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# Brief Interventions That Fit the Real World

*Practical CBT, ACT, MI, and relaxation skills for use in mental health*

**90-minute applied workshop**

**Tools that can be used immediately**

**Brief EBP informed model**

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# Brief description: what this workshop is designed to address

## 1 Access pressure

Patients often need useful help before a traditional psychotherapy opening is available.

## 2 High clinical variability

Tools must flex across anxiety, depression, adjustment, SUD, stress, and medical comorbidity.

## 3 Limited time

The intervention has to fit inside real-world visits, not idealized therapy conditions.

## 4 Disposition needs

Brief care should clarify self-management, group, specialty care, medication, community resources, or higher level of care.

Brief intervention is not “less care.” It is dose-matched, focused care that creates movement now.

Audience focus: practical tools staff can implement quickly, such as guiding a breathing reset rather than delivering a full mindfulness protocol.

# Learning / educational objectives

1 **Identify appropriate clinical situations**

Identify clinical situations in which a focused brief intervention may be appropriate and select an initial treatment target that can reasonably be addressed in a limited number of contacts.

2 **Apply practical brief strategies**

Apply brief, immediately usable strategies drawn from CBT, ACT, MI, and relaxation-based interventions to common community mental health presentations.

3 **Structure the encounter**

Structure a focused clinical encounter that moves from identifying the primary problem to intervention, between-session practice, and a clear next step or disposition.

Workshop promise: participants leave with language they can use on their next clinical day.

## 90-minute roadmap

| Time | Segment | Core Work |
|---|---|---|
| 0-10 Minutes | Frame brief care | What brief intervention is and is not |
| 10-25 Minutes | Build the session frame | Target, agenda, practice, disposition |
| 25-45 Minutes | CBT tools | Goal, activation, thought check, exposure/problem-solving |
| 45-62 Minutes | ACT + MI tools | Values, willingness, ambivalence, change plan |
| 62-75 Minutes | Relaxation tools | Deep breathing, PMR/body scan, imagery |
| 75-90 Minutes | Cases + implementation | Choose tools, document, troubleshoot |

# The clinical stance: focused, warm, and active

## Not this

- “I only have a few minutes, so here is advice.”
- “Let’s solve everything today.”
- “The patient must fit my favorite model.”
- “If they need more care, this failed.”

## But this

- “Let’s pick the most useful next step.”
- “We can make one meaningful movement.”
- “The model fits the stuck point.”
- “Disposition planning is part of good care.”

# A Brief EBP-informed brief care episode

| Visit 1<br>Focus | Visit 2<br>Practice | Visit 3<br>Adjust | Visit 4<br>Plan |
|---|---|---|---|
| Clarify target + first step | Review practice + build skill | Strengthen plan + rehearse | Finalize plan + disposition |

Usable outside psychotherapy

The same logic can fit a single visit, case-management contact, medication visit add-on, group module, or short therapy episode.

Target → tool → practice → next-care decision

# What brief intervention is — and is not

| It is | It is not | It requires |
| --- | --- | --- |
| Focused, collaborative, skill-based, time-aware, and connected to a documented next step. | Crisis care, denial of specialty care, generic advice, a full protocol compressed into one visit, or indefinite check-ins. | Screening for risk, fit, readiness, cultural/contextual barriers, and practical feasibility. |

Ethical anchor: a brief model should increase access and clarity without using “brief” as a reason to ignore clinical need.

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PART 1

# Part 1: Structure the brief encounter

A repeatable frame reduces drift and helps staff know what to do first.

# The 20–45 minute brief intervention frame

## 1 Check risk + fit

"Before we focus, I want to make sure we address safety and immediate needs."

## 2 Name one target

"What is the most useful thing we could work on today?"

## 3 Choose one tool

CBT, ACT, MI, relaxation, problem-solving, exposure, or referral planning.

## 4 Practice in session

Do not only explain the tool; rehearse it.

## 5 Assign next step

Small, specific, scheduled, and realistic.

## 6 Document disposition

What is the care pathway after this contact?

# Tool: The focus funnel

| Broad concern | Functional stuck point | Brief target |
|---|---|---|
| “Everything is overwhelming.”<br><br>“Anxiety is ruining my life.”<br><br>“I keep messing up.” | What is the pattern?<br><br>Avoiding? Isolating? Ruminating? Conflict? Substance use? Not following through? | A behavior, situation, decision, or skill that can move within the next 1–2 weeks. |

Script: “We may not solve the whole problem today. If we could make one useful movement by the end of this visit, what would be worth focusing on?”

# Practice: narrow the focus in 3 minutes

Pair up
One person names a common broad concern from your setting. The other person practices narrowing it.

| Ask | Listen for | End with |
|---|---|---|
| What is the situation where this shows up the most? | Avoidance | “So our focus today is…” |
| What do you do next? | Loss of routine | “One small step could be…” |
| What happens in the short term? | Conflict cycle | “Before next contact, you will try…” |
| What does this cost you later? | Substance use trigger | |
| | Panic/tension loop | |
| | Unclear motivation | |

Debrief question: What made the target more specific without making the person feel dismissed?

# Before selecting a tool: safety, fit, and level of care

## Safety

Is there current danger to self/others?
Is crisis protocol needed?

Is the patient able to use outpatient brief care safely?

## Fit

Is there one target that can move?

Is the patient able to practice between contacts?

Are barriers modifiable?

## Level of care

Does the patient need:

- specialty therapy
- withdrawal management hospitalization
- intensive outpatient care
- case management first?

Clinical rule: if safety or level of care is unclear, pause the brief intervention and consult. A good handoff is a valid intervention.

# Home practice is not homework; it is the intervention continuing

**1 Specific**

What exactly will the person do?

**2 Scheduled**

When and where will it happen?

**3 Small**

Could the person do it on a bad day?

**4 Informative**

If it does not happen, what will we learn?

Script
“Let’s make the practice so small and clear that future-you knows exactly what to do.”

Barrier plan
Ask: “What might get in the way, and what is your backup plan?”

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PART 2

# Part 2: CBT tools

Change one part of the cycle: thoughts, actions, avoidance, or problems.

# CBT in one slide: change one part of the loop

| Situation | Thoughts | Feelings/body | Behavior |
|---|---|---|---|
| What happened?<br>Where?<br>With whom?<br>What trigger? | What went through the mind?<br><br>What prediction, meaning, or rule? | What emotion or physical sensations showed up? | What did the person do, avoid, use, say, or stop doing? |

Brief CBT question: Which part of the loop is most changeable this week?

# Tool 1: Behavioral activation - action before motivation

## When to use

- Low activity, Isolation
- Loss of routine
- Low reinforcement
- 
- “I’ll do it when I feel better.”

## How to do it

Choose one activity in:

- Pleasure
- Mastery
- Connection
- Meaning
- Health

Make it tiny and scheduled.

## Measure

Mood/energy before and after.

Did action create information or momentum?

Script: “We are not waiting for motivation to appear. We are testing whether a small action can create the first ounce of momentum.”

# Tool 2: Thought check: balanced thinking without arguing

**1 Name the situation**

What happened?

**2 Catch the thought**

What did the mind say?

**3 Rate the emotion**

How strong, 0–100?

**4 Check evidence**

What supports it? What does not?

**5 Build balance**

What is realistic and useful?

**6 Re-rate**

What changed?

Avoid this trap: do not debate the patient into positivity. The goal is accuracy, flexibility, and usefulness.

# Tool 3: Exposure - approach what avoidance has been shrinking

## Good fit

- Specific avoided situations
- Panic cues
- Social avoidance
- Health anxiety rituals
- OCD-like avoidance
- Trauma-adjacent avoidance (only when clinically appropriate)

## Brief method

Create a small ladder/hierarchy.

Choose a safe, legal, values-consistent step.

Repeat enough to learn: “I can handle this.”

## Do not use when

- Acute safety concerns
- Intoxication
- Unstable trauma symptoms
- 
- Unclear risk
- No consent/readiness for the approach.

Script: “The goal is not to make anxiety disappear. The goal is to practice doing what matters while anxiety naturally rises and falls.”

# Tool 4: Problem-solving: when the barrier is practical

| 1 Define | 2 Brainstorm | 3 Choose | 4 Plan | 5 Review |
|---|---|---|---|---|
| What is the specific problem? | What are 3–5 possible steps? | What is realistic this week? | When, where, who, and backup? | What happened and what did we learn? |

Best use
Use problem-solving when the patient is stuck because of logistics, resources, competing demands, or uncertainty about next action—not when the primary stuck point is avoidance or ambivalence.

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PART 3

# Part 3: ACT and MI tools

When control, values, ambivalence, or readiness are the central stuck point.

# ACT/FACT: shift from feeling control to values-based action

| Notice | Allow | Choose |
| --- | --- | --- |
| Name thoughts, feelings, urges, memories, sensations, and stories as experiences showing up. | Make room for experiences without needing them to disappear before taking action. | Take one small action that moves toward values, even with discomfort present. |

Clinical shift: instead of “How do I get rid of this feeling?” ask “What matters enough that I would take a small step with this feeling present?”

# Tool 5: The 90-second ACT reset

**1 Notice**

"My mind is telling me…"
"My body is feeling…"
"The urge showing up is…"

**2 Allow**

"I can let this be here for now."
"I do not have to win a fight with this feeling before I act."

**3 Choose**

"The next small move toward what matters is…"

## Use when

- The patient is stuck fighting thoughts/feelings
- Waiting to feel ready
- Needing distress to disappear before acting.

## Avoid when

- The patient needs immediate crisis stabilization
- Intoxication/withdrawal management
- Concrete safety intervention first.

# Values: toward moves and away moves

## Away moves

Behaviors that reduce discomfort now but shrink life later.

Examples: avoid, isolate, use, lash out, numb, procrastinate.

## Toward moves

Behaviors that move toward values even when discomfort is present.

Examples: ask, attend, apologize, schedule, walk, call, practice.

Values questions: “What kind of person do you want to be in this situation?” “What would your behavior show if it were guided by that value?” “What tiny action would count?”

# Motivational Interviewing: when ambivalence is the problem to work with

## Spirit of MI

Partnership, acceptance, compassion, and evocation.

Work with the patient's reasons, not against them.

## OARS

Open questions
Affirmations
Reflections
Summaries

Use more reflections than questions.

## Change talk

Listen for:

- Desire
- Ability
- Reasons
- Need
- Commitment
- Activation
- Taking steps.

Clinical trap: the more we argue for change, the more the patient may rehearse reasons not to change.

# Tool 6: Importance and confidence rulers

## Importance

"On a 0–10 scale, how important is this change to you right now?"

Follow-up: "Why that number and not lower?"

## Confidence

"If you decided to try one small step, how confident are you that you could do it?"

Follow-up: "What would raise confidence by one point?"

Low importance: clarify target or values. High importance + low confidence: make the step smaller and evoke strengths.

# MI change plan: move from talk to one step

## 1 Change being considered

What is the patient considering — not what do we want them to do?

## 2 Patient's reasons

Summarize desire, ability, reasons, and need in their words.

## 3 Hesitations

Respect sustain talk without strengthening it.

## 4 Strengths/supports

Past successes, resources, people, routines, and skills.

## 5 Small step

Specific, realistic, scheduled, and chosen by the patient.

## 6 Backup plan

What will they do if the first plan does not work?

Summary script: "Let me pull together what I heard: part of you is unsure, and part of you wants… Your reasons are… The step you are willing to try is…"

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PART 4

# Part 4: Relaxation and body-based tools

Sometimes the first intervention is calming the body enough to choose the next step.

# Relaxation: not “calm down,” but skillful downshifting

## Use when

- Stress
- Muscle tension
- Panic sensations
- Sleep difficulty
- Irritability
- Medical stress
- Pain-related tension
- Overwhelm

## Teach as practice

Brief in-session rehearsal beats long explanation.

The patient needs to feel the skill, not just understand it.

## Use carefully

Relaxation can become avoidance when the clinical goal is to approach or tolerate feared sensations.

Match the tool to the function.

Phrase to use: “Let’s help your body come down one notch so you can choose your next step.”

# Tool 7: 60-second breathing reset

## Guide this slowly, with a calm voice

“Put both feet on the floor. Let your shoulders drop slightly. Breathe in gently through the nose. Exhale slowly through the mouth. Make the exhale just a little longer than the inhale. Do not strain or hold your breath. For the next few breaths, pair the exhale with a word like steady, settle, or release.”

## Then ask

“What changed by even 5%?”
“What is the next helpful thing you can do?”
“When would this be useful this week?”

## Safety note

Use a comfortable pace. Stop or modify if dizziness, pain, medical symptoms, trauma activation, or panic escalation occurs.

# Tools 8, 9,10: Three quick relaxation options

## Progressive muscle relaxation

Best for muscle tension, clenched jaw, shoulders, hands, or restlessness. Tense gently for 5 seconds; release for 10–15 seconds.

## Body scan

Best for sleep, pain, or generalized stress. Notice one body area at a time and soften by 5–10%, not perfectly.

## Calm-place imagery

Best for racing thoughts or stress images. Notice what the calm place looks, sounds, smells, and feels like.

Adaptation: eyes open is fine. Skip injured areas. Stop if the exercise feels unsafe or overwhelming.

PART 5

# Part 5: Choose the right tool

The model is practical only if staff know which door to open first.

# Skill selection matrix

| Stuck point | First tool | What to listen for |
|---|---|---|
| Low activity / withdrawal | Behavioral activation | “I don’t do anything anymore.” |
| Rigid prediction / self-criticism | Thought check | “This will definitely go badly.” |
| Avoidance of safe situations | Exposure / approach step | “I feel better when I avoid it.” |
| Practical obstacle | Problem-solving | “I don’t know what to do next.” |
| Fighting internal experiences | ACT reset / values action | “I can’t act until this feeling goes away.” |
| Ambivalence / low readiness | MI ruler / change plan | “Part of me wants to, but…” |
| High arousal / tension | Relaxation reset | “My body is too keyed up.” |

## Case application 1: low mood and withdrawal

**Presentation**

Patient reports depression, fatigue, staying home most days, and feeling “useless.” No acute safety concerns after screening.

# Case application 1: low mood and withdrawal

## Presentation

Patient reports depression, fatigue, staying home most days, and feeling “useless.” No acute safety concerns after screening.

## Best first moves

Focus funnel → behavioral activation → small values-linked activity → practice schedule.

## Example practice

“Walk outside for 7 minutes after lunch on Tuesday and Thursday; rate mood/energy before and after.”

Disposition / caution
If severe depression, persistent suicidality, psychosis, inability to care for self, or repeated nonresponse: consult and consider higher level/specialty care.

## Case application 2: anxiety and avoidance

### Presentation

Patient avoids phone calls, bills, and appointments because anxiety spikes. Avoidance lowers distress today but creates bigger problems.

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## Presentation

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## Best first moves

CBT loop → avoidance cost → small exposure/approach step → relaxation only if it supports approach.

## Example practice

“Call one office during business hours. Stay on the line through the first anxiety spike. Record anxiety before/after.”

Disposition / caution
Do not make relaxation the whole treatment if it reinforces avoiding feared situations. Use it to support approach, not escape.

## Case application 3: ambivalence about substance use

### Presentation

Patient says alcohol is causing problems but also says it is the only way to sleep and relax. They are tired of people telling them what to do.

# Case application 3: ambivalence about substance use

| Presentation | Best first moves | Example practice |
| --- | --- | --- |
| Patient says alcohol is causing problems but also says it is the only way to sleep and relax. They are tired of people telling them what to do. | MI stance → reflect both sides → importance/confidence ruler → elicit reasons → patient-chosen next step. | “Track drinking and sleep for three nights” or “Call sponsor/peer/support before the usual drinking time,” depending on patient choice and clinical plan. |

Disposition / caution

Follow agency policy for withdrawal risk, intoxication, medication-assisted treatment, safety, and level-of-care referral.

## Case application 4: stress and tension

### Presentation

Patient reports irritability, tight shoulders, poor sleep, fast breathing, and snapping at family when overwhelmed.

# Case application 4: stress and tension

| Presentation | Best first moves | Example practice |
| --- | --- | --- |
| Patient reports irritability, tight shoulders, poor sleep, fast breathing, and snapping at family when overwhelmed. | Stress signature → 60-second breathing reset → body scan or PMR → next-step question. | “Practice 60-second breathing after parking at work and before entering home; note tension before/after.” |

Disposition / caution
After downshifting: choose a values-based action or problem-solving step.

# Document the brief intervention clearly

## 1 Target

The focused problem or stuck point addressed today.

## 2 Risk/fit

Relevant safety screen and level-of-care considerations.

## 3 Tool used

CBT, ACT, MI, relaxation, problem-solving, exposure, or referral planning.

## 4 Practice plan

What, when, where, barrier, backup.

## 5 Disposition

Self-management follow-up, group, specialty care, medication, case management, higher level of care.

Example note sentence
“Brief intervention focused on avoidance cycle related to phone calls. Completed anxiety/avoidance formulation, developed one-step exposure plan, reviewed safety, assigned call practice, and will reassess fit/disposition next contact.”

# Common pitfalls—and safeguards

| Pitfall | Safeguard |
| --- | --- |
| Too much assessment, no intervention | Use the session frame; practice one skill in the room. |
| Advice-giving replaces collaboration | Use MI reflections and patient-chosen steps. |
| Limited-session limitations | Track session number and require rationale for extensions. |
| Wrong patient fit | Screen risk/level of care before choosing brief tools. |
| Practice is vague | Specify what, when, where, barrier, backup. |
| No disposition plan | Start disposition thinking early; document next pathway. |

# Practice lab: choose a tool and script the next step

In small groups:

Pick one common presentation from your setting. Fill in the five boxes.

| Target | Stuck point | Tool | Practice step | Disposition |
|---|---|---|---|---|
| What is the one focused concern? | What maintains the problem? | CBT, ACT, MI, relaxation, or referral? | What exactly will the patient try? | What is the next care pathway? |

Report out: “Our patient is stuck in ___. We chose ___ because ___. The practice step is ___.”

# Implementation checklist for Monday morning

## 1 Pick two tools

Do not implement everything at once. Start with focus funnel + one clinical tool.

## 2 Use shared language

Target, stuck point, tool, practice, disposition.

## 3 Create a tiny handoff path

Who gets specialty care, group, case management, med follow-up, or higher level of care?

## 4 Review in supervision/team huddle

Ask: Was the target clear? Was a tool used? Was practice assigned? Was disposition documented?

## 5 Measure one thing

For the first month, track only one or two indicators: completed brief interventions and documented next-step plans.

# Four scripts to take back to work

| Focus | MI | ACT | Relaxation |
|---|---|---|---|
| “If we could make one useful movement today, what would be worth focusing on?” | “On a 0–10 scale, how important is this?<br><br>Why that number and not lower?” | “What would move you toward what matters, even with this feeling present?” | “Let’s help your body come down one notch so you can choose your next step.” |

Closing thought: brief work succeeds when every contact has a target, a tool, a practice step, and a next-care decision.

# Selected references and source models

Cully, J. A., Dawson, D. B., Hamer, J., & Tharp, A. L. (2020/2021). A Provider's Guide to Brief Cognitive Behavioral Therapy. VA South Central MIRECC.

Strosahl, K., Robinson, P., & Gustavsson, T. (2012). Brief Interventions for Radical Change: Principles and Practice of Focused Acceptance and Commitment Therapy. New Harbinger.

Miller, W. R., & Rollnick, S. (2013). Motivational Interviewing: Helping People Change (3rd ed.). Guilford Press.

Motivational Interviewing Network of Trainers. (2014). Motivational Interviewing Training New Trainers Manual.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). Acceptance and Commitment Therapy: The Process and Practice of Mindful Change (2nd ed.). Guilford Press.

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

bPAC patient and therapist materials developed for focused brief care.

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# Questions and implementation discussion

Take away thought:

What is one brief intervention tool you could realistically try in your setting next week?