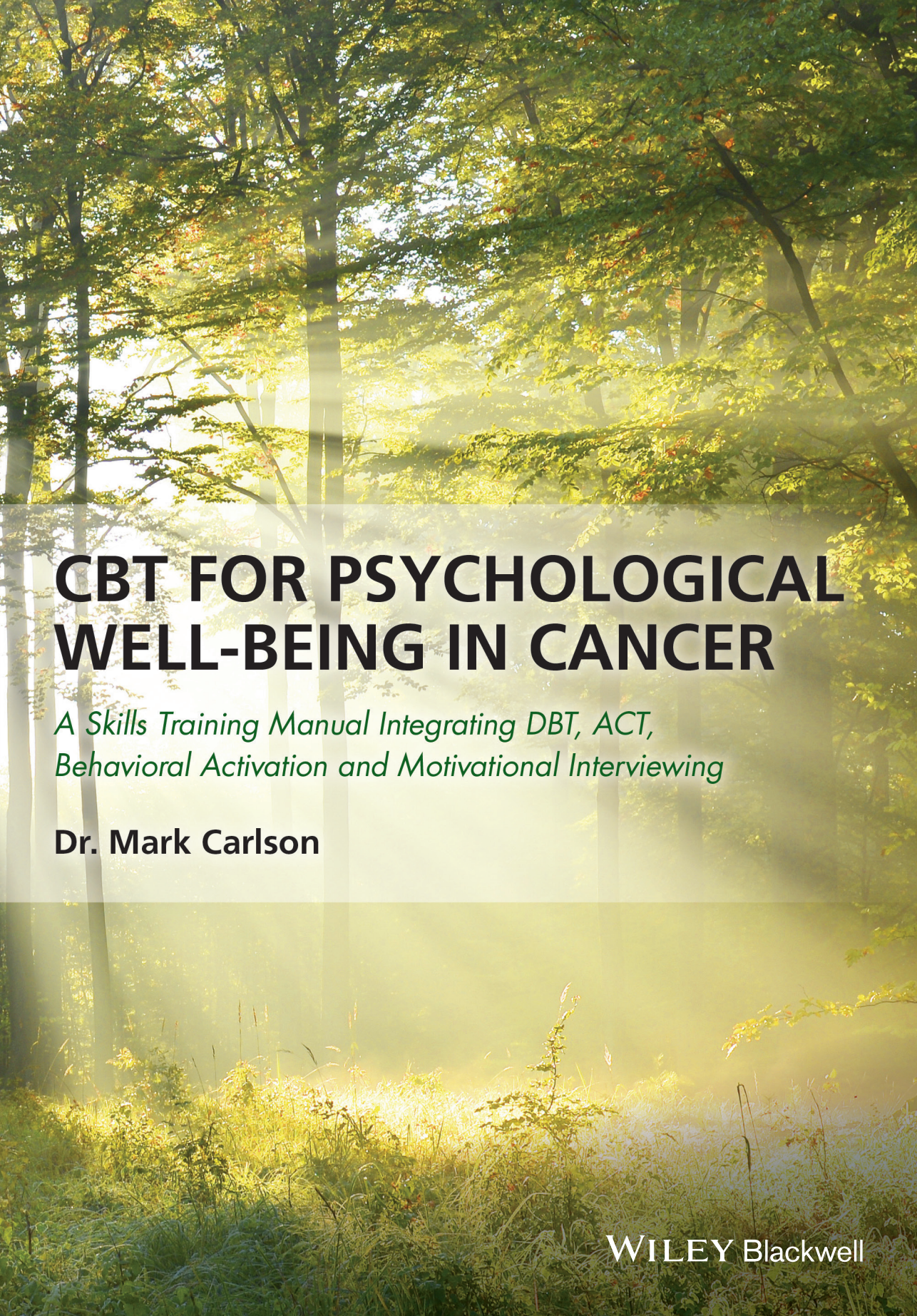
CBT FOR PSYCHOLOGICAL WELL-BEING IN CANCER
A Skills Training Manual Integrating DBT, ACT, Behavioral Activation and Motivational Interviewing
Dr. Mark Carlson
WILEY Blackwell

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This work is dedicated to my son, Spencer.

Thank you for sharing the world through your experience: You stop to see the beauty when others rush by, you love without condition, you laugh with your whole being, you open your heart to all around you, you are strong in life, you have an undying curiosity, you find hope and compassion when many do not, you believe, and you are amazing! I hope that you stay connected to who you are and what you are capable of doing even in times of pain and diversity. Know that I love you with all of my being, I will always be with you, and I am proud to be your dad.

Contents

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Julie – for being there every step of the way!

Chapter 1

Introduction to CBT for Psychological Well-Being in Cancer: Orientation to the Manual

When the word "cancer" is mentioned, people typically pay attention. When it is in the context of a medical appointment, or when discussing testing results, one of our biggest fears may become reality. Most everyone knows someone with cancer. There are stories of triumphs and stories of pain in every family. Reactions to the diagnosis of cancer, its treatment, and its course vary greatly between individuals. Although individual reactions may be quite different, there are many common themes found in what is experienced and what is needed. The first main theme is that cancer affects an individual's functioning and their quality of life. The other main themes can be organized into biological, psychological, and social perspectives. The focus of this manual is to address the complex needs of individuals diagnosed with cancer. Since there are more than 100 types of cancer, I have chosen not to focus on any one specific type. It seemed more appropriate to address the common reactions and issues that individuals with cancer experience. This is not designed to be an exhaustive and all-inclusive work, but rather another step in the direction toward treating the whole person.

Chapter 2 provides an overview of cancer statistics and treatments, to orient the reader to the enormity of the impact of cancer. Chapter 3 outlines a proposed treatment structure that addresses flexible treatment modalities for the professional. Chapter 4 makes up the bulk of the manual, and is organized into four sections: general, biological, psychological, and social. The general section consists of six headings that orient the clinician to the treatment of this population, ranging from skills training to work with safety issues. The biological section addresses themes such as treatment compliance and self-advocacy. The psychological section addresses issues of anxiety, depression, finding meaning, and more. The social section focuses on the individual's needs, as well as the needs of their support systems and strategies to increase healthy interactions.

Each section of Chapter 4 is presented with an outline of its contents, beginning with an introduction to the topic and points of discussion. The discussion points can

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be covered in either group or individual therapy as a way to ground the individual and explore their experience. The sections then transition into sets of skills to teach, which are designed to increase the patient's functioning and quality of life. They also provide assessments tools, which can be used to track progress or identify key aspects of the patient's functioning. Participants are encouraged to practice the skill sets in session using handouts, and to generalize what they are learning outside of the therapeutic sessions by completing the homework assignments/tracking tools and reviewing them in the following session. The sections conclude with notes to the clinician, which are designed to highlight key points and provide suggestions.

There is no "right" way to incorporate a manualized approach. The goal is to focus on the needs of the individual seeking services, while striving to increase their functioning and quality of life. Our health care system is moving toward integrated health care. This manual is designed to assist in narrowing the gap between health care professions by integrating different treatment approaches in order to increase overall health and wellness. The World Health Organization (1948) defines health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. This definition has not changed since it was adopted in 1948, and I hope this work will help clinicians move in the direction of embracing it.

Chapter 2

Cancer Statistics and the Scope of the Topic

The prevalence and cost of cancer are a growing concern in the United States and beyond our borders. There is an immense need for coordination of medical and psychological management to treat individuals suffering with cancer and residual conditions that often result from the disease. The American Cancer Society reported that in 2013 "about 1,660,290 new cancer cases are expected to be diagnosed in the US", with "about 580,350 Americans…expected to die of cancer, almost 1,600 people per day." It further estimated that in 2014 there were 14.5 million Americans alive with a history of cancer and that by 2024 there will be 19 million. Currently in the United States, "men have a 1 in 2 lifetime risk of developing cancer; for women, the risk is a little more than 1 in 3" (American Cancer Society, 2013). "Cancer is the second most common cause of death in the US, exceeded only by heart disease, [accounting] for about 1 of every 4 deaths in 2013" (American Cancer Society, 2013). Nearly one-fourth of people with chronic conditions also reported experiencing limitations to daily activity due to their illness and experienced clinical mental health concerns. "The 5-year relative survival rate for all persons diagnosed with cancer between 2002 and 2008 is 68%, which is up from 49% in 1975–1977" (American Cancer Society, 2013). This indicates that "60% of 1-year cancer survivors experience clinically significant concerns about disease recurrence influencing the individual's functioning and quality of life" (American Cancer Society, 2014).

Survival from chronic health conditions brings new challenges for individuals throughout their lifespan, including lifelong and acute physical, psychological, and social adjustment difficulties. According to the American Childhood Cancer Organization (2013), "Two-thirds of those who survive the disease develop at least one chronic health condition that is classified as severe or life-threatening caused by late-effects of treatment. These effects often include heart damage, lung damage, infertility, cognitive impairment, growth deficits, hearing loss, and second cancers." Childhood

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cancer often results in lifelong disabilities, in addition to chronic health conditions. Because of this, cancer survivors are subject to ongoing monitoring across their lifespan. "Persons diagnosed with cancer will likely need physical and psychosocial care throughout their lives" (American Childhood Cancer Organization, 2013). "Patients and providers often are influenced by life circumstances and competing priorities, attitudes and beliefs about specific treatments, health literacy and understanding the health care system. These factors influence treatment compliance and overall cost" (American Cancer Society, 2014).

Health Care Costs

Cancer is linked with a wide range of illness, injuries, diseases, and mental health issues. "Cancer has been found to cause pain and the associated symptoms arising from a discrete cause, such as postoperative pain or pain associated with a malignancy. Millions suffer from acute or chronic pain every year and the effects of pain exact a tremendous cost on our country in health care costs, rehabilitation, and lost worker productivity, as well as the emotional and financial burden it places on Survivors and their families" (American Academy of Pain Medicine, 2015). According to a recent Institute of Medicine (IOM) report titled "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research," "pain is a significant public health problem that costs society at least $560–$635 billion annually, an amount equal to about $2,000.00 for every person who lives in the United States. This includes the total incremental cost of health care due to pain ranging from $261–$300 billion and losses of productivity and associated issues ranging from $297–$336 billion. The costs of cancer can result in longer hospital stays, increased rates of re-hospitalization, increased emergency room visits, and a decreased ability to function that leads to lost income and insurance coverage. As such, Survivors' conditions often result in an inability to work and maintain health insurance, especially over the duration of their medical treatment."

"The financial costs of cancer are high for both the person with cancer and for society as a whole" (American Cancer Society, 2013). According to the National Institutes of Health (National Cancer Institute, 2015a), cancer "is a significant public health problem that costs society an estimated overall cost of $201.5 billion annually: $77.4 billion for direct medical costs (total of all health expenditures) and $124.0 billion for indirect mortality costs (cost of lost productivity due to premature death)." According to the American Cancer Society (2013), in 2006, the average cost of a single 30-day cancer drug prescription was $1,600; it is even higher today. Newer cancer treatments can cost as much as $10,000 for a month, and many protocols require more than a month of treatment. The American Cancer Society (2013) reports that "while those with health insurance face less worry regarding payment for treatment, those with no health insurance acquire extra worries when facing such an expensive disease. There is no guarantee that cancer expenses will be covered through insurance plans. Most personal bankruptcies that happen as a result of medical problems are filed by people who have health insurance."

Cancer and Functioning

A diagnosis of cancer causes distressing emotional experiences that decrease a person's ability to cope with their disease and treatment effectively. It is common for signs of impaired coping abilities to go unnoticed due to the severity and symptoms of the disease and treatment. Medical teams can assist patients in managing various side effects and symptoms, but patients may also benefit from mental health, social work, and counseling services to restore their quality of life and teach them coping skills (American Cancer Society, 2014). The American Cancer Society (2014) has found that 30–40% of patients have diagnosable mood disorders. Additionally, it suggests that psychological interventions can improve treatment adherence and patient–provider communication. Complete treatment adherence and improvements in communication between patients and their care teams were found to be correlated with low levels of depression and anxiety among cancer patients. Subpopulations at particular risk for elevated distress include racial/ethnic minorities, people diagnosed at younger ages, and those of lower socioeconomic status. These subpopulations have also been found to report greater difficulty regaining their quality of life in recovery. Distress is reported to negatively impact education and employment, at great cost to society (American Cancer Society, 2014).

The American Cancer Society (2014) states that "cancer patients experience pain at the time of diagnosis, during the course of active treatment, and after treatment has ended, even if their cancer does not return." Among cancer patients, pain is often underreported and undertreated. It has been found that 59% patients in active treatment report significant pain and about 33% of survivors report significant long-term pain post-treatment. Surgery, radiation therapy, and chemotherapy drugs can cause nerve damage. What manifests is chronic pain and a heightened risk of suicide among this population (American Cancer Society, 2014).

The comorbidity of mental health and physical problems resulting from pain is well established in research (Gatchel, 2004). Common comorbidity includes anxiety, depression, adjustment disorder, obsessive–compulsive disorder (OCD), histrionic personality disorder, and borderline personality disorder (BPD). The triggers are the pain and the uncertain prognosis of the diagnosed condition – specifically around progression of the disease, recurrence, reduced lifespan, end-of-life issues, treatment and side effects, cognitive, physical and behavioral impairments, and functional limitations (Ownsworth, 2009). Pain often results from chronic illness, injury, degeneration, and many related triggers in a chronic population. "People who experience chronic pain often experience a decrease in quality of life including: overall physical and emotional health, psychological and social well-being, fulfillment of personal expectations and goals, economic burden and financial stability, functional capacity to carry out daily routines, and activities of daily living. Additionally, destruction of family and social life, problems with treatment adherence and support systems, and decreased participation in sports or leisure activities have been found to increase the risk of clinical anxiety and depression, resulting in greater functional impairment and poor quality of life" (Pao & Weiner, 2011). This functional impairment and reduction in quality of life often leads to a variety of mental health concerns, including demoralization and a reduction in effective participation in treatment, as well as in life in general.

Cancer and Suicide

Cancer is often seen as a death sentence by mainstream society. Within the past decade, research has consistently demonstrated a strong correlation between cancer and suicide. In a survey of 2,924 cancer outpatients treated at one regional cancer center, 7.8% thought they would be "better off dead" or had considered hurting themselves in response to their diagnosis. While the general American population has a suicide rate of 10.6 out of every 100,000 persons per year, about 24 cancer patients out of every 100,000 complete suicide. Gender, prognosis, type of cancer, stage of disease, ethnicity, and family situation all contribute to suicide risk. Male cancer patients are nearly five times more likely to commit suicide than female patients, which remains consistent with suicide rates in the general population. Given the correlations, cancer patients may benefit from psychosocial support (Kendal & Kendal, 2012).

Medical Interventions

"Cancer is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. Cancer can result in death, if the spread of abnormal cells is not controlled" (American Cancer Society, 2013). The American Cancer Society (2014) reports that cancer can be caused by both external factors (including tobacco, infectious organisms, chemicals, and radiation) and internal factors (including inherited mutations, hormones, immune conditions, and mutations that occur from metabolism). Together, these factors initiate or promote the development of cancer. The World Cancer Research Fund estimates that factors including obesity, physical inactivity, and poor nutrition will contribute to about one-quarter to one-third of new cancer cases expected to occur in the United States. Thus, with adequate lifestyle modification, cancer can be prevented.

A variety of medical interventions are frequently implemented in the treatment of cancer. The American Cancer Society (2013) reports that cancer is treated with surgery, radiation, chemotherapy, and hormone therapy. The recommendations for use vary based on cancer conditions. Attending to risk factors and engaging in regular medical screening tests that allow the detection and removal of precancerous growths can prevent cancer, but these procedures are costly. According to statistics provided by the National Cancer Institute (2010), 70% of cancer patients are treated with primary medical interventions of chemotherapy and radiation, and are subject to secondary medical interventions. By default, the majority of medical interventions used to treat cancer can result in costlier medical conditions among survivors. Bone and heart issues are two documented impairments. Many cancer treatments result in osteoporosis and heart damage due to reduced bone density and sustained high blood pressure. Increased risk of fractures and heart failure is associated with poorer quality of life among the general population; therapeutic interventions can improve these impairments among survivors (American Cancer Society, 2014).

Pharmacotherapy

Pharmacologic management is often included in the treatment regimen of cancer conditions; however, protocols vary according to individual differences, including the disease state and treatment response. The average cancer drug therapy costs over $100,000 per year (Sikora, 2004). Pharmacologic management of cancer tends to be unique and is tailored to the individual based on treatment response. Pain is comorbid with cancer. Pharmacotherapy for the treatment of pain includes the use of anticonvulsants, antidepressants, benzodiazepines, *N*-methyl-D-aspartate (NMDA) receptor antagonists, nonsteroidal anti-inflammatory drugs (NSAIDs), opioid therapy (e.g., oral, transdermal, transmucosal, internasal, and sublingual), skeletal muscle relaxants, and topical agents (American Society of Anesthesiologists, 2010).

Physical Therapy

The use of physical or restorative therapies for the treatment of chronic pain caused by cancer has been popular. A review of available research on the use of physical or restorative therapies conducted by the American Society of Anesthesiologists (2010) indicated promising results. Randomized controlled trials (RCTs) that incorporated a variety of these therapies, including fitness classes, exercise therapy, and physiotherapy, were effective in treating low back pain. American Society of Anesthesiologists and American Society of Regional Anesthesia members recommended that physical or restorative therapies be implemented in the treatment strategy for patients with low back pain and other chronic pain conditions. Additionally, restorative therapies may be beneficial in restoring function lost due to the cancer itself.

Palliative Care

Palliative care is care given to improve the quality of life of patients who have a serious or life-threatening disease, such as cancer. The goal of palliative care is to prevent or treat, as early as possible, the symptoms and side effects of the disease and its treatment, in addition to any related psychological, social, and spiritual problems. The goal is not to cure. Palliative care is also called "comfort care," "supportive care," and "symptom management" (National Cancer Institute, 2015a).

Integrated Behavioral Health

Integrated medical care will require more than just "integrating" mental health and behavioral health clinicians into the existing health care team of physician, nurse practitioner, nurse, physical therapist, and nutritionist: it will require "integrated behavioral health," meaning that behavioral health clinicians must provide "integrated" services

that combine and integrate individual and family dynamics and individual and family or systemic interventions. The need for behavioral health is important because about 50% of all patients in primary care present with psychological comorbidities, and 60% of psychological or psychiatric disorders are treated in primary care settings (Pirl et al., 2001).

A major meta-analysis of 91 studies published between 1967 and 1997 provided evidence for what researchers call the "medical cost-offset effect." Behavioral health interventions, including various forms of psychotherapy, were provided to medical patients with a history of overutilization, as well as to patients being treated for only psychological disorders, such as substance abuse. Average savings resulting from the implementation of psychological interventions were estimated to be about 20% (Chiles et al., 1999). In short, the medical cost-offset effect occurs when emotionally distressed medical patients receive appropriate behavioral health treatment. As a result of this treatment, they tend to reduce their utilization of all forms of medical care. Even though there is a cost associated with behavioral health treatment, the overall cost savings is considerable.

Clinical Implications of Integrated Behavioral Health

The emerging integrated health care philosophy is that integrated behavioral health care will utilize behavioral interventions for a wide range of health and mental health concerns. The primary focus will be on resolving problems within the primary care setting, as well as on engaging in health promotion and compliance enhancement for "at-risk" patients. The goal of health care integration is to position the behavioral health counselor to support the physician or other primary care provider and bring more specialized knowledge to problems that require additional help.

Accordingly, the behavioral health counselor's role will be to identify the problem, target treatment, and manage medical patients with psychological problems using a behavioral approach. They will help patients replace maladaptive behaviors with more adaptive ones. In addition, they will use psychoeducation and client education strategies to provide skills training.

More specifically, the behavioral health counselor will be expected to provide expertise in dealing with undermotivated, noncompliant, or otherwise resistant patients. They will utilize motivational interviewing (MI) with individual patients (Rollnick et al., 2008) and with patients' families to increase readiness for change. They will also utilize focused cognitive behavioral strategies to increase compliance with treatment regimens, reduce symptoms, and increase acceptance of chronic and life-threatening illnesses (Sperry, 2006).

Cognitive Behavioral Therapy

Cancer has a significant impact on patients' lives and on the support systems around them. Adult cancer patients and their family members suffer from traumatic psychological distress, and psychological interventions may be beneficial (Butler et al.,

2006; Han et al., 2005; Koopman et al., 2002). Cognitive factors play an important role in the experience of cancer (Gatchel et al., 2007). Group therapy, using cognitive behavioral therapy (CBT), has been found to be successful in treating anxiety and depression among those diagnosed with cancer (Edelman et al., 1999; Monga et al., 2009). Clinical insight suggests that group therapy can be an effective intervention for parents of this population, and can decrease anxiety (Edelman et al., 1999; Gilder et al., 1978; Mitchell et al., 2006).

According to Gatchel et al. (2007), CBT interventions are based on the view that an individual's beliefs, evaluation, and interpretation of their health condition, in addition to their pain, disability, and coping abilities, will impact the degree of both physical and emotional disability of the disease condition. Currently, CBT-based techniques vary widely in the literature; they can include distraction, imagery, motivational self-talk, relaxation training, biofeedback, development of coping strategies, goal setting, and changing maladaptive beliefs about pain and disease.

It is common for cancer patients to experience acute and chronic pain. Morely et al. (1999) conducted a meta-analysis of randomized trials of CBT in the treatment of chronic pain. They concluded that the use of CBT treatment to replace maladaptive patient cognitions and behaviors with more adaptive ones is effective for a variety of pain conditions. More recently, Linton & Nordin (2006) reported a 5-year follow-up of an RCT of CBT intervention for clients suffering from chronic back pain. They found that CBT interventions (compared to the control group) resulted in significantly less pain, a more active life, higher perceived quality of life, and better overall health. In addition, significant economic benefits were associated with the clients who had completed CBT treatment.

Scope of the Book

Psychological interventions are supportive and typically ancillary in nature for most cancer patients. There are many individuals who have exhausted their options for primary medical interventions and are faced with the challenge of having pain and disease as a part of their lives, with little or no hope for positive change or a cure. Demoralization is a common reaction to this reality. The field of psychology has few treatment manuals and integrated treatment options for clients as they move through the process of finding a cure, or learning to live with disease. One of the goals of this book is to provide practitioners with one of the first comprehensive manuals for the treatment of cancer patients, which can be applied across modalities and levels of care.

Chapter 3

Introduction to the TAG Concept for Group and/or Individual Therapy

The TAG Concept for Cancer and Psychological Well-Being

Therapists are encouraged to adopt the TAG (Teach, Apply, and Generalize) concept (Carlson, 2014) when in session with individuals. I am often asked by clinicians across the United States, "How do we know when we are doing effective work?" I consistently answer that we need to be **Teaching** skills and approaches, have patients **Apply** these skills and approaches during session, and **Generalize** what is learned to their lives outside of the therapeutic session, while tracking outcomes. The TAG concept has its roots in the philosophy of contextualism. Leaders in contextualism include James, Dewey, Mead, K. Burke, and Bormann. The predominant character of behavior analysis – or, at least, what is central and distinctive about behavior analysis – is contextualistic (Hayes, 1998). The philosophy of contextualism corresponds well with behavioral analytic concepts of the operant, accomplishment of attainable goals, the active role of the therapist, and working with order and randomness. The TAG concept incorporates these key aspects into its fundamental structure and operations. TAG is based on CBT through practice, primary intervention strategies, and skills training. It incorporates skills and core components of: dialectical behavior therapy (DBT), MI, acceptance and commitment therapy (ACT), and behavioral activation (BA). Grief and loss work, existential approaches, mindfulness, and identity development are also incorporated. The manual is written from the perspective of evidence-based practice in psychology (EBPP): the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (American Psychological Association, 2015).

There are many theories and approaches in the field of psychology. In developing TAG, empirically supported treatments (ESTs) were identified and relevant research was reviewed. It was decided to continue its development through a contextual model that incorporates components shared by all approaches to psychotherapy, as well as six

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elements that are common to the rituals and procedures used by all psychotherapists. Arkowitz (1992) suggests that dissatisfaction with individual theoretical approaches spawned three movements: (i) theoretical integration, (ii) technical eclecticism, and (iii) common factors. The contextual model is a derivative of the common factors view (Wampold, 2001).

According to Wampold (2001):

> A contextual model was proposed by Jerome Frank in his book, *Persuasion and Healing* (Frank & Frank, 1991). According to Frank and Frank (1991), "the aim of psychotherapy is to help people feel and function better by encouraging appropriate modifications in their assumptive worlds, thereby transforming the meanings of experiences to more favorable ones" (p. 30). Persons who present for psychotherapy are demoralized and have a variety of problems, typically depression and anxiety. That is, people seek psychotherapy for the demoralization that results from their symptoms rather than from symptom relief. Frank has proposed that "psychotherapy achieves its effects largely and directly by treating demoralization and only indirectly treating overt symptoms of covert psychopathology"…

Frank & Frank (1991) describe the components shared by all approaches to psychotherapy. The first component is an emotionally charged, confiding relationship with a helping person (i.e., the therapist). The second component is that the context of the relationship is a healing setting, in which the client presents to a professional whom they believe can provide help and who is entrusted to work on their behalf. The third component is a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them. The final component is a ritual or procedure based on the rationale (i.e., believed to be a viable means of helping the client), which requires the active participation of both client and therapist.

Frank & Frank (1991) discuss six elements that are common to the rituals and procedures used by all psychotherapists. First, the therapist combats the client's sense of alienation by developing a relationship that is maintained after the client divulges feelings of demoralization. Second, the therapist maintains the patient's expectation of being helped by linking hope for improvement to the process of therapy. Third, the therapist provides new learning experiences. Fourth, the client's emotions are aroused as a result of the therapy. Fifth, the therapist enhances the client's sense of mastery or self-efficacy. Sixth, the therapist provides opportunities for practice.

Wampold (2001) furthers this concept by adding that in the contextual model, specific ingredients are necessary to construct a coherent treatment that therapists have faith in and that provides a convincing rationale to clients.

The Biopsychosocial Model

This manual is written using a biopsychosocial model of treatment. The American Psychological Association defines the **biopsychosocial model** as: a model of health and illness that suggests that links among the nervous system, the immune system, behavioral styles, cognitive processing, and environmental factors can put people at risk of illness. The biopsychosocial model is an extension of the biomedical model

(Sperry, 2006) that incorporates psychological and sociocultural dimensions with the biomedical dimension. The biopsychosocial model fosters integrative care and is the operative model in the practice of behavioral health (Sperry, 2014).

Developing a Program through the TAG Concept

Many clinicians will choose to infuse the contents of this manual into their existing practice. There is a large need among individuals diagnosed with cancer and mental health issues for more structured and intensive services. The TAG concept can easily be adapted to create a program and serve as the foundation of a service delivery model.

The TAG program was created for individuals experiencing issues with comorbid mental health and cancer. It is designed to be 3–6 months in duration, or more, and to have flexibility in implementation across modalities of treatment. The concepts and skills training of the TAG program can be easily applied in individual therapy if that is the primary modality for intervention. The individual therapist will be able to modify the format and select concepts and skill sets to customize for the individual. Such modification relies on the education, training, and expertise of the clinician, since it deviates from the initial design and intensity of the program.

The design that will initially be discussed is a group skills training model. Groups meet two times weekly for 3 hours. A clinician does not need to adhere to a specific order for the sessions. The structure of the program provides the clinician a high degree of flexibility. This allows for individualization and customization of the skills and concepts to each individual in the group. Each session is formatted to have goals for each individual and for the group as a whole. There are multiple discussion topics, designed to assess each individual's strengths and barriers to effective functioning, and to establish a baseline of understanding and coping. The discussion points can also provide a general orientation and segue to the coping skills. Each session has general coping concepts and specific skill sets for each individual to learn. The individual is taught a set of skills, encouraged to practice in the session, and then told to generalize the skills to multiple aspects of their lives through problem solving.

Group/Session Structure

The group structure of the TAG program is designed to meet twice a week for 3 hours. Each hour is designed to have a specific focus for each individual and for the group as a whole.

Section 1: teaching

The teaching section is prioritized as the first section of the day, to provide grounding for each individual, to establish expectations that all members will be focusing on learning and applying skills, and to reinforce participation throughout the process. This section is designed to be 45–50 minutes in length.

The first part of this section introduces the specific goals for the teaching. It starts with an introduction to the topic and an explanation of why the topic is challenging for individuals. Each individual is engaged in the process, to identify whether this is a strength area for them or a barrier to more effective functioning. If an individual identifies the topic as a strength area, they are encouraged to establish a goal of building consistency and a sense of mastery with the skills. If an individual identifies it as a barrier to more effective functioning, they are encouraged to establish a goal of learning the core concepts of the skill sets, create an initial plan, and commit to practice the skills in session. Individuals who are working toward building consistency and mastery may then serve as mentors to those who are newer to the skill sets. Once the individuals and the group as a whole have set goals, the general topic is discussed from a variety of perspectives. This allows for engagement in the process, general orientation to the topic, and establishment of baselines of functioning. Individuals are encouraged to provide examples from their lives as to why and how the topic is relevant. The clinician is encouraged to identify strengths, barriers to effective functioning, and needs, and to provide a segue to the specific skill sets to be taught. This part is designed to be highly interactive and organic in its process. This is where members discuss the topic's relevancy to their situation and see that they are not isolated in their experience as other members are encouraged to share. This provides a direct grounding experience for many individuals and "normalizes" their reality.

The next part of the teaching section is the skills training component. This is the core of the TAG program. Each session has multiple skill sets to teach. The curriculum is designed to have multiple skill sets that work directly with the current topic and have generalizability to global coping. This is intended to ground the individual in their current needs, strengths, coping strategies, and global functioning. The next step is to teach specific sets of cognitive and behavioral skills and concepts designed to increase each individual's functioning and/or quality of life. The skill sets are focused on the current topic and how the individual can learn and apply the skills directly in the session. Each individual incorporates a set of skills into their identified goal work and commits to a plan to generalize the skills into their daily functioning. This plan is then reviewed in the third part, where it is problem solved to address the individual's strengths and barriers.

Section 2: application

The application section is designed to focus on pattern recognition and awareness (based on the principles of self-monitoring and adherence to treatment). This section is designed to be 45–50 minutes in length. A tracking card or diary card is the primary tool used. Each individual completes their tracking card before the session, and reviews it with the clinician and the entire group. The card includes areas of functioning, needs, strengths, skills used/attempted, and how effective the individual's application of skills has been since the last session. Peers provide feedback in the form of support, challenge, and suggestions to increase the effective application and generalizability of the skill sets. Treatment goals and objectives are also reviewed daily in this section.

Section 3: generalization (problem solving)

The problem-solving section is designed to assist individuals in applying their strengths to overcoming barriers to effective coping. This section is designed to be 45–50 minutes in length. Each individual is expected to identify one goal area that they want to focus on. They take problem-solving time to discuss their strengths, difficulties, skill implementation plan, and commitment to skill use, and to receive feedback from the clinician and their peers on their action plan. The goal of this section is to have the individual commit to applying their skills outside of the therapeutic setting, create a clear action plan designed to increase the efficacy of their coping strategies (incorporating new skills that have been taught in the program), and establish a review/completion time before the next session. The completed action plan will be reviewed in Section 2 of the next group session. This increases the individual's accountability for follow-through and establishes continuity between sessions.

Curriculum Overview

The manual starts with seven sessions to orient the clinician to the population, the methodology, and the proposed approach. This provides the clinician with the necessary tools to integrate this manual into their existing practice, or to create an entire program with the manual as a foundation.

The curriculum is designed to be topic-driven (arranged by topic) in an open group format. Therapy is multimodal, incorporating group and individual therapy. The program is organized through the biopsychosocial model. There are seven sessions targeting coping with the biological aspects of mental health and cancer, seven sessions targeting coping with the psychological aspects of mental health and cancer, and seven sessions targeting coping with the social aspects of mental health and cancer. The term "individual" is used in place of "patient" or "client" to challenge stigma labeling. Personalizing therapeutic approaches leads to adherence, ownership of the process, and personal responsibility.

Sources and recommended readings

It is recommended that the clinician review the original publications and material in the References section of the book for further conceptual depth and understanding.

General curriculum

Seven sessions form the focus of orienting the clinician to the manual's approach. This section includes:

1. Orienting the individual to therapy
2. Skills training
3. Interventions and strategies
4. Safety assessment and contracting
5. Cognitive and behavioral analysis

6. Self-regulation and illness perceptions
7. Chronic illness

Biological curriculum

Seven sessions form the focus of skills training designed to target issues related to the biological nature of the individual's mental health and cancer. This section includes:

1. Increased functioning and quality of life
2. Goal setting and motivation
3. Orientation to change
4. Working with your team
5. Adherence to treatment protocols
6. Pain
7. Healthy habits and sleep

Psychological curriculum

Seven sessions form the focus of skills training designed to target issues related to the psychological nature of the individual's mental health and cancer. This section includes:

1. Anxiety
2. Depression
3. Trauma and retraumatization
4. Increasing resiliency through stress management
5. Anger management
6. Finding meaning
7. Stigma

Social curriculum

Seven sessions form the focus of skills training designed to target issues related to the social nature of the individual's mental health and cancer. This section includes:

1. Intimacy
2. Problem solving
3. Nurturing support systems
4. Managing conflict
5. Demoralization and remoralization
6. Styles of interacting
7. Grief and loss

Goals of the Program

The goals of the program are to reduce hospitalizations and emergency room visits, decrease unneeded doctor visits, improve individual functioning, improve