Rising to the Occasion of This COVID–19–Impacted Nation: Development, Implementation, and Feasibility of the Brief Assessment–Informed Skills Intervention for COVID–19 (BASIC)

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The COVID-19 pandemic has had a profound impact on the global economy, physical health, and mental health. This pandemic, like previous viral outbreaks, has resulted in spikes in anxiety, depression, and stress. Even though millions of individuals face the physical health consequences of infection by COVID-19, even more individuals are confronted with the mental health consequences of this pandemic. This significantly increased demand for mental health services cannot be easily met by existing mental health systems, which often rely on courses of therapy to be delivered over months. Single session interventions (SSIs) may be one important approach to meeting this increased demand, as they are treatments designed to be delivered over the course of a single meeting. SSIs have been found to be effective for a range of mental health challenges, with durable effects lasting months to years later. Here, we describe an SSI designed for the COVID-19 pandemic. This Brief Assessment-informed Skills Intervention for COVID-19 (BASIC) program draws upon therapeutic skills from existing empirically supported treatments to target common presenting complaints due to this pandemic. We discuss the process of developing and implementing this intervention, as well as explore feasibility and initial clinical insights. In short, BASIC is an easy-to-adopt intervention that is designed to be effective in a single session, making it well-suited for handling the increased demand for mental health services due to COVID-19.

T HE novel coronavirus (COVID-19) has had a global impact on public health and the economy, with over 1,960,000 deaths and 91,400,000 cases at the present moment. The consequences of the COVID-19 pandemic on mental health is a critical area of ongoing research. Research on previous viral outbreaks (e.g., severe acute respiratory syndrome [SARS] and, more recently, Ebola) has suggested viral outbreaks can have short- and long-term impacts on mental health. Accumulating evidence suggests the mental

health impact of COVID-19 has been substantial, leading to widespread calls for the development of mental health intervention efforts (Galea et al., 2020; Zhou et al., 2020).

Past viral outbreaks (e.g., SARS and Ebola) have had a clear and significant impact on mental health. Individuals who contracted SARS experienced heightened levels of depression, anxiety, and posttraumatic stress symptoms immediately following their illness (Cheng et al., 2004; Wu et al., 2005), and at 30-month follow-up, survivors of SARS showed nearly twice the rate of psychiatric morbidity as the general population, including 25% meeting diagnostic criteria for PTSD (Mak et al., 2009). Indeed, health care workers that had fallen ill showed evidence of greater stress and general psychological distress at 1-year follow-up than non-health-care workers (Lee et al., 2007). Survivors of Ebola also experienced a similar increased risk of mental health concerns, including depression (Keita

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et al., 2017) and PTSD (Hugo et al., 2015). Research investigating the relation between the COVID-19 pandemic and mental health suggests a similar widespread impact. Preliminary work from China found that 53.8% of respondents rated the psychological impact of the outbreak as moderate or severe, with 28.8% reporting moderate to severe anxiety, 16.5% reporting moderate to severe depression symptoms, and 8.1% reporting moderate to severe stress levels (Wang et al., 2020). Recent meta-analyses aggregating the current body of global research indicate elevated anxiety, depression, and stress (Cooke et al., 2020; Salari et al., 2020), which also appears evident among health care providers who represent a high-risk group. Initial longitudinal findings demonstrate a prepandemic to during-pandemic deterioration of general mental health (in the U.K., Pierce et al., 2020), deterioration of mood and mood-regulation strategies (in the Netherlands: Taquet et al., 2020), and stress/emotional distress (in Switzerland: Shanahan et al., 2020).

Taken together, there is emerging evidence pointing to an increased prevalence of mental health concerns, particularly in the domains of anxiety, stress, and depression, resulting from the COVID-19 pandemic. The significant, and growing, burden to existing mental health care models calls for increased research on scalable clinical interventions (Holmes et al., 2020; Pfefferbaum & North, 2020). Given an increased need for scalable mental health services, single-session interventions may offer an economical and efficient therapeutic option. Single-session interventions (SSIs) have been defined as an intentionally singular intervention session, either therapist-administered or through a self-delivery format (Schleider & Weisz, 2017). SSIs can have an immediate and lasting impact, with significant, positive effect sizes in the small-to-medium range across a number of diagnoses and across a range of symptom severities (Schleider & Weisz, 2017). These improvements have been found to be maintained at 1-month posttreatment (Perkins, 2006) and even longer (Başoğlu et al., 2005; Boscarino et al., 2005). Notably, preliminary evidence suggests that they may have similar efficacy as time-unlimited therapies (Bloom, 2001). Although not a metric of treatment efficacy, it is worth noting that patients frequently give single-session interventions good ratings in terms of acceptability and satisfaction (Hymmen et al., 2013; Perkins, 2006). Finally, as the modal number of therapy sessions is one—regardless of patient diagnosis, therapy modality, or problem severity—scaling interventions to fit the single-session model makes sense from a practical standpoint (Young et al., 2012). Taken together, these results indicate that SSIs are acceptable vehicles to deli-

ver key elements of treatment in a cost-effective and scalable fashion. Given the potential burden on mental health services by the COVID-19 pandemic, we sought to develop an SSI that targeted the most common symptom domains of this pandemic (e.g., uncertainty related to the pandemic, isolation due to social distancing) with a skill-based approach.

Intervention Development
General Structure

BASIC was originally inspired by, and adapted from, another brief intervention for the COVID-19 pandemic developed by Dr. Michael Mullarkey. His intervention, CBT-based One-Session Distress Tolerance for Emergency Responders (CODE; open source treatment manual available at https://osf.io/j64ms/), is a single-session intervention that was created very early during the COVID-19 pandemic based on the rapidly increasing demand for mental health support for front-line medical staff and emergency responders tasked with handling this pandemic. CODE showcased the possibilities of brief interventions to meet this increased demand for mental health services during a pandemic.

Further investigation into the structure and utility of brief interventions for large scale stressors like natural disasters and humanitarian crises highlighted additional brief interventions that have been used to maximize clinical resources (Paul & van Ommeren, 2013). Based on these collective interventions, a number of themes and potential strategies emerged:

1. Single-session interventions benefitted from a clear focus on a singular problem that would be the target of that session.
2. The session should be solution-focused and ideally identify the minimum change necessary that would indicate a successful session from the perspective of the patient. Given the constraints of very limited time, addressing more than one problem is generally not feasible.
3. Brief interventions appeared particularly well-suited for teaching therapeutic skills, as well as detailed discussions of skill implementation and addressing barriers to implementation. In fact, brief interventions that are more supportive and non-directive in nature can be harmful when applied in traumatic situations (Williams et al., 2020).
4. Brief interventions appeared to require an explicit setting of expectations—that there will be a clear limit on the number of sessions provided and session agendas are designed to make the most out of that time.

These themes provided a basic infrastructure: well-structured, single-problem focused, skills-based sessions. After drawing upon details provided by Mullarkey (2020) and Paul and van Ommeren (2013), we added in brief psychoeducation to build self-compassion regarding the experience of anxiety and stress in the midst of a pandemic, as well as resilience building, as the final components of our brief intervention (Bluth & Eisenlohr-Moul, 2017; Padesky & Mooney, 2012; Warren et al., 2016). We then constructed our session with the assumption that it would be a single 50-minute session intervention and that only a small subset of patients would require booster sessions. We declined to add any further elements as we wanted to have enough time to cover each component in sufficient detail, yet also cover as much as possible with our patients.

Leveraging Automation for Scalability

We were interested in minimizing the amount of pre-treatment contact required to identify and schedule patients appropriate for this intervention. This approach was meant to prevent limited administrative staffing from being a bottleneck for our ability to serve the community. We also wanted to be able to refer individuals who might come across our program while searching for COVID-19-related resources or assistance to the appropriate websites and information as well. Last, we wanted to have interested patients provide us as best of a picture as possible of the information relevant to this brief intervention. This information included what specific presenting complaints were considered top treatment priorities that brought them in search of services, factors that exacerbated or alleviated their target of treatment, identifying the smallest step forward that would indicate their life was moving in the "right" direction, and sources of support for them. We structured our electronic screening form to allow us to accomplish all of these various goals. The end result was that, after completing the online screening form, our sole clinic administrator was able to match patient availability to therapist availability and then send an e-mail confirming the appointment to both parties. This interaction was often the only one necessary before the therapist and patient were able to meet by teleconference software (i.e., HIPAA-compliant Zoom).

Presenting Complaint Identification

We wanted to present an array of options to potential patients to help them with summarizing the challenges they were facing and also facilitate treatment planning and supervision for the clinical team. We identified six general problem domains that would likely capture the presenting complaints of most individuals requesting this brief intervention. These domains were feelings of loneliness and isolation, difficulty tolerating uncertainty related to the pandemic, difficulty managing negative emotions, lack of structure or motivation for engaging in daily activities and routines, feelings of stress, anxiety, or worry related to the pandemic, and difficulty solving problems that have presented themselves as part of the pandemic. These domains were identified based on clinical work with existing patients, the research available at that time on the impact of COVID-19 and previous pandemics on mental health (e.g., Cheng et al., 2004; Kang et al., Wang et al., 2020; Wu et al., 2005), news articles on the mental health challenges brought on or exacerbated by the pandemic, and by personal experience on the part of the team developing the intervention.

Therapeutic Modality Selection and Evidence Base Available

We selected therapeutic skills from Acceptance and Commitment Therapy, Dialectical Behavior Therapy, and Cognitive Behavior Therapy to use in BASIC for three reasons. First, all three interventions have been found to be effective for anxiety and, to a lesser extent, depression (e.g., Cape et al., 2010; Swain et al., 2013; Twohig & Levin, 2017; Watts et al., 2015). As anxiety seemed to be the most common mental health challenge presenting during a pandemic (e.g., Cabello et al., 2020; Kang et al., 2020; Wang et al., 2020), we wanted to lean on interventions with demonstrated efficacy for elevated anxiety at minimum. Second, all three therapeutic modalities have well-established and well-articulated therapeutic models to draw from for case formulation. These models made it much easier to plan sessions and connect presenting complaints with therapeutic skills. Notably, the well-established nature of these interventions made it easier to teach and disseminate BASIC as the therapists we worked with were familiar with most, if not all, of the interventions listed. Third, skill utilization for the specific therapeutic skills in each of these interventions has been associated with symptom reduction (Neacsiu et al., 2014; Swain et al., 2013; Twohig & Levin, 2017; Valentine et al., 2015; Webb et al., 2016). These findings provide us some reassurance that decoupling the specific therapeutic skills taught in each of these interventions from the broader therapeutic modality could still lead to an effective brief intervention.

Piloting and Revision

We took an iterative approach to the development of BASIC. As a new intervention, we have wanted to obtain regular feedback from therapists who were delivering the intervention and from therapists who have no experience with BASIC at all. Feedback from therapists experienced with implementing BASIC enabled us to fold in their clinical insights and experiences trying to use the intervention components with patients presenting for treatment. This feedback process was conducted in multiple waves, with an initial round of feedback being delivered after seeing 10 patients. Thereafter, we solicited another round of feedback from therapists after seeing 20 additional patients. Aspects of BASIC that we improved upon included approaches to addressing patients that report high levels of confidence in their ability to confront stressors or report no barriers to implementation, or the removal of ratings of Subjective Units of Distress between each round of present-focused thinking skill practice (to avoid emphasizing present-focused thinking skills as an experiential avoidance technique rather than a present-focused thinking technique). We will continue to periodically obtain feedback from therapists delivering BASIC to continually improve upon the intervention.

We also reached out to a number of colleagues with no experience with BASIC to obtain external feedback on the protocol, including feedback on the treatment manual and the pretreatment assessment. These therapists varied in their familiarity with the therapeutic modalities and skillsets incorporated into BASIC. None had ever been exposed to BASIC and thus were able to deliver input from the perspective of therapists new to the intervention that might be interested in adopting BASIC for their own clinical work during the pandemic. These colleagues, Drs. Tali Ball, Michael Mullarkey, Broderick Sawyer, and Sarah Victor, provided thoughtful suggestions for how to improve upon aspects of BASIC for therapists not familiar with the intervention or all of its skill sets. Presented in the remainder of this article is the culmination of these collective efforts, describing the overall organization and implementation of BASIC in our clinic.

Intervention Description
General Overview

BASIC seeks to integrate the structure and approach of brief interventions (e.g., single-problem focus, clearly structured, and skill-based) with more traditional approaches to psychotherapy (e.g., developing a case conceptualization to guide intervention delivery). Although brief interventions designed to meet the increased need for mental health care due to the COVID-19 pandemic do not allow for rich, sophisticated case formulations, the structure of BASIC at least allows for the development of a simplified case formulation due to the pretreatment assessment. This approach ultimately aims to provide a personalized intervention that draws upon existing research on evidence-based therapeutic skills.

Pretreatment Assessment

Prior to treatment, interested patients complete an online pretreatment module that includes assessment of eligibility criteria and several clinical measures. Patients identify their top three treatment priorities out of the following: feelings of loneliness/isolation, difficulty tolerating uncertainty related to the pandemic, difficulty managing negative emotions, lack of structure or motivation for engaging in daily routines and activities, feelings of stress, anxiety, or worry related to the pandemic, and difficulty solving problems that have presented themselves as part of the pandemic. Patients also describe their most critical concerns, contributing stressors, coping strategies, treatment goals, personal strengths, and cultural considerations. Patients also complete the Generalized Anxiety Disorder scale (GAD-7; Spitzer et al., 2006) and the Patient Health Questionnaire (PHQ-8; Kroenke et al., 2009) to assess current symptom severity. Patients then provide their demographic information, contact information, and scheduling preferences.

As described above, the therapist uses the information reported in the pretreatment assessment to formulate a case conceptualization of the patient, including identifying the patient's top two treatment targets and one to two skills that are most likely to be helpful for the patient. The therapist may also identify up to two measures that can be used to assess existing symptoms and skills, as well as progress from pre- to post-treatment. Measures include assessments of distress tolerance, such as the Distress Tolerance Scale (DTS; Simons & Gaher, 2005) and the Negative Urgency subscale from the Short Form of the UPPS Impulsive Behaviour Scale (UPPS-SF; Cyders et al., 2014); worry, such as the Repetitive Thinking Questionnaire (RTQ-31; McEvoy et al., 2010); values-driven behavior, such as the Behavioral Activation for Depression Scale (BADS; Kanter et al., 2007); difficulty managing negative emotions, such as the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) and the Emotion Regulation Questionnaire (ERQ; Gross & John, 2003); and problem solving, such as the Social Problem Solving Inventory–Revised (SPSI-R; D'Zurilla

et al., 2012). The therapist then sends the patient the PHQ-8 (Kroenke et al., 2009), GAD-7 (Spitzer et al., 2006), and any additional measures, scheduling information, and the Session Takeaway Sheet.

Pretreatment Supervision

Pretreatment supervision is recommended for therapists unfamiliar with BASIC, trainees still developing their clinical skills (e.g., practicum students), or any therapist who is interested in obtaining consultation before meeting with their patient. Once licensed therapists are well accustomed to BASIC and comfortable with its delivery and approach to case conceptualization, they can forego pretreatment supervision. This pretreatment supervision process is meant to help therapists with developing a case conceptualization for the patient based on the assessment data available, guiding the selection and delivery of therapeutic skills before even meeting with the patient.

During pretreatment supervision, therapists review the pretreatment assessment, including the patient's treatment priorities and current life stressors. With support from a supervisor, the therapist identifies the two skills that are most likely to be helpful for the patient and discusses any additional considerations based on the data available. This process can be repeated for booster sessions as needed.

Initial Session Structure

Agenda Setting

The therapist begins the session by explaining the format of the intervention and collaboratively setting an agenda with the patient. Patients may be unfamiliar with an intervention of this nature, so the therapist takes the first few minutes to socialize the patient to the goals and structure of the session. Specifically, the therapist explains that the goal is to teach the patient a specific skill or tool which can be taken beyond the session in order to better manage the distress they are experiencing. It is important to emphasize that the goal is *not* to eliminate anxiety or distress, but rather to better manage it. The patient is informed that the goal is to accomplish this in one session, with the option for up to two additional boosters. A typical agenda includes (a) collaboratively setting the treatment target, (b) practicing a specific skill, and (c) problem solving implementation of the skill. Agenda setting is presented to the patient as a way of valuing their time and ensuring that we make the most out of a single session. The agenda setting process is also used by the therapist to quickly establish rapport with the patient and bring them on board as a collaborator.

Normalize Experiences of Stress and Anxiety and Build Self-Compassion

In the initial phase of the session, the therapist endeavors to normalize the appearance of distress, anxiety, or low mood that the patient may be experiencing. Using Socratic questioning, the therapist assesses the magnitude of the distress, as well as the degree to which the patient finds these symptoms helpful versus destructive to his/her/their life. The therapist then provides psychoeducation around the nature and purpose of anxiety (or other symptoms of distress), emphasizing that during a crisis this is *the typical response*. Despite stress and anxiety being the typical response to a situation such as this, as the patient has identified, it is not always helpful and can often interfere with individuals' lives. Thus, the therapist aims to help the patient come to a place where they see the goal as not to eliminate distress or anxiety, but rather to manage it more effectively.

Target Identification

The therapist then works with the patient to collaboratively identify the treatment target for the session. Using the information gathered from the pretreatment assessment, the therapist reviews the top two treatment targets that the patient identified as priorities and assesses whether or not these targets remain the priority for the patient. The therapist also reviews with the patient what they identified as "the smallest change [they'd] need to see to feel that things are moving in the right direction." The therapist and patient collaboratively identify a target that is (a) high priority for the patient, (b) reasonable to work on in a single session, (c) something for which a specific skill or strategy can be employed, and (d) moves the patient toward feeling like they're moving in the right direction. The therapist aims to help facilitate this process by presenting the patient with examples of the kinds of skills that can be practiced within the areas the patient has identified as priorities. When multiple potential targets or skills exist, it can be helpful to choose the one the patient is more familiar with to make it easier to apply.

Skill Building and Practice

The therapist then teaches the skill associated with the patient's primary treatment target, ensuring to leave time in session for several rounds of collaborative hands-on practice when appropriate. Prior to initiating the skill-building exercise, the therapist provides the patient with a clear rationale for the selected skill, tailoring their rationale to the language used by the patient in the pretreatment assessment and throughout the session. This rationale is meant to improve patient understanding and buy-in for adopting this

skill for their presenting complaint. For example, a patient who identifies their primary treatment target as "feelings of stress, anxiety, or worry related to the pandemic," stating in their pretreatment assessment that they "find difficulty completing their daily tasks due to feeling anxious and distracted by the prospect of falling ill and losing their job," may benefit from practicing the skill of present-focused thinking. Before teaching this skill, the therapist explains that at the height of anxiety, individuals frequently engage in either future- or past-oriented thinking which, in turn, has no bearing on their ability to problem-solve effectively regarding their daily tasks in the present moment. As such, though this type of thinking is understandable, and in some cases expected given the circumstance, it is rarely helpful. Conversely, present-focused thinking allows one to bring their attention back to the present moment while acknowledging their anxiety, thereby maximizing their ability to effectively prepare for, and manage, current challenges. The manual outlines a series of such skills designed to address the patient's modifiable treatment targets including distress tolerance, present-focused thinking, value-driven behavior, flexible emotion regulation, and problem solving, which are described in detail below. Each of these skills are, in turn, practiced using a series of tools for which all handouts and worksheets are provided with the manual. For example, the therapist may use TIP (Temperature, Intense Exercise, Paired Muscle Relaxation) Skills (Linehan, 2014) and Progressive Muscle Relaxation (McCallie, Blum, & Hood, 2006) to practice distress tolerance, Building Mastery and Cope Ahead (Linehan, 2014) to teach the skill of flexible emotion regulation, Dropping Anchor or Mindful Breathing to practice present-focused thinking, and the Values Checklist and SMART Goals to practice value-driven behavior (Dropping Anchor, Mindful Breathing, Values Checklist and SMART goals worksheets are freely available at https://www.actmindfully.com.au), or use structured problem solving to enhance the skill of effective problem solving (Nezu et al., 2012; Overholser, 1996). After the therapist teaches the skill, the patient is given the opportunity to practice the skill in session and encouraged to think of concrete ways in which they will implement their newly learned skill over the next few days.

Barriers to Skill Implementation

To ensure continued success outside of session, the patient is asked to identify one or two key barriers to their skill implementation. Once these barriers have been identified, the therapist helps the patient problem solve their identified barriers using a problem-solving framework. Sometimes, simply figuring out when and how to implement the skill can address a patient's key barrier. However, if a patient is unable to identify any barriers, they are encouraged to think of previous barriers that have prevented them from implementing a specific skill, and problem-solving is used to address these prior barriers instead. Additionally, the therapist may discuss barriers that other patients have identified in the past and the methods they used to overcome them. Critically, the therapist encourages the patient to practice self-compassion when trying to utilize their newly learned skill outside of session. The patient is reminded that learning a skill and implementing it in their everyday life takes practice and approaching skill use with curiosity or in an iterative/experimental manner may prove more beneficial than engaging in self-criticism.

Reinforce Resilience

Before ending the session, the therapist asks the patient to once again rate the degree to which they feel prepared in the present moment to manage their negative emotions or situation and compares this rating to the one provided at the start of the session. Additionally, the therapist asks the patient to identify some inner strengths or resiliency factors and how they may help the patient further manage their stress and augment their use of the skill learned in session. These factors may include having a positive outlook, spiritual convictions, a sense of hope or feelings of personal control, creativity, humor, and/or a strong support network of family, friends, or partner. If the patient struggles to identify any personal strengths, the therapist asks them to think back to a time when they had overcome a challenge and how they got through that difficult period. Prior to ending the session, the therapist asks the patient to reiterate what they have learned from the session, answer any of the patient's remaining questions, reinforce their decision to engage in this program, and encourage them to return for a booster session if they need additional support with skill implementation or have a secondary treatment target that they wish to address.

Optional Booster Sessions

Patients may request up to two booster sessions following the initial session, for a total of three possible sessions. Booster sessions are meant to acknowledge two truths: (a) therapeutic skills can be hard to implement and sometimes require additional support from a therapist to problem-solve barriers to skill implementation and success; and (b) the COVID-19 pandemic can impact patients' lives in multiple ways, not just a single problem domain or symptom dimension. Booster ses-

sions thus have two main purposes: to troubleshoot skills taught in the first session and/or to teach a new skill. As with the initial session, booster sessions are meant to focus on specific symptom domains associated with the COVID-19 pandemic and not more complex psychopathology (e.g., PTSD, personality disorders) that generally require multiple sessions of treatment to achieve treatment response.

Prior to each booster session, the patient completes a prebooster session questionnaire, which the therapist uses to plan for the booster session. This online questionnaire assesses the problems and skills addressed at the previous session, skill utilization, and goals for the booster session. Pretreatment supervision can be repeated as necessary prior to the booster session. If possible, the same therapist who conducted the initial session should conduct booster sessions.

Booster sessions begin with agenda setting again before reiterating where the patient is having difficulty; for some individuals, it may be that they haven't attempted the new coping skills. For others, they may have attempted the skills and not found them helpful. A third group may express wanting to learn an alternative coping skill. In the former instances, therapists adopt a problem-solving framework and help the patient address barriers to skill implementation or effectiveness. If the therapist teaches an alternative coping skill, they employ the same approach as in the initial session, with in-session practice and identifying barriers to skill implementation.

Core Skills

As described by Linehan (2014), distress tolerance is a set of skills for managing acutely elevated distress that individuals experience as impairing or overwhelming. Distress tolerance skills are intended to be used for short periods of time to help the patient cope with the situation without making it worse. These skills are most often used when patients endorse difficulty managing negative emotions as their primary concern, and can also be used for acutely elevated distress, difficulty coping, or maladaptive coping. Distress tolerance skills can include intense temperature (e.g., running hands under hot or cold water, splashing cold water on face), and intense exercise, paced breathing, and progressive muscle relaxation.

As described by Harris (2009), present-focused thinking is a set of attentional control skills for reducing functional impairment due excessive worry or rumination by helping the patient redirect their attention to the present moment. This set of skills is helpful for patients who endorse difficulty tolerating uncertainty related to the pandemic or feelings of stress, anx-

iety, or worry related to the pandemic as their primary treatment concern. Present-focused thinking may also be helpful for patients who report difficulty staying present and report repetitive negative thinking (e.g., rumination, worry). Common strategies for redirecting attention include grounding, mindful breathing, and scheduling worry time.

As described by Lejuez et al. (2011), values-driven behavior involves increasing patients' participation in meaningful/valued activities. This is helpful for patients presenting with feelings of loneliness/isolation, a lack of structure or motivation for engaging in daily routines and activities, indecisiveness, inactivity, lack of structure, or boredom. Strategies include values identification, setting SMART (specific, measurable, attainable, realistic, time-framed) goals, or behavioral activation (i.e., behavior monitoring and scheduling).

As described by Linehan (2014), flexible emotion regulation includes strategies for reducing vulnerability and increasing resilience to negative affective states. These skills may be used for patients identifying treatment priorities such as difficulty managing negative emotions, emotion dysregulation, difficulty with mood-independent behavior, or difficulty with self-care. This includes skills such as reducing vulnerability to negative emotions (e.g., basic self-care, accumulating positive emotions, building mastery), opposite action to change emotions, or behavioral activation.

As described by Nezu and colleagues (2012), problem solving is a structured approach to defining and systematically considering potential solutions to specific problems. Problem solving may be useful for patients identifying their primary concern as difficulty solving problems that have presented themselves as part of the pandemic, difficulty adjusting to a new environment, or who request help managing a specific situation. Problem solving is also useful during booster sessions for patients experiencing difficulties implementing BASIC skills at home.

Manual and Resources

To support the dissemination of BASIC, we have created a detailed treatment manual available to the public (bit.ly/BASICTx). The BASIC manual is designed to provide therapists of all levels with comprehensive guidelines for delivering the BASIC intervention. The manual provides background information on the impact of the COVID-19 pandemic as well as an overview of the intervention objectives and approach. The remainder of the manual focuses on the structure and approach of BASIC sessions, including plans for assessment and treatment, session outlines, and an overview of core skills taught in sessions.

The assessment and treatment plan guide the therapist through case formulation and treatment planning. First, as described above, the therapist identifies the top two treatment priorities as indicated by the patient on the pretreatment survey, which includes demographic information, a brief summary of the presenting problem, and a rank order of treatment targets. Table 1 in the manual helps the therapist develop an initial case formulation, identify corresponding treatment targets, and administer relevant questionnaires based on information reported in the pretreatment survey. For example, based on Table 1, a primary treatment target of feelings of loneliness or isolation would correspond with the core skill value-driven behavior and the Behavioral Activation for Depression Scale (BADS-SF; Kanter et al., 2007). The therapist records the target skill and assessment instrument in the treatment plan.

The manual also includes detailed outlines for Session 1 and up to two booster sessions, as well as a patient handout. Patients follow along with the Session Takeaway Sheet during the session. The structure of the handout mirrors the therapist outline and includes patient self-efficacy ratings (pre- and post-skill instruction), identification of the treatment target, selection of skill to be learned in session, problem-solving barriers, and a review of strengths/resources that can help the patient succeed.

Our manual also includes two therapist cheat sheets, which provides concrete tips for establishing rapport and providing psychoeducation around distress during disaster. The final section of the manual provides an overview and resources (e.g., handouts, worksheets, recordings) for each of the core skills.

Feasibility

Feasibility

With the aim of providing a widely disseminable intervention that can be delivered in the wake of large-scale stressors, it is important that the intervention can be adopted quickly and by therapists with varying levels of expertise. In our clinic, the treatment was primarily delivered by 10 doctoral students in their third year of a clinical psychology doctoral program, who all had completed coursework and practica focusing on the theory, evidence, and implementation of cognitive-behavioral therapy. We found that students were able to deliver the intervention in standard 50-minute sessions with the use of the manual and group supervision, and we were able to accomplish this without a comprehensive workshop or training session. Further, therapists reported which major aspects of the protocol they were able to accomplish after each session (set an agenda, provided psychoeducation and normalized experiencing distress during distressing times, collaboratively set a goal for the session, utilized the Session Takeaway Sheet, taught a core skill, problem solved barriers to implementation, and reviewed sources of strength/resiliency) and indicated they were able to cover all seven of these aspects 81% of the time. The most commonly unused protocol element was explicit use of the Session Takeaway Sheet, which was not done in 13% of sessions. It is important to note that this does not mean that the patients did not use the sheet, as they received it prior to the session and were asked to use it; rather, it indicates that therapists might not have explicitly mentioned it during the session.

As highlighted above, we developed a detailed manual in order to facilitate use of the intervention outside of our clinic. The manual aids therapists with no exposure to BASIC in the delivery of the intervention, providing specific instruction for elements to include in a first session, including agenda setting, psychoeducation, identifying a target, teaching and practicing a skill, problem solving for barriers, and reinforcing resilience and strengths, along with estimates for minutes to allot to each task in order to facilitate completion of the session agenda within a 50-minute session. We also created skills worksheets adapted to the nature of the COVID-19 pandemic for patients that review skills learned in session in a manner consistent with the language and delivery described in the BASIC manual. These handouts include a brief overview of the rationale for the skill, as well as reminders for implementation. Finally, we developed mock training videos demonstrating delivery of each core skill as a resource for training and implementation. These resources are freely available online (bit.ly/BASICWebsite) and meant to greatly increase the feasibility of implementing BASIC in other clinic settings.

Initial Clinical Insights

Based on the delivery of BASIC to over 50 patients thus far, a number of common themes and helpful insights have emerged. Below, we describe these insights in further detail.

Framing Treatment as an Iterative Approach

We have found it helpful to describe this treatment as something that requires trial and error to be successful. By doing so, it sets expectations for the process of developing, implementing, and refining therapeutic skills. Specifically, we frame BASIC as a test and refine approach in multiple ways, involving (a) the (attempted) identification of a specific skill best matched

to address presenting concerns, (b) the systematic testing and practicing of that skill in session, and (c) the refinement of skill implementation to maximize specificity and efficacy. Given this structure, regular assessment is critical to ensure patients are matched with a skill that, when implemented accurately and consistently, adequately addresses their concerns. To that end, it is crucial to include a mix of assessment formats, with patients answering both structured questions related to their treatment priorities, as well open-ended questions that offer additional insight into optimal treatment targets. Based on this information, therapists are able to identify the skill that likely best matches the patient's needs in advance of the session while maintaining the flexibility to shift targets in-session if requested. In addition to fostering collaboration, this approach is also useful for adapting to ongoing changes arising as a function of the pandemic. Indeed, common presenting problems have shifted over time as more individuals are directly impacted by COVID-19, with impending anxiety about the uncertainty of the pandemic giving way to distress related to concrete losses. The multi-skill structure of BASIC allows therapists to respond and adapt to these changing concerns over time, while still attending to more ubiquitous patient needs.

Present–Focused Thinking as a Primary Skill

Although presenting concerns have evolved over the course of the pandemic, most treatment matching has consistently resulted in skills that emphasize present-focused thinking, or the ability to flexibly redirect attention to the present moment and to the controllable aspects of an experience. Present-focused thinking is well-matched to address a range of pandemic-related concerns, precisely because many people are grappling with worries that are intrinsically uncontrollable during this time. As a result, most sessions include some psychoeducation related to present-focused thinking, regardless of the primary skill being implemented.

Prior to the introduction of this skill, patients are informed that the primary goal of present-focused thinking techniques is to help them more effectively manage their anxiety. It is crucial that a clear distinction is made between managing anxiety—shifting attention from uncontrollable and overwhelming worries toward domains that facilitate a sense of control and self-efficacy—and ameliorating anxiety—simply supplanting negative emotions with positive ones (e.g., inducing relaxation). Highlighting this distinction early in the session has shown success in calibrating patient expectations and maximizing the utility of

the intervention. Rather than approaching the session with a vague hope of eradicating feelings of anxiety and a push for experiential avoidance, the patient and therapist work together toward a goal that is more circumscribed and more attainable. The therapist guides the patient in identifying specific times when anxiety is unhelpful for the patient and helps the patient develop a present-focused thinking strategy to help mitigate the impact of anxiety in those moments. As an example, one patient reported extreme distress and emotional dysregulation when arriving at her job at a grocery store. She would become flooded by the same anxious worries: *Why did I come to work today? What if my co-workers are all sick? What if the patrons aren't wearing masks?* The therapist clarified that the focus of the intervention was not to answer these questions or undo these emotions, but rather to create space from these overwhelming feelings by reorienting her to the present, controllable circumstances—she had already decided to go to work that day, she had taken every responsible precaution, and she was maintaining a safe distance from others.

Providing the patient with the resources to accomplish this goal requires translating present-focused principles into present-focused action. Patients learn and practice a single skill designed to target their most pressing concern. If time allows, the skill is rehearsed over multiple trials and patients are encouraged to provide feedback about the aspects of the skill that were most effective. Implementing and rehearsing present-focused thinking during the session has demonstrated several benefits for patients. First, practicing present-focused thinking during the session functions as both an intervention and prevention tactic, depending on the particular circumstances of the patient. In a session with a first responder, the patient reported increased anxiety related to managing his team safely and competently. Despite the session taking place on his day off, the patient received a call from work during the session. Practicing present-focused thinking in that moment served as an intervention—the patient was able to learn to distance himself from spiraling uncertainties and regain control over his attention during a moment of acute anxiety. After engaging in the skill, he reported feeling more equipped to handle the call from work. Other patients report to the session with lower baseline levels of anxiety. In these cases, building a present-focused thinking repertoire serves a preventative purpose—it motivates healthy habits and instills a sense of optimism and confidence that anxiety can be managed when it strikes. For many patients, collaborating with the therapist to tailor the skill to the patient's needs has been an important determinant of patient satisfaction. Examples of this include empha-

sizing particular senses during grounding techniques (Dropping Anchor; Harris, 2016), incorporating additional muscle groups during progressive muscle relaxation, and adjusting the timing of inhalations and exhalations during mindful breathing. Finally, practicing present-focused thinking skills in session allows for therapists to troubleshoot with patients on the implementation and goal of this skill. Present-focused thinking skills can, at times, be difficult to adopt and sometimes used as experiential avoidance tools. Only through a continuous discussion regarding skill implementation can this error be caught. As a consequence of this in-session implementation, patient takeaways from these in-session trials have been encouraging: almost all patients have reported a decrease in feelings of anxiety after practicing present-focused thinking and have indicated greater self-efficacy in coping with feelings of anxiety in the future.

Once the patient has developed some fluency with the skill, the patient and therapist then work together to create an implementation plan. Implementation planning has inspired creative solutions for anxiety management in patients. For some, they foresee present-focused thinking techniques being most beneficial as a daily practice. Many patients have reported needing help transitioning from work to home life; using present-focused thinking techniques as a daily exercise to bridge these transitions has served to ground patients and redirect their attention from stressors toward more manageable aspects of their environment. Other patients envision using these techniques as acute intervention strategies. In the case of the patient who experienced distress upon arriving at work, she planned to practice mindful breathing and progressive muscle relaxation in her car before entering work to best cope with the predictable spike in anxiety. During these conversations, flexible application of the skill is emphasized. In the case of the first responder, he reported increased anxiety at work during times when a comprehensive present-focused thinking routine would not be feasible. Implementation planning thus entailed adapting lessons from this practice to his unique situation—for example, focusing briefly on the tension and relaxation of certain covert muscle groups. These discussions have generated motivation to use present-focused skill sets in ways that are optimal for each patient.

For some individuals, making best use of the skill requires additional refinement and problem solving. In such cases, one to two booster sessions can be provided to reduce barriers associated with effective skill implementation. Importantly, BASIC emphasizes the consistent use of a single skill, rather than teaching as many skills as possible for different contexts or con-

cerns. While this treatment feature is partly attributable to the single-session format, it is also a function of the larger intervention goal: to help patients to conscientiously and persistently use a skill they have been taught. At times, this aim has been at odds with patient goals. Indeed, one patient requested multiple booster sessions in an attempt to gain exposure to the greatest number of skills possible, rather than to set goals around the actual usage of a skill. To that end, we have found it to be critical to socialize patients to this iterative skill implementation model, and to collaboratively ensure the skill being taught is appropriately matched to presenting concerns. When patients have sought to "maximize their toolkit," they have often neglected implementing the skills already provided and change the focus of therapy towards a less helpful approach.

Conclusion

The COVID-19 pandemic has had a broad global impact, harming economic markets as it places significant strain on physical and mental healthcare systems. The mental health burden of COVID-19 will inherently outpace the physical health burden. Not all will be infected, but most will have to cope with the anxiety, stress, and relative isolation imposed by this pandemic. Existing mental health care systems that rely on existing interventions designed to be delivered over months will not be able to deliver services to all that may want or need care. To rise to this occasion, scalable approaches to mental health care are essential. BASIC is one such approach.

BASIC is well configured to meet the needs of patients facing COVID-19-related stressors. For front-line health care workers and essential workers, free time is at a premium and existing interventions may be too burdensome. Yet BASIC is designed to be delivered in a single standard 50-minute therapy session. It targets the presenting complaints most likely to arise in the midst of a pandemic and draws from empirically supported treatments and evidence-based principles to do so. BASIC focuses on psychoeducation, skill implementation, and resilience-building all in a format that many therapists can implement with minimal training. Each session is personalized to the patient's presenting complaint and context. In most clinical contexts, BASIC may be an ideal approach to meeting the needs of potential patients.

Even with the strengths noted above, there are important limitations to be considered for BASIC. First, it is not designed to handle significant distress in the form of active suicidal ideation or behavior, nor is it designed to treat clinical challenges like PTSD or OCD. Although we have been able to treat individuals with these comorbid disorders, they were not the

primary target of treatment. Second, the intervention is built around being able to administer a pretreatment assessment before the first session. Although an abbreviated assessment could be incorporated into BASIC to make up for the lack of a pretreatment assessment, certain therapists (e.g., trainees) may lose out on the benefits of having pretreatment assessment data to develop a case formulation and obtain supervision. Third, effectiveness data does not currently exist for BASIC. Such data are being collected but will not be available for some time. BASIC does draw upon empirically supported treatments like CBT, DBT, and ACT that have all found the skills delivered as part of the intervention play an important role in treatment response. As of yet, however, BASIC cannot be considered an empirically supported treatment. Finally, we have no sense of the durability of these effects. Other brief interventions have found to have durable treatment effects lasting months to years, but whether BASIC is capable of delivering such benefits is unclear.

In addition to addressing some of the limitations outlined above, a few future directions exist for BASIC. Both are meant to improve the overall impact of BASIC on the mental health burden imposed by COVID-19. First, BASIC may be suitable for adaptation to a group format. Each group could focus on a specific presenting complaint domain (e.g., difficulty tolerating uncertainty related to the pandemic) and teach one or two skills to address that domain, with time spent in session practicing the skills and addressing potential barriers to implementation together. Although BASIC would lose its personalized, patient-centered approach, it may have a larger impact due to the group format. The second future direction for BASIC is fitting it into a stepped-care treatment model. The initial, bottom level could either have trained lay persons provide supportive listening or psychological first aid, or the bottom level could deliver self-guided interventions. Patients who need additional care may benefit from BASIC as a second tier treatment approach. For individuals who do not benefit from (or seem suited for) BASIC could be referred to more experienced therapists for more standard interventions. This stepped care approach could really maximize the benefits of BASIC while meeting the varying needs and capacities of a large mental health care system.

In conclusion, BASIC draws from our current understanding of the mental health burden of pandemics and what interventions are suited to address this burden. It provides a personalized, skills-based treatment in only 50 minutes. Further, BASIC has been feasible to implement in a variety of settings, including with trainees. Finally, the treatment manual and training videos are freely available online and accessible to all interested parties.

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