MODULE 9
MOOD MANAGEMENT

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Module 9: Mood Management

The primary objectives of this module are to 1) instruct clients in the use of cognitive behavioral techniques to manage moods and negative feelings, and 2) help clients learn to replace destructive and avoidant ways of responding to negative moods (such as drinking) with positive responses.

Module Outline

Target Discussion Points

- ☑ Check-in
- ☑ Set the agenda
- ☑ Introduce the three phases of Mood Management
- ☑ Teach clients STORC model of emotion
- ☑ Demonstrate how clients can monitor their subjective mood states
- ☑ Use self-monitoring information to assess and address cognitive themes.
- ☑ Plan strategies to counter automatic thoughts related to negative moods
- ☑ Use the thought replacement worksheet to plan cognitive and behavioral change
- ☑ Complete agency - specific tasks
- ☑ Summarize session
- ☑ Preview next session
- ☑ Review home assignment
- ☑ End session

Check-in

The Clinician should conduct a brief check-in to assess how the client has been doing. Time for discussion of client's thoughts, questions, or concerns about the session material from the previous week can be taken as needed.

> *"Welcome back. It's good to see you again. How have you been doing since our last session?"*
>
> *"Do you have any questions or thoughts about what we worked on last time we met?"*

Provide rationale for discussing mood

> *"One of the triggers for drinking that you identified when we were planning your treatment was unpleasant mood. It is very common for negative moods to be a trigger for drinking. If we work on helping you cope with unpleasant feelings or*

have more control over them, it may be a big help for your goal of quitting drinking. How does that sound to you?"

Set the agenda
Set the agenda for the session including: 1) teach clients a model of emotion to help them understand negative moods, 2) help clients identify automatic thoughts that lead to negative emotions, and 3) plan ways to counter automatic thoughts and related negative moods with cognitive and behavioral challenges.

> *"Today we are going to address some of these feelings, and some of the thoughts you may have that lead to negative emotions. We will start by looking at a simple model that can be used to understand your feelings better. Then we can talk about ways to counter negative emotions and related thoughts so that your mood can be better managed. How does that sound to you?"*

About the STORC model
Negative moods do not occur or continue in a vacuum. Emotions can be thought of as a sequence of events occurring within a particular context. The acronym STORC is useful for explaining this sequence to your client. An emotion occurs in a particular Situation, which is interpreted through a person's Thoughts, Organ responses (i.e., physical bodily sensations) are usually involved, and the person's behavioral Responses to this chain of events lead to certain Consequences, which in turn affect his or her Situation, thus repeating the cycle.

The MOOD module is a relatively straightforward application of cognitive-behavioral principles:

1. Teach the client to identify the five factors (STORC) that make up human emotion, and discuss the connections between them, drawing on examples from the client's experiences.

2. Start the client with self-monitoring to identify the particular STORC components of moods that are experienced in different situations.

3. Focus on automatic thoughts that support or exacerbate negative mood. Emphasize that changing thoughts and the style of thinking can improve mood.

4. Discuss automatic, maladaptive behaviors.

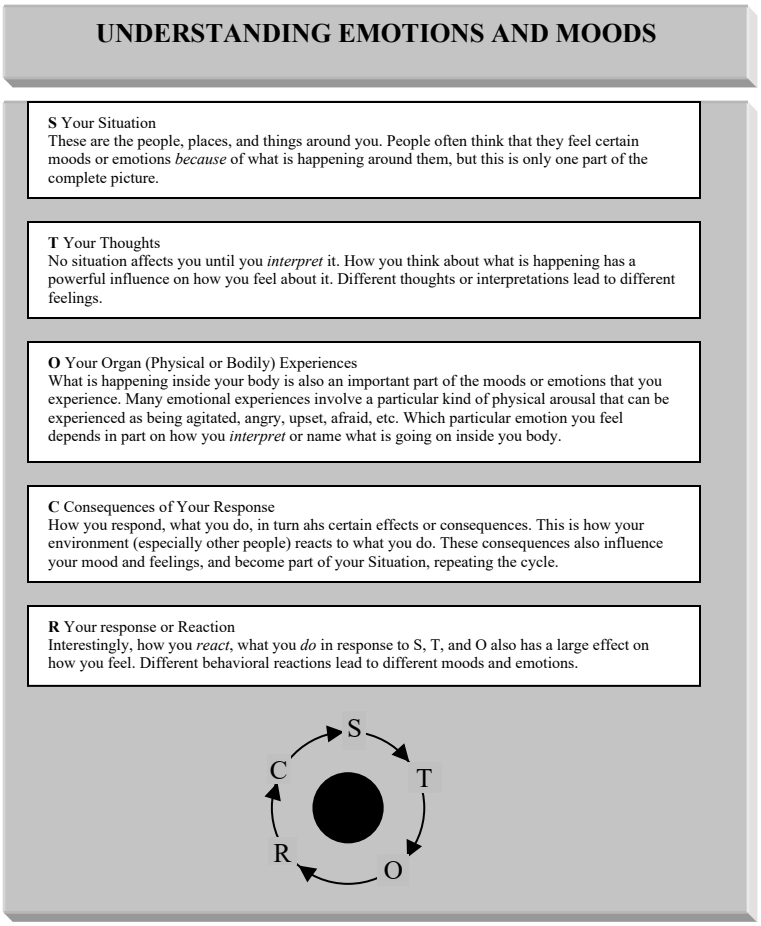
5. Help the client plan cognitive and behavior change.

With these methods, clients learn how to have greater self-control over the frequency and intensity of negative moods by restructuring automatic thoughts and changing maladaptive behaviors.

It is important to make it STORC model directly relevant and applicable to the client's life, using real-life examples and assignments.

Discuss the STORC model
The client is given a copy of the Understanding Emotions and Moods Handout (Appendix A), which outlines the model that is the basis of this module. Understanding the components of STORC, and the role each plays in mood, is useful for the findings ways to change negative mood states.

For each of the five components, the handout has a section that describes how that component affects mood. An optimistic aspect of this model is that change can start anywhere in the STORC cycle. The degree of emphasis placed on each component is determined by the Clinician and client. Strategies for managing negative emotions are highlighted in the following review of the five components of STORC.



UNDERSTANDING EMOTIONS AND MOODS

S Your Situation
These are the people, places, and things around you. People often think that they feel certain moods or emotions *because* of what is happening around them, but this is only one part of the complete picture.

T Your Thoughts
No situation affects you until you *interpret* it. How you think about what is happening has a powerful influence on how you feel about it. Different thoughts or interpretations lead to different feelings.

O Your Organ (Physical or Bodily) Experiences
What is happening inside your body is also an important part of the moods or emotions that you experience. Many emotional experiences involve a particular kind of physical arousal that can be experienced as being agitated, angry, upset, afraid, etc. Which particular emotion you feel depends in part on how you *interpret* or name what is going on inside you body.

C Consequences of Your Response
How you respond, what you do, in turn ahs certain effects or consequences. This is how your environment (especially other people) reacts to what you do. These consequences also influence your mood and feelings, and become part of your Situation, repeating the cycle.

R Your response or Reaction
Interestingly, how you *react*, what you *do* in response to S, T, and O also has a large effect on how you feel. Different behavioral reactions lead to different moods and emotions.

"This handout describes the STORC model, which explains how negative moods occur. Most Emotions do not occur in a vacuum. They usually occur in particular **S**ituations that are interpreted through your **T**houghts. **O**rgan responses like body sensations are involved. Your behavioral **R**esponses to the experience lead to certain **C**onsequences. Let's look at each of these five factors together on this handout. Later we will use an example to tie them together to explain how you may feel a particular negative emotion."

Situational Factors (Environmental Component)
The Situation (S) refers to the people, places and things that surround a person at a particular point in time. There are conditions that promote negative mood and depression. For example, prolonged exposure to stressors such as a significant loss, crowding, or noise. Continual exposure to conditions of low positive reinforcement (such as not being appreciated) can also lead to negative mood and depression. Clients often attribute their moods to these external sources. However, it is important that clients learn that the situation is only one part of how moods occur. How one copes with the situation is critical for determining mood.

> "The Situation in which negative emotions occur refers to the people, places, and things around you. For example, you have said in the past that you get bored and depressed when you are home alone. Tell me more about this situation. Are there things about being in your home that bother you? Are there things missing from your home that lead to boredom? Okay, so you've given me a really good example of the aspects of one situation that seem to contribute to your negative moods."

Exploring the client's environment can provide clues for where to intervene cognitively and behaviorally. What can be done at the level of situational factors to prevent or reduce negative mood states? The main emphasis is on planning and arranging for a "balanced diet" in daily life. One strategy is to plan intentionally for each day to include some pleasant events, large or small, that function like "psychological vitamins" to help keep the rest of the day in balance.

> *"What can you do to help these situations that trigger negative emotions? Sometimes self-monitoring can be useful here to increase awareness of the daily balance, by keeping a daily record of pleasant and unpleasant events that occur. If the unpleasant or stressful events seem to dominate and outweigh pleasant events, it is important to plan time for additional positive experiences. For example, regular social support can be an important source of positive and balancing experiences, especially when you are home alone and bored."*

Thought Patterns (Cognitive Component)

Although situational factors do play a role in mood, it can be argued that nothing in the external situation is really responsible for one's mood. Positive and negative emotions are not direct reactions to the "real" world, but rather are responses to how a person perceives that world – the person's *Thoughts*. For example, "depressing" events may not be inherently depressing; rather, a persons' mood depends on how he or she perceives the events. Within the context of a positive or optimistic attitude, events that might otherwise be considered stressful or depressing can have a diminished or different impact.

> *"Next, we will look at the Thoughts that you may have regarding the situations you encounter. How you interpret the situation has an influence on how you feel about it. For example, what were your thoughts about being home alone?"*

Attributions: The Clinician may want to instruct the client about *attributions*, which are particularly important cognitions when it comes to mood. Attributions are explanations of why things happened (or did not happen), i.e., the causes of life events. Attributions can be either *internal* or *external*. An internal attribution is a perception that a particular event was caused by one's own actions. An external attribution, by contrast, is a perception that a specific event was caused by factors beyond one's own influence. Attributions can also be either *stable* or *unstable*. Stable attributions explain an occurrence as being due to something that is not likely to change. An unstable attribution, on the other hand, is a perception that a cause is highly changeable.

In the midst of depression, adverse outcomes tend to be attributed to negative internal causes that are perceived to be stable (e.g., "That's how it always goes; I mess up everything I touch" and "I'm a loser in every relationship; who could care for somebody like me?") Positive outcomes, on the other hand, tend to be attributed to external causes (e.g., "I just got lucky," "They let me win because they feel sorry for me," and "She's nice to everybody").

> *"You mentioned that you get bored and depressed when you are home alone. Do you know what you are thinking when you are home by yourself? Do you think you are always bored and depressed when you are home alone, or do you think this is an infrequent situation? What do you think is the reason for you being home alone? Do you think it has something to do with you, or do you think it is due to other thing outside of your control? Later we will look at how you can change your thoughts about these situations, which can have an impact on your negative mood."*

Organ Experience (Physical Component)

Physical changes occur in the context of a mood. A diffuse autonomic arousal is associated with many emotions, and individuals may experience this as physical changes such as dry mouth, cold hands, a hot face, stomach contractions, etc. Exploring with a client the physical symptoms associated with their feelings (e.g., upset, angry, sad, afraid, etc.) is informative for treatment planning. Emotions are influenced, in part, by how the person interprets the accompanying arousal. Sometimes those emotions are amplified in direct response to an internal physical sensation.

> *"The next factor that is an important part of the moods you experience is what is happening inside your body – the Organ response. Many of our emotions involve a particular kind of physical arousal, which may be experienced as agitated, angry, upset, afraid, and so on. Which emotion you feel depends on how you interpret or name what is going on inside your body."*

Response Patterns (Behavioral Component)

When a client experiences mood-relevant physical changes, what happens? What does the client do in response to emotional arousal? Once a person begins to experience a negative mood, how he or she responds to this feeling can make a big difference.

> "Next, what you do in response to a situation, your thoughts, and your physical sensations, has a large effect on how you feel. Different behavioral reactions lead to different moods and emotions. For example, what do you typically do when you are home alone and feeling bored and depressed?"

The Clinician can look for two maladaptive response patterns: avoidance and aggression.

Avoidance: A common and often unhealthy response to negative mood is avoidance, or withdrawal. The reaction may seem quite understandable, even natural. Being down and experiencing low self-esteem, people feel like poor company. They may not feel up to

usual social contacts, or may not want others to see them in this dejected state. Yet avoidance tends to strengthen negative emotions. Depressed individuals who withdraw from their social support network are cut off from important sources of feedback and reinforcement, thus exacerbating the depression.

Aggression: Another maladaptive response to negative moods is aggressive behavior. Aggression can sometimes be reinforced by the immediate and desired effects that follow. For example, aggressive behavior is sometimes used to gain control or avoid other's scrutiny. Over time, however, aggression is likely to change a person's social environment in ways that promote more, not less, negative emotion.

Maladaptive behavior in response to negative affect may reflect a deficit in an important coping skill. For example, an individual with deficient social skills may e unable to establish a reinforcing and supportive network of friends. Repeated failure at initiating friendships may lead to avoidant or aggressive behavior, which further decreases resistance to depression.

Consequences (Environmental Reactions)
Mood and depression are influenced by how the social environment responds to one's behavior. An environment lacking sufficient positive reinforcement can foster negative mood and depression. In such situations, no matter what the person does, very littler reinforcement is forthcoming. A prolonged period of this may result in an attitude of helplessness and pessimism, which itself feeds negative emotionality.

> "The last factor that influences your moods is the consequences of your response. This is how people around you react to what you do. These consequences also influence your mood and feeling, and become part of your situation, repeating the cycle. For example, if you avoid people when you are feeling depressed, they may think that you are not interested in socializing and therefore may not ask you to join them. Instead, if you find common activities to do with people, they may be more likely to include you in social plans. This would decrease the amount of time you are home alone feeling depressed. Can you think of anything you can do in that situation that would lead to a positive consequence?"

The Clinician can review the STORC cycle and help clients understand, using examples from their own lives, the links between the five factors contributing to moods.

Explore negative mood states
Sometimes people have a difficult time naming or describing their own moods directly. They may describe their thoughts rather than their feelings (e.g., "I felt like she was being mean," "I felt like drinking," "I thought they were all jerks.") For such clients, reflective listening may be fruitful, and you may be able to infer a mood from the client's more general description of STORC elements of a particular event. This is accomplished by exploring a recent specific situation in which the person felt a negative emotion.

CLINICIAN: "So – give me an example. When was the last time you had a strong negative feeling?"
CLIENT: "Well, yesterday, when I was stuck in traffic, I thought all those people were jerks."
CLINICIAN: "You were in a traffic jam and you were feeling a strong mood. What name would you give that mood?"
CLIENT: "I didn't feel anything in particular; I just thought about what jerks people are, and how I wished I was anywhere but there. I kind of wanted a drink."
CLINICIAN: "So you're not sure what to call your feeling, but it was pretty negative. It sounds, even in your tone of voice right now, like you were a little irritated."
CLIENT: "I guess you could call it irritated."
CLINICIAN: "And that feeling of irritation led up to you wanting to have a drink."
CLIENT: "I suppose so. It's strange to think about it that way. I just blamed it on the traffic."
CLINICIAN: "That not unusual, to think that your feeling is the direct result of the situation you are in. However, as we have been discussing, the situation is only one small part of how negative moods happen."
CLIENT: "I guess I was more irritated than I realized."
CLINICIAN: "And now you see it . Good for you! It's pretty common for people to have an urge to drink when they get into a negative mood like that , and it sounds like you, feeling angry is a particularly powerful one. The point, though, is that you have a lot of say about your own mood. You can, to a large extent, decide how you feel about something. And as this experience shows, even if you do get into a negative mood, you don't have to give in to the urge to drink that goes with it."

Complete the Mood Monitoring Sheet

Elicit an experience of negative emotion
Once the Clinician has adequately explained the STORC model so that the client understands the concepts, the client is asked to begin self-monitoring mood states. The client should be instructed to begin by completing one column of the Mood Monitoring Sheet (Appendix A), based on the most recent time he or she experienced a negative feeling. In the top (Mood) box the client records a rating of his or her mood at the time the negative feeling occurred. The mood rating ranges from -10 (very negative feeling) to +10 (very positive feeling).

CLINICIAN: "Okay, now let's try out keeping a mood diary on these sheets. What will be most helpful is if you keep a record of times when you have a particularly positive or negative feeling. You don't have to put every feeling in the diary, or you could be at it all day, but when there is what seems like a significant feeling – something especially positive

or negative, write it down, As an example, think back to the last time this week when you experienced a particularly negative feeling. When was that?"
CLIENT: "Just before I came in here. I had a big fight with one of my kids."
CLINICIAN: "Okay, fine. Now in this first box, I want just a rating of how good or bad you were feeling. It's a rating scale from minus ten (which is feeling about a s bad as you can feel) to plus ten (which is feeling on top of the world, about as good as you can feel). Where would you rate your mood in that situation?"
CLIENT: "During it? I was so mad I could hardly talk. Minus 8 or 9, maybe."
CLINICIAN: "So, a very negative feeling – almost as mad as you ever get."
CLIENT: "Well, minus seven, maybe."
CLINICIAN: "Okay, write that down."

What was the Situation (S)?
The Situation box is fairly easy to complete. The client is asked to first describe the situation to the Clinician, and then make a brief note in the S box to indicate the external circumstances.

CLINICIAN: "Now, what was going on just before this feeling happened? What was the situation?
CLIENT: "Toni, my 18 year-old, showed up with her navel pierced and bleeding. She decided to have one of her friends pierce it to put in one of those rings. I was so mad."
CLINICIAN: "So she hadn't discussed it with you, and just went ahead and did it."
CLIENT: "We had discussed it all right, and I had told her No way."
CLINICIAN: "All right. Just make a note in the Situation box there- maybe, "Toni came home with a navel ring."

What was the client thinking (T)?
The Clinician should reiterate that feelings are not automatic results of a situation; rather, feelings result from thoughts that occur, often so quickly and automatically that we are unaware of them.

CLINICIAN: "Now what were you thinking to yourself when you saw her with the ring?"
CLIENT: "I thought, how stupid can you be? That's going to get infected. What were you thinking?"
CLINICIAN: "What else?"
CLIENT: "You did this just to spite me. I told you 'No,' and you defied me." I felt that was about at the end of my rope with this kid."
CLINICIAN: "Great! Write that in there."

What was the client's physical/organ response (O)?
The client is now asked to write in any specific physical sensations experienced, as well as a name for the emotional state. How did the person feel in this situation? The client may need help distinguishing between thoughts and feelings.

CLINICIAN: "So then come the feelings. Really mad, you said."
CLIENT: "Yup, Furious."
CLINICIAN: "Put that in there: Really mad. Furious."

What did the client do(R)?
To complete the R box, the client is instructed to write a brief not about anything he or she said or did in response to the situation, thought, and feeling. How did the client react?

CLINICIAN: "Okay – you're thinking, "I'm at the end of my rope. This kid intentionally disobeyed me, and did something stupid." And then you feel furious, really angry. So what did you do?"
CLIENT: "I said something like, 'How could you be so stupid? You're grounded for a month.' I wasn't thinking. I couldn't even see straight, I was so mad."
CLINICIAN: "Actually you were thinking – says so right there. And what you were thinking got you pretty hot. Just make a little note about what you said."

What were the consequences (C)?
Finally, in the C box, the client should write what happened as a result of his or her behavior. How id others react, or what changed?

CLIENT: "Anyhow, I told her she was grounded, and she called me a name and ran out of the house."
CLINICIAN: "Ok, so in the C box, make a note that Toni yelled at you and ran out of the house."
CLIENT: "Right then – I almost had a drink. I really felt like it."
CLINICIAN: "That sounds important. Let's explore that a little, and keep going with this. The consequences – what happened – become part of a new situation for you, and the process continues. So let's do the next column. The situation is that Toni just yelled at you and ran out of the house. That goes up there in the next S box… And you think to yourself, I'd really love to have a drink." What were you actually feeling at that point?"

Once clients are comfortable with how to fill in the Mood Self-Monitoring Sheets, they should be asked to use them as a diary between this session and the next, and to bring them back at the next session. ("Would you be willing this week to keep these as a kind of diary?") If they agree to do the exercise, clients should be given a supply of forms and the instruction to record situations in which either *positive* or *negative* emotions occurred. It should be emphasized that both are useful.

About automatic thoughts
The concept of "automatic thoughts" can be very helpful for clients as they begin to understand the power their thoughts have on their emotions. Automatic thoughts are distorted or unrealistic thoughts that can lead to negative emotions. The Clinician can assess the degree of understanding a client has regarding automatic thoughts by asking the client to provide examples. Those with experience in A.A. may link this to the concept of "stinking thinking." Examples from the mood monitoring sheets can be used to illustrate how thoughts are linked to emotions. As clients begin to break down their negative mood sequences according to the STORC model, a pattern of automatic thoughts that are mood magnifiers should emerge. The Clinician should be looking for patterns, themes, or consistencies. These maladaptive automatic thoughts might be likened to weeds in the garden, with the analogy of plucking them out, one by one, to allow room for what you want to grow.

It is important to emphasize that emotions are transient – they come and go. For an emotion, like anger, to persist, it has to be fueled by thoughts.

Another important point, strange to some clients, is that we choose how we think about things. This is a crucial point, because mood management involves changing thought patterns, pulling weeds, pulling fuel out of the fire.

The thought-changing process involves two steps. First, the client must learn to recognize the automatic thoughts, to catch them as they go by. Second, the client must learn to replace them with more balanced thoughts.

It is important for the Clinician to evaluate consistencies in thought patterns that lead to negative emotions. Consideration of both consistencies of content as well as distorted thought processes is helpful. Some common erroneous thought processes, described by David Burns (1990), are presented below. The list is not to be given to the client; rather, it is meant to assist the Clinician to think clearly about any systematic, automatic distortions that may be occurring.

Filtering involves selective attention, looking only at certain elements of a situation while ignoring others.

Black and white thinking classifies reality into either/or categories without recognizing the many degrees of difference.

Overgeneralization involves broad conclusions based on limited evidence, such as "making a mountain out of a mole hill."

Mind reading makes assumptions about what others are thinking and feeling, what motivated their actions, etc.

Catastrophizing assumes that the worst will happen.

Personalization is the error of seeing every experience as related to your own personal worth.

Blaming is holding other people responsible for your own pain.

Shoulds or **Oughts** can be rules that are rigid, not flexible enough to take into account human frailties.

Emotional reasoning is when feelings overrun reality-checking: if you feel it, it must be true.

Fallacy of external control is the perception that one has no power or responsibility for what happens in his or her life.

Fallacy of omnipotent control is the opposite pattern: believing that you control (or are responsible for) everything. This another common them discussed in A.A. meetings (see Kurtz, 1979).

CLINICIAN: "Okay – you have completed several of these sheets. What we're going to focus on today is how your thoughts affect your moods, and what you can do about that. Sound okay?"
CLIENT: "Sure."
CLINICIAN: "Well- let's see what you have here. (Looks over sheet.) I see that you had some pretty strong negative moods on this sheet, with some urges to drink."
CLIENT: "Yeah – that one night was especially tough."
CLINICIAN: "And I see some real mood magnifiers here."
CLIENT: "I don't know what you mean."
CLINICIAN: "Well – close your eyes for a minute, and imagine its Friday night again. You're sitting in the chair at home alone, channel surfing. What are you saying to yourself?"
CLIENT: "Here I am on a Friday night, watching television by myself. What a loser I am!"
CLINICIAN: "A loser – and that kind of says, "It's just how I am. It will never get better." Does that sound right?"
CLIENT: "Uh huh."
CLINICIAN : "So how are you feeling? Can you feel it now?"
CLIENT: "Lonely. Depressed… discouraged."
CLINICIAN: "Exactly. If the problem is who you are – if this something hopeless that can never change, then of course you feel demoralized. The thought is a mood magnifier."
CLIENT: I can see that."

Challenging hot thoughts

This leads naturally to the next step of challenging and finding alternatives to the automatic thoughts that result in the most distress (hot thoughts). Once the client and Clinician have identified thought patterns that lead to negative emotions, they work together to find ways to challenge and replace those thoughts. The emphasis here is that this is a matter of choice. The client does not have to think differently. (In fact, to say so would be to practice a distortion.) Rather the client can choose how to think (T) about situations (S), and thus have some choice about how to feel (O) and act (R) as well, which in turn influences what happens (C) in the client's external world. It is also not the Clinician's job to prescribe for the client the "correct" or "rational" thoughts that he or she ought to have. The client should be invited to suggest different ways of thinking about the various contributors to a mood event. If the client has difficulty generating alternative thoughts, the Clinician can suggest different possible interpretations. This process can be likened to developing a menu of options from which the client chooses.

There are at least two basic ways to intentionally challenge hot thoughts. On is to think (T) differently; that is, a person uses logic to replace dysfunctional thoughts with helpful thoughts. Another is to act (R) differently, to live as if different assumptions are already true.

Just as negative moods can be magnified by either thoughts or actions, they can also be counteracted in the same two ways.

To illustrate the process of replacing automatic thoughts with more realistic, balanced thoughts, the Clinician can use the *Thought Replacement Worksheet* (Appendix A). Often it is best introduced by working through a specific example or two.

CLINICIAN: "Are you willing to try to pick some weeds here, clean out the garden a little?"
CLIENT: "How do I get rid of thinking that way?"
CLINICIAN: "Well – let's look at the thought that things will never get better. How accurate do you think that is? Are you 100% sure that things will never get better?"
CLIENT: "Not really – but I do think that there's a good chance things won't improve."
CLINICIAN: "What are the odds you would give yourself, in your head? 50/50? There's a 50% chance that things will get better?"
CLIENT: "Yeah – I don't know about this."
CLINICIAN: "I agree. It's not easy. Here- let's take a look at that thought about things never getting any better. I'm going to use this new sheet here." (Takes out the Thought Replacement Worksheet.)
CLIENT: "Okay. How do you want to look at it?"
CLINICIAN: "Well, you said that your mood was really negative on Friday night. How did you feel on Saturday morning?"

CLIENT: "Okay, I guess. Yeah- I had some stuff to do, and I hadn't had anything to drink, so I was feeling a little better."
CLINICIAN: "So- you were improved the next day?"
CLIENT: "Well, yeah – somewhat – but I wasn't totally happy or anything."
CLINICIAN: "Not perfect – and that's a point well taken. We're not looking for total perfection here- we're just looking for what moves your mood one way or the other. What if you had decided to drink on Friday night?"
CLIENT: "Would have been much worse. Okay – I see where you're headed with this. I have some choice about what happens."
CLINICIAN: "So let's try a little mind experiment here. This is your initial thought on Friday night – hopeless – I'm writing it in the Automatic Thought box. And we know where that one leads – you felt lonely, depressed, discouraged – I'm writing that in here."
CLIENT: "Right."
CLINICIAN: "Now, just use your imagination. What else could you have said to yourself, sitting there at the television, besides, I'm a loser, and I'm always going to be a loser."
CLIENT: "Something like, I may feel miserable right now, as if I was never going to feel better, but chances are I will feel better tomorrow."
CLINICIAN: "All right! That's a much more balanced thought. Good work! I'm writing that in here, in the Thought Replacement box. And what do you suppose your feeling would have been if you had said that to yourself instead?"
CLIENT: "A little more peaceful, maybe."
CLINICIAN: "Peaceful. Okay. I'll put that in here. You get the idea?"
CLIENT: "Uh huh. I think so."
CLINICIAN: "Okay. Now you try one. Here's the sheet. Let's look back at your mood diary for this week and find another example of a time you had negative feelings. How about this one? Upset, it says. And under Thoughts you have "Unfair." What's the mood magnifier there?"

Thought Replacement Worksheet

Hot Thought	Resulting Feeling	Replacement Thought	Resulting Feeling
I'm a real loser. It's never going to change. I'm always going to be this way.	Depressed Lonely	I'm feeling lonely right now, but I'll probably feel better in the morning. What else could be doing besides sitting here watching TV?	More hopeful Less depressed

Consider other ways of responding

In the same way, what the client does in negative mood situations (R), and how this may be a mood magnifier, is examined. As before, it is not the Clinician's job to confront, criticize, or correct the client's behavior. Rather, the client is encouraged to generate ideas of what he or she could have done instead, and what consequences might have resulted. As with thought substitution, the idea is to emphasize that the client has a choice about how to respond. A problem-solving approach works well in this context, with Clinician and the client working together to generate a list of different response options that could have different effects on moods. Some common examples of behaviors that may serve to reinforce negative moods are: withdrawing, arguing, sulking, drinking, driving aggressively, smoking, overeating, and criticizing or blaming.

CLINICIAN: "Now, a piece we haven't talked about yet is how what you do can also be a mood magnifier. Looking back at your Friday night, you say you were watching TV alone and eating chips. And doing that, you felt lonely, discouraged, depressed. Now what are some other possible actions you might have taken. What else could you have done when you were feeling that way?"
CLIENT: "I could have had a drink or twenty."
CLINICIAN: "Right- and you chose not to. What if that's what you had done? What would have happened?"
CLIENT: "Like I said, I would have felt a lot worse on Saturday. I would probably have stayed home on Saturday and drank all day, instead of going out and getting things done."
CLINICIAN: "All right. What else could you have done differently on Friday night besides staying home alone, that might have had better results?"
CLIENT: "What else am I supposed to do?"
CLINICIAN: "It's a real challenge sometimes to figure out what to do instead of a mood magnifying behavior. First identify the behavior that's magnifying your mood, and then try some healthier options."
CLIENT: "I don't know – maybe it's best just to be alone."
CLINICIAN: "I hear some mood magnifying thoughts right there?"
CLIENT: "Well, the being alone thing really bugs me. I know I don't want to be alone, which is a more balanced thought, I guess, but at the same time, I'm nervous about meeting people. I guess that's what AA meetings are for."
CLINICIAN: "You can meet people at meetings. You can also meet them at many other places. And going out and doing something around other people is just one set of possibilities. What else could you do?"
CLIENT: "You mean like call somebody on the phone?"
CLINICIAN: There's a good idea! What if you had done that instead on Friday night?"

Summary
Thought substitution and response substitution lend themselves well to task assignments between sessions. The spirit here is one of experimentation – of trying out different thoughts and different behaviors, to see what happens. The Clinician and client need to negotiate specific assignments, drawing heavily on the client's own ideas whenever possible. It can be useful to continue keeping the Mood Monitoring sheets during this period when new thoughts and responses are being tried.

Complete agency specific tasks
Complete any agency specific paperwork with the client as needed.

Summarize session
The Clinician should provide a closing summary of the session highlighting major accomplishments mad during the session, reviewing any commitments the client has made to try new strategies, and recognizing the client's efforts.

> *"We have made some progress today and I think you have a solid understanding of this STORC model. You can see how sometimes you have a lot of control over your emotions by the choices you make in how you think about and react to situations. As you get more experience thinking about your moods within the STORC model, I think you will begin to see some places where changing the way you think gives you some control over your mood."*

Preview next session
After the initial session using this module, the Clinician may spend one or more additional sessions working on problematic moods as needed. The follow-up sessions should be focused on helping the client strengthen skills for conceptualizing mood within the STORC model, identifying automatic thoughts that contribute to negative mood states, and on challenging/replacing distorted thinking.

> *In our next session, we can spend some more time talking about the unpleasant moods you have been having, and apply this model to understand where you might be able to get some control over the way you feel. How does that sound?"*

Review home assignment
The Clinician may make additional use of the Mood Monitoring Sheet as a homework assignment as needed. Clients should also be encouraged to practice replacement thoughts between sessions.

> *"Would you be willing to keep monitoring your mood over the coming week?"*
>
> *"Today we identified a replacement thought for the times that you feel… It should help you tone down the intensity of your feelings, but only if you use it. That can be hard sometimes, much of our thinking happens automatically. The task is to catch yourself thinking the old way and try to replace that thinking with the new way. I*

am wondering if you would also be willing to practice using your replacement thought over the next week?"

End Session

"*Do you have any other questions, concerns or thoughts before we end today?"*

APPENDIX A
MOOD MANAGEMENT
SESSION MATERIALS

UNDERSTANDING EMOTIONS AND MOODS

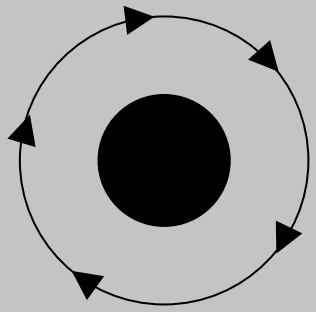
S Your Situation
These are the people, places, and things around you. People often think that they feel certain moods or emotions *because* of what is happening around them, but this is only one part of the complete picture.

T Your Thoughts
No situation affects you until you interpret it. How you think about what is happening has a powerful influence on how you feel about it. Different thoughts or interpretations lead to different feelings.

O Your Organ (Physical or Bodily) Experiences
What is happening inside your body is also an important part of the moods or emotions that you experience. Many emotional experiences involve a particular kind of physical arousal that can be experienced as being agitated, angry, upset, afraid, etc. Which particular emotion you feel depends in part on how you interpret or name what is going on inside your body.

R Your Response or Reaction
Interestingly, how you react, what you do in response to S, T, and O also has a large effect on how you feel. Different behavioral reactions lead to different moods and emotions.

C Consequences of Your Response
How you respond, what you do, in turn has certain effects or consequences. This is how your environment (especially other people) reacts to what you do. These consequences also influence your mood and feelings, and become part of your Situation, repeating the cycle.



MOOD MONITORING SHEET

Mood Level: rating: _____ **-10 •••••••• 0 •••••••• +10** **very neutral very negative positive**	**Mood Level: rating: _____** **-10 •••••••• 0 •••••••• +10** **very neutral very negative positive**	**Mood Level: rating: _____** **-10 •••••••• 0 •••••••• +10** **very neutral very negative positive**
S Situation:	**S Situation:**	**S Situation:**
T Thoughts:	**T Thoughts:**	**T Thoughts:**
O Feelings:	**O Feelings:**	**O Feelings:**
R What I did:	**R What I did:**	**R What I did:**
C What happened:	**C What happened:**	**C What happened:**

Thought Replacement Worksheet

Hot Thought	Resulting Feeling	Replacement Thought	Resulting Feeling
Hot Thought	Resulting Feeling	Replacement Thought	Resulting Feeling
Hot Thought	Resulting Feeling	Replacement Thought	Resulting Feeling

Module 9 Session Checklist

Mood Management

PREPARATIONS	✓
Session checklist	
Agency-specific paperwork	
Understanding Emotions and Moods handout (STORC model)	
Mood Monitoring Sheet	
Thought Replacement worksheet	
GETTING STARTED	
Check-in	
Set the agenda	
DISCUSSING THE STORC MODEL	
Situational Factors	
Thought Patterns	
Organ Experience	
Response Patterns	
Consequences	
DISCUSSING NEGATIVE MOOD STATES	
Help the client to label negative mood states	
COMPLETING THE MOOD MONITORING SHEET	
Client fills out and discusses in session	
DISCUSSING AUTOMATIC THOUGHTS	
Identify Hot thoughts	
Challenge hot thoughts (*Thought Replacement Worksheet*)	
COMPLETING AGENCY SPECIFIC TASKS	
WRAP UP	
Summarize session	
Preview next session	
Assign home exercise	