An Individual Counselling Program Designed to Decrease Anxiety in a 16-Year-Old Male Using Cognitive-Behavioural Techniques

by

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DEDICATION

I would like to dedicate this thesis to my mom; the person who has always believed in me and has allowed me to believe in myself.
ABSTRACT

Objective: Cognitive Behaviour Therapy (CBT) is a first-line treatment for anxiety disorders. Anxiety symptoms can negatively affect youth physically, cognitively, and behaviourally. This study was aimed to decrease anxiety symptoms through the use of an evidence-based counselling program that incorporated CBT strategies such as psychoeducation, behavioural, and cognitive techniques. Method: A sixteen year old male in an alternative learning center participated in the study. The participant was experiencing anxiety symptoms and was referred by the coordinators of the learning center. An individualized CBT program was designed. The counselling program consisted of eight sessions, two sessions weekly for four weeks. Sessions included psychoeducation, relaxation strategies, systematic desensitization, identifying and recording automatic thoughts, cognitive restructuring, and challenging negative thoughts. Data were collected using baseline and weekly treatment phase measures. Baseline data were collected prior to and at the beginning of session one using the Beck Anxiety Inventory (Beck and Steer, 1993). Data for the treatment phase were collected once a week using the same measure. In addition, at the beginning of every session the participant completed a brief Outcome Rating Scale (Miller, Duncan, & Johnson, 2002) in order to indicate his self-perceived level of functioning. At the end of each session the participant completed a brief Session Rating Scale (Miller, Duncan, & Johnson, 2002) in order to measure therapeutic engagement. Results: The average score on the BAI during baseline was 15 with a standard deviation of 1.4. The mean score on the BAI during intervention was 14 with a standard deviation of 2.9. ORS data during intervention showed a mean score of 29.4, with a standard deviation of 5.1. The average rating for the SRS during intervention was 35.3 with a standard deviation of 1.6. Conclusion: Overall, the individualized CBT program showed questionable effectiveness in decreasing the participant’s anxiety symptoms, as shown on the BAI. Thus, the hypothesis was not supported. The participant showed some decrease in symptoms; however, the decrease was not significant. The participant’s self-rated level of functioning was reasonably high, but showed little change over time while his level of therapeutic engagement was high and decreased slightly throughout the sessions.
ACKNOWLEDGMENTS

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Chapter I: Introduction

Smith and Jenkins (2010) state that one third of people classify themselves as non-worriers (worrying less than an hour and a half each day), over half of people classify themselves as moderate worriers (worrying between 10 and 50 percent of the day), and the rest classify themselves as chronic worriers (worrying more than eight hours a day). Worry and anxiety can be helpful in threatening situations; however excessive worry or anxiety can be harmful to one’s health (Davison, Blankstein, Flett, & Neale, 2008). Anxiety disorders are the most common mental health disorders (Public Health Agency of Canada, 2002). According to Davison et al., (2008) almost everyone will experience anxiety within any one week of their lives.

Anxiety disorders are also one of the most prevalent mental health concerns among adolescents (Mash & Wolfe, 2007). Anxiety symptoms can negatively affect youth physically, cognitively, and behaviourally. Anxiety creates the flight or fight response, producing a general activation of the individual’s entire metabolism. There are chemical effects, cardiovascular effects, respiratory effects, sweat gland effects, and other physical effects. Even when there is no immediate threat, anxious youth are searching for danger, and therefore it is difficult to concentrate on everyday tasks. In addition, if children cannot find any danger when searching for a threat, they may overthink situations or try to find danger where no danger exists, which may cause distortions of the situation. Anxiety also affects youth’s behaviour as they may become aggressive or avoidant in situations (Mash & Wolfe, 2007).

In addition, numerous studies have explored the relationship between anxiety and somatic complaints (Zolog et al., 2011). In conjunction, anxiety disorders and somatization are also common among youth who are absent from school (Walter et al., 2010). This is concerning as extended school absenteeism is shown to be associated with a number of adverse consequences including increased probability of delinquency, school dropout, and a wide range of challenges in adulthood (Walter et al., 2010). Moreover, Yen et al. (2011) demonstrated that higher levels of anxiety in adolescents predict poorer ratings in all domains of quality of life. Thus, it is imperative to combat adolescents’ anxiety to improve their mental health, coping abilities, and overall quality of life.

The current case study targeted a 16-year-old male who was experiencing pervasive anxiety symptoms. His anxiety symptoms were negatively affecting areas in his life such as his home, school, and social life. He was experiencing abdominal pain and nausea causing absenteeism. Through the use of an evidence-based counselling program that incorporated strategies such as psychoeducation, behavioural, and cognitive techniques, it was hypothesized that anxiety symptoms experienced by the participant would decrease. Furthermore, it was anticipated that the counselling program would not only alleviate the participant’s existing anxiety but also teach the skills necessary to cope with anxiety in the future.

Overview

The main chapters covered in this thesis are literature review, methodology, results, and conclusion/discussion. The literature review (Chapter II) examines anxiety and its treatment. The method (Chapter III) describes the participant, design, setting and apparatus, measures, and procedures in the present study. The results section (Chapter IV) provides the findings from the
study presented in tables and figures. The conclusion and discussion (Chapter V) provides a summary of the overall study, including strengths and limitations of the study, multilevel challenges, implications for the behavioural psychology field, and recommendations for future research.
Chapter II: Literature Review

Anxiety

Anxiety is the body’s reaction to a threat (Lindsay, Paulhus, & Nairne, 2008). Anxiety becomes problematic when the level of worry becomes so extreme it interferes with normal functioning. Anxiety disorders affect 12 percent of the population and cause mild to severe impairments in functioning (Public Health Agency of Canada, 2002). Symptoms of anxiety have shown to decrease quality of life ratings (Yen et al., 2011).

The DSM-IV-TR (American Psychiatric Association, 2000) outlines a number of anxiety disorders. These disorders have been characterized into general areas of: phobias, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and acute stress disorder. There is some overlay and similarity of symptoms and criteria among the different disorders (Davison et al., 2008). Some of these commonalities are that somatic signs of anxiety, such as perspiration or increased heart rate, are among the symptoms included for diagnostic criteria for panic disorder, phobias, and posttraumatic stress disorder. Also, criteria for generalized anxiety disorder and phobia both include thoughts and feelings that stressors cannot be controlled.

Anxiety and Adolescents

Lifetime prevalence estimates of anxiety are between 8 and 27 percent (Costello, Egger, & Angold, 2005, as cited in Mash & Wolfe, 2007). Almost half of children diagnosed with an anxiety disorder continue to have the disorder for eight years or more (Keller et al., 1992, as cited in Mash & Wolfe, 2007). Three to six percent of children are diagnosed with general anxiety disorder (Albano et al., 2003, as cited in Mash and Wolfe, 2007).

Zolog et al., (2011) reported the most common somatic complaints relating to anxiety for adolescents were: headaches, stomach aches, muscle tension, and trembling. Mash and Wolfe (2007) discuss the potential misperceptions between developmental fears and anxiety disorders in adolescents. Common objects of fear in adolescence are: personal relations, personal appearance, school, political issues, the future, animals, supernatural phenomena, natural disasters, and safety. It is important to note that, although there are normal worries or fears for adolescents, if they become excessive or occur in a developmentally inappropriate context, it may be of concern.

Effectiveness of Cognitive-Behavioural Therapy

Wright, Basco, & Thase (2006) propose that cognitive-behavioural therapy (CBT) is the most effective treatment for most anxiety disorders. Ishikawa, Okajima, Matsuoka, and Sakano (2005) conducted a meta-analysis consisting of twenty studies evaluating the effectiveness of cognitive-behavioural therapy for children and adolescents with anxiety disorders. Results indicated large effect sizes for all 20 studies, significant effect sizes relating to improvements in anxiety symptoms, as well as lasting effect sizes at follow-up. Another follow-up study examining the long term effects of CBT programs for youth with anxiety disorders showed
lasting gains eight to 13 years post treatment (Saavedra, Silverman, Morgan-Lopez, & Kurtines, 2010).

Moreover, Warner et al., (2011) investigated the effectiveness and practicality of a cognitive-behavioural treatment for youth with anxiety disorders and somatic complaints that could not be medically accounted for. Forty children and adolescents ages 8 to 16 years old participated in the study. All participants had a diagnosis of an anxiety disorder and presented somatic symptoms. The majority of participants reported experiencing gastrointestinal symptoms. Participants were randomly assigned to a waiting list control group or treatment of anxiety and physical symptoms (TAPS), a cognitive-behavioural treatment targeting anxiety and pain. Findings from self- and parent ratings indicated a reduction in somatic and anxiety symptoms post-treatment. Overall, Warner et al., (2011) suggest the TAPS program is an appropriate treatment for youth undergoing anxiety and somatic symptoms.

Components of CBT

The main components of CBT include teaching participants to understand how their thoughts and thinking contribute to anxiety, cognitive restructuring, skills training, and exposure (Mash & Wolfe, 2007; Payne, Bolton, & Perrin, 2011; Sburlati, Schniering, Lyneham & Rapee, 2011).

Sburlati et al., 2011, examined empirically supported treatments and defined the specific CBT techniques required for effective treatment of anxiety and depression in children and adolescents. First, they identified management of negative thoughts; recognizing what one is thinking and altering those thoughts from maladaptive to adaptive. Also noted were changing maladaptive behaviours. Changing these behaviours might include but were not limited to exposure to anxiety provoking situations, motivating clients into participating in activities, and practicing how the client may act in a particular situation. In addition, participants are taught how to relax using breathing exercises and visualization exercises. Participants are also taught to recognize and identify emotions, which helps manage moods. Another important CBT technique mentioned was general skills training. Skills commonly taught in CBT were problem-solving skills, interpersonal skills, and communication skills along with others. Sburlati et al. also indicated that modifying the family environment was an important CBT technique; this consisted of family communication and conflict resolution, parental management, and parents showing adaptive behaviour.

The Coping Cat Program, a widely known and used program, is an empirically supported program for treating anxious youth (Albano & Kendall, 2002). The core elements of this program are cognitive and behavioural techniques. These components are recognizing anxious thoughts and physical symptoms, identifying maladaptive cognitions, developing coping strategies, exposure, and self-evaluation and self-reinforcement. The Coping Cat program also utilizes modeling, role-play, relaxation training, and reinforcement. In addition, homework is assigned to reinforce and generalize skills learned in the program.

The above studies appeared to be effective in reducing anxiety symptoms for youth. The studies utilized psychoeducation, identifying automatic thought and cognitive restructuring, basic skills training, exposure, and homework. These components appear to be essential in the efficacy
of cognitive-behavioural therapy.

**Psychoeducation.** Many components of CBT necessitate psychoeducation (Wright, Basco, & Thase, 2006). Psychoeducation involves teaching the client the theory and purpose of the strategies used in session. Educating clients promotes learning, instills hope, and improves the effectiveness of therapy. Therapists commonly teach clients the basic CBT cycle; informing them of the influences their thoughts have on their feelings and behaviour and vice versa (Arch, Eifert, Davies, Vilardaga, Rose & Craske, 2012; Donegan & Dugas, 2012; Hains, 1992; Newman & Fisher, 2013; Rees, McEvoy, & Nathan, 2005).

**Identifying and recording automatic thoughts.** Automatic thoughts are usually private and unspoken (Wright et al., 2006). Automatic thoughts are the cognitive processes that are just below the surface of the conscious mind; they are what one is thinking to himself. Therapists help clients identify these automatic thoughts by teaching them about automatic thoughts, recognizing mood changes, and trying to get the client to imagine the situation and its details, how they were feeling, and what they were saying to themselves (Wright et al., 2006). Identifying and recording automatic thoughts will allow for identification of errors in thinking, leading treatment to cognitive restructuring (Arch et al., 2012; Donegan & Dugas, 2012; Hains, 1992; Newman & Fisher, 2013; Rees, McEvoy, & Nathan, 2005).

**Cognitive restructuring.** Cognitive restructuring consists of helping the participant to identify and change maladaptive thoughts (Wright et al., 2006). There are a number of methods used to accomplish this. Due to the impact thoughts have on feelings and in turn on behaviour, cognitive restructuring is used to alter the thoughts to more adaptive ones that will influence feelings and behaviours related to the new adaptive thoughts. Therapists help clients to generate more adaptive thoughts.

A study by Shurick et al., 2012, examined the effectiveness of cognitive restructuring in decreasing conditioned fear responses, and if these effects would be maintained over time. Seventy-nine healthy participants were included in the study. Participants were conditioned using images of snakes or spiders that were periodically paired with a mild shock on the wrist allowing subjective fear reports and electrodermal activity which measured change in brainwaves. Once participants had been conditioned, half of the participants received cognitive restructuring training, and the other half of participants received no treatment. Both groups of participants returned after 24 hours to repeat the conditioning session. Results indicated that cognitive restructuring reduced fear and electrodermal activity across sessions suggesting that cognitive restructuring can create lasting changes in emotional responding. Although findings appear promising, there are limitations to the study: the effects of cognitive restructuring were only measured once after training, and the study relied on subjective data measurements and physiological measures.

Similarly, Hains (1992) studied the effectiveness of two cognitive-behavioural interventions aimed to assist adolescent males cope with stress and other emotional difficulties such as anger and depression. One CBT treatment consisted of cognitive restructuring and the other CBT program consisted of anxiety management training. Twenty-five adolescents participated in the study. Participants were randomly assigned to the cognitive restructuring
group, anxiety management group or a control group. Both treatment programs included group and individual sessions. The cognitive restructuring intervention included: teaching participants to identify, challenge, and alter automatic negative thoughts; practicing using their adaptive thoughts in imagined and real situations; and discussing how to use the techniques in future situations. The anxiety management intervention included: teaching participants to identify cues and triggers of anxiety, teaching relaxation strategies, and pairing visualization of anxiety provoking situations with relaxation techniques. Anxiety, anger, depression, use of anxious self-statements, and self-esteem were measured at pre- and post-assessments for all participants. Findings from the study showed that both treatments were significantly more effective for all dependent variables compared to the control group. Treatment gains were maintained at the 11-week follow-up for both treatment groups. There were no significant differences between the CBT interventions at post-treatment or follow-up. Unfortunately, follow-up data was not obtained for the control group, and thus cannot be compared to the treatment groups. Also, the youth who participated in the study were self-referred and may not accurately represent the general population of adolescent males.

**Basic skills training.** Basic skills training is aimed at helping participants successfully engage in exposure-based programs for anxiety symptoms (Wright et al., 2006). Skills taught in this program include: relaxation training, thought stopping, distraction, and breathing retraining. The basic skills taught aim to increase coping abilities and relaxation. The skills taught are not intrusive or time consuming. They are cost-effective and can be used at any time in any situation. This is important as these skills are the tools needed for coping with stress and anxiety.

Relaxation training has been demonstrated to reduce anxiety. Donegan and Dugas (2012) investigated how symptoms changed across two treatments for general anxiety disorder. Donegan and Dugas compared the effects of cognitive-behavioural therapy and applied relaxation. Fifty-seven adults seeking treatment with a primary diagnosis of general anxiety disorder participated in the study and were randomly assigned to one of the 12-week intervention programs. The CBT treatment program consisted of psychoeducation, identifying automatic thoughts and exposure, cognitive restructuring, problem solving training, and imaginal exposure. The applied relaxation treatment was comprised of psychoeducation, relaxation training, and practicing relaxation techniques in everyday activities. Symptom severity, non-worry symptoms, and changes in worry and somatic anxiety were measured through assessment and intervention. The cognitive-behavioural therapy and applied relaxation treatments both showed significant reductions in the amount of time participants spent worrying and experiencing somatic anxiety. Findings suggest that applied relaxation decreased anxiety symptoms. The majority of participants included in the study had a diagnosis of panic disorder or specific phobia and thus does not accurately represent the most common anxiety disorders, and results may not be generalizable to other anxiety disorders. Also, baseline measures of daily symptom ratings were not obtained in this study, and therefore, treatment gains cannot be compared to baseline data.

A meta-analysis conducted by Siev and Chambless (2007) compared the effectiveness of cognitive therapy and relaxation therapy in the treatment of panic disorder without agoraphobia and generalized anxiety disorder. Results revealed that in the treatment of generalized anxiety disorder cognitive therapy and relaxation therapy were equally efficacious. Cognitive therapy produced better results compared to relaxation therapy in the treatment of panic disorder;
however, findings suggest both treatments are suitable for the two disorders.

**Exposure.** As mentioned, exposure is a core component of CBT (Wright et al., 2006). Exposure is used to break the pattern of avoidance. There are two types of exposure: imaginal exposure and in vivo exposure. Imaginal exposure involves only imagining the feared stimuli and in vivo exposure involves directly facing the feared stimuli. First clients are taught relaxation methods; once mastered, clients gradually confront the anxiety provoking stimuli paired with relaxation. Both types of exposure include the client and therapist collaboratively creating a hierarchy of anxiety provoking situations. Exposure is used to overcome avoidant behaviours caused by anxiety.

Newman and Fisher (2013) investigated duration of generalized anxiety disorder (GAD) as a moderator of cognitive behavioural therapy compared to cognitive therapy and desensitization, and an increase in dynamic flexibility of symptoms through therapy as a mediator of such moderation. Seventy-six participants diagnosed with generalized anxiety disorder were randomly assigned to cognitive-behavioural therapy, cognitive therapy, or self-control desensitization. Each condition utilized manuals to guide the 14 weekly sessions. The cognitive therapy condition consisted of thought restructuring, identifying cognitive errors, decatastrophizing, and supportive listening. The self-control desensitization treatment included progressive relaxation training, controlled relaxation training, breathing retraining, imagery, applied relaxation training, desensitization, and supportive listening. The cognitive-behavioural therapy consisted of all the components in the cognitive therapy and self-control desensitization conditions, omitting the supportive listening component of therapy. Results indicated that participants with longer duration of GAD demonstrated more reliable change from cognitive therapy and self-control desensitization than cognitive-behavioural therapy. On the other hand, results suggested that participants with shorter duration responded better to CBT. Findings propose that focused treatments may be more effective for individuals with a longer duration of GAD, and treatments that provide more coping techniques may be more effective for individuals with a shorter duration of GAD.

Exposure techniques are not only effective in reducing anxiety symptoms in the short-term; the effects of treatment are possibly long-lasting. The long-term effects of exposure-based cognitive behavioural treatment for phobic and anxiety disorders in children and adolescents were assessed by Saavedra, Silverman, Morgan-Lopez, and Kurtines (2010). Participants included youth who participated in one of two published randomized clinical trials with a diagnosis of phobic or anxiety disorder. Both treatments were exposure-based cognitive therapy in group or individual sessions. Results showed that treatment gains were maintained 8 to 13 years post-treatment. Thus, short-term gains of exposure for childhood anxiety may carry through young adulthood.

**Homework.** Additionally, homework is an essential element of the CBT process and serves many purposes (Wright et al., 2006). The main purpose of homework is to enhance the skills learned in session needed for improved coping outside of sessions. Another important function of homework is that it adds structure to sessions and bridges sessions together. Homework is used in treatment programs to maintain gains made in session.
The importance of homework is illustrated in a study by Rees, McEvoy, and Nathan (2005). Rees, et al. (2005) examined the relationship between quality and quantity of homework completion and outcomes on different variables in a cognitive-behavioural treatment program for participants experiencing anxiety and depression. Ninety-four participants with a primary diagnosis of an anxiety disorder or depression participated in a ten-week group cognitive behaviour therapy program. Homework completion predicted outcome on measures of anxiety, depression, and quality of life. Both quality and quantity of homework completion were associated with predicted outcome measures and were maintained at a one-month follow-up. Findings indicate that participants benefit from homework completion regardless of perfection.

**Manualized CBT Programs for Treating Anxious Youth**

A number of studies have combined these components into manualized CBT programs. For example, a pilot study by Warner et al. (2011) assessed effectiveness of a particular CBT treatment for anxiety and physical symptoms (TAPS). TAPS was a 10-week program that addressed anxiety and somatic symptoms. The program identified when and where the symptoms were present, taught relaxation techniques, cognitive restructuring, and exposure techniques. Results suggested that treatment acceptability for both participants and parents were high. Post-treatment measures showed 45 percent of participants no longer met criteria for an anxiety disorder, indicating that CBT treatments for anxiety that address somatic complaints are effective. It is important to note that parents of the participants actively sought treatment for their children and may represent a bias in the population. Furthermore, most participants were from an urban area, middle class, and Caucasian. Also, follow-up data could have been extended to demonstrate more concrete maintenance of treatment gains.

Albano and Kendall (2002) reviewed the empirical support of the efficacy of cognitive behavioural therapy for children, its transportability, and its adaptability to differing populations of youth, treatment types, and treatment settings. The Coping Cat Program was used to illustrate how a CBT manual can be effective in treating anxious youth. The main elements of the Coping Cat program include identifying anxious feelings and physical sensations, identifying automatic negative thoughts, learning coping skills, exposure strategies, and self-evaluating and reinforcing. Findings from the study demonstrate that the Coping Cat CBT manual is an empirically supported program found to be effective for a diverse population of youth as well as a range of anxiety disorders. In addition, Albano & Kendall (2002) suggest efficacious adaptability of the program to different populations of youth and to a variety of anxiety disorders. However, results should be interpreted cautiously as the CBT programs used to compare with the Coping Cat Program contained many participants with specific phobias and may have produced more dramatic results and therefore do not accurately represent the general population of anxious youth.

**Therapist Competencies**

The study by Sburlati et al. (2011) aimed to identify not only the most effective empirically supported treatment for childhood anxiety and depressive disorders, but also the therapist competencies required for the most effective treatment. Examination of ten empirically supported treatments for childhood anxiety and depression indicated that cognitive behavioural
treatment is the most suitable treatment. Competencies related to CBT were identified and grouped into three categories: understanding relevant CBT theory and research; devising, implementing, and revising a CBT case formulation; and collaboratively conducting CBT sessions. Generic therapeutic competencies were also noted and included: practicing professionally, understanding relevant child and adolescent characteristics, building a positive relationship, and conducting a thorough assessment.

In addition, Albano and Kendall (2002) advised flexibility when working with youth of diverse backgrounds, ages, and developmental stages. Also, they noted that therapists must have sufficient knowledge in abnormal child psychology and maintain an empirical and theoretical approach to understanding, measuring, and treating childhood emotional disorders.

**Relevance to Current Study**

The literature verifies that untreated anxiety may become debilitating and has the ability to interfere with daily functioning and quality of life. Thus, it is important to treat impairing anxiety symptoms. The literature indicates that best practice for treating anxiety is cognitive-behaviour therapy.

Warner et al., (2011) suggest the TAPS program, outlined above, is an appropriate treatment for youth undergoing anxiety and somatic symptoms. The CBT program developed for the current study was adapted from the TAPS program. The TAPS program was chosen since the client was experiencing anxiety with a dominant somatic complaint (gastrointestinal symptoms) and experiencing abdominal discomfort.

As noted, the main components of CBT include teaching participants to understand how their thoughts and thinking contribute to anxiety, cognitive restructuring, skills training, and exposure (Mash & Wolfe, 2007; Payne et al., 2011; Sburlati et al. 2011). Cognitive components, behavioural components, and homework all contribute to the reduction of anxiety symptoms, have lasting effects, and improve quality of life (Donegan & Dugas, 2012; Hains 1992; Newman & Fisher 2013; Rees et al. 2005; Saavedra et al., 2010; Shurick et al., 2012; Siev & Chambless, 2007). There is no consensus on which elements of CBT are the most effective; however, these elements have been effective in treating anxiety symptoms in adolescent populations. The majority of components were included in the current treatment program to maximize the probability of treatment success. Including more than one component of CBT allows participants to experience a number of coping skills and targets both the thoughts and behaviours that contribute to anxiety symptoms. In congruence with the literature, these main components were incorporated in the treatment program designed.
Chapter III: Method

Participant

There was one participant included in the study. A 16-year-old male was chosen to participate in the study. Inclusion criteria included: a need for treatment, referral from staff at the agency, and scheduled attendance at the agency for a minimum of one month. Staff recommended the participant as he was encountering obstacles at home, school, and in his social life. Staff reported that absenteeism had been an issue in the past and believed the participant’s absence was due to his anxiety levels. A functional assessment was conducted using a structured interview. The FACTS sheet was utilized with two staff members which revealed information regarding the topography, common routines, predictors, and consequences of the behaviour (March et al., 2000; Appendix A & B). Informed consent was required in order to take part in the counselling sessions offered at the alternative learning center.

Informed consent. A consent form was developed which outlined student and faculty information and contact information, a description of the purpose of the project and of all procedures planned in which the participant was involved, assurance that the identity of the participant would be kept confidential and how this would be accomplished, amount of time required of the participant, and describing that participation was voluntary and the participant could choose to stop participating at any time (Appendix C). The consent form was read aloud to the participant, and he was given the same copy to read over himself. The consent form was signed, allowing therapy to proceed. Since the agency was governed by the Child & Family Services Act, he was able to provide informed consent for himself; however, he was also given the option of having his parent(s) informed of his participation in the sessions. (He declined this option.) This research study was approved by the St. Lawrence Research Ethics Board.

Design

The design of the study was a single subject case study, with a measure of anxiety (outlined below) that was administered prior to treatment, and at regular intervals throughout treatment (weekly). In addition, measures of client-rated clinical outcome and measures of client-rated therapeutic engagement were administered at each therapy session. The independent variable was the counselling program and the dependent variables were severity of anxiety symptoms, clinical outcome, and therapeutic engagement. Data was analyzed visually using tables and graphs. The trend, percentage of nonoverlapping data, and percentage of data points exceeding the median were determined.

Setting and Materials

The treatment sessions were conducted in a designated room at the agency where the participant attended Monday to Friday. Sessions were held on Mondays and Thursdays from 9:00a.m. to 10:00a.m. Materials required included a writing utensil, paper, treatment space, table and chairs. All materials were provided by the agency and the student researcher.
Measures

Data were collected using the measures in the manner described above. Baseline data were collected at the beginning of session one using the Beck Anxiety Inventory (Steer & Beck, 1997). Since the BAI is copyrighted it is not included in the appendices. Baseline and intervention data were collected each week using the BAI and are displayed in Appendix D. The BAI is a 21 item self-report measure, created to evaluate the symptoms of anxiety. Scores range from 0 to 63, with higher ratings indicating greater anxiety. Scores from 0-21 indicate low anxiety, 22-35 indicate moderate anxiety, and 36 or over indicate high anxiety. Osman, et al. (2002) examined the psychometric properties of the BAI in relation to adolescent inpatient and adolescent high school populations. Results indicated that reliability, convergent validity, and discriminant validity were all acceptable for this population. The participant was completing this measurement, not for diagnosis but to assess severity or levels of anxiety.

In addition, at the beginning of every treatment session the participant completed a brief Outcome Rating Scale (Miller, Duncan, Brown, Sparks & Claud, 2003) to indicate how he felt that he was doing in four general areas: individually, interpersonally, socially, and overall. This was done by having the participant simply indicate his rating on a 10 cm. visual analog scale in each area. The overall score is determined by summing the scores on each scale; hence scores can range from 0 to 40 with higher scores indicating better functioning. At the end of each session, the participant was asked to complete a brief Session Rating Scale (Duncan et al., 2003). This questionnaire measures therapeutic engagement in four areas: relationship, goals and topics, approach or method, and overall. Once again, the participant simply indicated his rating on a 10 cm. visual analog scale in each area. The overall score is determined by summing the scores on each scale; hence scores can range from 0 to 40 with higher scores indicating greater therapeutic engagement. Campbell and Hemsley (2009) evaluated the psychometric properties and psychological practice of the SRS and ORS. Findings established good reliability and concurrent validity for both the SRS and ORS. These measures were chosen because they are ongoing measures of how well the therapeutic process is going, and they are cost-efficient, time-efficient, easy to administer, and easy for the participant to complete. Since the ORS and SRS are copyrighted, these measures are not included in the appendices.

Procedure

The counselling program consisted of eight sessions, two sessions weekly for four weeks. Sessions included psychoeducation, identifying and recording automatic thoughts, cognitive restructuring, basic skills training, exposure and homework. Each session was bridged by assigning homework at the end of the session and reviewing homework at the beginning of the following session. For a brief overview of the sessions see Table 1.
### Table 1

**Brief Overview of Sessions**

<table>
<thead>
<tr>
<th>Session</th>
<th>Items on Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session: 1</td>
<td>• BAI</td>
</tr>
<tr>
<td></td>
<td>• Provide rationale for CBT approach</td>
</tr>
<tr>
<td></td>
<td>• Teach CBT Model</td>
</tr>
<tr>
<td></td>
<td>• Outcome Rating Scale and Session Rating Scale</td>
</tr>
<tr>
<td>Session: 2</td>
<td>• Teach biopsychosocial model</td>
</tr>
<tr>
<td></td>
<td>• Review CBT model</td>
</tr>
<tr>
<td></td>
<td>• Identifying negative thoughts</td>
</tr>
<tr>
<td></td>
<td>• Homework: record negative thoughts</td>
</tr>
<tr>
<td></td>
<td>• Outcome Rating Scale and Session Rating Scale</td>
</tr>
<tr>
<td>Session: 3</td>
<td>• BAI</td>
</tr>
<tr>
<td></td>
<td>• Cognitive Restructuring</td>
</tr>
<tr>
<td></td>
<td>• Challenging Negative thoughts</td>
</tr>
<tr>
<td></td>
<td>• Homework: Practice Thought change record</td>
</tr>
<tr>
<td></td>
<td>• Outcome Rating Scale and Session Rating Scale</td>
</tr>
<tr>
<td>Session: 4</td>
<td>• Goal Setting</td>
</tr>
<tr>
<td></td>
<td>• Set goals</td>
</tr>
<tr>
<td></td>
<td>• Basic Skills Training</td>
</tr>
<tr>
<td></td>
<td>• Homework: TRC and identify cognitive distortions</td>
</tr>
<tr>
<td></td>
<td>• Outcome Rating Scale and Session Rating Scale</td>
</tr>
<tr>
<td>Session: 5</td>
<td>• BAI</td>
</tr>
<tr>
<td></td>
<td>• Develop anxiety hierarchy</td>
</tr>
<tr>
<td></td>
<td>• Go through hierarchy</td>
</tr>
<tr>
<td></td>
<td>• Homework: Practice relaxation</td>
</tr>
<tr>
<td></td>
<td>• Outcome Rating Scale and Session Rating Scale</td>
</tr>
<tr>
<td>Session: 6</td>
<td>• Continue Hierarchy</td>
</tr>
<tr>
<td></td>
<td>• Relaxation</td>
</tr>
<tr>
<td></td>
<td>• Homework: Practice Relaxation</td>
</tr>
<tr>
<td></td>
<td>• Outcome Rating Scale and Session Rating Scale</td>
</tr>
<tr>
<td>Rating Scale</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>--</td>
</tr>
<tr>
<td><strong>Session: 7</strong></td>
<td></td>
</tr>
<tr>
<td>- BAI</td>
<td></td>
</tr>
<tr>
<td>- Review Skills learned</td>
<td></td>
</tr>
<tr>
<td>- Role play anxiety provoking situation</td>
<td></td>
</tr>
<tr>
<td>- Outcome Rating Scale and Session Rating Scale</td>
<td></td>
</tr>
<tr>
<td><strong>Session: 8</strong></td>
<td></td>
</tr>
<tr>
<td>- Terminate Program</td>
<td></td>
</tr>
<tr>
<td>- Prevention</td>
<td></td>
</tr>
<tr>
<td>- Address any questions or concerns</td>
<td></td>
</tr>
<tr>
<td>- Outcome Rating Scale and Session Rating Scale</td>
<td></td>
</tr>
</tbody>
</table>

Therapist guidelines were detailed outlines of each therapy session (Appendix E). The guidelines were created to direct the content and flow of each session. For each session, the guidelines included an agenda item list and accompanying step-by-step directives. Materials and worksheets used in each session were also included in the guidelines.
Chapter IV: Results

Functional Assessment

Staff identified anxiety as the problem area and thus were asked to participate in a structured interview using the FACTS sheet (March et al., 2000; Appendix A & B). Questions were asked regarding the topography, common routines, predictors, and consequences of the behaviour. Results from the interview indicated the participant was most often anxious during the morning and after using his cell phone to communicate with his girlfriend. His symptoms of anxiety consisted mainly of physical illness, withdrawal, and flushed face. The main consequence for anxious symptoms was going home sick. The participant disclosed that he did not like thinking about his upcoming court date and that he feared he would be incarcerated. The participant also shared that he could not concentrate when he sent or received text messages from his girlfriend. The participant identified that he mostly tried to sleep when he would go home ill.

Data Obtained using the BAI

Using the BAI, baseline results indicated that the participant was experiencing low levels of anxiety symptoms with raw scores of 14 and 16 (Appendix D). Particular symptoms the participant reported as being moderate to severe were: unable to relax, fear of the worst happening, nervous, scared, and indigestion or discomfort in the abdomen.

Although baseline data was not stable, as there were not enough data points, intervention was introduced due to time restrictions. Average scores on the BAI during baseline and intervention were very similar. The average score on the BAI during baseline was 15 with a standard deviation of 1.4. The mean score on the BAI during intervention was 14 with a standard deviation of 2.9 (See Table 2). There was a minor decrease from baseline to intervention. The intervention data was more variable than the baseline data. The trend during baseline cannot be confidently determined with only two data points; however, there appeared to be an increasing trend in anxiety symptoms (See Figure 1). The intervention phase shows a slightly decreasing trend. Baseline and intervention results with trendlines for the BAI data have been presented in Appendix F. The percentage of nonoverlapping data (PND) was 50%. The percentage of data points exceeding the median (PEM) was also 50%, indicating that the intervention effectiveness was questionable.

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Median</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>15</td>
<td>15</td>
<td>1.41</td>
</tr>
<tr>
<td>Intervention</td>
<td>14</td>
<td>14</td>
<td>2.94</td>
</tr>
</tbody>
</table>
At the beginning of every counselling session, the participant completed a brief Outcome Rating Scale (ORS) which was a measure of self-perceived clinical progress (Miller, Duncan, Brown, Sparks & Claud, 2003). Rating scores could range from 0-40; 0 indicated things were not going well in the participant’s life, and 40 indicated everything was going well in the participant’s life. Raw data are presented in Appendix G. Data showed a mean score of 29.4, with a standard deviation of 5.1 (See Table 3). Scores indicated that the participant perceived the aspects of his life to be going moderately to reasonably well throughout the intervention program (Appendix H). Scores from each session have been displayed in Figure 2.

Table 3

<table>
<thead>
<tr>
<th>Self-perceived Clinical Outcome as Measured by the ORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>29.4</td>
</tr>
</tbody>
</table>
Similarly, at the end of each session, the participant completed a brief Session Rating Scale (Duncan et al., 2003), a measure of therapeutic engagement. Likewise, rating scores could range from 0 to 40; 0 indicated low therapeutic engagement in the session, and 40 indicated high therapeutic engagement. Raw data are displayed in Appendix I. The average rating for the SRS was 35.3 with a standard deviation of 1.6 as presented in Table 4. Data appeared to be stable, as shown in Appendix J, with relatively high levels of engagement in the sessions throughout intervention. Scores from each session have been displayed in Figure 3.

### Table 4

**Therapeutic Engagement as Measured by the SRS**

<table>
<thead>
<tr>
<th>Mean</th>
<th>Median</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.3</td>
<td>36</td>
<td>1.6</td>
</tr>
</tbody>
</table>

*Figure 2. Visual representation of scores obtained during intervention using the ORS*
**Figure 3.** Visual representation of therapeutic engagement reported on the SRS during intervention
Chapter V: Discussion

It was hypothesized that through the use of an evidence-based counselling program that incorporated strategies such as psychoeducation, behavioural, and cognitive techniques, anxiety symptoms the participant was experiencing would decrease. Overall, the individualized CBT program showed questionable effectiveness in decreasing the participant’s anxiety symptoms, as shown on the BAI. Thus, the hypothesis was not supported. The participant showed some decrease in anxiety symptoms; however, the decrease was not significant. Results from the Outcome Rating Scale indicated the participant’s self-rated level of functioning was high and showed little change over the course of treatment. Results from the Session Rating Scale indicated the participant’s self-rated level of therapeutic engagement was high and decreased slightly throughout treatment.

The treatment program included psychoeducation, identifying and restructuring automatic thoughts, basic skills training, exposure, and homework. All components have been identified as essential for the effectiveness of CBT programs. However, psychoeducation was provided to the client only in session one and two. Psychoeducation could have been extended throughout treatment to teach the participant the rationale for all CBT components and exercises. Also, the four-week program may not have given adequate time to master the skills and concepts learned in treatment. Moreover, homework was assigned during five sessions. The participant completed homework twice. The participant’s homework completion was low and may account for the non-significant change in anxiety symptoms. The participant disclosed that incomplete homework was due to time constraints and illness.

Summary and Interpretation of Results

Results from the BAI indicated that the client’s anxiety did not decrease significantly below that of baseline during the counselling intervention. Most empirical evidence for the effectiveness of CBT programs included participants with a formal diagnosis of anxiety and anxiety disorders. The non-significant change may have been due to the participant not having a clinical level of anxiety during baseline. In addition, the participant had a couple of anxiety-producing circumstances occur (e.g. a death in the family) during intervention. Without treatment, it could be hypothesized that during such anxiety provoking situations anxiety symptoms would increase significantly. Notably, the changes in scores at that time, for the participant, were still in the mild to moderate range on the BAI. Scores on the BAI did not increase significantly during the anxiety provoking situations, and this may suggest that the intervention actually was effective. Results revealed variability on the Beck Anxiety Inventory and the Outcome Rating Scale. Both measures appeared to vary together. When anxiety symptoms on the BAI increased, the scores on the ORS decreased; the ORS results paralleled the BAI results, indicating that the participant felt that he was faring quite well in most areas of his life, except for those times of external stress. SRS results indicated that the client was highly engaged in the sessions. However, there was a slightly decreasing trend in the data. The drop in SRS scores was not significant and may indicate a normative decline in engagement in sessions that adolescents may experience. Another explanation for the decreasing trend in the SRS data may be due to the increased effort and involvement required of the participant during sessions.
Findings from the functional assessment and the intervention effectiveness suggest that anxiety may not have been the primary or sole problem for the participant.

**Strengths and Limitations**

A major strength of this study was that it was based on sound evidence based treatments as shown by the use of CBT, which is considered a front-line method for treating anxiety. The treatment program consisted of all the important concepts: teaching participants to understand how their thoughts and thinking contribute to anxiety, cognitive restructuring, skills training, and exposure, as outlined by Mash & Wolfe (2007), Sburlati et al. (2011), and Payne et al. (2011). Another strength of this study was the development of the Therapist Guidelines. A detailed documentation of all sessions and session content was created which allows the intervention to be replicated. The main limitation was the inadequate functional assessment. Although staff members believed anxiety to be the core issue, a more in-depth functional assessment would have been beneficial. It is possible that the participant may have been more depressed than anxious. This hypothesis emerged when the participant identified “lack of enjoyment in activities” as one of his automatic negative thoughts. In addition, the participant faced a number of stressors over the course of intervention including the death of a parent, having a sibling incarcerated, fear of being incarcerated himself at his upcoming court trial, and a breakup with his girlfriend. Time was another limitation to the study. The program was restricted to a one month period, due to student researcher time restraints. In addition, follow-up data was not obtained. Furthermore, this was a single-case design making results more difficult to generalize to other populations and target problems.

**Multilevel Challenges**

When designing and implementing treatment programs, there can be challenges at the client level, program level, agency level, and societal level.

**Client level.** Challenges at the client level can include attendance. Services cannot be implemented if the participant is not present. When working with youth, especially at-risk youth, absenteeism may be of concern. Homework completion may also be a challenge for clients. To help overcome this challenge, it is important to plan for make-up dates and allow time in case of setbacks.

**Program level.** Another possible challenge may relate to the program. The program was not designed for counselling sessions, so the classroom did not have an extra room for individual sessions to be held. This is a challenge as the program needs space in which to be run. The best suggestion for overcoming this obstacle is to be flexible and creative; make do with what exists.

**Organizational level.** A lot of agencies are non-profit. Some of these non-profit agencies rely extensively on volunteers for program functioning. Volunteers do not always show up, and staff coverage is not always available. Thus, there are times when the intervention program may not be able to run. It is important to set priorities and ensure the understanding of the importance of service implementation.
Societal level. There is some stigma in regards to receiving treatment. Some teens think counselling is embarrassing. Some participants may be hesitant to participate in service due to perceived stigma. To help with this challenge, possibly consider avoiding the term “counselling”. Another suggestion is to be discrete when taking participants to and from session. Also, confidentiality also prevents stigma, as others should not know if someone is receiving treatment or what that treatment is.

Contribution to the Behavioural Psychology Field

This study highlights the importance of a good functional analysis. When using a sound intervention and receiving no significant results, it is important to consider what other factors may be influencing the clinical outcome. It may be important then to go back and conduct another, more in-depth functional assessment.

Recommendations

For future research, incorporating a more extensive functional assessment may improve treatment. It may not be beneficial to take the opinions of those in the participant’s life at face value. For example, if it is hypothesized that anxiety is the main issue, instead of using the Beck Anxiety Inventory use the Beck Youth Inventory, which looks at a variety of symptoms. Also, the effectiveness of having two sessions a week in comparison to one session per week has not been established. It may also be beneficial to investigate the effectiveness of condensed interventions in comparison to interventions with sessions more spread over time. For example, comparing a treatment program that consists of a 12-week, 12 session treatment compared to a 6-week, 12 session treatment. It may also be interesting to examine if a decreasing trend in Session Rating Scales is typical for adolescents and participants of all ages.
References


Appendix A
Functional Assessment with Teacher

Functional Assessment Checklist for Teachers and Staff (FACTS-Part A)¹

Student/Grade: __________________________  Date: Oct. 9, 12
Interviewer: ____________________________________________
Respondent(s): __________________________

Student Profile: Please identify at least three strengths or contributions the student brings to school.

Strong work ethic, polite, respectful

Problem Behavior(s): Identify problem behaviors

- Tardy
- Unresponsive
- Withdrawn
- Fight/physical Aggression
- Inappropriate Language
- Verbal Harassment
- Verbally Inappropriate
- Disruptive
- Insubordination
- Work not done
- Self-injury
- Theft
- Vandalism
- Other anxiety

Describe problem behavior:

Identifying Routines: Where, When and With Whom Problem Behaviors Are Most Likely.

<table>
<thead>
<tr>
<th>Schedule (Times)</th>
<th>Activity</th>
<th>Likelihood of Problem Behavior</th>
<th>Specific Problem Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:45am</td>
<td>Working away</td>
<td>Low 1 2 3 4 5 6 High 1 2 3 4 5 6</td>
<td>N/A</td>
</tr>
<tr>
<td>9:00am</td>
<td>Feeling unwell</td>
<td>1 2 3 4 5 6</td>
<td>call home</td>
</tr>
<tr>
<td>9:30am</td>
<td>Chewing on fingernails</td>
<td>1 2 3 4 5 6</td>
<td>anxious</td>
</tr>
<tr>
<td>10:00am</td>
<td>Biting fingernails</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>11:00am</td>
<td>Checking phone</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>11:10am</td>
<td>Rush to the bathroom</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
</tbody>
</table>

Select 1-3 Routines for further assessment: Select routines based on (a) similarity of activities (conditions) with ratings of 4, 5 or 6 and (b) similarity of problem behavior(s). Complete the FACTS-Part B for each routine identified.

**Functional Assessment Checklist for Teachers & Staff (FACTS-Part B)**

**Student/Grade:**

**Interviewer:**

**Date:** Oct. 9, 2012

**Respondent(s):**

**Routine/Activities/Context:** Which routine (only one) from the FACTS-Part A is assessed?

<table>
<thead>
<tr>
<th>Routine/Activities/Context</th>
<th>Problem Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>School day</td>
<td>Anxiety</td>
</tr>
</tbody>
</table>

Provide more detail about the problem behavior(s):

- **What does the problem behavior(s) look like?** Tapping knee + biting fingernail
- **How often does the problem behavior(s) occur?** Often 1-2 times/day
- **How long does the problem behavior(s) last when it does occur?** Varies
- **What is the intensity/level of danger of the problem behavior(s)?** Low

**What are the events that predict when the problem behavior(s) will occur? (Predictors)**

<table>
<thead>
<tr>
<th>Related Issues (setting events)</th>
<th>Environmental Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>illness</td>
<td>reprimand/feedback</td>
</tr>
<tr>
<td>drug use</td>
<td>physical demands</td>
</tr>
<tr>
<td>negative social</td>
<td>socially isolated</td>
</tr>
<tr>
<td>conflict at home</td>
<td>with peers</td>
</tr>
<tr>
<td>academic failure</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>structured activity</td>
</tr>
<tr>
<td></td>
<td>unstructured time</td>
</tr>
<tr>
<td></td>
<td>tasks too boring</td>
</tr>
<tr>
<td></td>
<td>activity too long</td>
</tr>
<tr>
<td></td>
<td>tasks too difficult</td>
</tr>
<tr>
<td></td>
<td>break-up</td>
</tr>
</tbody>
</table>

**What consequences appear most likely to maintain the problem behavior(s)?**

<table>
<thead>
<tr>
<th>Things that are Obtained</th>
<th>Things Avoided or Escaped From</th>
</tr>
</thead>
<tbody>
<tr>
<td>adult attention</td>
<td>Hard tasks</td>
</tr>
<tr>
<td>peer attention</td>
<td>reprimands</td>
</tr>
<tr>
<td>preferred activity</td>
<td>peer negatives</td>
</tr>
<tr>
<td>money/things</td>
<td>physical effort</td>
</tr>
<tr>
<td></td>
<td>adult attention</td>
</tr>
<tr>
<td>leaving school</td>
<td>early</td>
</tr>
</tbody>
</table>

**SUMMARY OF BEHAVIOR**

Identify the summary that will be used to build a plan of behavior support.

<table>
<thead>
<tr>
<th>Setting Events &amp; Predictors</th>
<th>Problem Behavior(s)</th>
<th>Maintaining Consequence(s)</th>
</tr>
</thead>
</table>

**How confident are you that the Summary of Behavior is accurate?**

<table>
<thead>
<tr>
<th>Not very confident</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Very Confident</th>
</tr>
</thead>
</table>

**What current efforts have been used to control the problem behavior?**

<table>
<thead>
<tr>
<th>Strategies for preventing problem behavior</th>
<th>Strategies for responding to problem behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>schedule change</td>
<td>reprimand</td>
</tr>
<tr>
<td>seating change</td>
<td>office referral</td>
</tr>
<tr>
<td>curriculum change</td>
<td>detention</td>
</tr>
<tr>
<td>mechanism</td>
<td>If 'sick', he goes home.</td>
</tr>
</tbody>
</table>

Appendix B
Functional Assessment with Program Coordinators

Functional Assessment Checklist for Teachers and Staff (FACTS-Part A)

Step 1
Student/Grade:
Interviewer:
Date: Oct 4, 2023
Respondent(s):

Step 2
Student Profile: Please identify at least three strengths or contributions the student brings to school.
Hardworking, polite, open to help

Step 3
Problem Behavior(s): Identify problem behaviors

<table>
<thead>
<tr>
<th>Tardy</th>
<th>Fight/physical Aggression</th>
<th>Disruptive</th>
<th>Theft</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unresponsive</td>
<td>Inappropriate Language</td>
<td>Insobordination</td>
<td>Vandalism</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>Verbal Harassment</td>
<td>Work not done</td>
<td>Other</td>
</tr>
<tr>
<td>Verbally Inappropriate</td>
<td></td>
<td>Self-injury</td>
<td>Anxiety</td>
</tr>
</tbody>
</table>

Describe problem behavior:

Step 4
Identifying Routines: Where, When and With Whom Problem Behaviors are Most Likely.

<table>
<thead>
<tr>
<th>Schedule (Times)</th>
<th>Activity</th>
<th>Likelihood of Problem Behavior</th>
<th>Specific Problem Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning Schoolwork, completing</td>
<td>Low</td>
<td>1 2 3 4 5 6</td>
<td>Overthinking</td>
</tr>
<tr>
<td>All day when he is not occupied</td>
<td>High</td>
<td>1 2 3 4 5 6</td>
<td>Stomach</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
</tbody>
</table>

Step 5
Select 1-3 Routines for further assessment: Select routines based on (a) similarity of activities (conditions) with ratings of 4, 5 or 6 and (b) similarity of problem behavior(s). Complete the FACTS-Part B for each routine identified.

---

## Functional Assessment Checklist for Teachers & Staff (FACTS-Part B)

### Step 1
Student/Grade: __________________________ Date: Oct 4, 2019
Interviewer: __________________________ Respondent(s): __________________________

### Step 2
**Routine/Activities/Context:** Which routine (only one) from the FACTS-Part A is assessed?

<table>
<thead>
<tr>
<th>Routine/Activities/Context</th>
<th>Problem Behavior(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most often in the morning</td>
<td>Visibly distraught &amp; physically sick</td>
</tr>
</tbody>
</table>

### Step 3
Provide more detail about the problem behavior(s):
-toolbar or text:
  - Head, sick to stomach, withdrawn
  - Daily, security affecting school & court once a week

### Step 4
What does the problem behavior(s) look like?
- toolbar or text:
  - Head, sick to stomach, withdrawn

### Step 5
How often does the problem behavior(s) occur?
- toolbar or text:
  - Daily

### Step 6
How long does the problem behavior(s) last when it does occur?
- toolbar or text:
  - All day

### Step 7
What is the intensity/level of danger of the problem behavior(s)?
- toolbar or text:
  - Level of danger = Low intensity for youth = high

### Step 8
What are the events that predict when the problem behavior(s) will occur? (Predictors)

<table>
<thead>
<tr>
<th>Related Issues (setting events)</th>
<th>Environmental Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness</td>
<td>reprimand/correction</td>
</tr>
<tr>
<td>Drug use</td>
<td>structured activity</td>
</tr>
<tr>
<td>Negative social</td>
<td>physical demands</td>
</tr>
<tr>
<td>Conflict at home</td>
<td>unstructured time</td>
</tr>
<tr>
<td>Academic failure</td>
<td>socially isolated</td>
</tr>
<tr>
<td>Other</td>
<td>with peers</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>tasks too boring</td>
</tr>
<tr>
<td></td>
<td>activity too long</td>
</tr>
<tr>
<td></td>
<td>tasks too difficult</td>
</tr>
</tbody>
</table>

### Step 9
What consequences appear most likely to maintain the problem behavior(s)?

<table>
<thead>
<tr>
<th>Things that are Obtained</th>
<th>Things Avoided or Escaped From</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult attention</td>
<td>Other: related to school</td>
</tr>
<tr>
<td>Peer attention</td>
<td>Reprimands</td>
</tr>
<tr>
<td>Preferred activity</td>
<td>Other: physical demands</td>
</tr>
<tr>
<td>Money things</td>
<td>Other: social isolation</td>
</tr>
<tr>
<td></td>
<td>Other: structured time</td>
</tr>
</tbody>
</table>

### Step 10
SUMMARY OF BEHAVIOR
Identify the summary that will be used to build a plan of behavior support.

<table>
<thead>
<tr>
<th>Setting Events &amp; Predictors</th>
<th>Problem Behavior(s)</th>
<th>Maintaining Consequence(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Step 11
How confident are you that the Summary of Behavior is accurate?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>Not very confident</td>
<td>Very Confident</td>
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</table>

### Step 12
What current efforts have been used to control the problem behavior?

<table>
<thead>
<tr>
<th>Strategies for preventing problem behavior</th>
<th>Strategies for responding to problem behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule change</td>
<td>Reprimand</td>
</tr>
<tr>
<td>Seating change</td>
<td>Office referral</td>
</tr>
<tr>
<td>Curriculum change</td>
<td>Detention</td>
</tr>
</tbody>
</table>

Appendix C
Consent Form

Appendix A: Consent Form

Project title: An Individual Counselling Program Designed to Decrease Anxiety in a 16-Year-Old Male Using Cognitive-Behavioural Techniques

Principal Investigator: Becky Loney

Name of supervisor: Dr. Susan Meyers

Name of Institution: St. Lawrence College

Name of partnering institution/agency: Alternative Learning Center

Invitation

You are being invited to take part in a research study. I am a student in my 4th year of the Behavioural Psychology program at St. Lawrence College. I am currently on placement at School for Success where you attend. As a part of this placement, I am completing a research project (called an applied thesis). I would like to ask you for your help to complete this project. The information in this form will help you understand my project. Please read the information carefully and ask all the questions you might have before you decide if you want to take part.

Why is this study being done?

My project is a counselling program designed to decrease anxiety symptoms.

The program will teach you about anxiety and ways to help manage any anxiety that you are feeling, especially in particularly stressful times.
Your anxiety levels before, during, and, after the program will be measured and used to determine if the program was helpful.

What will you need to do if you take part?

If you choose to take part in this study, you will be asked to take part in eight counselling sessions over four weeks. The sessions will be held on Monday and Thursday mornings at the agency and last about one hour. The session will be run by me. At the beginning of the first, third, fifth, and seventh session you will be asked to complete a questionnaire that will take you about 5 minutes to fill out. In addition, at the beginning of each session you will be asked to complete a rating scale that will take about one minute to complete and one at the end of the session that will also take about one minute to complete. Once the program is done, you will be asked to complete the questionnaire once a week for three or four weeks.

What are the potential benefits of taking part?

Benefits of taking part in this research study may include feeling less worried or anxious, learning how to relax when worries are overwhelming, and learning skills to help you in the future.

What are the potential benefits of this research study to others?

Results from this study may provide information and direction to future programs for youth who are experience anxiety. In turn, this may allow for more effective treatments in the future.

What are the potential disadvantages or risks of taking part?

Potential disadvantages or risks include not enjoying the sessions, feeling anxious during the sessions, less time to work on schoolwork, and being bored.

What happens if something goes wrong?

If something goes wrong and you experience anything uncomfortable or negative you can talk to me about it directly. If you do not feel comfortable talking to me you can talk to the agency coordinators or someone in the building you feel comfortable talking to. Whoever you decide to talk with will then inform me, and the agency coordinators, you, and I will discuss and move forward with a plan of action to solve the issue.
Will my information you collect from me in this project be kept private?

We will make every attempt to keep any information that identifies you strictly confidential. All documents will be free of any identifying information. No real names will be used on any document; they will all have a code number instead of your name. All information and documents will be kept on a password-protected USB that is stored at the agency. Only the researchers will have access to your data. You will not be identified by name in any reports, publications or presentations resulting from this study.

Do you have to take part?

Taking part is voluntary. It is up to you to decide whether or not to take part in this research project. If you do decide to take part, you will be asked to sign this consent form. If you do decide to take part in this research project, you are free to stop participating at any time, without giving any reason, and without any negative consequences. You also have the option to have your parents be informed about the research. This is your choice and will not have any negative consequences for you if you decide to have them informed or NOT to have them informed.

Contact for further information

This project has been approved by the Research Ethics Board at St. Lawrence College. The project has been developed under the supervision of Dr. Susan Meyers, my supervisor from St. Lawrence College. I really appreciate your cooperation and if you have any additional questions or concerns, feel free to ask me. You can also contact my College Supervisor (smeyers@kos.net) or you may also contact the Research Ethics Board at reb@sl.on.ca.

Consent

If you agree to take part in this research project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. The original consent form will be stored in a secure location at St. Lawrence College for 10 years, after which it will be destroyed.
By signing this form, I agree that:

- The study has been explained to me.

- All my questions were answered.

- Possible harm and discomforts and possible benefits of this study have been explained to me.

- I understand that I have the right not to participate and the right to stop at any time.

- I am free now, and in the future, to ask any questions I have about the study.

- I have been told that my personal information will be kept confidential.

- I understand that no information that would identify me will be released or printed without asking me first.

- I understand that I will receive a signed copy of this consent form.

- I hereby consent to take part.

Name of participant (print)     Signature of participant  Date

Name of person obtaining     Signature of person obtaining consent  Date
<table>
<thead>
<tr>
<th>Name of witness (print)</th>
<th>Signature of witness</th>
<th>Date</th>
</tr>
</thead>
</table>

Yes ☐  No ☐  I agree to have my parent(s) informed of the research.
### Appendix D
Baseline and Intervention BAI Raw Scores

<table>
<thead>
<tr>
<th>Week</th>
<th>Raw Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline 1</td>
<td>14</td>
</tr>
<tr>
<td>Baseline 2</td>
<td>16</td>
</tr>
<tr>
<td>Intervention 1</td>
<td>17</td>
</tr>
<tr>
<td>Intervention 2</td>
<td>11</td>
</tr>
<tr>
<td>Intervention 3</td>
<td>16</td>
</tr>
<tr>
<td>Intervention 4</td>
<td>12</td>
</tr>
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Appendix E
Therapist Guidelines

Therapist Guidelines

Becky Loney
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Session 1

**Agenda**
- Welcome participant
- Beck Anxiety Inventory
- Outcome Rating Scale
- Anxiety
- Teach CBT Model and Provide rationale for CBT approach
- Session Rating Scale

1. **Welcome Participant**
   - “Thank-you for meeting with me”, “how are things going for you today?” Etc.
   - Remind client of confidentiality
2. **Beck Anxiety Inventory**
   - Ask participant to complete the BAI
   - Remind participant to be completely honest
   - Administer the Beck Anxiety Inventory
3. **Outcome Rating Scale**
   - Demonstrate to the participant how to use the rating scale
   - Ask the participant to complete the rating scale
   - Remind participant to be completely honest
   - Administer the Outcome Rating Scale
4. **Anxiety**
   - Play clip from beginning and stop clip at 1:50min
     - [http://www.youtube.com/watch?v=m4ERGJQRyD0&feature=related](http://www.youtube.com/watch?v=m4ERGJQRyD0&feature=related)
5. **CBT Model and Rationale**
   - “Script”
     - I’m wondering if you can think of anything that happened in the last week that made you feel anxious or worried?
       - Find situation.
     - What was going through your mind when facing the situation
     - How did you feel during situation?
     - What did you do?
     - Did it make you feel better?
     - Did it make you feel worse?
       - Explain automatic thoughts
- What is going through your mind
- What you are saying to yourself
- Ex 1: when getting dressed in the morning you may say to yourself “I should wear a sweater because it might be cold out this morning. Maybe it is supposed to rain today I better wear it just in case. I can always take it off if I get too warm. Etc.
- Ex 2: You hear about a test, you may say to yourself “oh no, I’m going to fail. I’m going to forget everything. I can never remember anything.”
- Automatic thoughts aren’t always negative
- Ex 1: Getting dressed in the morning you may say “I can’t wait to wear my new sweater. It’s warm and I’m sure I will get a lot of compliments from it.”
- Ex 2: You hear about a test you could say “I’m ready for this test, I did the homework, if I start studying now I might be able to bring my mark up.”

- “You were able to tell me a few of those earlier, can you remember what they are?
  - Make a list
- “As you look at these how do they make you feel?”
- “Okay the next part is what you did. So you started thinking (summarize the automatic thoughts the participant identified) then you were feeling anxious or worried, then what did you do?”
- “CBT is based on two basic viewpoints:”
  - Write down on blank piece of paper then read aloud:
    - 1. Our thoughts influence our feelings and behaviour
    - 2. How we act can influence our thoughts and feelings
- Draw out cycle using “teen-friendly” language on a blank piece of paper
  - Event =situation
  - Cognitive Appraisal= what you were saying to yourself
  - Emotion= What you were feeling
  - Behaviour= what you ended up doing
- Use Example the participant provided earlier in the session
- “One of the reasons we use this is to look at where in the cycle we might be able to make some changes so that maybe we can have a different outcome in the other areas of the cycle.”

6. **Session Rating Scale**
   - Show the participant how to complete the rating scale
   - Ask the participant to complete the rating scale
   - Remind the participant the importance of honesty
   - Administer the rating scale
   - Leave the room while the participant completes the rating scale
References


Session 2

<table>
<thead>
<tr>
<th>Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome Participant</td>
</tr>
<tr>
<td>2. Outcome Rating Scale</td>
</tr>
<tr>
<td>3. Introduce Biopsychosocial model</td>
</tr>
<tr>
<td>4. Review CBT model</td>
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<tr>
<td>5. Identify Negative Thoughts</td>
</tr>
<tr>
<td>6. Psychoeducation on Automatic Thoughts</td>
</tr>
<tr>
<td>7. Homework</td>
</tr>
<tr>
<td>8. Session Rating Scale</td>
</tr>
</tbody>
</table>

1. **Welcome Participant**
   - “How are you?”, “I’m glad you could make it again” Etc.
   - Go over Agenda
   - Ask if there is anything the participant would like to add to the agenda or if there is anything specific the participant would like to discuss

2. **Outcome Rating Scale**
   - Ask the participant to complete the rating scale
   - Remind participant to be completely honest
   - Administer the Outcome Rating Scale

3. **Introduce Biopsychosocial Model**
   - “Last time we talked about anxiety and what anxiety is and you may be wondering what it has to do with you not feeling well. Some people believe in what is called the biopsychosocial model. Basically that means that what is going on around us, our physical health, and our mental health all affect each other. Sometimes when we have a lot of stress or worries and we don’t know how to deal with them our bodies turn these worries into physical symptoms that are unpleasant but you can deal with.”

4. **Review CBT Model**
   - “If you can remember the CBT model, with the situation, thoughts, feelings, and actions, and how they all influence each other, the biopsychosocial model is somewhat similar in the way that if you change one aspect of the cycle you can change the others”

5. **Identifying Negative thoughts**
   - “How have the last couple of days been?”
   - “Can you think of a situation where you were feeling particular worried or sick?”
   - “What were you doing?”
   - “How were you feeling” or “Can you recall what you were thinking at the time?”
If the participant is having a difficult time identifying thoughts try:

- **Guided imagery:**
  - 1. Pursue lines of questioning that stimulate emotion
  - 2. Be specific
  - 3. Focus on recent events instead of the distant past
  - 4. Stick with one line of questioning and one topic
  - 5. Dig deeper

- **Imagery:**
  - Ask the participant to go back and imagine being in the situation again

- **Role play:**
  - Take the role of a person in the participant’s life and try to simulate a situation that may stimulate automatic thoughts

6. **Psychoeducation of Automatic thoughts**
   - List the negative automatic thoughts the participant identified aloud
   - Ask participant if they see a relationship between the negative thoughts and the sick or worried feelings.
   - “If you can notice when you are thinking these negative thoughts, eventually you can start to test and challenge them”
   - Complete a Thought Record Form with the participant using the situation discussed

7. **Homework**
   - “So later today or tonight whenever you have time, to practice identifying those negative thoughts, complete one of these forms that we just completed together. If you don’t want to carry around this sheet or for more privacy, you can do the same thing on your cellphone and just text it to yourself and show me next time.”

8. **Session Rating Scale**
   - Ask the participant to complete the rating scale
   - Remind the participant the importance of honesty
   - Administer the rating scale
   - Leave the room while the participant completes the rating scale
References
Session 3

Agenda
- Welcome participant
- Beck Anxiety Inventory
- Outcome Rating Scale
- Bridge Session
- Cognitive Restructuring
- Homework
- Session Rating Scale

1. Welcome Participant
   - “It is nice to see you here again”, “Thanks for making it here today” Etc.

2. Beck Anxiety Inventory
   - Ask participant to complete the BAI
   - Remind participant to be completely honest
   - Administer the Beck Anxiety Inventory

3. Outcome Rating Scale
   - Ask the participant to complete the rating scale
   - Remind participant to be completely honest
   - Administer the Outcome Rating Scale

4. Bridge Session
   - Go over agenda with participant
   - Ask participant if there is anything he would like to add to the Agenda
   - Review and discuss homework

5. Cognitive Restructuring
   - Briefly describe Cognitive Errors and give the participant a handout of Cognitive Errors to take home (See Appendix A)
   - Go over Unhelpful Thinking Strategies and provide the participant with a handout (Appendix B)
   - Show participant the Thought Change Record Form (Appendix C)
   - Explain step-by-step how to complete the thought change record and complete the thought change record using an example as you explain each section:
     - Time, Date: Be as specific as possible about the time and date. Avoid writing "morning," or "when I got home." Sometimes, the time is important
for understanding pieces of the situation. Complete the thought change record form as soon after the situation as possible as later on it may be more difficult to recall important information and detail of the moment.

- **Situation:** Write a short statement, no more than a few sentences that sums up the situation. You may be tempted to describe the situations in detail, possibly trying to justify your reactions. All you need to do here jot down simple description that helps you remember the event later on.

- **Automatic Thoughts:** Writing down your thoughts is a little harder than it sounds. It takes a little practice to write them in a way that is helpful later on. Some things that may help are:
  - Write one thought at a time.
  - Don't write questions. Rewrite them as statements
  - Stay away from exclamatory statements like, "Oh darn!" or "Crap!" or "Oh great!"
  - Save feelings for the "Feeling/s" column. Thoughts are not feelings and feelings are not thoughts.
  - Automatic Thoughts can be images that come to mind. Some people tend to think more in images or pictures than with words. For example, instead of noticing a thought such as, "My boss will yell at me," a visual person might see his or her boss yelling, glaring and waving a finger. For the Automatic Thought/s column, you can go ahead and describe the image, but also try to write out what the image means to you in a thought or statement form.

- **Feelings:** Generally you will be writing one or two words at most. You might find this challenging at first. If you want we can create a feeling list together that may be helpful [If client indicates that this may be helpful write on a blank piece of paper possible feelings]. Make sure you write down what feelings you experience for each separate thought. It may be only one feeling, or it could be several.

- **Rating:** On a scale from 0 to 100 percent, you should rate how much you believe each separate thought. Zero percent would be absolutely no belief in the thought, while 100 percent indicates that you believe that the thought is absolutely true. It's not unusual to have a variety of thoughts about any situation, but you'll likely find that some thoughts are stronger than others.

- **Adaptive Responses:** Create more adaptive thoughts

- **Rating Adaptive Thoughts:** On a scale from 0 to 100 percent, you should rate how much you believe each separate thought. Zero percent would be absolutely no belief in the thought, while 100 percent indicates that you believe that the thought is absolutely true
- **Outcome:** Rate how much you believe the AT and write down the emotions and feelings you have now
- Help the participant complete a thought record form using one of his personal situations
- Strategies for helping the participant modify Automatic thoughts:
  - **Socratic Questioning:**
    - Ask questions that reveal opportunities for change
    - Ask questions that get results
    - Ask questions that get the patients involved in the learning process
    - Pitch questions at a level that will be productive for the client
    - Avoid asking leading questions
    - Use multiple-choice questions sparingly
  - **Generating Rational Alternatives**
    - Ask client to open their mind to possibilities [It may be helpful to have the client think like a “scientist” or imagine what a trusted friend or family member might say]
    - Ask client to try thinking like their old self
    - Brainstorm
  - **Examining the Evidence**
    - Use the “Examining the evidence” worksheet Appendix C) and write down evidence for and against the automatic thought
    - Have the client try to spot cognitive errors (if any) in the evidence for column
    - Help client revise and record a modified thought
  - **Decatastrophizing**
    - focus on correcting distorted predictions
    - work on preparing the client to cope with possible outcomes
  - **Reattribution**
    - Choose automatic thoughts that may respond to reattribution intervention
    - Explain attributional biases:
      - Internal vs. external
      - General vs. specific
      - Invariant vs. variable
    - Use a pie graph (Appendix D) to help the participant make healthier attributions
6. Homework
   • “Take the thought change record with you, or use your cellphone again, and as you notice your mood changing fill it out just as we have today. Continue using the TCR over the next couple of days and we will discuss them at our next session.”

7. Session Rating Scale
   • Ask the participant to complete the rating scale
   • Remind the participant the importance of honesty
   • Administer the rating scale
   • Leave the room while the participant completes the rating scale

End Session
   • Have client return SRS
   • Ask if client has anything else they need to discuss before leaving
   • Praise client for efforts and progress made in session
   • Share a mood enhancing activity, [e.g. an appropriate you-tube video, or listening to a song of client’s choice] in order to lighten client’s mood before returning to the classroom
References

Session Four

**Agenda**

- Welcome participant
- Outcome Rating Scale
- Bridge Session
- Goal Setting
- Basic Skills Training
  - Relaxation Training
  - Thought Stopping
  - Distraction
  - Breathing Retraining
- Homework
- Session Rating Scale

1. **Welcome Participant**
   - “It is nice to see you here again”, “Thanks for making it here today” Etc.

2. **Outcome Rating Scale**
   - Ask the participant to complete the rating scale
   - Remind participant to be completely honest
   - Administer the Outcome Rating Scale

3. **Bridge Session**
   - Go over agenda with participant
   - Ask participant if there is anything he would like to add to the Agenda
   - Review and discuss homework: Thought Change Record
4. Goal Setting

- Educate participant on goal-setting techniques
  - “We’ve been chatting for a while now and I think we have a good understanding of what is bothering you as well as some of your strengths. What do you think about trying to set some goals for treatment?”

- Show the participant a copy of the SMART Goals acronym (See Appendix A) on a separate sheet of paper

- “To help us set goals that are effective there is an Acronym we can use to make sure we are setting good goals.”
  - S- Specific “Our goals need to be specific and defined”
  - M- Measurable “If we can measure our goals we will know when we have achieved them and what progress has been made”
  - A- Attainable “Make sure your goal is important to you and that you have a way of making it happen”
  - R- Realistic “Your goal must be something you are both willing and able to work on.”
  - T- Timely “Set yourself a time frame to complete the Goal”

- Collaboratively establish a short-term and long term-goal with the participant

5. Basic Skills Training

- Visualization
  - Use script (Appendix B) to guide the participant to a relaxing place
• Thought Stopping
  
  o “Thought stopping aims to stop automatic negative thoughts and replace them with more adaptive thoughts. There are a couple of steps to do this”
  
  • **Recognize** the automatic negative thoughts
  
  • **“Give a self-command to stop the thought**, for example tell yourself in a demanding way, ‘STOP!’, or ‘Quit thinking like that!’ you can do say this aloud or in your head.”
  
  • **Visualize** to make the command more effective, for example, picture a stop sign, or red light, or a hand sticking out”
  
  • **Switch the Image** from the stop sign or whichever you choose to something pleasant or relaxing for example, a vacation you went on, or your favorite person or place or photo”.

  o Practice the thought stopping technique a couple of times in session and ask participant for feedback, and then make any necessary changes.

• Distraction

  o “Distraction is used to lessen the impact of worrisome thoughts. There are a number of things you can do to distract yourself from the anxiety. Let’s make a list of some things you could do” [make a written list with the participant].

  • Commonly used distractions include: reading, going to the movies, hanging out with friends, or working on a hobby or project.

• Breathing Retraining

  o See and complete script (Appendix C)
6. **Homework**

- Negotiate particular times when the participant will practice the breathing exercises. Problem-solve about which times would be best.

7. **Session Rating Scale**

- Ask the participant to complete the rating scale
- Remind the participant the importance of honesty
- Administer the rating scale
- Leave the room while the participant completes the rating scale

**End Session**

- Have client return SRS
- Ask if client has anything else they need to discuss before leaving
- Praise client for efforts and progress made in session
- Review key points
- Give and elicit feedback
- Share a mood enhancing activity, [e.g. an appropriate you-tube video, or listening to a song of client’s choice] in order to lighten client’s mood before returning to the classroom
References

Session Five

**Agenda**

- Welcome participant
- Beck Anxiety Inventory
- Outcome Rating Scale
- Bridge Session
- Develop anxiety hierarchy
- Imaginal Exposure
- Homework: Practice relaxation
- Session Rating Scale

1. **Welcome Participant**
   
   - “Glad you could make it”, “Thanks for making it here today” Etc.

2. **Beck Anxiety Inventory**
   
   - Ask participant to complete the BAI
   - Remind participant to be completely honest
   - Administer the Beck Anxiety Inventory

3. **Outcome Rating Scale**
   
   - Ask the participant to complete the rating scale
   - Remind participant to be completely honest
   - Administer the Outcome Rating Scale

4. **Bridge Session**
   
   - Go over agenda with participant
   - Ask participant if there is anything he would like to add to the Agenda
   - Review and discuss homework

5. **Develop Anxiety Hierarchy** (Wright, Basco, & Thase, 2006)
• On a blank sheet of paper work together with the participant to identify anxiety provoking situations.
  ○ Write out specific and clear descriptions of the stimuli

• Ask the participant to rate the situations for amount of expected anxiety [use a scale of 0-100; 0 being no anxiety and 100 being the greatest anxiety]

• Arrange the situations on a new blank piece of paper in a list with the most anxiety provoking situation on the top and the least anxiety provoking situation on the bottom.
  ○ If the participant does not list situations with varying degrees of anxiety help him list steps with a range of ratings, low, midrange, and high.

6. Imaginal Exposure (Wright, Basco, & Thase, 2006)

• Using the relaxation techniques taught in the previous session, help guide the participant into a relaxed state

• Once the participant is relaxed present the least anxiety provoking situation.
  ○ Try to use environmental cues to generate vivid images
  ○ Use cognitive restructuring, relaxation, or thought stopping to decrease anxiety
    ▪ Coach the participant on ways to cope with the anxiety
    ▪ Check in frequently with the participant about what level his anxiety is- if it has increased as he imagines the stimulus, have him deepen his relaxation, looking at where he feels the anxiety
• For example: if you notice him clenching his jaw, you might repeat the jaw relaxing part of the relaxation instructions, etc.

• Present the rest of the situations in a hierarchical manner
  o Do not move up the hierarchy until the participant can imagine the situation with only a minimal amount of anxiety.

Ask the participant to choose the specific steps

7. **Homework**

• Ask the participant to continue practicing the preferred methods for relaxation, recognizing levels of anxiety and feelings before and after the exercises.

8. **Session Rating Scale**

• Ask the participant to complete the rating scale

• Remind the participant the importance of honesty

• Administer the rating scale

• Leave the room while the participant completes the rating scale

**End Session**

• Have client return SRS

• Ask if client has anything else they need to discuss before leaving

• Praise client for efforts and progress made in session

• Share a mood enhancing activity, [e.g. an appropriate you-tube video, or listening to a song of client’s choice] in order to lighten client’s mood before returning to the classroom
References

Session Six

**Agenda**

- Welcome participant
- Outcome Rating Scale
- Bridge Session
- Continue Imaginal Exposure
- Homework
- Session Rating Scale

1. **Welcome Participant**
   - “How are you doing today?”, “Good to see you, glad you could make it” Etc.

2. **Outcome Rating Scale**
   - Ask the participant to complete the rating scale
   - Remind participant to be completely honest
   - Administer the Outcome Rating Scale

3. **Bridge Session**
   - Go over agenda with participant
   - Ask participant if there is anything he would like to add to the Agenda
   - Review and discuss homework

4. **Continue Imaginal Exposure**
   - Using the relaxation techniques from the previous sessions, help guide the participant into a relaxed state
   - Once the participant is relaxed, continue working up the hierarchy, developed with the participant from the last session, pairing imaginal exposure and relaxation
   - Tips to Remember when using imaginal exposure:
     - Try to use environmental cues to generate vivid images
o Use cognitive restructuring, relaxation, or thought stopping to decrease anxiety
  ▪ Coach the participant on ways to cope with the anxiety
o Check in frequently with the participant about what level his anxiety is- if it has increased as he imagines the stimulus, have him deepen his relaxation, looking at where he feels the anxiety.
  ▪ For example: if you notice him clenching his jaw, you might repeat the jaw relaxing part of the relaxation instructions, etc
o Present the rest of the situations in a hierarchical manner
  ▪ Do not move up the hierarchy until the participant can imagine the situation with only a minimal amount of anxiety.
  ▪ Ask the participant to choose the specific steps

5. **Homework**
   - Ask the participant to continue practicing the preferred methods for relaxation paired with the anxiety provoking situations already mastered in the sessions.
   - Ask the participant to complete the rating scale
   - Remind the participant the importance of honesty
   - Administer the rating scale
   - Leave the room while the participant completes the rating scale

**End Session**
   - Have client return SRS
   - Ask if client has anything else they need to discuss before leaving
   - Praise client for efforts and progress made in session
• Share a mood enhancing activity, [e.g. an appropriate you-tube video, or listening to a song of client’s choice] in order to lighten client’s mood before returning to the classroom
References

Session Seven

**Agenda**
- Welcome participant
- Beck Anxiety Inventory
- Outcome Rating Scale
- Bridge Session
- Review Skills Learned
- Homework
- Session Rating Scale

1. **Welcome Participant**
   - “Glad you could make it”, “Thanks for making it here today” Etc.

2. **Beck Anxiety Inventory**
   - Ask participant to complete the BAI
   - Remind participant to be completely honest
   - Administer the Beck Anxiety Inventory

3. **Outcome Rating Scale**
   - Ask the participant to complete the rating scale
   - Remind participant to be completely honest
   - Administer the Outcome Rating Scale

4. **Bridge Session**
   - Go over agenda with participant
   - Ask participant if there is anything he would like to add to the Agenda
   - Review and discuss homework

5. **Review Skills Learned**
   Ask the participant what they can remember or tell you about the following concepts and then review the main idea of each concept:
• CBT Model
  o Our thoughts, feelings, and behaviour all impact each other. By changing one area we can change the others.
• Biopsychosocial Model
  o Our feelings, thoughts, behaviour, physical health impact each other
• Automatic Thoughts
  o Identifying Automatic thoughts:
    ▪ Guided imagery:
      • 1. Pursue lines of questioning that stimulate emotion
      • 2. Be specific
      • 3. Focus on recent events instead of the distant past
      • 4. Stick with one line of questioning and one topic
      • 5. Dig deeper
    ▪ Imagery:
      • Ask the participant to go back and imagine being in the situation again
    ▪ Notice mood change:
      • Notice when your mood changes and make a conscious effort to notice what you are thinking or saying to yourself
  o Challenging Automatic Thoughts:
    ▪ Examining the Evidence
      • write down evidence for and against the automatic thought
    ▪ Decatastrophizing
      • Focus on correcting distorted predictions
  o Altering Automatic Thoughts
  o Generating Rational Alternatives
    ▪ open your mind to possibilities [It may be helpful to think like a “scientist” or imagine what a trusted friend or family member might say]
    ▪ Try thinking like your “old self”
    ▪ Brainstorm
• Basic Skills
  o Visualization
    ▪ Find your “Peaceful Place”
  o Thought Stopping
- Recognize the automatic negative thoughts, tell yourself to stop and visualize a stop sign, then switch the stop sign to something more pleasant (Maybe your peaceful place)
  - Distraction
    - Just what it sounds like, find an activity that will distract you from your worries. Make sure you are not *only* using distraction to cope.
- Breathing Retraining
  - Use the breathing exercise APP on your Iphone [Breathe2relax]
- Imaginal Exposure
  - Pairing anxiety-provoking situations with relaxation

6. **Homework**
   - Create a list of the skills and techniques you are most likely to use when feeling anxious.

7. **Session Rating Scale**
   - Ask the participant to complete the rating scale
   - Remind the participant the importance of honesty
   - Administer the rating scale
   - Leave the room while the participant completes the rating scale

**End Session**

- Have client return SRS
- Ask if client has anything else they need to discuss before leaving
- Praise client for efforts and progress made in session
• Share a mood enhancing activity, [e.g. an appropriate you-tube video, or listening to a song of client’s choice] in order to lighten client’s mood before returning to the classroom
References

# Session Eight

## Agenda
- Welcome participant
- Outcome Rating Scale
- Bridge Session
- Prevention
- Session Rating Scale
- Terminate program

## 1. Welcome Participant
- “Hi, how are things?”, “Glad you could make it” Etc.

## 2. Outcome Rating Scale
- Ask the participant to complete the rating scale
- Remind participant to be completely honest
- Administer the Outcome Rating Scale

## 3. Bridge Session
- Go over agenda with participant
- Ask participant if there is anything he would like to add to the Agenda
- Review and discuss homework

## 4. Prevention
- Have client share his list of techniques most likely to use from the homework assignment. Work with the client to develop helpful hints and tips to add to the list.
  - Ask the participant to create a “Coping Page” in the note section of his cellphone; copy the list the client has just made into the phone.
- Remind client that they have the skills to deal with their anxiety and that they now have some tips right in their pocket to help them if they are having some difficulty.

## 5. Session Rating Scale
• Ask the participant to complete the rating scale
• Remind the participant the importance of honesty
• Administer the rating scale
• Leave the room while the participant completes the rating scale

6. Terminate Session

• Have client return SRS
• Ask the client if they have any questions or concerns [about program termination]
  ○ Address all questions and concerns
• Suggest a referral if appropriate
  ○ Inform the participant of how to seek a helping professional for future reference
• Ask if client has anything else they need to discuss before leaving
• Praise client for efforts and progress made in program
  ○ Emphasize changes and gains were because of the participant not the helper
• Share a mood enhancing activity, [e.g. an appropriate you-tube video, or listening to a song of client’s choice] in order to lighten client’s mood before returning to the classroom
References

Appendix F
Visual Representation of Baseline and Intervention BAI Scores
Appendix G
Outcome Rating Scale Raw Data

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Appendix H

Visual Representation of ORS Scores

![Graph showing the trend of ORS scores across sessions.](image-url)
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Appendix J
Visual Representation of SRS Scores