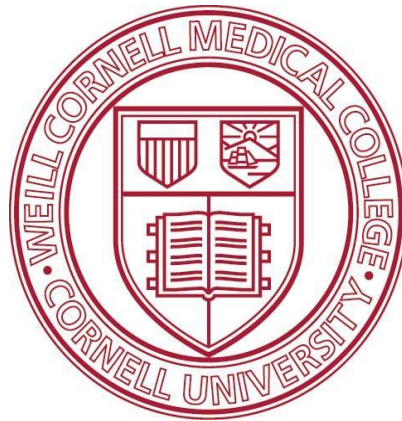


# **ECOSYSTEM FOCUSED THERAPY (EFT)**

## **EFT MANUAL**



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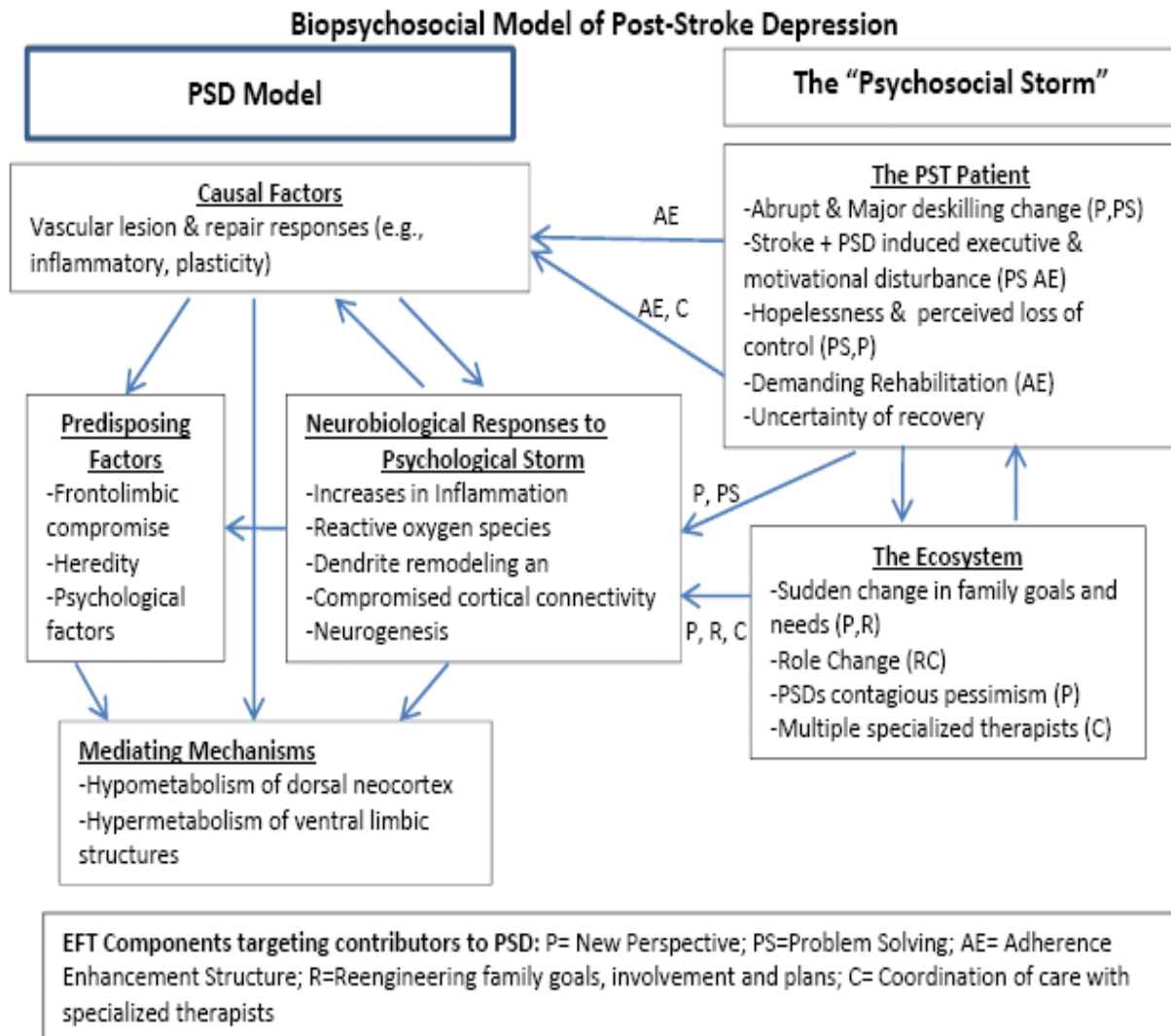
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# PRINCIPLES OF EFT

## Definition

Ecosystem Focused Therapy (EFT) is based on the view that maximizing the ability of patients with post-stroke depression (PSD) to use their remaining skills and resources is critical but often insufficient. For this reason, EFT is designed as a home-delivered intervention intended to help patients with PSD optimize their "ecosystem" (family, specialized therapists) so that it best contributes to their recovery.

## PSD Model



EFT addresses the factors of the biopsychosocial context in which PSD is occurring. We conceptualize the proposed intervention in the context of our model of late-life depression, expanded to make explicit the targets of EFT. The model suggests that stroke increases vulnerability to depression by compromising brain structures (frontolimbic

circuitry) though the ischemic event itself and the ensuing brain responses (inflammatory and resculpting processes). The "psychosocial storm" to which the stroke victim is exposed exacerbates these events and further contributes to PSD.

**Psychosocial Storm:** The "psychosocial storm" originates both from the sudden disability and the resulting change in patient's needs and family life. The patient becomes deskilled by the abrupt loss of strength, coordination, language, executive functions, behavioral disorganization, lack of motivation, and hopelessness caused by stroke and PSD, but also by the pressure of a demanding rehabilitation regimen. Taken together, these factors along with lack of preparedness often lead to a feeling of incompetence (self-efficacy), further fueling the experience of stress and promoting depression.

The family experiences a similar storm. The usual family goals and tasks are now anachronistic. The family needs to reengineer itself and learn how to meet new demands of the disable stroke victim. The family needs to assist the patient both with daily routine and by coordinating and facilitating (driving, waiting, etc) physical, occupational, and speech therapies. The family members play a role even when they do not live with the PSD patient (coordination of caregivers, finances, relocation). The pessimism and resignation of the PSD patient often contaminates those expected to help and immobilizes them. Without guidance, even the most committed family members cannot find their way to help effectively and may even become a hindrance.

Finally, physical, occupational, and speech therapists need to understand the context of the PSD patient and his/her "ecosystem" and coordinate their interventions (dose, timing, barriers) so that they are not excessively demanding and disorienting to patients and families.

These problems need to be addressed early after the onset of stroke because there may be a time window in which interventions are most effective.

### **The Role of EFT**

The goal of EFT is to enable patients to assimilate new perspective and skills and change their "ecosystem", including family and specialized therapists, and to enable this ecosystem to accommodate to the patients' new state. EFT provides patients an optimal chance at adaptation, promotes adherence to rehabilitation, increases their feeling of competence (self-efficacy), and reduces their depression.

A central principle of EFT is that its components must be personalized at the patient, environment and time level so that they capture the interaction between the patient's ability and the challenges posed by the environment. Personalization of EFT follows the classical *adaptive functioning principle*, according to which adaptive behavior is a function of the person's competence as well as the demands of his/her environment. Competence is the highest capacity individuals can achieve given their health, cognition, motoric behavior, and sensation-perception. Using the WHO concepts, personalized EFT even when it minimally influences neurological *impairment*, can reduce depression, *disability*, and

*handicap* (function within the family, community and workplace). EFT personalization follows the basic rehabilitation medicine principle, i.e. "motivation is highest and performance is optimal when a behavioral goal is set above the current level of performance but within reach."

The presumed biological mechanisms of rehabilitation therapies after stroke include enhancement of appropriately guided brain "plasticity," resulting in a new functional architecture. Accordingly, behavioral enrichment may help recovery of function both directly and by enhancing the effects of specific types of rehabilitation therapies.

**The EFT Components:** EFT has five therapeutic components targeting the main contributors of the "psychosocial storm" experienced by the PSD patients and their ecosystem (Figure). These are:

- 1) New Perspective;
- 2) Adherence enhancement structure;
- 3) Problem solving structure;
- 4) Reengineering family goals, involvement, and plans;
- 5) Coordination of care with specialized therapists.

Please note that aspects of each of these components may be pertinent to the PSD patient, the ecosystem or both.

New Perspective: EFT helps the patient develop a perspective appropriate to his/her new state. Using a language that the patient can understand and accept, the EFT therapist describes the prognosis of depression, the interaction of depression and stroke-related disability, the role of rehabilitation, and valued and rewarding activities that are still possible at present and in the future (psychoeducation). The EFT therapist identifies and corrects patient misconceptions.

Adherence Enhancement Structure: Enhancing adherence to rehabilitation and other medical treatment recommendations is critical because non-adherence contributes to disability. The EFT therapist uses education and direction as an Adherence Enhancement Structure to address adherence problems (see Appendix A). Because of cognitive and behavioral limitations, patients may require reminders and environmental cues and strategies. Aided by this structure intended to maximize adherence, the therapists helps mitigate the effects of resignation, executive dysfunction and motivational disturbances. The family and/or professional caregivers participate based on need.

Problem Solving Structure: The EFT therapist provides training in problem solving, helping patients select as an initial target a solvable problem that they value and is pertinent to his/her current daily functioning. The goal of problem solving structure in EFT is to engage PSD patients in valued and rewarding activities and relationships and by improving daily functioning in their lives. Targeting problems in these areas can lead to behavioral

activation, increase the patient's sense of competence and improve depressive symptoms. Accordingly, the EFT therapist guides PSD patients to prioritize their problems and address specific problems likely to be successfully solved. Patients learn to ask themselves the following questions in evaluating the problems they face: 1) **What** is the problem? 2) **How** might I try to solve the problem? 3) **Which** one of my ideas to solve the problem do I want to try? 4) **When** am I going to try it?

*Reengineering Family Goals, Involvement, and Plans:* The EFT therapist facilitates discussion with the patient and family member (usually a spouse or an adult child) to help clarify family members' involvement and responsibilities after the turmoil of stroke. For example, the therapist assists in determining level of supervision needed by family and/or home health aides as necessary. The therapist provides both a short-term and a long-term perspective emphasizing realistic positive developments in the patient. The therapist helps the family reengineer its goals and plans to accommodate the patient's disability and its impact on the family. For example, the therapist provides a realistic perspective on the patient's likely occupational functioning in the near future and directs attention to issues such as possible plans for retirement or taking temporary leave.

*Coordination of Care:* Physical, occupational and speech therapies demand patient effort and cooperation. While therapists specialized in these treatments focus on adherence to their own specific recommendations, they may not have a comprehensive understanding of view of the patient and his/her ecosystem or of the role of depression and its interplay with care. The EFT therapist gathers information from specialized therapists to arrive to a synergistic approach aiming to motivate the patient, and to help the patient and family develop a plan for participation in rehabilitation and make use of community resources, e.g. support groups, exercise programs and recreational services for physically challenged persons.

# EFT SESSION 1

## PREPARATION

1. Review baseline assessment information, such as demographics, scores on depression, cognitive, and disability measures, and other information gathered from referral source and/or baseline research assessment.

The therapist becomes familiar with the information about the patient, his/her stroke, and the level of depression and disability following the stroke. The therapist can confer with the research assistant to ascertain any other pertinent information about the patient, his/her family, home situation, interaction with the research assistant, and attitude towards research study participation.

2. Organize for further assessment in Session 1

In addition to the information from the baseline interview, the EFT therapist adds to the list of standard questions to be asked at the first session. These could be questions that the therapist would like clarified based on the results of the baseline assessment or impressions from the research assistant. The therapist will also prepare release of information forms to obtain patient's permission to contact his/ her rehabilitation specialists.

## SESSION 1

Session 1 takes place at the inpatient or outpatient rehabilitation unit or at the patient's home.

### GOALS AND AGENDA

- 1) Development of rapport and introduction of EFT's rationale and components to the patient.
- 2) Clinical evaluation of the patient focusing on: The impact of stroke on the patient and his/her current perspective on life after stroke; symptoms and severity of depression; areas of disability; current rehabilitation recommendations, goals, and adherence to rehabilitation; effects of stroke on family roles and plans and what challenges stem from this.
- 3) Provide summary of problem areas and explain how EFT can address them with the five therapeutic components. Begin correcting patient's perspective.
- 4) Make arrangement with patient to invite family member/caregiver to next session.
- 5) Feedback

**I. Introduction of EFT** (Adjust these instructions to a language that the patient can understand)

Deliver the following message to the patient: *Ecosystem Focused Therapy (EFT) is a treatment for depression of stroke patients, delivered at the patient's home. It targets both difficulties in everyday function as well as depressive symptoms (like feeling down, blue, hopeless) that many patients experience after stroke. People with stroke and depression often have problems getting around, doing rehabilitation exercises, taking good care of themselves, understanding others, going out, etc. They often also experience sadness and tension in their relationships with family and friends. It is important to identify the problems and difficulties that you are currently facing and to find ways of solving the problems and better managing difficulties.*

*EFT consists of 10 weekly sessions followed by 4 more sessions spaced over one year. Each session lasts approximately 50 minutes, although sessions may be shorter depending on your energy level. During the first two sessions, I will be asking you questions about areas of your life and living situation that have changed after the stroke. I would like to get a thorough history so I can better understand your current problems.*

*During subsequent sessions, we will work to address any difficulties in sticking to your rehabilitation and other treatment recommendations. We will also work on other problems that you may be experiencing and that you feel are contributing to your depression. One way in which we will do this is to use a structured way of addressing problems. This process includes understanding and identifying problems, developing ideas on how to solve them, evaluating those ideas, and then actually trying one of those ideas to see if it solves the problem. Learning these skills can help you to solve problems more effectively, help you work on your rehabilitation goals, and most importantly help you to feel better.*

*At times, I will ask to have your family member/caregiver participate and help us solve a problem or discuss issues that affect both of you. Sometimes this will involve us talking about changes in family life that have been made or will need to be made because of the stroke. At times, the three of us may work on solving problems together. Other times, we will be using specific techniques, like keeping notes or posting plans on your calendar, to help you organize your activities and solve some of the problems.*

*Every week you and I, and your family member when needed, will be setting written plans for you to work on during the week. Research has shown that doing consistently what your rehabilitation therapists recommend and increasing your activities will facilitate your recovery and improve feelings of depression. You may experience some problems that can get on your way of your recovery. Our sessions will target some of these problems and help you develop new skills for solving them. I will ask you to practice some of these skills throughout the week.*

**II. Clinical Evaluation:** This evaluation focuses on the impact of stroke on the patient and his/her current perspective on life after stroke (*New perspective*); symptoms and severity of depression and areas of disability/inactivity (*Problem Solving for Valued Activities and Interactions*); current rehabilitation recommendations, goals, and adherence (*Rehabilitation Adherence*); how family life has changed after stroke and what challenges



stem from this (*Reengineering Family Goals, Involvement, and Plans*); and patient's permission to communicate with other care providers (*Coordination of Care*).

**Impact of Stroke, Perspective:** Ask the patient questions about how the stroke impacted his/her life and how life has changed. What can he/she do and not do after the stroke? How does he/she view life right now? Try to understand the patient's perspective about his/her stroke and resultant disability. Be aware that depression may color the patient's view about the future of his disability. Does he/she think it is all over? Does he have unrealistic expectations about recovery? Does he feel that he has failed his rehabilitation treatment so far? Does he/she feel that life would be meaningless if he/she has to live with disability?

Notice if the patient's descriptions are in agreement with the medical records or other collateral information? If not, try to understand the source of discrepancy. Be aware that the helplessness and pessimism of depression may explain why some patients are more likely to exaggerate their disability. The opposite may also be true in some cases. Patients may minimize their disability or depression due to poor insight or the fact that others are assisting them and doing things for them. In this case, the therapist needs to assess what activities a patient can do versus what he/she does do.

**Depression, Activities, Interactions:** How does the patient feel? Does he/she feel depressed? Review symptoms of depression with the patient. Some patients may endorse depressive symptoms outright. Other require more inquiry and rephrasing to capture if symptoms are present. See if the description of the patient's depression in the clinical record corresponds with your impression of the patient during the interview. Ask specific questions to ensure that you understand clearly what depressive symptoms are present.

What activities has the patient given up since the stroke? What is the patient doing for socialization? Has the patient withdrawn or become isolated? Has the patient stopped engaging in activities or lost interest in activities that he/she used to enjoy or find rewarding? Are there relationships that the patient has given up since the stroke?

Ask about thoughts of death. Then, ask whether the patient wishes he/she were dead (passive suicidal ideation). Finally, ask whether he/she ever thought about harming or killing him/herself (active suicidal ideation). If they acknowledge such thoughts, follow-up by asking about the nature of the thoughts and plans, e.g. ask how they might harm themselves. Inform your supervisor immediately once you identify active suicidal ideation.

Try to understand what the patient knows about depression. Is this view realistic? Are there concerns about stigma? Is there resistance to being called depressed? Is the patient capable of understanding your explanations about depression and the role it may play in their recovery?

**Rehabilitation Adherence:** Ascertain the patient's current rehabilitation recommendations and goals, including type and frequency of exercise or practice (home-based and outpatient appointments), and other medical treatments (e.g., antidepressant

medication). The therapist may already have some of this information from the referral source and/or the baseline assessment. In this first session, the therapist obtains the patient's understanding of his/her rehabilitation. In other sessions and extra session communication, the therapist gathers further information from family members/caregivers, and other specialized therapists (e.g., physical, occupational and speech therapists). Assess whether the patient is having difficulty performing rehabilitation exercises or adhering to medication recommendations. Assess reasons for any problems with adherence, such as misconceptions about stroke and its treatment, dissatisfaction with treatment, practical barriers, poor acceptance of depression, and hopelessness (See Appendix A).

**Family Goals, Involvement, and Plans:** Ask the patient what problems he/she has encountered after discharge to home. Is he/she worried about being a burden to his/her spouse, children, etc? Is he/she concerned about returning to work, managing home responsibilities, or participating in family activities? What did the patient enjoy doing before that he/she either cannot do or has stopped doing? How has the family been affected? Gain the patient's view of changes in family roles and immediate and future plans.

**Coordination of Care:** Obtain permission to contact the patient's physical, occupational, and/or speech therapists to discuss the current rehabilitation regimen.

**III. Provide summary of problem areas and how EFT can address them with the five therapeutic components. Begin correcting the patient's perspective.**

Review the results of your clinical evaluation with the patient, organizing patient's report of problems, difficulties, and concerns into problem areas of negative perspective, lack of engagement in rewarding activities, poor rehabilitation adherence, disrupted family life, and poor coordination of care. Discuss with the patient how depression can be related to each of these problem areas (e.g., not engaging in rewarding activities can lead to exacerbation or maintenance of depression). Reiterate EFT rationale of targeting these problem areas and working together to successfully solve and manage these problems can help decrease depression, improve rehabilitation adherence, improve functioning and adjustment within the family context, and cope more effectively with the effects of stroke. Provide psychoeducation to the patient to help correct misconceptions that the patient may have and to help the patient develop a more realistic understanding of his/her situation.

**IV. Make arrangements with the patient to invite a family member/caregiver to the next session.**

Convey this message to the patient: *I will ask to have your family member/caregiver participate in our next session. Your family member/caregiver will help me understand changes in family life that have been made or will need to be made because of the stroke.*

**V. Feedback**

Ask the patient whether he/she understood the goals and approaches of EFT and elicit his/her response to it. Does the patient see EFT as helpful, burdensome or intrusive? Are there any areas that the patient would prefer to work on? Offer the patient an opportunity to express freely any remaining concerns or complaints that have not been voiced during the session and indicate that you would try to address them in subsequent sessions. Clarify the collaborative nature of EFT.

# EFT SESSION 2

## GOALS AND AGENDA

- 1) Introduce EFT to the family member/caregiver and review the problem identified in Session 1.
- 2) Understand the perspective of the family member/caregiver. Gain family member/caregiver view of changes in family roles and short-term and long-term plans.
- 3) Assess the family member/caregiver's ability and availability to help.
- 4) Complete a comprehensive problem area list and prioritize. Select one problem area to begin addressing.
- 5) Feedback

### **I) Introduce EFT to the family member/caregiver and review the problems identified in Session 1.**

Use the same approach that you used to introduce EFT to the patient. However, point out that the family member/caregiver comes to the assistance of the patient only when the patient alone cannot deal with his/her own assignments because of depression or stroke-induced limitations. Review problems related to negative perspective, lack of engagement in valued activities and interactions, poor rehabilitation adherence, disrupted family life, and poor coordination of care.

### **II) Understand the perspective of the family member/caregiver. Gain family member/caregiver view of changes in family role and short-term and long-term plans.**

First, inquire about the functions that this family member/caregiver performs. Try to understand the perspective of the family member or caregiver. What does he/she see as problems? Ask the family member/caregiver what problems he/she identifies that the patient has encountered after his/her discharge to home. Is the family member/caregiver concerned about the patient's ability returning to work, managing home responsibilities, or participating in family activities? What did the patient enjoy doing before that he/she either cannot do or has stopped doing? How has the family been affected? Gain the family member/caregiver's view of changes in family function and immediate and future plans. The family member may confirm and agree with the patient's view of the problems, may disagree with the patient's view, and/or may identify new problems not mentioned by the patient. New or different information provided by the family member now can be incorporated into the targeted problem areas.

### **III) Assess the family member/caregiver ability and availability to help the patient**

EFT encourages the patient to maximize his/her independence and to do as much as possible for his/her rehabilitation. However, in areas that the patient cannot function independently, help from family members/caregivers is necessary.

As discussed in the Introduction of this Manual, EFT should be personalized at the patient, environment and time (from session to session) level so that it captures the interaction between the patient's ability and the challenges posed by the environment. Accordingly, you should work with the patient, caregivers, and therapists to set goals and continuously "calibrate the environment" to the PSD patient's competence level. To accomplish this calibration, you need to understand the impact of the patient's disability on the family (e.g. finances, time commitment) and changes that need to be pursued in order to make the human and physical environment conducive to the patient's recovery and adherence to rehabilitation (facilitating arrangements).

A careful evaluation of the family member/caregiver needs to be done to determine the extent to which he/she can assist in EFT. The evaluation must include:

- 1) The family member/caregiver's physical ability to help, i.e. physical limitations, cognitive impairment.
- 2) The family member/caregiver's availability to help.
- 3) The family member/caregiver's motivation to help. Lack of motivation may interfere with the ability to help the care recipient in dealing with everyday problems. An unmotivated or overburdened family member/caregiver may become easily overwhelmed, and create tension that may be counter-therapeutic.
- 4) The family member's/caregiver's relationship to the patient. A positive relationship between the care recipient and the family member/caregiver can facilitate appropriate administration of EFT.
- 5) The family member/caregiver's understanding of current rehabilitation exercises, tasks and appointment with rehabilitation professionals as well as of patient's adherence to these.

The therapist should explain the goals of treatment, the treatment methods, the anticipated outcomes, and potential inconveniences of treatment. The therapist should explore the family member's/caregiver's concerns and answer questions. Establishing a therapeutic alliance with both the patient and the family member/caregiver is likely to be experienced as empowering by both of them.

Careful evaluation of the family member/caregiver's role participation is critical throughout EFT. Encountering difficulties in helping patients with their EFT assignments may be frustrating to family members/caregivers. Some may lose their enthusiasm. Others may become resentful of their role and angry with the patient. Acknowledgment of the problem, reassurance, and encouragement to continue, offered in a timely manner by the EFT therapist, may mitigate these problems.

**IV) Complete a comprehensive problem area list and prioritize. Select one problem area to begin addressing:** After discussion with both the patient and the family member, the therapist verifies that all current stroke-related problems have been identified. The therapist organizes the problems under the five therapeutic components of EFT. The therapist asks the patient what he/she sees as the most pressing or important problem. This question will help the therapist get a sense of how the patient is prioritizing the various problems. Together, the therapist and the patient agree on one problem upon which to focus. If time permits, the therapist begins to address the selected problem in the session using the corresponding EFT therapeutic component (e.g., social isolation can be addressed with problem solving); if not, the therapist indicates to the patient that this problem will be the focus of the third session. A copy of the problem list is left with the patient so that he/she may review it and add to it if necessary prior to the next session.

**If the Family Lives Apart from the PSD Patient:** The tasks of session 2 described below assume that a family member lives with the PSD patient. A minority of patients will not have a family member living with them. However, the family of PSD patients is almost always affected even when they live apart from the patient. The reason is that they need to help with arrangements for patient care, coordination and transportation to rehabilitation services, financial rearrangements, changes in the patient's physical environment, and assistance with relocation when needed. For families that live apart from the patient and are unable to participate in person, communication should be made by telephone using a similar approach as above.

#### **V) Feedback**

Ask the patient and family/caregiver whether they understood the goals and approaches of EFT and try to understand their reactions to it. Do they see EFT as helpful, burdensome or intrusive? Are there any areas that they would prefer to work on? Offer them an opportunity to express freely any remaining concerns or complaints that have not been brought during the session and indicate that you would try to address them in subsequent sessions.

# EFT SESSIONS 3-10

## GOALS AND AGENDA

- 1) Clinical Evaluation Update
- 2) Select specific target areas to address among the five therapeutic components (new perspective; adherence enhancement structure, problem solving structure reengineering family's goals, involvement, and plans, coordination of care with specialized therapists)
- 3) Summary of the session's main points and homework assignment
- 4) Feedback

**I. Clinical Evaluation Update:** The goal of this evaluation is to review the patient's clinical state and the ecosystem's (family/caregiver, specialized therapists) status with the explicit goal of selecting appropriate targets for the 5 components of EFT. Review and update progress made in the patient's current perspective on life after stroke; symptoms and severity of depression; areas of disability; current rehabilitation recommendations, goals, and adherence to rehabilitation; effects of stroke on family roles and plans and what challenges stem from this.

Note and write down: Any changes since the last meeting? How has the patient been dealing with each problem area? Have the proposed plans to address these areas been effective? What part of the plan was effective? What part was not effective?

Review the assigned homework.

**II. Select specific problem areas to address further:** The components of EFT vary from patient to patient and from session to session. Each patient and family require a different "dose" from each of the EFT component. The "dose" depends on the areas in which the patient and family have most difficulties. While keeping a broad perspective and use all five EFT components as a frame for your strategy, select with the patient and family the areas to target in each session. The focus will change as the patient's needs and the family's contribution change. Examples are given in the Cases described in this Manual. What follows outlines some of the tasks pertinent to each of the five EFT components.

**New perspective:** Reassess the patient's and family's understanding of the course of stroke-related disability, the nature of depression and its impact on the patient's thinking and behavior. Try to identify misconceptions, especially those originating from hopelessness. Offer a realistic alternative perspective and help them develop a "vision" about the patient's life and the role of the family as the patient recovers. Some patients and families will require an ongoing dialogue in this area as the level of the patient's disability changes (or persists) and as their thinking and adaptation matures.

***Adherence Enhancement Structure:*** Stroke rehabilitation requires adherence to a demanding rehabilitation regimen. Patients either need to go to an outpatient rehabilitation clinic or work with rehabilitation therapists at their own home. Transportation, waiting, and registration procedures may pose problems. A busy rehabilitation clinic may be difficult to negotiate. PSD patients may need services by different specialized therapists, e.g. physical therapists, occupational therapists, speech therapists. Each of them may emphasize the importance of their treatment but may not be aware of the overall plan and the response of the patient and family to all these demands.

Misconceptions about the role of each therapy may contribute to non-adherence and to inadequate help by the family. Finally, resignation, behavioral disorganization, and motivational disturbance (from stroke, PSD and executive dysfunction) may interfere with patient participation to rehabilitative exercises and even medication adherence.

Reevaluate what the patient and the family think and do. Cover each of the above areas in your evaluation and help the family and patient to understand what needs to be done, why, and how. Set up a structure that would ensure adherence to appointments and rehabilitation assignments. Use the "Strategy Set" of this Manual in making concrete suggestions.

***Introduce and/or Use the Problem Solving Structure:*** While many problems respond to clarification, psychoeducation, and direct instruction, others require development of problem solving skills. The PSD patient may be "locked-in" a helpless position and cannot find his/her way to deal with everyday problems. As a consequence, life may appear gloomy and meaningless, thus, exacerbating the hopelessness, worthlessness and resignation of depression.

Start by indicating to the patient that developing a Problem Solving Structure can make him/her able to see aspects of a problem that may not be apparent otherwise. Update the list that the patient and family made during Session 1 and 2. Identify problem areas that the patient values and their resolution would have a rewarding effect if addressed (e.g. meeting often with a close friend). Among them, help the patient select a problem that can be solved taking into considerations the patient's limitations and his/her family's resources. Adding a valued dimension to the patient's life would be rewarding and lead to behavioral activation and a sense of empowerment ("self-efficacy").

Teach the patient to address the problem using the EFT Problem Solving Structure. This approach is based on the Problem Solving Therapy literature and is simplified and adapted to the PSD patient's needs. Help the patient formulate the following four questions in your presence, while focusing on the selected problem:

What is the problem?

How might you try to solve the problem?

Which one of your ideas to solve the problem do you want to try?



When are you going to try it?

Model for the patient some possible responses. Encourage the patient to try several times and praise each successful attempt. Ask the patient to implement the plan to which he/she arrived in between sessions.

**Reengineer the Family's Goals, Involvement, and Plans:** Information gathered during Session 2 must have oriented you to the views of the family/caregiver. These views may be changing as the patient's depression and disability change. Continue to explore what the family/caregiver thinks needs to be done for the patient, what he/she does for the patient at present, and what the family member realistically can do. How is the family's everyday life affected? Is the family financially burdened? Is relocation to a nursing facility or a smaller apartment necessary? Is relocation expected to be temporary or permanent? Can the patient and family afford it? Does the family participate directly in the patient's everyday care? Does a family member help patient with transportation, appointments, etc. Does this involvement inconvenience the family (e.g. a working daughter, a family with children)?

Reexamine whether the family's views are realistic or whether there are misconceptions about what needs to be done or what the consequences of the family's actions might be on the patient's recovery. Does the family exaggerate or minimize the impact of its involvement of the patient? Does the family exaggerate or minimize the impact of the patient's needs on the family? As discussed above, depression is "contagious" and can "contaminate" the family leading to pessimism, helplessness, and unrealistic anticipation of negative outcomes and developments. Assess the impact of the patient's depression on the family.

As you arrive to a current understanding of the family's involvement, work with the family to convey a realistic understanding of what needs to be done in the short and in the long-run. The family plans need to be informed by both current patient needs and a view of the patient's anticipated progress. Make sure to communicate to the family that, in most cases, PSD improves. With improvement of PSD, pessimism and resignation subside and the patient would increase his/her participation in rehabilitation, self-care and social activities.

**Coordination of Care with Specialized Therapists:** In most cases, your contact with specialized (physical, occupational, speech) therapists will take place outside the session. However, the session with the patient and the family can help you understand how the patient and the family see the role of specialized therapists and inform your dialogue with them.

As discussed in the Introduction of this Manual, specialized therapists are part of the patient's ecosystem. Your goal is to arrive to a synergistic approach aiming to motivate the patient and help the patient and family develop a plan for participation in rehabilitation

and for use of community resources, e.g. support groups, recreational services for the physically challenged.

Specialized therapists are often busy and unable to obtain a broad view of the patient's overall care. They may have limited training in depression and may not have a clear picture of the role of depression-induced helplessness and resignation. While they are concerned with adherence to their own recommendations, they may be unaware of some of the complexities of the patient's ecosystem. However, they can be a major source of help in understanding what the patient does or does not do towards his/her rehabilitation. They may also provide information on the patient's prognosis. You may use this information in helping the patient and the family develop an appropriate perspective about their situation.

Your role is to understand where the specialized therapists are. What they think about the patient's outcome, what difficulties they experience in working with the patient, which of their interventions had been helpful, and which had failed.

Once you have a clear view of the role and concerns of specialized therapists, provide a summary of the patient's and his/her ecosystem's overall status to each therapist. Inform them of the role of depression in patient's behavior and response to therapy recommendations and of the family's role in meeting the patient's needs. Jointly, make a plan for enhancing the patient's participation in rehabilitation and for socialization, including realistic use of community resources (e.g. recreation centers).

**III. Summary of the session's main points and homework assignment:** Before you end the session, summarize the most important points, including an update of the problem areas, progress made, problem solving techniques used, and the family's role.

After the summary, discuss with the patient a homework assignment. The homework assignment has to be related to the problems the patient faces and must have a therapeutic goal that will be made clear to the patient. Discussion of homework is critical and must be part of the session's agenda. If the patient had difficulty completing earlier homework, explore what prevented a successful completion. For example, did the patient think the homework is unhelpful, irrelevant to his/her goals, too difficult, too elementary, ill-defined?

**IV. Feedback:** Ask the patient, and when appropriate the family, to provide feedback on the session. Your questions may include: What was helpful about the session? What was not helpful about the session? Were there any particular techniques that you found not useful or difficult to employ? Any areas that you wanted to cover but we did not cover? Clarify the collaborative nature aspect of EFT and reinforce both positive and negative feedback.

# BOOSTER SESSIONS 11-13

Sessions 11 to 13 are sessions designed to help patients maintain gains over the rest of the year. As time goes on, patients will encounter new problems as well as different versions of previous problems. The booster sessions help patients navigate these changes by administering the EFT therapeutic components in an efficient and direct manner. While patients will have experienced success in managing previous problems, drift away from the use of EFT strategies can also be expected. Booster sessions help to correct drift, remind patients to use EFT strategies, and re-align patients with the goal of continued adaptation and enhanced competence.

## GOALS AND AGENDA

- 1) Review and update progress in problem areas with the patient and family member/caregiver. Assess what strategies have been used or not used.
- 2) Identify new problem areas to be addressed with EFT.
- 3) Provide targeted and direct instruction in applying EFT therapeutic components to on-going or new problem areas.
- 4) Summarize the main points of the session.
- 5) Elicit feedback.

**I) Review and update progress in problem areas with the patient and family member/caregiver. Assess what strategies have been used and not used:** The therapist reviews with the patient and the family member/caregiver the problem areas discussed and addressed in previous weekly sessions. The therapist obtains information on the results of completed EFT actions as well as on on-going efforts. The therapist learns about and comments on how strategies have been implemented, troubleshoots lingering obstacles, and examines why strategies were not used or are no longer required. The therapist provides praise and positive feedback on successful implementation of EFT strategies and management of problem areas. The therapist also provides encouragement and support when there have been difficulties managing problem areas and/or implementing strategies to good effect.

**II) Identify new problem areas to be addressed with EFT:** The therapist inquires of the patient and the family member/caregiver what new problems have emerged since Session 10. New problem areas can reflect the patient's changed physical, occupational, and/or speech abilities (e.g., patient has recovered enough to return to work but is embarrassed to use a cane in front of clients) or might emerge from previous EFT efforts (e.g., previously isolated patient successfully returned to senior center activities, but now neighbor is no longer able to drive her there). The therapist works to understand the

nature of these new developments and select appropriate EFT therapeutic component to use.

**III) Provide targeted and direct instruction in applying EFT therapeutic components to on-going or new problem areas:** Because sessions are infrequent at this stage, the therapist must efficiently attend to the problems at hand and provide direct information, assistance, or suggestions to the patient and the family member/caregiver. While some applications of the EFT therapeutic components can be done almost completely in this session (e.g., new perspective, discussion of adjustments to family plans), other applications of EFT may not (e.g., problem solving, rehabilitation adherence). In the latter case, the therapist must provide the patient and family member/caregiver with a workable plan for how they will proceed after the session. If rehabilitation therapists are still involved in the patient's care at this point, they may also be contacted.

**IV) Summarize the main points of the session:** Summarize the most important points of the session, including the latest developments in problem areas and new problem areas. The therapist discusses with the patient "next steps" in addressing on-going and new problem areas. For some patients, this may be reflecting on important discussion points (e.g., when addressing patient or family member perspective), reminders to do a particular rehabilitation activity, or following through on a plan for a valued activity.

**V) Elicit feedback:** Ask the patient to provide feedback on the session. Questions include "What was helpful about this session? What was not helpful about this session? Were there any particular techniques that you found not useful or difficult to employ? Any areas that you wanted to cover but we didn't cover?" Clarify the collaborating aspect of therapy and reinforce both positive and negative feedback.

# THE LAST SESSION (SESSION 14)

## GOALS AND AGENDA

- 1) Review the work done over the course of EFT and positive changes that have been made.
- 2) Review EFT strategies that can be useful in preventing depression and continuing rehabilitation efforts.
- 3) Help the patient and family member/caregiver to separate from the therapist.

**I) Review the work done over the course of EFT and positive changes that have been made:** The patient, family member/caregiver, and therapist discuss the problem areas that were targeted and review the relative success of the implemented strategies and positive changes that have been made. Sometimes, patients forget or minimize the changes and adaptation that they have made. The therapist can help the patient reflect on adaptation by reviewing changes in physical, speech, and occupational functioning, depressive symptoms, skills in managing problems and engagement in activities and relationships.

**II) Review EFT strategies that can be useful in preventing depression and continuing rehabilitation efforts:** The patient, family member/caregiver, and therapist review the EFT strategies used and emphasize their role in preventing recurrence of depression and/or in promoting and maintaining rehabilitation.

Start this review by conveying the following: *"Depression can come back. Despite the improvement that you have shown, it is possible that you will face challenging circumstances in the future that may trigger depressive symptoms. To be better prepared to deal with depression if it ever comes back, we will review the problem areas that we worked on and look at what strategies you found useful. We will also discuss how you might react when similar problems arise in the future."*

**III) Help the patient and family member/caregiver to separate from the therapist:** *It has been a great pleasure to work with both of you. As you know, this is our last scheduled meeting. You have made a great deal of progress in managing the problems and changes that you faced after stroke and while being depressed. I trust that you will continue to use the skills you have learned and continue to successfully adapt to the changes in your life. If you need to call me, do not hesitate to do so. Here is my number, etc.*

# TREATMENT ADHERENCE ENHANCEMENT STRUCTURE

Setting up an adherence enhancement structure to rehabilitative and medical recommendations requires an understanding of likely barriers to adherence, tools used by physical, occupational, speech therapists, and a set of strategies that the EFT therapist may use. What follows is a review of common barriers to adherence, a description of tools that rehabilitation therapists use, and tools and strategies that the EFT therapist may employ.

## A. Barriers to Adherence

As a rule, multiple problems interfere with treatment adherence in depressed stroke patients. Problems include but are not limited to misconceptions about the illness and treatment, dissatisfaction with treatment, practical barriers, poor acceptance of depression, and hopelessness. Providing an Adherence Enhancement Structure involves an extension of offering an appropriate perspective, specifically regarding the role of rehabilitation and medical treatment. This Structure also involves direction, reminders, and involvement of family members as needed.

We first describe a number of barriers to adherence, and then describe corresponding interventions to overcome these barriers.

**Misconceptions about Stroke and its Treatment:** The EFT therapist should review the patient's perceptions on the need for the current medical and rehabilitative regimen and identify symptoms that are particularly problematic. Specific attention should be paid to the patient's understanding or misunderstandings about his/her treatment. The EFT therapist should identify patient views that may interfere with active participation in treatment, e.g. taking medication consistently, performing exercises consistently, using new adaptive techniques, keeping rehabilitation appointments, asking therapists to clarify poorly understood aspects of treatment.

*Open-ended questions*, phrased in a non-judgmental way, can be useful for initial identification of problem areas. Examples are: What is the most important problem that you experience after the stroke? Do you think that the leg, arm, and walking exercises are helpful? Follow the lead provided by the open-ended questions to identify in greater depth *individual views* that may interfere with treatment adherence.

Examples of common misconceptions are:

When I walk I feel worse. I never feel better.

I follow do any of the muscle exercises for a whole week and I do not seem to move any better.

These exercises are too hard; I feel too tired afterwards.

I feel better when I am sitting.

I am taking too many medications. This is not healthy.

These and other beliefs interfering with treatment can be expressed in a variety of ways depending on the individual patient. Each patient has a special way of addressing these areas. It is important for the EFT therapist to *learn and use the patient's language* when you refer to these areas.

**Dissatisfaction with Treatment:** The EFT therapist should identify dissatisfaction with specific treatment, therapists or services. The patient, then, can be focused on areas that can be changed and helped to accept areas that cannot be changed.

**Poor Acceptance of Depression:** The EFT therapist should review with the patient his/her views about depression and its treatment, and ask about the views of others in the patient's environment, e.g. who knows about your psychological and physical symptoms and your treatment? What has their reaction been? Attention should be paid to shame and low self-esteem related to depression and reinforced by poor acceptance of depression.

**Practical Barriers:** The EFT therapist should review the patients' practical concerns about treatment, including cost of treatment and medications, scheduling and access to office visits, transportation, and insurance. Review should include the practical implementation of the treatment plan, e.g. how the patient will attend appointments, payment for visits and medication, reminders about taking medication and conducting exercises.

**Hopelessness:** Many of the above negative attitudes may be accentuated by hopelessness. The EFT therapist should identify the patients' views about their future and focus on their medical health but also on their expectations in other meaningful areas to them. Hopelessness is often more pronounced in some areas than others. Open-ended questions can orient you to specific areas of hopelessness. Nonetheless, since the main goal is to improve adherence to rehabilitation, the EFT therapist should identify thoughts of hopelessness that interfere with treatment. Examples are:

#### On Stroke

Nobody recovers fully after stroke. There is no good reason to keep trying since it won't make a difference.

Stroke makes me a burden to my family. That can never change.

Stroke made me useless and I can't do things the way I used to.

These therapies are useless. I do not believe that they can help me.

Everybody has given up on me, what is the use to go on.

I do not see how any treatment can help somebody like me. I see no need to continue all these medications and the rest of the torture.

#### On Depression

I have been a strong person. Depression is only for the weak. I do not have depression.

If you had a stroke, you would have been depressed too.

I am not depressed now. I do not see why I should continue treatment.

### **Interventions**

**Misconceptions about Depression, Stroke and Treatment:** The EFT therapist should provide information about depression in general, and review the specific depressive symptoms of the patient. It is important to *link the patient's symptoms* to the DSM-IV criteria for depression and come to an agreed upon label for the illness. The EFT therapist should emphasize that improving depression not only can enhance quality of life but also can provide the *motivation and energy needed in order to engage in stroke rehabilitation*. The EFT therapist should provide the Information Booklet on Late Life Depression (by the National Institute of Mental Health).

The EFT therapist should work with the patient to identify symptoms and impairments in functioning that are distressing and could be helped by treatment. The patient should be encouraged to identify 2-3 reasons to remain in treatment that can be reviewed when uncertainty arises.

It is critical to explain the role of the prescribed rehabilitation regimen treatment in reducing disability associated with stroke. It often is useful to emphasize that going through the prescribed rehabilitation routine with regularity is important even when patients feel fatigued and disinclined to do so. The EFT therapist should discuss the role of pharmacotherapy and its potential side effects. It is important to address misconceptions about each treatment.

**Dissatisfaction with Treatment:** The EFT therapist should help the patient to develop a plan for addressing his/her concerns about treatment. Interventions may include coaching the patient to report and discuss side effects with the rehabilitation therapists and physicians and addressing office issues such as waiting time and other logistic issues.

**Practical Barriers:** The EFT therapist should help the patient to develop a strategy for addressing his/her practical concerns. Often, it is helpful for the patient to enlist the help of family members, friends, and social services. Review of the patient's practical concerns about treatment should include cost of medications, scheduling and access to office visits, transportation, and insurance. A strategy should be developed jointly with the patient for addressing practical barriers. The EFT therapist should review the practical implementation of the treatment plan, and help the patient find ways to attend appointments and devise reminders for taking medication and conducting exercises.

**Poor Acceptance of Depression:** When poor acceptance of depression by the patient or others is identified, the EFT therapist should acknowledge that there is a social prejudice against depression. The EFT therapist should work with the patient to identify persons with whom the patient wishes to share issues related to their treatment and enlist their



support and help when needed. The patient should be encouraged to think about ways of disclosing or reasons for not disclosing depression and help him/her with these decisions. Metaphors/analogies may be helpful in reducing self-blame, e.g. depression is an illness. In fact, it is an illness like heart disease, diabetes, etc. With good care, you can keep depression under control. When appropriate, the EFT therapist may mention public figures known to experience depression and to try to counter views of mental illness as a character weakness. It is important to emphasize that eliciting support and help can improve the outcomes of both depression and stroke.

**Hopelessness:** Hopelessness should be identified as a symptom with a *central role* in fueling poor expectations from treatment and an attitude of resignation. Helpful statements may be: "When you feel hopeless you may overestimate your difficulties in doing your exercise. What is most important for you now is to follow the treatment that would improve your walking, your flexibility, your dexterity, and your overall functioning. I am confident that you will change your mind after you see results."

### **B. Strategies and Tools Used by Rehabilitation Therapists**

These strategies are usually introduced by physical, occupational and speech therapists. Increasing use of computers and other electronic devices may be quite useful. Examples relevant to patients with mobility problems are: 1."Sticky" keyboard computer settings for patients with poor motor control (this is a setting most computers/keyboards have as a standard option); and 2. Touch pad computer screens instead of a keyboard or a voice activated computer. An example for aphasic patients is "augmenting communication devices-communication computers".

#### **Strategies and Tools Used by Rehabilitation Therapists**

##### Strategies Related to Mobility

Cane, Walker, Manual or powder wheelchair, Stair glide, Ramps, Bath/toilet safety equipment  
Stocking aides  
"Sticky" keyboard computer settings"  
Touch pad computer screens  
Voice activated computers  
Meal preparation devises for one-hand use

##### For the Aphasic Patient

Cueing Pacing  
Rhythm and melody enhancing word fluency  
Communication boards  
Pictograms  
Yes/no response paradigms  
Augmentative communication device-  
Communication computer

The Role of the EFT Therapist: While computer devices can be helpful to stroke survivors, most stroke patients of this generation are unfamiliar with computers. Explore the patients' understanding of when and how to use them. Try to understand when and how the patient actually uses them. With the patients' permission contact the therapists and form with them a specific plan for integrating these strategies in EFT. Discuss the plan with the patient and family member/caregiver and outline the role of EFT in utilizing these strategies.

## C. Strategy Set for the EFT Therapist

### Strategies for Planning

Executive dysfunction is a common neuropsychological impairment in PSD patient leading to disorganized behavior. What follows summarizes some of the techniques the EFT therapist may use to address this problem.

Step-by-step division of a task: This is a useful technique for starting a specific action or a sequence of actions. Step-by-step division of actions can be used in conjunction with other strategies, like signs, reminders, etc. For example, going out for a walk in the morning can be divided into several steps: Getting out of bed, taking a shower, getting dressed, eating breakfast, going out for a walk. Step by step planned activities can be part of a checklist when needed, and provide a helpful structure for patients with action initiation problems.

Preparatory steps for a task: This strategy is used to increase the likelihood of implementing a plan and is used in conjunction with the step-by-step task division. For example, a patient who stays with his/her night clothes the whole day may make the following plan with the EFT therapist: Wake up using an alarm at 9:00 am, take a shower at 9:15 am, and get dressed at 10:00 am. The preparation of the plan includes: Checking the alarm, preparing a checklist to make sure he/she has everything needed for a shower, helping the patient select the clothes he/she will wear the next morning and placing them on a chair near the bed. Patients experiencing difficulty following the preparatory steps may receive help by their family members/caregivers.

Calendars: Calendars are tools important for keeping track of scheduled actions such as appointments, activities, etc., and they can be useful to every patient. Calendars can be used as triggers to start a scheduled activity and follow a scheduled action. For example, a note on the calendar may remind the patient to call the pharmacy for refill of a prescription. To minimize distractions, the pharmacy's telephone number and the prescription number may be put on the calendar or on a sticky notepaper attached to the calendar. If the patient is so impaired that he/she cannot learn how to use a calendar, the family member/caregiver may provide help. Patients with difficulty initiating action and following through may welcome this structure.

Filing Folders: Filing folders may not be directly effective in triggering specific actions. However, instructions and checklists may be kept in folders for the patient to use when needed. Instructions and lists of sequential tasks in approaching specific activities may be an important resource. A table of contents for each folder should be placed in a visible place near the folders. The family member/caregiver may help the patient organize the folders and create a table of contents.

### Strategies for Attention Deficits

Shaping procedure to sustain attention: This procedure can be used to initiate specific actions or to remind the patient of specific task steps by helping the patient to avoid

distractions. For example, a patient has decided to call his/her friend, but because another event distracts him/her, he/she does not make the phone call. During the EFT session, the therapist may observe the patient as he/she is going through the steps from deciding to call his/her friend to actually making the phone call. The EFT therapist should utilize reinforcers (encouragement, praise, assignment of credits) to sustain the patient's attention. Another patient may be unable to read and follow an article in his/her preferred magazine because he/she gets distracted and he/she does not remember where he/she stopped. The EFT therapist may recommend a short break after reading each paragraph and teach the patient to mark with a pencil the point where he/she stopped so that he/she can go back to reading without getting confused. The patient may count the times that he/she was able to return back to the point he/she stopped and receive credit by the EFT therapist. The EFT therapist may keep records of the solution for each problem and give it to the patient for future reference.

Minimize distractions: During this process, the EFT therapist may remove environmental distractions. In the example of a patient who wishes to make a phone call, the EFT therapist may ask the patient to make all his/her calls of the day from a specific room and at a specific time when distractions are least likely to occur. In the reading example, the EFT therapist may instruct the patient to do his/her reading in a room with minimal distractions and at a time least likely to be disturbed.

### ***Initiation Strategies***

Notebooks: Selected initiation prompts may help patients initiate tasks that they neglect, e.g. "taking a shower in the morning makes me feel better during the day." For patients whose writing and reading abilities are impaired, the family member/caregiver may assist in preparing motivational prompts. Memory notebooks may be used by patients, whose writing and reading abilities are relatively intact to remind themselves of important details as well as the sequence of actions in a specific activity. For example, the patient may write down important procedures like the steps need to be taken to refill his/her medications. Appropriately placed notes with directions may reduce the need for attention. Notebooks can be used in conjunctions with checklists, which help the patient complete all the steps of the instructions.

Diaries: Patients, whose writing and reading abilities are relatively intact, may utilize diaries to keep track of thoughts and feelings regarding a specific behavior, for example, "Today, I spoke with my friend Susan. Whenever I call her, my mood is lifted." Another patient may keep in the diary his/her doctor's or occupational therapist's recommendations and describe his/her understanding about the benefit from following. For patients with impaired reading and writing abilities, the family member/caregiver may help the patient write the necessary material and read it back to the patient. Reading them may motivate the patient to initiate desirable actions. For patients with impaired reading and writing abilities, the family member/caregiver may write the patient's thoughts and feelings and read them to the patients in order to motivate them for specific actions.

## ***Strategies Utilizing Visual Cues***

***Signs:*** Placement of signs should be appropriate for any hemispatial neglect which is seen in up to 30% of patients following stroke. Left hemispatial neglect is most prevalent and accounts of 70% of all hemispatial neglect. It is usually more severe and persistent than right hemispatial neglect. Patients with neglect of left hemispace require sign placement toward the right side of body midline, in their intact right visual field. Signs may not offer adequate assistance to severely impaired patients and the family member/caregiver may need to help. Large print must be used for patients with poor eyesight.

Signs can be used to remind patients to perform an action. For example, a sign inside the front door "Did you take your cane, eyeglasses, money, keys, and identification cards with you?" may serve as a reminder. Another sign may remind the patient to put the cane and eyeglasses in a specific place when he/she comes back so he/she will be able to find them when he/she needs them again.

***Checklists:*** Checklists are helpful to most patients. Checklists may remind patients of sequences of actions that need to be taken before a task is completed. Patients often benefit by checking off the steps that they accomplish.

***Pictures:*** Pictures may be helpful in initiating certain tasks. A picture of a man shaving placed in the bathroom mirror may reinforce the need to shave. A picture with newspapers and magazines with an arrow pointing at a paper wastebasket may help the patient to dispose the newspapers/magazines in the right wastebasket.

***Sticky notepapers and Reminders:*** Sticky notepapers and reminders can be used to elicit a response from mildly impaired patients. Sticky notepapers are not as large as signs and they may not capture the attention of moderately and severely impaired patients.

***Magnetized notepads:*** Magnetized notepads, like sticky notepapers, can be useful for mildly impaired patients.

***Colored tags:*** Colored tags can be useful to capture the patient's attention and be used in conjunction with signs and reminders to initiate actions.

***Large bold font computer monitor settings:*** These can be pre-set and are often used for macular degeneration. However, they can be helpful for some visual perceptual impairments post-stroke.

## ***Strategies Utilizing Auditory Cues***

***Customized audiotapes:*** Customized audiotapes with specific instructions using real time (which lets the patient continue on while the tape is on) can help a patient to initiate a specific action, maintain attention, and perform a sequence of actions; they should use pauses to allow long processing time. For example, customized audiotapes saying, "Prepare your clothes for next morning. First, select your clothes from the closet .... Second, put them on the chair near your bed ...", may help a patient prepare for the next morning. A customized audiotape may have instructions on how to prepare for going for a walk or even

how to use other reminding tools, like checklists, voice alarms, timers, or pre-recorded messages. For example, customized audiotapes saying, "please take the checklist of household chores from the drawer in the bedroom ..., check off the first item on the check list..., pick up and hang your clothes ..., did you check off the first item? ... ", may help the patient keep an orderly home.

Voice alarms: Voice alarms can help a patient to initiate a specific action. For example, a voice alarm saying "call your daughter" may help the patient make the phone call. Voice alarms can be used as reminders of an action or of a sequence of actions; For example, a voice alarm saying, "Always set the timer when you use the stove", may help the patient avoid overcooking his/her food and even prevent accidents. The EFT therapist may instruct the family/caregiver to prepare the voice messages together with the patient and teach the patient how to use a voice alarm. The instructions for use of a voice alarm should be with the voice alarm. A family member or family member/caregiver may help the patient, if necessary. Different tones may be used for different actions i.e. oven bell for cooking.

Computerized phone calls: Computerized phone services are commercially available and function like the wake-up call services offered in hotels. Specifically, a computer program may trigger a phone call to the patient at a specific time and through a pre-recorded message remind the patient to perform an action. For example, a patient may be called in the morning and reminded to take medication. Or a computer program may trigger a phone call and remind the patient that he/she should expect a visit by a physical therapist in one hour and that he/she needs to start getting dressed. The EFT therapist must have prepared a step-by-step plan for the patient to follow so that he/she will be ready for the appointment. The computer may generate another phone call 15 minutes before the appointment to make sure that the patient did not get distracted and got ready for his/her appointment.

Timers: Timers can be used to indicate both the beginning and the end of a task. They are helpful in initiating a sequence of actions. For example, timers can be used to draw attention to begin the next household chore out of a list of chores. Timers can help patients with attention deficits to keep track of a sequence of actions. Timers may put a high demand on memory unless they are combined with other tools, like notebooks and signs that will indicate the kind of action that needs to be taken. For example, a checklist, a sign, and a timer may help the patient prepare lunch. The checklist can provide the list of the ingredients. For each step, a sign will ask the patient to set up the timer. The sound of the timer will indicate the end of one step and the beginning of the next step. The family member/caregiver may be involved when necessary.

Timed pre-recorded messages: Timed pre-recorded messages are a great tool to trigger specific behaviors. Messages like "it is time to get dressed" can be used to initiate action. Timed pre-recorded messages may be used to remind patients of specific actions. For

example, a repeated message like "call your daughter at 941-5684" can help the patient make the phone call.

Beeping Watches: They can be used to help patients begin a scheduled action. For example, a beeping sound may remind the patient that he/she has to call his/her daughter. For severely impaired patients, watches may be used in conjunction with other tools, like signs or reminders. The watches may be difficult to use in patients with significant memory impairment and should be coupled with notebooks and signs specifying the action or actions that need to be taken. For example, a beeping sound coupled with a sign "Call your daughter at the sound" may serve as an effective reminder.

Alarms: Alarms could be used to trigger action. For example, in order to help a mobile patient who often stays in bed much of the time, the alarm may be set to ring every five minutes and placed away from the patient's bed so that the patient has to get up in order to disable the alarm. A family member/caregiver may help the patient buy an alarm that will be easy to use and keep the instructions close to it. For more impaired patients, the family member/caregiver may help the patient set the alarm.

# CASE EXAMPLES

## Mr. B

### Primary Focus: New Perspective

Mr. B is a 68-year-old accountant who lives with his wife of 30 years in a two-bedroom apartment. They have one daughter who lives with her 6-year-old son an hour away from Mr. & Mrs. B. Mr. B suffered a stroke two months ago, which has left him with significant calculation difficulties and disability in his right arm, which he can only use to pick up small objects. Mr. B had started working part-time in the year before the stroke as he wanted to retire by the age of 70. After the stroke, he was unable to work and the possibility of returning to work is remote. His inability to work has greatly contributed to Mr. B developing a major depressive episode a few weeks after his stroke. He felt hopeless and believed that "his life is over because I can't do anything." He denied suicidal ideation and said that he would "never do that to my family." Though strongly encouraged by his neurologist and physical therapist to use a cane to prevent falls, Mr. B opposed the use of the cane because he viewed it as a sign of weakness. In the week prior to the first EFT session, Mr. B fell twice but continued to not use his cane. He was also reluctant to perform his physical therapy exercises because he did not believe they would make a difference. Further, he became increasingly isolated and did not want his daughter and grandson to come visit him, something that she had routinely done every few weeks. Mr. B's wife became increasingly frustrated with her husband's reluctance to stick with his treatment recommendations and to be with their daughter. Mrs. B received a lot of emotional support from her daughter and did not understand why her husband seemed to be pushing their daughter away.

After considering the different problem areas that Mr. B presented, the EFT therapist selected New Perspective as the primary EFT therapeutic component to address with Mr. B. During the initial sessions, the therapist helped Mr. B to change his perspective. First, the therapist helped Mr. B understand that despite his physical disability, he could still engage in valued activities (i.e. playing with his grandson, reading, going to the opera). Second, the therapist increased Mr. B's awareness of the consequences of not using his cane that he may continue to sustain falls and potentially break of his hip, which would further deteriorate his physical functioning. Third, in Session 2 in which his wife participated, Mr. B acknowledged that the recent falls have strained his relationship with his wife, who had become increasingly anxious about his health, was losing sleep, and had become more irritable with him. As a result of his changed perspective, Mr. B decided to try to use the cane more in the following weeks.

The EFT therapist addressed Mr. B's other problem areas with the other four EFT therapeutic components in the following ways:

Problem Solving Structure: After addressing Mr. B's perspective, the EFT therapist targeted his increased social isolation and lack of involvement in activities. By asking Mr. B the What, How, Which, and When questions of the Problem Solving Structure, the therapist helped the patient identify four activities (reading, listening to music, going to church, visiting with his daughter and grandson) that he valued and found rewarding. Mr. B and the therapist created a specific plan to help the him actually proceed with these activities on a regular basis. To reduce social isolation, the patient decided through using the Problem Solving Structure to get in touch with his friends, many of whom were retired, and who he had refused to see since the stroke. Mr. B found that his friends were much more accepting and understanding of his new situation than he feared they would be.

Reengineering family goals, involvement, and plans: Mr. B frequently expressed his concern that he may not be able to return to work. The therapist discussed with Mr. B and his wife the potential financial consequences of Mr. B not returning to work. The EFT therapist had also spoken with Mr. B's daughter and learned that potentially she was in a position to help her parents financially if her father could not return to work. Mr. and Mrs. B and their daughter began an on-going discussion of whether Mr. and Mrs. B could find a place to live closer to their daughter and grandson. Towards the end of the course of EFT, Mr. B and his wife held off on making a decision about moving because they wanted to see how successful the rehabilitation would be. They decided to revisit the issue at the end of 3 months.

Adherence Enhancement Structure: Although addressed initially with helping Mr. B to change his perspective, the EFT therapist wanted to address directly Mr. B's attitude, lack of motivation to do the physical therapy exercises, and reluctance to use his cane. The EFT therapist, after speaking with Mr. B's rehabilitation therapists, created a plan with Mr. B that helped him schedule home exercises into his day and worked with Mrs. B to provide positive reinforcement when he performed the exercises. The therapist also coached Mrs. B in providing simple, empathic responses when he was not cooperating. Although Mr. B continued to sometimes "forget" to use a cane, he became more consistent with using one after his grandson saw a cane with a handle in the shape of a dog's head. Mr. B was more inclined to use this cane, stating "It's got personality and doesn't look like I just came out of the hospital!"

Coordination of care: The EFT therapist spoke with the physical and the occupational therapists in the beginning of treatment and they had follow-up phone calls every couple of weeks to evaluate Mr. B's progress. All were concerned about Mr. B's difficulties in following through on home exercises and on using his cane. The plan was to continue encouraging Mr. B's participation in treatments while gently responding to his discouraging comments and attitude. Both rehabilitation therapists reminded Mr. B of how much progress he made when he worked diligently on his exercises.



## Mrs. J

### **Primary Focus: Reengineering Family Goals, Involvement, and Plans**

Mrs. J is a 75-year-old widowed woman whose occupational therapist suspected that she was depressed after suffering a stroke seven weeks ago. Prior to her stroke, Mrs. J lived by herself in the large house where she and her husband had raised their two daughters. One of her daughters lives a few towns away with her husband and their three small children. Mrs. J's other daughter lives on the west coast. After two weeks of inpatient rehabilitation, Mrs. J returned to her home; however, even with appropriate modifications such as a chairlift, she is considerably overwhelmed by the management of so large a house. Mrs. J is easily tired by walking between rooms and struggles to take care of the cleaning and organizing. Although she and her husband were comfortable financially, Mrs. J is careful with her money and does not want to spend it on "unnecessary" expenditures, such as hiring a cleaning service. She becomes frustrated frequently when she calls her daughter to ask for assistance with household chores, transportation, and paying bills and her daughter is unable to come. Mrs. J has shared her frustrations and disappointment about her home life and family with her occupational therapist.

During the initial EFT session, Mrs. J spoke about her own experience caregiving for her mother. Mrs. J's mother came to live with her when her mother's dementia worsened. Mrs. J described this experience as difficult but non-negotiable—"That's just what you do—you take care of your own." With further discussion, Mrs. J explained that she had an expectation of her daughters that they too would "take me in" when she needed extra help. Thus, Mrs. J's frustration with her daughter's unavailability to help was compounded by a sense that her daughter did not care enough for her and that Mrs. J's expectations were not being met.

In the second EFT session, Mrs. J's daughter was present and shared her perspective and concerns. From this discussion, Mrs. J's daughter indicated that, while she would love to help her mother more and even take her in, she just did not know how this was possible. She delineated many obstacles to helping her mother more, including working a full-time job, raising three children, and the 45-minute drive to her mother's house. She also described her own house as modest and with barely room for herself, her husband, and the children. Mrs. J's daughter intimated that finances were a major concern too.

In reviewing Mrs. J's problem areas, the therapist selected to use Reengineering Family Goals, Involvement, and Plans as the primary EFT therapeutic component to address: Mrs. J's concerns about managing her home and household chores; how family roles have and may continue to change; and the immediate and future plans of both Mrs. J and her daughter. The EFT therapist worked with both Mrs. J and her daughter to find a realistic understanding of what Mrs. J could and could not do in the house. This discussion led Mrs. J and her daughter to decide that the house really was too big and unmanageable for Mrs. J alone. They decided that downsizing would be more manageable for Mrs. J and that the

eventual sale of the house would give her additional savings. Initially, Mrs. J and her daughter did not see eye-to-eye on how involved Mrs. J's daughter should be in Mrs. J's care. Her daughter thought that once a week was sufficient and that her mother could have a friend come over to help more; Mrs. J thought that she should move in with her daughter, or at least her daughter should come over after work most days. Over a number of sessions, the therapist facilitated discussion between Mrs. J and her daughter so that they were able to understand that a new path with different expectations would have to be forged for this family. Eventually, Mrs. J agreed to move into an apartment in the same town as her daughter. This allowed her daughter to come over more to help. In doing so, Mrs. J felt that she was receiving the care she needed and her daughter felt better able to provide this care. This arrangement also made it more convenient for Mrs. J to see her three grandchildren and she began to feel much closer to them—"I'm involved in their day-to-day lives now."

Although reengineering family goals, involvement, and plans was the primary focus, the therapist employed other EFT therapeutic components in the following way:

New Perspective: The EFT therapist worked with Mrs. J to develop a more adaptive perspective on her abilities after stroke. Specifically, they established what tasks she still could do around the house, which ones required modification, and which ones her daughter really needed to do for her. This was done again after Mrs. J moved to her apartment. The therapist also provided psychoeducation to Mrs. J on how fatigue and self-doubt were part of depression and how depression contributed to her often underestimating her own abilities.

Adherence Enhancement Structure: Mrs. J adhered quite well to her rehabilitation goals and spoke about how much she liked her occupational therapist. However, at times when she felt fatigued or frustrated, she not feel like doing her occupational therapy exercises at home. The therapist worked with Mrs. J on coming up with a reminder notecard that used encouraging words and phrases, some of which came directly from Mrs. J's occupational therapist.

Problem Solving Structure: Mrs. J had quite a talent for knitting and crocheting. After her stroke, her fine motor skills were too impaired for her to engage in this work. This was very frustrating for Mrs. J, but this also helped her to continue to work in occupational therapy. She wanted to find another way in which she could continue to engage in this valued activity. The therapist applied the problem solving structure to this situation and Mrs. J eventually solved this problem in two different ways. First, she decided to spend one day a week with her friend who owned a yarn shop. This allowed her to have more social interaction with other knitters and she felt useful in helping with small tasks such as stocking yarn bins and sorting colors. Second, when she moved to her new apartment, she was able to teach her oldest grandchild to crochet by guiding her with verbal instructions. Mrs. J took great delight in seeing her granddaughter's creations.

Coordination of Care: In addition to using the occupational therapist's encouraging phrases to enhance adherence, the EFT therapist also was in communication with the occupational therapist throughout the initial part of EFT. The therapist was able to provide guidance on what Mrs. J's abilities were (and thus with what tasks she required assistance) and encouraged Mrs. J's work in EFT when they would meet for occupational therapy sessions.

## Mr. A

### Primary Focus: Problem Solving Structure

Mr. A is a 70-year-old widowed man who suffered a stroke six weeks earlier and subsequently developed major depression. He has lost dexterity in his right hand but is able to ambulate with a cane and his speech is unaffected. Since his stroke, Mr. A has been unable to drive. He lives alone in a small house, which has been modified to meet Mr. A's needs. His son is divorced and lives nearby. However, Mr. A's son has a demanding job and little time to devote to Mr. A's care. He calls Mr. A to check up on him a couple of times a week and stops by once every couple of weeks to visit and do his father's laundry. Mr. A has no other immediate family, but has several cousins who live out of state. Prior to involvement in EFT, he had only left his house for medical and outpatient rehabilitation appointments, to which his son either drove him or he took a taxi, which was expensive. He has had little other contact with anybody. He relies on his son to do his laundry, but feels uncomfortable asking for further assistance with other tasks, such as bill paying and upkeep of the home. Prior to his stroke he enjoyed attending a neighborhood senior center, going to the library, and playing chess outside at a local park. Mr. A has not returned to any of these activities and indicated to the therapist at Session 1 that he did not see how he could possibly return to these activities. He also stated that finding new activities and social interactions in which to become involved would be too difficult for him.

After considering the different problem areas that Mr. A identified, the therapist selected Problem Solving Structure as the primary EFT therapeutic component to use with Mr. A. This component would help Mr. A to engage his social network more effectively in providing needed assistance and to address his social isolation. The EFT therapist helped Mr. A to understand how both of these problems interfered with his recovery, to identify ways that he might address these problems, and to develop a plan for when and how to address them. In Session 2, which his son attended, Mr. A's son explained how he would be willing and available to help Mr. A more, but was uncertain when Mr. A needed help. Using the Problem Solving Structure, the therapist helped Mr. A find specific ways that his son may be helpful (e.g., review personal finances, home upkeep, etc.). The therapist also helped Mr. A apply the Problem Solving Structure to eventually select and plan weekly social activities both in and out of the home. By asking Mr. A the What, How, Which, and When questions of the Problem Solving Structure, the EFT therapist helped Mr. A think of and sort through different options of resuming valued activities. In doing this, Mr. A decided to try to attend the senior center on Mondays and Wednesdays and go to the library on Thursdays. He also chose to return to playing chess at the local park on Saturdays and later in the year made a friend there who introduced him to an indoor chess club where he played during the winter months. In addition, the Problem Solving Structure helped Mr. A decide to learn how to take assisted public transportation when his son was not available.

The EFT therapist addressed Mr. A's other problem areas with the other four EFT therapeutic components in the following ways:

New Perspective: The EFT therapist described the impact of depression on Mr. A's ability to function at home, engage in outpatient rehabilitation, and also emphasized the importance of both treatment and engagement in socially rewarding activities in recovery from his depression. Mr. A tended to minimize the role his previous activities and interactions with others played in his life. The therapist's consistent message regarding the importance of including rewarding activities and interactions helped motivate Mr. A to engage in his Problem Solving Structure efforts.

Adherence enhancement structure: The EFT therapist identified Mr. A's discomfort relying on his son for transportation to outpatient rehabilitation appointments as a barrier to adherence. The EFT therapist educated Mr. A on the importance of regular attendance and helped ensure transportation that was available as needed. This included arranging rides with Mr. A's son but also learning about and using assisted public transportation as needed.

Reengineering family goals, involvement, and plans: The EFT therapist engaged Mr. A's son at Session 2 and educated him on the impact of his father's stroke and on his need for assistance. With Mr. A's permission, and following plans made as a result of Problem Solving, the therapist encouraged the son to provide more assistance in financial management and home upkeep. Mr. A's son attended some of the other EFT sessions and provided helpful feedback on his availability and willingness to help his father. Mr. A gradually began to see that his son wanted to help him more. He also understood that they both were not used to communicating with one another directly, especially about requests for help. The EFT therapist facilitated Mr. A's ability to ask for more help from his son and to work around conflicts as they occurred.

Coordination of care: The EFT therapist spoke with Mr. A's physical and occupational therapists about his goals for participation in rehabilitation and for getting out of the house more to increase social interaction. Specifically, they provided the EFT therapist with a better understanding of Mr. A's physical functioning, which allowed for more realistic planning of his goals. The physical and occupational therapists were also able to reinforce the notion of social activities and interactions as an important component of rehabilitation.

## Mrs. C

### Primary Focus: Adherence Enhancement Structure

Mrs. C is a married 74-year-old woman with a long history of depression who lives with her spouse. Her past episodes of depression were mild and were mostly characterized by feeling down and discouraged, having difficulty falling asleep, and feeling worthless. Mrs. C suffered a left hemisphere stroke, which resulted in difficulties using her right hand and mild aphasia. She also required frequent reminders to initiate and complete tasks. Mrs. C developed a major depressive episode after the stroke, which, in contrast with her previous episodes of depression, was moderate to severe and she experienced low energy, fatigue, lack of motivation to do most things, and feeling hopeless about her future. Mr. and Mrs. C do not have any children but they have a nephew who lives out of state and works full-time. He visits them every couple of months and, while he would be willing to become more involved in Mrs. C's care, he is not available to do so on a more frequent basis. Mr. C has been very supportive after Mrs. C's stroke and he has taken over the household responsibilities that she used to do (shopping, preparing meals, laundry, light housework). In addition, he has been driving her to her doctors' appointments. Mrs. C reported that she doesn't have the energy and motivation to do the physical and speech therapy exercises. She frequently changed her physical and speech therapy appointments. Sometimes in the middle of the sessions, she complained that she was too tired to continue. She also withdrew from her social circle and stopped engaging in previous activities (tai chi, involvement in activities in her synagogue). Even though her friends have been in touch with her, Mrs. C no longer initiated telephone calls and rejected her friends' invitations. Finally, her husband felt overwhelmed and helpless as he was unable to "convince" Mrs. C to adhere to her physical and speech therapy regimen.

After considering the different problem areas that Mrs. C presented, the EFT therapist selected Adherence Enhancement Structure as the primary therapeutic component to address. After the initial evaluation, the EFT therapist discussed the case with the rehabilitation (physical and speech) therapists. Both therapists were concerned with Mrs. C's lack of motivation and energy. They confirmed that she either cancelled sessions or wanted to cut the sessions short. Further, she was not eager to perform any exercises. The speech therapist was particularly concerned about Mrs. C's attitude towards him, as it appeared that she tuned him out. The EFT therapist discussed the speech therapist's concerns with Mr. C, who agreed that his wife often complained about her fatigue and the lengthy rehabilitation sessions. The EFT therapist and the rehabilitation therapists created a plan to improve adherence by having: a) the rehabilitation therapists arrange therapy sessions in the morning, when Mrs. C had more energy and was more eager to have sessions; b) the therapists begin sessions by reminding Mrs. C of the benefits of rehabilitation to encourage her participation; and c) Mr. C use reminders (sticky pads) and prompts (alarm clock) to encourage Mrs. C to perform the assigned exercises at home. The EFT therapist discussed the plan with the couple and Mrs. C decided to make an

effort to adhere to the plan and to accept her husband's reminders to perform the physical and speech exercises.

The EFT therapist addressed Mrs. C's other problem areas with the other four EFT therapeutic components in the following ways:

New Perspective: The EFT therapist educated Mrs. C about the "psychological storm" that occurs when someone has suffered a stroke and becomes depressed. The therapist helped her understand that there is a downward cycle that starts with lack of motivation or not caring, which leads giving up on participating in rehabilitation therapies, which in turns leads to lack of improvement in physical and speech abilities, and the worsening of depression. The EFT therapist also helped Mr. C understand the "contaminating" effects of his wife's depression and provided praise and encouragement for his involvement in her care.

Problem Solving Structure: After Mrs. C started adhering to her physical and speech therapy exercises, the EFT therapist targeted social isolation and lack of involvement in valued and rewarding activities. The EFT therapist highlighted the positive aspects of her social involvement, which may help her improve her mood. By asking Mrs. C the What, How, Which, and When questions of the Problem Solving Structure, the EFT therapist helped the patient create a plan to call two friends and to accept their invitations to have lunch together in the following weeks.

Reengineering family goals, involvement, and plans: The stroke affected Mrs. C's abilities to perform household chores. Even though he had taken over these responsibilities, Mr. C eventually shared that he felt overwhelmed with caretaking responsibilities and he would welcome additional help. The EFT therapist guided Mr. and Mrs. C in exploring the possibility of hiring someone to perform household chores so that Mr. C felt less overwhelmed. Fortunately, the couple had the finances to support additional help.

Coordination of Care: The EFT therapist was in contact with the rehabilitation therapists throughout the treatment and their collaboration was crucial for the rehabilitation adherence plan. They discussed Mrs. C's progress in physical and speech therapy exercises, her attitude towards the therapists, as well as the success of the adherence plan. Both therapists reported that Mrs. C's attitude improved as she became less depressed and that the adherence plan was effective and did not need to be revised.

## Mrs. D

### Primary Focus: Coordination of Care

Mrs. D is a 68-year-old divorced woman who lived on the second floor of her two-story house; she rented the first floor to a family friend. Mrs. D has one daughter, a 42-year-old single working mother with two children (8 and 10 years old), who lives half an hour away. Mrs. D's relationship with her daughter was strained and even though they had been speaking on the phone once or twice a week, they had not seen each other for the past month. Mrs. D believed that her daughter "doesn't care about her" and "doesn't help her," while her daughter described Mrs. D as "a very difficult, demanding, and angry woman."

Mrs. D suffered a right hemispheric stroke resulting in left-sided weakness in her arm and leg. As a result of her stroke, she had difficulty maintaining her balance (she was prone to falling if she walked without a walker) and she had difficulty grasping objects with her left hand. In addition, Mrs. D had difficulty performing household activities (such as preparing meals and cleaning) so a home aide began coming to the house for a few hours on weekdays. Since her stroke, Mrs. D developed a recurrent major depression episode. She reported feeling depressed, worthless, helpless and hopeless about her future. She lost interest in activities that she previously enjoyed such as going to the nearby senior center and visiting a friend who lives nearby. Mrs. D was recommended physical and occupational therapy but her experience of therapy has had a lot of ups and downs. She fired her previous physical therapist because he was not "understanding of my difficult situation" and did not accommodate to her schedule. Throughout the rehabilitation treatment, Mrs. D was uncooperative, frequently cancelling or changing appointments, and not following the rehabilitation therapists' advice.

After considering the different problem areas that Mrs. D presented, the EFT therapist selected Coordination of Care as the primary EFT therapeutic component. The EFT therapist discussed Mrs. D's situation with the rehabilitation therapists. Both the physical therapist and the occupational therapist described Mrs. D as irritable and not adhering to the recommended exercises. They described sessions as continuous "power struggles." The consensus among the therapists was that rehabilitation therapy was important for Mrs. D, but her behavior pushed people away and they were reluctant to help her further. The EFT therapist highlighted that Mrs. D's interpersonal difficulties were part of a long-standing pattern which the stroke and depression worsened. The therapists developed a plan which included reasonably accommodating to Mrs. D's requests to change appointments if she gave two days' notice. They also praised her when she kept her appointments, acknowledging that it was difficult for her but that she did it anyway. The therapists also planned sessions to be focused on the exercises and not on discussions that could sidetrack from the rehabilitation therapy. They encouraged Mrs. D to discuss any emotional issues or difficulties with the EFT therapist. Whenever Mrs. D became



irritable, the rehabilitation therapists tried to change the subject and focus back on the exercises. Meanwhile, the EFT therapist planned to work with Mrs. D and help her understand that the rehabilitation therapists can give her better service if she focuses mainly on rehabilitation work during interactions with them. After the initial plan, the EFT therapist and rehabilitation therapists remained in frequent communication to discuss emerging problems and progress.

The EFT therapist used the other four EFT therapeutic components in the following ways:

New Perspective: The EFT therapist educated Mrs. D on the effects of depression and stroke on her everyday functioning and highlighted how critical physical and occupational therapy was for her recovery. The EFT therapist indicated to Mrs. D that the rehabilitation therapists had time limitations. Even if they wished to help her, they might be unable to accommodate her in their schedules if she cancelled appointments frequently. Rather than seeing their difficulties as demeaning or uncooperative, the EFT therapist worked with Mrs. D to foster the view that the rehabilitation therapists were there to help ensure the best possible recovery from stroke. The therapist encouraged Mrs. D to keep her appointments to the extent possible and cautioned her that missing appointments endangered her recovery. The EFT therapist also discussed with Mrs. D the difficulties she had with her daughter and helped Mrs. D to see her daughter's perspective, i.e. her daughter worked full-time and, even though she would like to help more, she found it difficult to be available. In addition, the EFT therapist spoke with Mrs. D's daughter, who understood and was sympathetic to Mrs. D's reactions.

Problem Solving Structure: The EFT therapist targeted social isolation by helping Mrs. D go back to her social activities. By using the What, How, Which, and When questions of the Problem Solving Structure, the EFT therapist focused on helping Mrs. D go back to the senior center once a week. Also through the Problem Solving Structure, Mrs. D decided to ask her daughter if she could visit on weekends with her children. Mrs. D began to develop closer and warmer relationships with her grandchildren, who previously had been a little scared of visiting their grandmother.

Reengineering family goals, involvement, and plans: The EFT therapist, Mrs. D, and her daughter discussed Mrs. D's difficulties to walk up and down the stairs in her house. Mrs. D and her daughter suggested that it might be easier for Mrs. D to live in the apartment on the first floor. Mrs. D and her daughter agreed to discuss with the family friend the possibility of moving to the second floor so that Mrs. D could move to the first floor and not have to negotiate the stairs.

Adherence enhancement structure: The EFT and the rehabilitation therapists discussed Mrs. D's reluctance to perform the rehabilitation exercises when she was by herself. The EFT therapist and the rehabilitation therapists provided a structured schedule for every day of the week (e.g., 8:30am get out of bed, 9:00am shower, 9:30am do rehabilitation exercises). The EFT therapist also gave Mrs. D a sheet on which she could check off each time she performed the assigned exercise.

**FORM A-PATIENT**

Patient ID: \_\_\_\_\_

Age \_\_\_\_\_

Race: White \_\_\_ Black \_\_\_ Asian \_\_\_ American Indian \_\_\_ Pacific Islander \_\_\_

**Effects of the stroke: Functional and physical limitations**

Review the NIH Stroke Scale and the FIM and describe deficits below:

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**Depression**

Review depressive symptoms and describe below:

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Suicidal Ideation (Describe):

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**Cognition** Obtain scores from research assessment

**Executive Functioning**

DRS Initiation/Perseveration \_\_\_\_\_

Stroop Color-Word \_\_\_\_\_

**Memory**

DRS Memory \_\_\_\_\_

Attention

DRS Attention\_\_\_\_\_

\_\_\_\_\_

Overall Cognitive Impairment

MMSE Total\_\_\_\_\_

\_\_\_\_\_

DRS Total\_\_\_\_\_

\_\_\_\_\_

**Describe Behavior Related to Cognitive Impairment**

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**Other comments and considerations including pertinent information about the patient, his/her family, home situation, interaction with the research assistant, and attitude towards research study participation:**

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**FORM A-FAMILY MEMBER/CAREGIVER**

Patient ID \_\_\_\_\_

Family Member Age \_\_\_\_\_

**Availability of family member/caregiver to participate in treatment assignments  
(please circle)**

Daily

\_\_\_\_\_ times a week

\_\_\_\_\_ times a month

\_\_\_\_\_ times a year

1) **Functional and physical** ability to help (i.e. physical limitations, cognitive impairment).

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2) The family member/caregiver's motivation to help.

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3) The family member's/caregiver's relationship to the patient.

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4) The family member/caregiver's understanding of current rehabilitation exercises, tasks and appointment with rehabilitation professionals as well as of patient's adherence to these.

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**FORM B - Comprehensive Problem Area List**

**Patient's ID:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Organizing patient's report of problems, difficulties, and concerns into problems areas of negative perspective, poor rehabilitation adherence, lack of engagement in valued and rewarding activities, disrupted family life, and poor coordination of care.

1) New Perspective;	<hr/> <hr/> <hr/> <hr/>
2) Adherence enhancement structure	<hr/> <hr/> <hr/> <hr/>
3) Problem solving structure (engagement in <u>valued activities</u> and improvement in daily functioning)	<hr/> <hr/> <hr/> <hr/>
4) Reengineering family goals, involvement, and plans;	<hr/> <hr/> <hr/> <hr/>
5) Coordination of care with specialized therapists.	<hr/> <hr/> <hr/> <hr/>

**Other comments and considerations**

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